

MINIMUM STANDARDS FOR AGE AND DISABILITY INCLUSION IN HUMANITARIAN ACTION

Pilot Version



This pilot version of the Minimum Standards for Age and Disability Inclusion in Humanitarian Action was written by Sarah Collinson as part of ADCAP (Age and Disability Capacity Building Programme), on behalf of the Age and Disability Consortium, a group of seven agencies working to promote age and disability inclusive humanitarian assistance: CBM, DisasterReady.org, Handicap International, HelpAge International, IFRC, Oxford Brookes University and RedR UK.

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The Minimum Standards for Age and Disability Inclusion in Humanitarian Action is published as a pilot version for dissemination and use, in order to generate feedback for future versions.

During this pilot phase, the Age and Disability Consortium is holding a series of consultations to gather feedback from key stakeholders in humanitarian response, including disabled people’s organisations (DPOs), older people’s associations (OPAs), mainstream or generalist humanitarian agencies (UN, international and national NGOs, IFRC and Red Cross, Red Crescent National Societies, government agencies), and organisations specialised in ageing and in disability.

Methods include workshops in selected countries, discussions with key stakeholders, and desk reviews. The consultations, amongst other things, look at the extent to which the Minimum Standards fill a gap in guidance for the humanitarian sector, their consistency with other standards and legal instruments and potential areas for further development.

The pilot version of the Minimum Standards is also being tested in a limited number of humanitarian projects by agencies implementing the ADCAP programme. The testing aims to provide feedback for the

revision of the Minimum Standards, by considering, amongst other things, the relevance, usefulness and applicability of the current pilot version. This process will also track the effectiveness of the application of the standards in supporting humanitarian workers to develop programmes that respond to the needs of older people and people with disability. Methods include surveys, key informant interviews, focus group discussions with humanitarian workers, local authorities, older women and men, and women, men, boys and girls with disabilities, and other relevant stakeholders.

The results of the consultations and testing will be used to inform a revised version of the document, and to define a further strategy for endorsement and roll out.

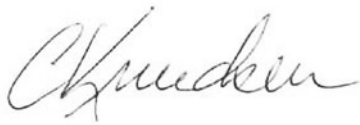
We are keen to receive additional feedback from users to complement this process. We would like to know how you have used the standards, which parts you have found particularly helpful and which ones less so, as well as gaps and suggestions for improvement. Please send your feedback or expressions of interest to participate in the formal consultation and feedback process to ADCAP@helppage.org. You can also use this email address to sign up to our newsletter for general updates about the ADCAP programme and the testing and consultation on the Minimum Standards.

The humanitarian principle of impartiality – providing assistance on the basis of need alone – requires that humanitarian actors must respond in a way that considers the needs of all people affected by a crisis as they determine priorities. Yet it is widely acknowledged that the humanitarian system still suffers from a blind spot on questions of disability and ageing.

Some 15 per cent of the world's population is living with some kind of disability today, and more than 1 in 8 people are already over the age of 60, with that number rising. The exclusion of older people and persons with disabilities from humanitarian assistance – or unintentionally hindering their access to such assistance – is much more than a blind spot; in reality it undermines the fundamental principle of impartiality and contributes to discrimination rather than supporting recovery.

To advance humanitarian quality and accountability, non-discrimination and inclusion of all vulnerable groups is essential. The Sphere Project was established with two fundamental beliefs at its core: that all of those affected by crisis have a right to life with dignity and that all possible steps must be taken to alleviate suffering in these crises. With the publication of these Minimum Standards for Age and Disability, practitioners and organizations have even stronger support and clear illustrations of what this means in practice and what actions can be taken.

The specific needs of older men and women, persons with disabilities, and carers are diverse and vary by context. These Minimum Standards for Age and Disability Inclusion in Humanitarian Action represent an important and extremely welcome step towards promoting and improving actions to address the needs of all, at all stages of a response, with principled impartiality.



Christine Knudsen, Director, The Sphere Project

1. INTRODUCTION

1.1 BACKGROUND

Humanitarian crises affect each person differently depending on their gender, age, disability and other personal characteristics. Older people and people with disabilities are often overlooked in humanitarian relief and response and they may find it harder than others to access the assistance and protection they need. The humanitarian principle of *impartiality* – providing assistance on the basis of need and without discrimination – requires agencies working in emergencies to reduce barriers so that people with disabilities and older people are not purposefully or inadvertently excluded from the humanitarian response.

The Minimum Standards for Age and Disability Inclusion in Humanitarian Action have been developed for use by all practitioners involved in humanitarian response, including staff and volunteers of local, national, and international humanitarian agencies, with the expectation that the inclusion of people with disabilities and older people is feasible at every stage of the response and in every sector and context. The Standards are intended to inform the design, implementation, monitoring and evaluation of humanitarian programmes; to strengthen accountability to people with disabilities and older people; and to support advocacy, capacity-building and preparedness measures on age and disability across the humanitarian system.

The Standards are drawn from a wide-ranging review of existing guidance and standards developed by humanitarian actors over recent years. This includes material from organisations with a special focus on disability and/or older age, together with key documents, including the Sphere Handbook,¹ the Sphere Companion Standards² and the Core Humanitarian Standard on Quality and Accountability (CHS).³ The Minimum Standards for Age and Disability

Inclusion do not create entirely new demands on humanitarian actors; rather, they clarify and reinforce what is already required if broader standards of impartial humanitarian programming and the principles of the Humanitarian Charter are to be upheld.

While generic standards on quality and accountability have helped to improve the overall coverage of humanitarian response, there is still a need for more relevant and systematic approaches to ensure the inclusion of older people and people with disabilities. Both (overlapping) groups are affected by many of the same or very similar barriers to access and participation, and there are simple measures that can be taken by humanitarian organisations to address these barriers by adapting existing programmes.

This pilot version of the Minimum Standards for Age and Disability Inclusion is intended as a live document to be adapted on the basis of on-going consultation and field testing (**see text box on page 1**). Feedback on the current version should be submitted via ADCAP@helpage.org

1.2 STRUCTURE OF THE MINIMUM STANDARDS

The Minimum Standards consist of eight Key Inclusion Standards and accompanying Sector-specific Standards.

The Key Inclusion Standards are derived from the first eight of the Nine Commitments of the Core Humanitarian Standard on Quality and Accountability (CHS). Gender-sensitivity and protection are incorporated as cross-cutting themes across all the Standards, with protection also included as a set of Sector-specific Standards. The role of carers is also included as a cross-cutting theme; this represents a crucial aspect of inclusive humanitarian programming that has so far not received the attention it deserves.

Each set of Sector-specific Standards relates to a particular theme (eg water, sanitation and hygiene (WASH), nutrition, health). These are intended for use by humanitarian technical teams and coordination mechanisms, including clusters, with reference to the Key Inclusion Standards; they are not designed to be used in isolation.

1. Available at www.spherehandbook.org/en/

2. These currently consist of the Livestock Emergency Guidelines and Standards (LEGS), the Small Enterprise Education and Promotion Network's Minimum Economic Recovery Standards (MERS), the Child Protection Working Group (CPWG) Minimum Standards for Child Protection in Humanitarian Action (www.sphereproject.org/sphere/en/about/companionships/child-protection-working-group/) and the Inter-Agency Network for Education in Emergencies (INEE) Minimum Standards for Education Preparedness, Response, Recovery (www.sphereproject.org/sphere/en/about/companionships/inter-agency-network-for-education-in-emergencies/). These Standards draw from the latter two in particular.

3. Available at www.corehumanitarianstandard.org/the-standard

MINIMUM STANDARDS FOR AGE AND DISABILITY INCLUSION IN HUMANITARIAN ACTION

KEY INCLUSION STANDARDS

The implementation of the standards needs to take into account how disability and age can affect women, men, girls and boys differently and ensure that people with disabilities and older people receive humanitarian assistance that is responsive to their gender-specific vulnerabilities, needs and capacities.

Across all sectors, people with disabilities and older people affected by crisis:

- 1. Are recognised to ensure they receive assistance that is appropriate and relevant to their needs.**
- 2. Have access to the humanitarian assistance they need.**
- 3. Are not negatively affected, and are more prepared, resilient and less at-risk as a result of humanitarian action.**
- 4. Know their rights and entitlements, have access to information, and participate in decisions that affect them on an equal basis with others.**
- 5. Have access to safe and responsive mechanisms to handle complaints on an equal basis with others.**
- 6. Receive and participate in coordinated and complementary assistance on an equal basis with others.**
- 7. Can expect improved assistance and inclusion as organisations learn from experience and reflection.**
- 8. Receive assistance from competent and well-managed staff and volunteers who are skilled and equipped to include them in humanitarian responses, and they have equal opportunities for employment and volunteering in humanitarian organisations.**

SECTOR-SPECIFIC STANDARDS FOR:

PROTECTION

**WATER, SANITATION
AND HYGIENE**

**FOOD SECURITY
AND LIVELIHOODS**

NUTRITION

**SHELTER, SETTLEMENT
AND NON-FOOD ITEMS (NFI_s)**

HEALTH

EMERGENCY EDUCATION

Each of the Key Inclusion Standards and each set of Sector-specific Standards are supported by a series of related Actions. Humanitarian actors should apply the Standards and implement those supporting Actions that are directly relevant to their areas of programming. The intention is that *collectively*,

humanitarian organisations, including coordination mechanisms such as clusters, will use the Standards to the maximum extent possible, to ensure an inclusive response overall. Each set of Sector-specific Standards includes case studies and a list of recommended documents for more detailed guidance.

1.3 USING THE MINIMUM STANDARDS

The main aim of this document is to support the inclusion of older people and people with disabilities in the programmes of all humanitarian organisations. Recognising that some people have specific needs requiring particular expertise, these Standards also encourage partnership and coordination with specialist organisations and associations representing people with disabilities or older people.

The Minimum Standards provide guidance for the delivery of humanitarian response that includes women, men, girls and boys of all ages and abilities equally. Gender, age and disability intersect to influence an individual's access to protection and assistance in times of crisis, for example through multiple layers of discrimination, or legal, social or cultural barriers. The analysis of age and disability is a key contributor to a strong gender analysis. Humanitarian programmes that are based on this understanding will directly contribute to realising equal access and opportunities.

The Key Inclusion Standards should be achievable from the early stage of a crisis. However, not every Sector-specific Standard will be equally applicable in this early phase. In situations of longer-term engagement in crisis-affected contexts, it should be possible to meet the Standards more comprehensively. Humanitarian actors should use the Actions suggested under each Standard to help identify what is immediately feasible and relevant to their context and what requires action in the longer-term. Anticipating and preparing for inclusion in advance of a crisis means that the needs of older people and people with disabilities will be met more effectively during the acute phase, and beyond as the response evolves. The Standards are designed to be relevant to all settings, including rural/urban communities and camps/non-camp settlements.

1.4 KEY DEFINITIONS: 'PEOPLE WITH DISABILITIES', 'OLDER PEOPLE' AND 'CARERS'

For the purposes of these Standards:

People with disabilities include women, men, girls and boys with long-term physical, mental, intellectual or sensory impairments which, in interaction with various barriers, may hinder their full and effective participation in society on an equal basis with others (see Article 1 of the UN Convention on the Rights of Persons with Disabilities).

Older people: The concept of older age must be understood in broad terms. In many countries and cultures, being considered old is not necessarily a matter of age, but it is rather linked to circumstances such as being a grandparent, or showing physical signs such as white hair. Where people live in hardship, some of the conditions that can be associated with older age, such as mobility problems or chronic disease, are present at younger ages. While many sources use the age of 60 and above as a definition of old age, a cut-off point of 50 years and over may be more appropriate in many contexts where humanitarian crises occur.

Carers are women, men, girls and boys who care for or nurse a relative, friend or partner requiring this support due to physical or mental ill health, disability, older age, frailty, substance misuse or any other cause.⁴

The systematic inclusion of people with disabilities and older people in data collection is essential to inclusive programming and is flagged up as a Key Action in the Minimum Standards. Annex I provides further information on collecting sex-, age- and disability-disaggregated data.

4. Adapted from Carers Worldwide, *Unpaid family carers – the scale of the issue in low and middle income countries*: www.ucl.ac.uk/lc-ccr/seminars/resources/Anil_Patil_Unpaid_Family_Carers_10th_Feb_2015.pdf

1.5 SUPPORTING PRINCIPLES

The Minimum Standards are based on the following overarching principles:

Principled humanitarian action: ensuring that humanitarian organisations offer services on the basis of the principles of humanity and the humanitarian imperative, recognising the fundamental rights of all people affected by disaster and conflict, including the right to life with dignity, the right to receive humanitarian assistance, and the right to protection and security. These fundamental principles apply to everyone affected by disaster and conflict, including persons with disabilities and older people.

Non-discrimination: ensuring that all of the affected population including older women and men, and women, men, girls and boys with disabilities can access assistance and benefit from humanitarian response on an equal basis with others.

Meaningful access: ensuring that any barriers affecting the access and participation of people with disabilities and older people in humanitarian assistance and protection are addressed.

Respect for the inherent dignity of people with disabilities and older people: ensuring that people with disabilities and older people are respected as having an active role in their families and communities, and in their own lives. An inclusive humanitarian response requires staff to be aware of disability and age and of how to respect and communicate with these groups.

Active and effective participation and equality of opportunities: ensuring that people with disabilities and older people participate in all aspects of the humanitarian response on an equal basis with others.

Respect for diversity, including equality between women, men, girls and boys of all ages: ensuring that all persons with disabilities and older people receive the assistance and protection that they need during a humanitarian response.

Recognition of the essential role of carers: ensuring the contribution provided by carers is recognised and their needs are supported, and acknowledging the fact that many people with disabilities, children and older people are themselves carers.

2. KEY INCLUSION STANDARDS⁵



The implementation of the Standards needs to take into account how disability and age can affect women, men, girls and boys differently and ensure that people with disabilities and older people receive humanitarian assistance that is responsive to their gender-specific vulnerabilities, needs and capacities.

KEY INCLUSION STANDARD 1:

People with disabilities and older people affected by crisis are recognised to ensure they receive assistance that is appropriate and relevant to their needs.

KEY INCLUSION STANDARD 2:

People with disabilities and older people affected by crisis have access to the humanitarian assistance they need.

KEY INCLUSION STANDARD 3:

People with disabilities and older people affected by crisis are not negatively affected and are more prepared, resilient and less at-risk as a result of humanitarian action.

KEY INCLUSION STANDARD 4:

People with disabilities and older people affected by crisis know their rights and entitlements, have access to information and participate in decisions that affect them on an equal basis with others.

KEY INCLUSION STANDARD 5:

People with disabilities and older people affected by crisis have access to safe and responsive mechanisms to handle complaints on an equal basis with others.

KEY INCLUSION STANDARD 6:

People with disabilities and older people affected by crisis receive and participate in coordinated, complementary assistance on an equal basis with others.

KEY INCLUSION STANDARD 7:

People with disabilities and older people affected by crisis can expect improved assistance and inclusion as organisations learn from experience and reflection.

KEY INCLUSION STANDARD 8:

People with disabilities and older people affected by crisis receive the assistance they require from competent and well-managed staff and volunteers who are skilled and equipped to include them in humanitarian responses, and they have equal opportunities for employment and volunteering in humanitarian organisations.

5. Based on the first eight of the nine Commitments of the Core Humanitarian Standard on Quality and Accountability (CHS).

KEY INCLUSION STANDARD 1:
People with disabilities and older people affected by crisis are recognised to ensure they receive assistance that is appropriate and relevant to their needs.

▶ ACTIONS TO MEET THE STANDARD

1.1 Systematically include people with disabilities and older people in data collection, registration and all assessments. Use this data to support the design, implementation, monitoring and evaluation of inclusive humanitarian responses. For example:

- Actively collect sex-, age- and disability-disaggregated data (SADDD) throughout the course of programmes.
- Collect and use the most reliable available data on, or estimates of, disability and older age within the affected population.
- Where national data is unreliable, plan on the assumption that 15 per cent of the population have some kind of disability⁶ and some 12.5+ per cent are aged 60+.⁷
- Use selected questions to allow for basic disaggregation of data on disability, activity and participation, as well as the need for services. Train personnel to use these (see **Annex I**).

1.2 Ensure participatory needs, vulnerability, capacity and all other assessments include direct and meaningful consultation with people with disabilities and older people, and their carers, to identify and address specific risks and barriers that affect them, and their capacity to participate in the response. For example:

- Use initial assessments to identify and include particularly vulnerable and excluded people with disabilities and older people.
- Use outreach action to identify groups who are not visible in usual assessments as soon as possible and maintain this process over time.
- Create protocols for sharing of data and referral processes between agencies, programmes and services, to avoid duplication in assistance and ensure data protection.

KEY INCLUSION STANDARD 2:
People with disabilities and older people affected by crisis have access to the humanitarian assistance they need.⁸

▶ ACTIONS TO MEET THE STANDARD

2.1 Design all sectoral humanitarian responses to maximise accessibility of services and inclusion of people with disabilities and older people. For example:

- Develop and provide services, infrastructure, communication and information using the principles of universal design.⁹
- Ensure humanitarian assistance and services meet the sector-specific age and disability minimum standards that follow in this document.

6. World Health Organization (WHO) (2014) Disability and health. Fact sheet No.352. Geneva: WHO. Retrieved at: www.who.int/mediacentre/factsheets/fs352/en/

7. UNHCR (2013) Working with older persons in forced displacement. Need to Know Guidance 5. Geneva: UNHCR. Retrieved at www.refworld.org/pdfid/4ee72aaf2.pdf

8. See also Sphere Protection Principle 2.

9. The design of products, environments, programmes and services to be usable by all people. The intent of universal design is to simplify life for everyone and it can benefit people of all ages and abilities. For further information, see: universaldesign.ie/Built-Environment/Building-for-Everyone

2.2 Adapt budgets to include costs for accessible services according to the needs of the community.¹⁰ For physical accessibility (buildings and latrines), budget an additional 0.5-1 per cent. To also include specialised non-food items (NFIs) and mobility equipment, budget 3-4 per cent. Include a transport budget for people with mobility challenges and their carers to access services.

2.3 Routinely identify, monitor and address barriers affecting participation and access to services for people with disabilities and older people. Take consideration of:

- Gender-specific factors (eg heightened risks of gender-based violence).
- Obstacles faced in accessing specific services (eg physical barriers affecting people with mobility-related limitations or visual impairments, communication barriers affecting people with hearing or intellectual impairments, or caring responsibilities).
- Discrimination and other attitudinal barriers (including attitudes of humanitarian service providers and community members) and social stigma affecting particular groups.

2.4 Encourage and support outreach services, community members, groups and organisations representing people with disabilities or older people to identify those who are not accessing services. Identify barriers and potential solutions to discrimination or exclusion, applying a gender analysis.

2.5 Refer people with disabilities and older people with specific needs to organisations with the relevant technical expertise and mandate, and advocate for those needs to be addressed.

KEY INCLUSION STANDARD 3:

People with disabilities and older people affected by crisis are not negatively affected and are more prepared, resilient and less at-risk as a result of humanitarian action.

► **ACTIONS TO MEET THE STANDARD**

3.1 Create and sustain an inclusive environment for people with disabilities and older people. Ensure that all activities promote and protect the inclusion and safety of these groups.¹¹ For example:

- Encourage national and local duty bearers to respect the rights, needs and capacities of people with disabilities and older people (including those who are refugees or internally displaced).
- Support culturally and gender-sensitive community awareness-raising initiatives to address negative attitudes and actions at the local level.

3.2 Include people with disabilities and older people, and their carers, in mechanisms to assess and reduce risks to vulnerable groups. These should include policies to prevent sexual exploitation, abuse or discrimination, taking into account the heightened risks for these groups. Systematically monitor humanitarian programmes to ensure that people with disabilities and older people are not exposed to additional risks or harm as a consequence of humanitarian action.¹²

3.3 Ensure that people with disabilities and older people, and their carers, are informed of their relief entitlements, the targeting criteria being used and the mechanisms through which they will receive assistance, to minimise risk of abuse by humanitarian actors or community members.¹³ Establish codes of conduct, protection policies, transparent decision-making and reporting mechanisms for the delivery of assistance. Put in place measures to protect the dignity and safety of older people and people with disabilities at distribution sites and when using other essential services. Consider specific risks to women, girls, boys and men.¹⁴

10. DFID 2013 'DFID Policy on Standards of Accessibility for Disabled People' notes that incorporating accessibility through Universal Design is cost-effective, accounting for less than 1 per cent of total construction costs. The cost of making adaptations after a building is completed is far greater. Available at: www.gov.uk/government/uploads/system/uploads/attachment_data/file/273923/DFID-Policy-standards-accessibility-disabled-people_.pdf

11. See also Sphere Protection Principle 3.

12. See also Sphere Protection Principle 1.

13. See also Sphere Protection Principle 4.

14. See also Sphere Protection Principle 4.

3.4 Be sensitive to protection risks that could arise from measures to facilitate access to assistance for people with disabilities, older people and other vulnerable groups (eg prioritising them for assistance may increase stigma and the risk of theft or even violence). Consider the impact of such measures, ensuring they do not increase risks for particular individuals or groups (take account of gender roles and social and cultural contexts).¹⁵

KEY INCLUSION STANDARD 4:
People with disabilities and older people affected by crisis know their rights and entitlements, have access to information and participate in decisions that affect them on an equal basis with others.

► **ACTIONS TO MEET THE STANDARD**

4.1 Ensure people with disabilities and older people can access all important information and accommodate for people with vision, hearing, communication, mobility and literacy limitations and/or difficulties with processing information. For example:

- Use a variety of communication methods, media and information channels to maximise the reach and coverage of key messages. Train and support staff, partners and volunteers accordingly.
- Make staff aware that many people with disabilities and older people cannot use or access mainstream communication (eg written messages or mobile phones).
- Monitor and evaluate the suitability of different communication methods and information channels for different disability and age groups.
- Ensure that policies and protocols on informed consent take into account people with disabilities and older people, including those with mental and/or intellectual disabilities.

4.2 Ensure people with disabilities and older people, and their carers, participate directly in needs assessments, consultation and feedback mechanisms to inform programming. For example:

- Use a range of accessible communication methods in consultation/engagement activities and train staff to support this (eg the use of pictures or photos, audio, large print, visual demonstrations, face-to-face explanations, clear/slower speech and simple language).
- Consult people with disabilities and older people about their communication needs or preferences. Partner with disabled or older people's organisations if specialist communication is required.¹⁶
- Ensure that meeting venues are physically accessible and safe for people with mobility limitations or visual impairments, that communication is as accessible as possible to all, and arrangements support carers.

.....
4.3 Take measures to include and consult 'hard-to-reach' people with disabilities and older people, and their carers, including those who cannot leave their homes or shelters. Use community outreach and/or partner with representative or specialised age and disability organisations.

16. eg sign language. Note that the accessibility of particular communication methods for particular disability or age groups should not be assumed. For example: not all people who are deaf or hard of hearing have sign language or literacy skills; the majority of people with a visual impairment do not use Braille; and literacy rates vary considerably among and within populations affected by crisis, with literacy rates often lower in older age groups compared with the wider population.

15. See also Sphere Protection Principle 2.

KEY INCLUSION STANDARD 5:

People with disabilities and older people affected by crisis have access to safe and responsive mechanisms to handle complaints on an equal basis with others.

► **ACTIONS TO MEET THE STANDARD**

5.1 Consult people with disabilities and older people on the design, implementation and monitoring of complaints-handling processes.

5.2 Ensure processes for making complaints and seeking redress are accessible for people with disabilities and older people.

5.3 Make sure that people with disabilities and older people have equal access to information about what to expect from agencies, how to make complaints, and what can and can't be addressed through the complaints process (see **Key Inclusion Standard 4**).

5.4 Ensure complaints are handled within an organisational culture that listens to and acts on complaints and respects the dignity, rights and capacities of people with disabilities and older people. For example:

- Include people with disabilities and older people in the organisation's policies relating to duty of care, codes of conduct, and protection of vulnerable people.
- Make staff aware of the risks that many people with disabilities face, in particular sexual exploitation, abuse and discrimination.
- Train staff on how to communicate respectfully with people with disabilities and older people.

5.5 Ensure that people with disabilities and older people who are survivors of abuse are sensitively and appropriately supported and/or referred for assistance or protection (see **Protection Standard 1**).

KEY INCLUSION STANDARD 6:

People with disabilities and older people affected by crisis receive and participate in coordinated, complementary assistance on an equal basis with others.

► **ACTIONS TO MEET THE STANDARD**

6.1 Include the needs of people with disabilities and older people in the agendas of sector/cluster meetings and other coordination mechanisms as a matter of routine. Ensure that disability- and age-sensitive programming is systematically addressed by all sectors and integrated into coordination mechanisms to ensure a holistic approach to inclusion (eg addressing interrelated shelter, water, sanitation and hygiene (WASH), psychosocial and protection needs).

6.2 Map services and organisations in your area, to identify actors who provide targeted assistance for these people and other vulnerable groups, such as treatment of chronic diseases, or provision of mobility aids/assistive devices and physical rehabilitation. Include this information in service directories and referral systems and keep all relevant actors updated.

6.3 Develop partnerships between mainstream humanitarian actors and age- and disability-specialised organisations, including disabled people's and older people's organisations. Ensure that disabled people's and older people's organisations participate effectively in the humanitarian response by making appropriate use of their expertise, capacities and resources.

6.4 Make sure actions focused on the needs of people with disabilities and older people are not delivered in isolation, and are accompanied by appropriate follow up. Ensure older people and people with disabilities benefit from synergies between mainstream and targeted interventions, to increase their impact and effectiveness.

KEY INCLUSION STANDARD 7:

People with disabilities and older people affected by crisis can expect improved assistance and inclusion as organisations learn from experience and reflection.

▶ ACTIONS TO MEET THE STANDARD

7.1 Aim to continuously improve the accessibility and quality of assistance and protection for people with disabilities and older people. This can be achieved by:

- Learning from experience with routine monitoring.
- Consulting specialised organisations representing people with disabilities and older people.
- Consulting directly with individuals and families.

7.2 Define and use appropriate age- and disability-indicators in baseline data, monitoring forms and evaluations (eg percentages of people with disabilities and older people accessing services).

7.3 Include people with disabilities and older people in monitoring and evaluation. Include groups that may be overlooked in routine monitoring, such as children and adolescents with multiple disabilities (and their carers) and people with mental or intellectual disabilities. Budget for accessibility in evaluations.

7.4 Ensure people with disabilities and older people participate in monitoring and evaluation alongside other people affected by crisis. Include their experiences in lesson-learning and actions to improve the accountability, accessibility, and safety of humanitarian responses.

7.5 Share learning, good practice and innovation related to the inclusion of people with disabilities and older people within your organisation and with other stakeholders, such as partners, national organisations and authorities.

KEY INCLUSION STANDARD 8:

People with disabilities and older people affected by crisis receive the assistance they require from competent and well-managed staff and volunteers who are skilled and equipped to include them in humanitarian responses, and they have equal opportunities for employment and volunteering in humanitarian organisations.

▶ ACTIONS TO MEET THE STANDARD

8.1 Train staff at all levels to deliver impartial assistance that recognises gender, age and disability, and to assist in recognising these factors as a source of potential vulnerability or reduced capacity. Make sure that no group or individual is intentionally or unintentionally overlooked or excluded (ie discriminated against) because of their gender and/or age and/or disability. Ensure humanitarian staff are aware that people with disabilities and older people are not homogeneous groups, and that they understand people's individual specific needs, capacities and vulnerabilities.

8.2 Make all partners and staff aware of the rights of people with disabilities and older people and the importance of including them in humanitarian response. Include disability and age in induction programmes and training to raise awareness of:

- Disability-, age- and gender-based discrimination.
- Risks that may particularly affect people with disabilities and older people (eg difficulty accessing services and risks of gender-based violence (GBV) and sexual exploitation and abuse, particularly for women and girls), and the importance of protection standards and policies for these groups.
- The importance of collecting and using sex-, age- and disability-disaggregated data.

8.3 Appoint staff at appropriate (including senior) levels within the organisation to support and monitor cross-organisation and partner awareness to deliver age and disability inclusive response, and/or establish inter-agency disability, age and gender focal points for this purpose.
.....

8.4 Make staff and partners aware of international, national and local agencies focusing on disability and age as well as organisations representing people with disabilities and older people.
.....

8.5 Make provision within organisations to ensure that people with disabilities and older people have equal opportunities for employment and volunteering; budget for this accordingly.

3. SECTOR-SPECIFIC STANDARDS



Jonas Uresch/HelpAge International



PROTECTION¹⁷

Have you read the
 Key Inclusion Standards?

PROTECTION STANDARD 1:

People with disabilities and older people, and their carers, are fully included in the design, implementation, monitoring and evaluation of protection activities and services, and they participate in relevant protection assessments and monitoring. Humanitarian organisations identify and address specific protection concerns affecting people with disabilities and older people, including exclusion from services and assistance.

PROTECTION STANDARD 2:

Humanitarian actors make all possible efforts to ensure a safe, inclusive and protective environment for older people and people with disabilities affected by crisis, and these groups play a full role in community-level protection action.

PROTECTION STANDARD 3:

People with disabilities and older people, and their carers, have full access to protection services and to all information relevant to their protection.

PROTECTION STANDARD 4:

People with disabilities and older people have full access to registration systems and identification and other documents that are essential for their legal and social protection.

PROTECTION STANDARD 5:

People with disabilities and older people are protected from physical and psychological harm arising from violence and abuse, including gender-based violence (GBV).

PROTECTION STANDARD 6:

People with disabilities and older people living in residential institutions and hospitals are protected.

PROTECTION STANDARD 7:

People with disabilities and older people are protected in situations of displacement and return.

17. These Protection Standards are intended to be used alongside the Sphere Protection Principles.



PROTECTION STANDARD 1:

People with disabilities and older people, and their carers, are fully included in the design, implementation, monitoring and evaluation of protection activities and services, and they participate in relevant protection assessments and monitoring. Humanitarian organisations identify and address specific protection concerns affecting people with disabilities and older people, including exclusion from services and assistance.

► **ACTIONS TO MEET THE STANDARD**

P1.1 Ensure all activities promote the inclusion, safety, security and dignity of people with disabilities and older people according to need and without adverse discrimination (eg provide safe and accessible protection services, shelter, water, food assistance and essential household items, healthcare, education, livelihood activities).¹⁸

P1.2 Include people with disabilities and older people, and their carers, in protection assessments and routine protection monitoring, including rapid assessments. Give consideration to hard-to-reach people with disabilities and older people (eg those unable to leave their homes or shelters or are purposely hidden by other household members; people with severe communication, intellectual or mental disabilities; or children who are caring for parents or siblings and may therefore not be going to school or accessing programmes for children). Ensure there are people with disabilities and older people among community focal points for assessment teams. Whenever possible, include people with disabilities and older women and men on assessment teams.

P1.3 Consult directly with people with disabilities and older people, and with their carers, about their protection concerns using gender-, age- and disability-sensitive techniques. Invite disabled people’s and older people’s organisations to participate in protection assessments, monitoring and responses, making appropriate use of their expertise and resources (see **Key Inclusion Standard 6**).

P1.4 Ensure that data collected to inform the design, implementation, monitoring and evaluation of all protection programmes is disaggregated by sex, age and disability (see **Key Inclusion Standard 1**).

P1.5 Put systems in place to identify, monitor and address specific protection risks affecting people with disabilities and older people (eg neglect, exploitation, abandonment, concealment, intimidation, lack of birth registration or other identification documents, separation from carers, etc) and to monitor their access to services and protective spaces.¹⁹

P1.6 Ensure that cases of violence or abuse, including GBV, affecting people with disabilities and older people (especially women and girls) are recognised and reported, and that survivors are referred appropriately for support.

P1.7 Ensure representation of people with disabilities and older people (women and men) in protection committees.

P1.8 Include people with disabilities and older people in evaluations of protection programmes.

18. See Sphere Protection Principle 2.

19. See Sphere Protection Principle 3.



PROTECTION STANDARD 2:

Humanitarian actors make all possible efforts to ensure a safe, inclusive and protective environment for older people and people with disabilities affected by crisis, and these groups play a full role in community-level protection action.

► ACTIONS TO MEET THE STANDARD

P2.1 Encourage inclusion of people with disabilities and older people in community-level protection activities, in partnership with disabled people’s and older people’s organisations. Make community activities accessible to older women and men and to people with different disabilities and communication needs (see **Key Inclusion Standard 4**), and support people with disabilities and older people to develop their own strategies to reduce risks.²⁰

For example:

- Make protective places, including child-friendly spaces (CFSs), age-friendly spaces, women’s safe spaces and non-formal education activities accessible (see **Education Standards**), so that people with disabilities and older people, and their carers, can meet and share information. Train centre staff in disability awareness and inclusion. Specific costs need to be included in budget planning.
- Strengthen or establish community-based protection mechanisms, eg community protection committees for children, older people and people with disabilities, that can identify, report and refer those at risk.
- Ensure the inclusion in community-level activities of isolated individuals with disabilities and older people, eg child heads of household, widows, people with severe mental health conditions, older people with dementia, or people with communication difficulties.

P2.2 Provide community-level psychosocial support, such as psychological first aid, for people suffering from psychological stress. Make sure this can be accessed by people with disabilities (including children) and older people, and their carers (see **Health Standard 9**). Promote access to education for children with disabilities as a protection measure (see **Education Standards**).

20. See Sphere Protection Principle 3.

PROTECTION STANDARD 3:

People with disabilities and older people, and their carers, have full access to protection services and to all information relevant to their protection.

► ACTIONS TO MEET THE STANDARD

P3.1 Actively include people with disabilities and older people in all targeted protection programmes and services (eg include children caring for family members with disabilities in child protection programmes, and recognise the role of older carers and the protection risks they may face).

P3.2 Use a range of communication channels and methods (see **Key Inclusion Standard 4**), to ensure that people with disabilities and older people have full access to all protection-related information,²¹ including information concerning:

- Threats of violence or abuse, including GBV, hazards in the immediate environment, and risks of GBV or other violence or abuse associated with particular activities, places, etc, and how to prevent or mitigate these.
- Protection services in the community (eg disseminate information about child protection services among older carers and carers with disabilities).
- How to report and seek help about protection concerns and following a protection incident, and what services are available.
- Rights and entitlements, and targeting criteria and mechanisms
- How to make complaints and how complaints will be handled (see **Key Inclusion Standard 5**).
- Registration systems, systems to access civil documentation, and legal and other specialised support services (see **Protection Standard 4**).

21. See Sphere Protection Principle 4.



PROTECTION STANDARD 4:
People with disabilities and older people have full access to registration systems and identification and other documents that are essential for their legal and social protection.²²

► **ACTIONS TO MEET THE STANDARD**

P4.1 Make sure that people with disabilities and older people, and their families/carers, are aware of the importance of registration, directly and through community members, outreach services, etc.

P4.2 Make sure that registration sites and systems are accessible to all, with special arrangements for people with communication, literacy and/or intellectual disabilities and those who cannot travel to registration sites (eg through mobile or proxy registration systems, organising transport). At registration sites, arrange prioritisation and/or separate queues or distribution times for people with disabilities and older people, and access to seating, shade, accessible and safe water and sanitary facilities.

P4.3 Make sure that registration teams are gender-balanced, with same-sex interviewers and, where necessary, same-sex interpreters, and include people with disabilities and older people on these teams. Train staff in disability- and age-awareness and make them aware of the risks of concealment or confinement of people with disabilities or older people within households. Ensure that registration teams:

- Record different types of disability and vulnerability (see **Annex I**).
- Are aware of special entitlements/targeting criteria and mechanisms for people with disabilities and older people (eg to disability ID or Senior cards).
- Refer those in need to basic or specialised services.
- Raise awareness of the importance of registration for all family members.

P4.4 Monitor registration rates against known or estimated population data relating to gender, people with disabilities and older people, in order to detect under-registration among certain groups and to inform remedial measures where needed.

P4.5 Ensure people with disabilities and older people are aware of the support services available to assist in securing or replacing documentation (such as birth certificates, death certificates, passports, land title or other property documents), and make these services accessible. Make relevant staff aware of the higher risk of children with disabilities not being registered at birth and of the protection risks associated with this, including statelessness.

22. See Sphere Protection Principle 4.



PROTECTION STANDARD 5:

People with disabilities and older people are protected from physical and psychological harm arising from violence and abuse, including gender-based violence (GBV).²³

► ACTIONS TO MEET THE STANDARD

P5.1 Monitor, prevent and respond to risks and incidences of physical and/or psychological harm, GBV and other forms of violence or abuse affecting people with disabilities and older people. Make relevant staff aware of the heightened risks of abuse that people with disabilities and older people may face, including particular groups (eg those with who are not mobile, have communication difficulties or are isolated, and for children and adolescents with disabilities).

P5.2 Include people with disabilities (including children) and older women and men in GBV prevention and response programmes. Address barriers to identification and reporting of incidents, for example through monitoring and outreach activities. Make sure support services for survivors are accessible, safe, confidential, and respond to the survivor’s individual wishes and needs. Put in place protocols for cases in which the standard procedures for informed consent to refer and share information cannot be satisfied because of an individual’s age, intellectual capacity or mental state.²⁴

P5.3 Recognise and address issues around protection that particularly affect people with disabilities and older people, including disability-based violence and age-based violence (eg physical restraint, stone-throwing, accusations of witchcraft, older people’s abuse).²⁵ Make staff aware of how gender, age and disability intersect and how this can increase risks, eg heightened risk of GBV for women and girls with disabilities.

23. See Sphere Protection Principle 3.

24. See Sphere Protection Principle 1.

25. Actions motivated by hatred or prejudice towards people with disabilities include discrimination, verbal/emotional abuse and harassment through to acts physical assault or extreme violence (which may be termed ‘disability hate crimes’); in some cultures, the use of physical violence against children with disabilities and other forms of degrading treatment (eg physical restraint) may be commonly accepted as a way of managing behaviour that is perceived as negative (see Women’s Refugee Commission, 2014).

PROTECTION STANDARD 6:

People with disabilities and older people living in residential institutions and hospitals are protected.

► ACTIONS TO MEET THE STANDARD

P6.1 Be aware of the high risk of abuse of people in institutions. Liaise with local and/or national authorities and the institutions concerned, and coordinate among protection actors to ensure that residential institutions are identified and visited regularly.²⁶

P6.2 Ensure that basic physical and psychosocial needs of people in institutions are met and that abuse is prevented and responded to. Where appropriate, organise for interventions to be led by local professionals, focused on protection and the re-establishment of basic care.

P6.3 When care is below medical and human rights standards, focus the emergency intervention on meeting general minimum standards and practices for psychiatric or other care. If staff have abandoned psychiatric institutions, mobilise human resources from the community and healthcare system to care for people with severe mental disorders. Ensure there are evacuation plans and procedures for patients.

26. Including residential homes for older people, psychiatric institutions, orphanages, special schools for children with disabilities, detention centres and prisons.



PROTECTION STANDARD 7:

People with disabilities and older people are protected in situations of displacement and return.

► **ACTIONS TO MEET THE STANDARD**

P7.1 Where populations are fleeing from conflict and natural disasters, coordinate with other humanitarian actors to assist the most vulnerable remaining behind, including people with disabilities and older people and carers.

P7.2 Provide safe, suitable and accessible transport assistance where appropriate. Avoid people’s separation from family members and carers, assistive devices and aids, and medication.

P7.3 Make reception centres accessible to displaced people with disabilities and older people. Ensure staff attend to people with disabilities or older people arriving alone or with children, and those who have significant difficulties with daily functioning.

P7.4 Provide temporary accommodation and WASH facilities at reception and transit centres where needed, and make these centres are accessible to all. Provide lighting and, where possible, partitions/separations of sleeping areas to enhance privacy and minimise risk of GBV, particularly for women and girls.

P7.5 Prioritise displaced people with disabilities and older people in family tracing and reunification, and include carers in reunification activities. Where reunification with carers and/or family is not possible, put systems in place to explore or support people to live independently or identify alternative suitable placements, eg with extended or ‘foster’ families.

P7.6 Consult people with disabilities and older people on their durable solution wishes. Ensure that return, resettlement or local integration occurs voluntarily, in safety and with dignity. Post-return, ensure that resettlement or local integration support arrangements (shelter/house construction, livelihoods support, etc) are inclusive; for example, ensure access to available social support, return packages by local government and healthcare for people with disabilities and older people.

Example of good practice:

UNHCR IN NEPAL

In Nepal, UNHCR has adopted a twin-track approach to promote access and inclusion in GBV prevention and response activities. Following consultations with people with disabilities about their GBV-related needs and capacities, UNHCR adapted existing GBV prevention and response activities by:

- Raising awareness with GBV stakeholders on environmental, communication, attitudinal and policy barriers to access for people with disabilities.
- Including examples of people with disabilities in GBV community awareness-raising tools.
- Developing an annex to the Inter-Agency Standard Operating Procedures (SOP) on consent, confidentiality and non-discrimination for people with disabilities.
- Identifying and training sign language interpreters on confidentiality and consent processes for GBV survivors.

At the same time, UNHCR started supporting disability-specific actions to increase participation of people with disabilities and promote empowerment in GBV programmes, including partnering with a local deaf people’s organisation to deliver sign language training in camps to deaf people and their family members, as well as community-based organisations and NGO staff, and supporting a local disabled women’s organisation to facilitate the formation of self-help groups of women with disabilities to provide an additional social support system and forum for preventing and responding to GBV.

Source: Women’s Refugee Commission, 2014, p.16.

**Example of good practice:****WOMEN'S REFUGEE COMMISSION AND UNHCR IN LEBANON**

People with disabilities in Lebanon were facing multiple protection risks. Staff responsible for protection case management referred the vast majority of people with disabilities to service providers for health, rehabilitation and provision of aids and devices. However, there was a gap in recognising and responding to other factors that increased vulnerability and risks. For example, many children with disabilities were not in school, people with disabilities were living in substandard shelters, and some were single parents or carers, or single women. Their situation required a more comprehensive assessment, referral to other non-health-related services and regular follow-up.

In response, the Women's Refugee Commission and UNHCR developed and piloted a training package on Individual Case Management – Identifying and Responding to the Needs of Persons with Disabilities for case managers engaged in the Syrian refugee response in Lebanon. This package supported registration staff, social workers and protection case managers to identify people with disabilities at heightened risk. It also guided them on how to conduct more detailed assessments, looking not only at people's needs, but also at their skills and capacities that could be used in individual case management responses.

Source: Women's Refugee Commission, 2014, pp.20-21.

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World Vision (2012) Minimum Inter-Agency Standards for Protection Mainstreaming. Retrieved from: reliefweb.int/report/world/minimum-inter-agency-standards-protection-mainstreaming-enar



Lucy Blouny/HelpAge International



WATER, SANITATION AND HYGIENE (WASH)

Have you read the
Key Inclusion Standards?

WASH STANDARD 1:

People with disabilities and older people, and their carers, are fully included in the design, implementation, monitoring and evaluation of WASH services and facilities, and they participate in relevant needs assessments.

WASH STANDARD 2:

Information on WASH services and facilities is fully accessible and available to people with disabilities and older people, and their carers.

WASH STANDARD 3:

People with disabilities and older people, and their carers, have full access to an adequate supply of water for drinking, cooking and other domestic use.

WASH STANDARD 4:

People with disabilities and older people have full access to latrine facilities that are appropriate for them to use safely and with dignity.

WASH STANDARD 5:

People with disabilities and older people, and their carers, have full access to hygiene services including an adequate and appropriate supply of hygiene items, and to hygiene facilities that are appropriate for them to use safely and with dignity.



WASH STANDARD 1:

People with disabilities and older people, and their carers, are fully included in the design, implementation, monitoring and evaluation of WASH services and facilities, and they participate in relevant needs assessments.

WASH STANDARD 2:

Information on WASH services and facilities is fully accessible and available to people with disabilities and older people, and their carers (see Key Inclusion Standard 4).

▶ ACTIONS TO MEET THE STANDARD

W1.1 Ensure data collected to inform the design, implementation, monitoring and evaluation of WASH programmes is disaggregated by sex, age and disability.

W1.2 Train WASH staff and partners, including outreach workers, in disability- and age-awareness and inclusion, and to recognise the specific needs of people with disabilities and older people. Monitor outreach programmes to ensure inclusion of people with disabilities and older people.

W1.3 Consult people with disabilities and older people, and their carers, about their needs, in order to inform the location, accessibility, design and use of all WASH services and facilities (water distributions, new or rehabilitated water and sanitation facilities; personal facilities; provision/distribution of hygiene items, etc). Conduct focus groups and other direct consultations involving people with disabilities and older people in single-sex groups with same-sex facilitators who are trained in disability- and age-awareness. Involve disabled people's and older people's organisations in WASH responses, including outreach programmes.

W1.4 Ask people with disabilities and older people, and their carers, directly about any specific WASH needs that they have, to inform additional/adapted services (for example, provision of additional items such as a commode or hygiene materials).

W1.5 Make sure that people with disabilities and older people (women and men) are represented in community water and sanitation committees.

W1.6 Include people with disabilities and older people in evaluations of WASH programmes.

▶ ACTIONS TO MEET THE STANDARD

W2.1 Inform all people with disabilities, older people, and their carers, about where, when and how water will be distributed, and about safe water storage. These groups should have full access to all information about WASH entitlements and services.

W2.2 Advise all people with disabilities and older people, and their carers, about the key public-health risks and benefits of water use and hygiene practices and how to mitigate risks. Train health/hygiene promoters in disability- and age-awareness.

W2.3 Inform those with specific WASH needs (eg incontinence) and their carers about the hygiene items, services and facilities that can be provided (including any additional or specialised items or facilities that may be needed). Where necessary, partner with other organisations or specialised agencies to provide specialised items or equipment. Make information about menstrual hygiene management accessible to girls and women with disabilities.

W2.4 Provide guidance on how to use WASH facilities safely for people with disabilities and older people (including those with communication, mental or intellectual disabilities), and their carers.



WASH STANDARD 3:

People with disabilities and older people, and their carers, have full access to an adequate supply of water for drinking, cooking and other domestic use.

▶ ACTIONS TO MEET THE STANDARD

W3.1 Ensure that a minimum of 15 per cent of taps/water pumps are accessible and safe for people with physical, mobility-related and/or visual limitations.²⁷ For example, provide smaller-sized water containers; install ramps, rails and guide ropes at water points/pumps; and provide pumps that are built using universal design (with extended handles, etc) and costings included in the budget planning.²⁸ If necessary, seek advice from specialist disability/older people’s organisations on how to ensure that water facilities and supplies are accessible. Consider accessibility when planning the locations of water points.

W3.2 Make special arrangements at water points (eg separate queues) to avoid people with physical disabilities and older people having to stand and queue for long periods.

W3.3 Ensure and monitor a safe and reliable supply of water to people with increased water needs (eg for the management of particular health conditions) and to people who are unable to leave their homes or unable to reach water distribution points, eg through outreach or community-based volunteer services.

27. The percentage should be based on participatory needs assessments and SADD. Where there is no reliable local data, 15 per cent is recommended, based on WHO global estimates. See www.who.int/mediacentre/factsheets/fs352/en/

28. See Key Inclusion Standard 2.

WASH STANDARD 4:

People with disabilities and older people have full access to latrine facilities that are appropriate for them to use safely and with dignity.

▶ ACTIONS TO MEET THE STANDARD

W4.1 Design, build or adapt a minimum of 15 per cent of latrine facilities – including separate facilities for women and men – to be accessible to people who have physical or visual mobility limitations, so that they can use them easily and with dignity.²⁹ Design new latrines on the basis of universal design principles (see **Key Inclusion Standard 2**), which include:

- Providing ramps, handrails and guided access (eg string marking the path for people with visual impairments).
- Ensuring door widths accommodate wheelchairs/crutches.
- Ensuring sufficient space to accommodate a wheelchair with the door closed and to enable carers to assist with access or personal care.

Adapt existing latrines for use by people with physical or visual mobility limitations on the basis of reasonable accommodation/adjustment principles. Locate accessible handwashing facilities (eg low-level and easy-to-use taps) close to accessible latrines. If necessary, seek advice from specialist disability/older people’s organisations on how to ensure that sanitation facilities are accessible.

W4.2 Locate accessible sanitation facilities and shelters so that people with physical limitations/reduced mobility can be accommodated close to accessible latrines and other WASH facilities.

W4.3 Provide special toilets or sanitation facilities/items where needed, eg toilets with permanent or removable seats, bed pans, potties or commodes.

29. The percentage should be based on participatory needs assessments and SADD. Where there is no reliable local data, 15 per cent is recommended, based on WHO global estimates. See www.who.int/mediacentre/factsheets/fs352/en/



WASH STANDARD 5:

People with disabilities and older people, and their carers, have full access to hygiene services including an adequate and appropriate supply of hygiene items, and to hygiene facilities that are appropriate for them to use safely and with dignity.

▶ ACTIONS TO MEET THE STANDARD

W5.1 Distribute additional hygiene products to people with disabilities and older people if required. Train assessment teams and WASH staff to consult in gender-sensitive ways with people with disabilities and older people about specific hygiene needs (and with carers where necessary). Use gender-sensitive distribution methods that protect people’s dignity (eg distributing intimate hygiene products directly to the person who needs them). Ensure that those with specific needs (eg incontinence) have easy access to additional hygiene products and intimate hygiene items according to their needs.

W5.2 Ensure that women and girls with disabilities have access to appropriate sanitary materials. Make sure that women and girls of all ages, including older women and those with disabilities, can access private spaces to wash themselves, to wash and dry stained clothing and cloths used for menstrual hygiene management, and to dispose of sanitary materials. Create sufficient space for the assistance of a carer if required.

W5.3 Ensure that accessible WASH facilities have locks and are well-lit, to enhance privacy and safety. Train all WASH personnel to be aware of the risks of GBV and other abuse faced by many people with disabilities and older people, particularly for women and girls, and take action to mitigate risks when designing WASH facilities.

W5.4 Identify and regularly visit residential institutions³⁰ (including early in the crisis) to ensure that people have their WASH needs identified and addressed in ways that protect their safety and dignity. Coordinate all activities with local and/or national authorities and the institutions concerned.

30. Including residential homes for older people, psychiatric institutions, orphanages, special schools for children with disabilities, detention centres and prisons.



Examples of good practice:

ASSISTANCE TO RETURNEES BY ACTION AGAINST HUNGER AND CBM IN CENTRAL AFRICAN REPUBLIC

Following political violence in Central African Republic in 2013, 40,000 people were displaced in camps in Bossangoa. When they returned ten months later, many people found that their villages had been looted or destroyed. Action Against Hunger (ACF) launched a WASH project to assist returnees with hand pump rehabilitation, latrine construction and hygiene promotion. Through a partnership with CBM, a disability expert visited three times during the one-year project to train staff and launch inclusive activities and monitor their implementation and impact. As a result, many people with disabilities were identified, outreach workers and communities were trained, and many of the latrines built by the families themselves were made accessible. One of the most important outcomes of this initiative was greater awareness and solidarity with people with disabilities among the ACF team, outreach workers and villagers.

Source: Action Against Hunger (written communication)

MULTI-SECTOR RESPONSE IN KYRGYZSTAN

In June 2010, ethnic violence in southern Kyrgyzstan led to massive displacement of people into Uzbekistan and 300,000 internally displaced persons. A multi-sector response was launched by UN agencies and NGOs to address the needs of the affected population. As a result of collaboration with Age and Disability Working Group members, the WASH Cluster adjusted the latrine design to meet international standards of accessibility, both in older people's homes and in public places. The revised design included wider doorways to allow room for wheelchairs and to enable carers to support people during use.

Source: HelpAge International, 2012d



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John Javelana/CBM



FOOD SECURITY AND LIVELIHOODS

Have you read the
Key Inclusion Standards?

FOOD SECURITY AND LIVELIHOODS STANDARD 1:

People with disabilities and older people are included in food security and livelihoods assessments, and in the design, implementation, monitoring and evaluation of food security programmes.

FOOD SECURITY AND LIVELIHOODS STANDARD 2:

Information relating to food assistance and food security programmes is fully accessible and available to people with disabilities and older people, and their carers.

FOOD SECURITY AND LIVELIHOODS STANDARD 3:

Food distributions and cash and voucher transfers use methods that ensure inclusion and access to adequate food for people with disabilities and older people, and that safeguard their dignity.

FOOD SECURITY AND LIVELIHOODS STANDARD 4:

Food-for-work, cash-for-work and livelihoods programmes are designed and implemented in ways that take account of the capacities of older people, people with disabilities and their carers seek to overcome or compensate for barriers to their participation, and meet their food security and livelihood needs.



FOOD SECURITY STANDARD 1:

People with disabilities and older people are included in food security and livelihoods assessments, and in the design, implementation, monitoring and evaluation of food security programmes.

► ACTIONS TO MEET THE STANDARD

FS1.1 Ensure that all data collected for food security and livelihood assessments and interventions is disaggregated by sex, age and disability (see **Key Inclusion Standard 1**). Use outreach programmes to access hard-to-reach groups and ensure inclusion on registration lists.

FS1.2 Train food security staff and partners in disability- and age-awareness and to recognise the specific needs of people with disabilities and older people (see **Key Inclusion Standard 8**).

FS1.3 Involve people with disabilities and older people, and their carers, in all vulnerability, capacity and needs assessments using accessible consultation methods (see **Key Inclusion Standard 4**).

Identify the specific risks faced by older people and people with disabilities related to food security and livelihoods. Consider the barriers they face in accessing food assistance, markets and productive activities. For example, older people may be particularly affected by isolation, by dependence on local markets, or availability of specific foods.

FS1.4 Include people with disabilities and older people, and their carers, in the design of food security and livelihoods programmes. For example, by:

- Adapting targeting criteria.
- Ensuring food or cash/voucher transfer systems are appropriate (in terms of the location, accessibility and frequency of distributions, and the acceptability of food items).
- Considering the capacities and livelihood strategies of people with disabilities and older people, and their carers and households, when designing food-/cash-for-work programmes.
- Using protection measures to safeguard those most at risk of GBV or other verbal or physical abuse, eg ensuring safe means of transport, safe arrangements for collecting rations, and safe livelihood activities.

FS1.5 Include people with disabilities and older people in focus groups, home visits and other routine monitoring activities.

FS1.6 Include people with disabilities and older people (women and men) in food management committees to promote better targeting and accessibility of food security programmes.

FS1.7 In all monitoring and evaluation activities, pay specific attention to the food security of people with disabilities and older people and their access to assistance, particularly those most at risk, such as widows, those living alone, people with multiple disabilities, those affected by non-communicable diseases and those living in institutions.



FOOD SECURITY STANDARD 2:

Information relating to food assistance and food security programmes is fully accessible and available to people with disabilities and older people, and their carers.

► ACTIONS TO MEET THE STANDARD

FS2.1 Use a range of communication channels and methods to ensure that people with disabilities and older people, and their carers, have access to all important information relating to food assistance and food security programmes (see **Key Inclusion Standard 4**). This includes information about entitlements, targeting criteria and mechanisms; food and/or cash/voucher transfers; storage and preparation of food; livelihood support; land and property rights and support agencies; and how to complain or report abuse.

FOOD SECURITY STANDARD 3:

Food distributions and cash and voucher transfers are designed, planned, implemented, monitored and evaluated using methods that ensure inclusion and access to adequate food for people with disabilities and older people, and that safeguard their dignity.

► ACTIONS TO MEET THE STANDARD

FS3.1 Ensure that people with disabilities and older people can easily access food sources, including food, cash and voucher transfers. Foods should be easy to prepare and consume and meet any additional protein and micronutrient requirements, particularly for those with specific impairments or vulnerabilities, and those affected by non-communicable diseases that require specific diet management.

FS3.2 Adapt food and/or cash and voucher transfer mechanisms to ensure safe, dignified and equitable access for people with disabilities and older people, particularly for those with mobility difficulties or who are at risk of exploitation, abuse or neglect:

- Consider the composition of food rations, how easy they are to carry, the frequency, location, accessibility and means of distributions, the distances people have to travel to distribution points, the need for support with transport, and the availability of outreach services.
- Prioritise and/or create separate queues or distribution times for people with disabilities and older people. Ensure the availability of seating, shade, accessible and safe water and sanitary facilities at distribution sites.
- Set up additional distribution mechanisms for people who cannot leave their homes or shelters or who have difficulty attending distributions. Ask those who cannot access or use distribution points about how they want to receive assistance, and make arrangements for alternative collection (eg by a trusted 'proxy') or direct delivery through outreach services or trusted community members. Monitor the arrangements to ensure they are reliable and sustainable and that beneficiaries are receiving their full grant.



- Ensure safe and equal access to cash or voucher transfer programmes.³¹ Ensure that older people and people with disabilities are not unfairly marginalised by distribution mechanisms (eg mobile phones, bank accounts or ATMs), or by lack of information about, or understanding of, the programme. Assist those with communication difficulties, with little or no literacy or limited familiarity with banking systems, cash assistance and associated technology (eg women may have had less access to education). Check that beneficiaries are receiving their full grant and are not exposed to increased risks by cash or voucher programmes.
- Coordinate with other food security actors to ensure that people living in residential institutions have their basic food and nutrition requirements assessed and addressed on a continuous basis (including early in the crisis), as the risk of severe neglect or abuse of people in institutions is extremely high.³²

FS3.3 Ensure households with members who need specific assistance with feeding have access to appropriate utensils, additional fuel, potable water and hygiene materials. Arrange carers for individuals who cannot prepare food or feed themselves. Provide outreach services or work with community organisations to support people with significantly reduced capacity to provide food to dependents (eg older people with disabilities caring for grandchildren).

FS3.4 Seek to ensure that people living in residential institutions have their basic food and nutrition requirements assessed and addressed, as the risk of severe neglect or abuse of people in institutions is extremely high.

FOOD SECURITY STANDARD 4:

Food-for-work, cash-for-work and livelihoods programmes are designed and implemented in ways that take account of the capacities of older people, people with disabilities and their carers, seek to overcome or compensate for barriers to their participation, and meet their food security and livelihood needs.

► **ACTIONS TO MEET THE STANDARD**

FS4.1 Ensure that people with disabilities and older women and men can participate in cash- or food-for-work programmes. Make any adaptations required (eg provision of assistive devices, ramps and alternative means of communication) and provide opportunities for participation in less arduous work. Use targeting criteria to match people with appropriate activities according to their skills, age, gender, and physical, sensory and intellectual capacities, etc. Make sure these groups are not channelled into lower paid or less desirable work, and that they have full and equal access to non-formal education and skills training.

FS4.2 Include people with disabilities and older people (men and women) in emergency and longer-term income-generation and employment programmes by taking into account their range of skills, capacities and pre-existing livelihoods as well as access to production and markets.

FS4.3 Seek to ensure that those with caring responsibilities can access food security and livelihood programmes, and that the impact on their caring responsibilities is minimised. This includes ensuring that childcare facilities and child-friendly spaces are accessible to children with disabilities.

FS4.4 Maintain unconditional safety-net measures (eg direct cash, voucher or food transfers) for people whose participation in work-based asset protection/replacement, livelihood activities and/or access to markets is significantly restricted by their age, disability or caring responsibilities (eg lone parents of children with multiple disabilities). Consider other support measures as required.

31. Note that the safe and equitable inclusion of people with disabilities and older people in cash programming requires further attention than it has received to date; there is currently a lack of evidence-based guidance on inclusive cash programming.

32. Including residential homes for older people, psychiatric institutions, orphanages, special schools for children with disabilities, detention centres and prisons.



Examples of good practice:

WOMEN'S REFUGEE COMMISSION

A multi-country study of the situation of people with disabilities among displaced and conflict-affected populations undertaken by the Women's Refugee Commission (WRC) in 2007 found that food distribution systems were often inaccessible for people with disabilities. In contrast, refugees with disabilities in Dadaab refugee camp in Kenya, were given priority by the World Food Programme (WFP) during food distributions so they did not have to wait in long queues, and members of the community were mobilised to help collect food rations for those unable to attend.

Source: Reilly, 2010

CAEPA IN DEMOCRATIC REPUBLIC OF CONGO

In the Democratic Republic of Congo, CAEPA, a local partner of HelpAge International, identified and provided support to older people whose granddaughters had resorted to transactional sex to earn money to buy food for the family. Both the older people and their granddaughters were aware of health and protection risks, but had no other access to income. By providing older people and their families with safer income-generating activities, such as mat and basket weaving, HelpAge and CAEPA were able to reduce the risks faced by the family, in particular the granddaughters.

Source: HelpAge International, 2012d

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Kate Holt/HelpAge International



NUTRITION

Have you read the
Key Inclusion Standards?

NUTRITION STANDARD 1:

The nutritional status of people with disabilities and older people is systematically assessed and monitored. Nutritional assessments are used to trigger and inform emergency nutrition responses that include or target people with disabilities and older people.

NUTRITION STANDARD 2:

People with disabilities and older people, and their carers, participate in the design, implementation, monitoring and evaluation of nutrition-related services and interventions, including nutrition assessments.

NUTRITION STANDARD 3:

Information relating to food and nutrition services and interventions is fully accessible and available to people with disabilities and older people, and their carers.

NUTRITION STANDARD 4:

Moderate acute malnutrition (MAM) and severe acute malnutrition (SAM) among people with disabilities and older people are prevented and treated on the basis of impartiality of humanitarian assistance.



NUTRITION STANDARD 1:

The nutritional status of people with disabilities and older people is systematically assessed and monitored. Nutritional assessments are used to trigger and inform emergency nutrition responses that include or target people with disabilities and older people.

► **ACTIONS TO MEET THE STANDARD**

N1.1 Use sex-, age- and disability-disaggregated data to assess the nutritional status of adults and children with disabilities and older people (see **Key Inclusion Standard 1**), so that registration lists for nutrition programmes identify people with disabilities and older people.³³ Use outreach programmes to identify and include those who cannot reach registration points.

N1.2 Systematically integrate the assessment, analysis and monitoring of the nutrition status of adults and children with disabilities and older people into health services. Use this to inform the design, targeting and delivery of nutrition programmes.

N1.3 Ensure nutrition assessments are informed by food security assessments, in order to identify and address factors affecting the nutritional status of people with disabilities and older people. Include these groups into strategies for the prevention of micronutrient deficiency.

N1.4 Implement systematic nutrition screening for older people and adults and children with disabilities at reception clinics and health centres; assess their nutritional status using middle-upper arm circumference (MUAC) criteria.³⁴ Train community workers to:

- Detect and record malnutrition in people with disabilities and older people (including recording of malnutrition oedemas).
- Refer people appropriately.
- Identify people with disabilities and older people who may be vulnerable to malnutrition.

N1.5 Screen the nutritional status of all children with disabilities in line with international guidance on the management of malnutrition in infants and children,³⁵ taking into consideration normal variation in children with developmental delay. Arrange outreach services to ensure identification and coverage of children with disabilities who are confined to their homes or shelters; be aware that some children with disabilities may be hidden from view by other household members. Ensure that children with disabilities (including those over the age of 5) are referred to nutritional services as needed, based on clinical evaluation of their health needs and not strictly based on their age.

N1.6 Seek to ensure that people living in residential institutions have their basic food and nutrition requirements assessed and addressed, as the risk of severe neglect or abuse of people in institutions is extremely high.³⁶

N1.7 Monitor the overall preventative and therapeutic coverage of adults and children with disabilities and older people as a matter of routine.

33. There is currently a lack of data or research-based evidence about nutrition risks for adults with disabilities at international or national levels, but children with disabilities are consistently reported to have high incidence of malnutrition, stunting and wasting, eg children with cerebral palsy can be up to three times more likely to be underweight compared to non-disabled children (Tüzün et al, 2013, cited in Groce, Challenger and Kerac, 2013). Girls with disabilities may present more often as underweight compared to boys, and children with disabilities admitted and treated for malnutrition are more than two times more likely to die than non-disabled children; systems that exist to improve the nutrition of children are often less accessible to meet those most in need, such as children with disabilities, particularly those living in poverty or remote locations (see Groce, Challenger and Kerac, 2013; see also Groce, Kerac, Farkas, Berman Bieler, 2013).

34. HelpAge International recommends the following case definition for acute malnutrition in older people: moderate acute malnutrition (MAM) when mid-upper-arm-circumference (MUAC) <210mm, and severe acute malnutrition (SAM) when MUAC <185mm and/or when presence of bilateral pitting oedema (HelpAge International 2013a). No guidelines currently exist for the measurement of individuals with physical disabilities. In some cases, MUAC measurements for malnutrition may be misleading. Alternatives to standard measures could be visual assessment, length, arm span, demi-span or lower leg length measurements (see the Sphere Handbook, appendix 4).

35. See for example WHO, 2013, Guideline: Updates on the management of severe acute malnutrition in infants and children.

36. Including residential homes for older people, psychiatric institutions, orphanages, special schools for children with disabilities, detention centres and prisons.



NUTRITION STANDARD 2:

People with disabilities and older people, and their carers, participate in the design, implementation, monitoring and evaluation of nutrition-related services and interventions, including nutrition assessments.

▶ ACTIONS TO MEET THE STANDARD

N2.1 Actively engage people with disabilities and older people, and their carers in discussions about the appropriateness and design of all nutrition programmes, including supplementary feeding programmes and programmes to address severe acute malnutrition. Involve them in the management, monitoring and evaluation of nutrition-related services and distributions of supplementary feeding items. Carry out focus group discussions and other consultations on nutrition services and interventions using a range of communication channels and methods (see **Key Inclusion Standard 4**).

N2.2 Maximise programme coverage through the involvement of community members, leaders and organisations, including older people's and disabled people's associations.

NUTRITION STANDARD 3:

Information relating to food and nutrition services and interventions is fully accessible and available to people with disabilities and older people, and their carers.

▶ ACTIONS TO MEET THE STANDARD

N3.1 Use a range of communication channels and methods to ensure that people with disabilities and older people, and their carers, have access to all important information about nutrition programmes (see **Key Inclusion Standard 4**). This includes:

- Nutrition education and public information campaigns relating to food and nutrition.
 - Information about diet diversity and the prevention of malnutrition.
 - Information about food distribution and food use (including that no favours should be exchanged for food or services).
-

N3.2 Ensure that those included in selective feeding programmes can access and understand information about the safe, hygienic and appropriate storage, preparation and use of specific food products, and about how to make complaints or report abuse.



NUTRITION STANDARD 4:

Moderate acute malnutrition (MAM) and severe acute malnutrition (SAM) among people with disabilities and older people are prevented and treated on the basis of impartiality of humanitarian assistance.

▶ ACTIONS TO MEET THE STANDARD

N4.1 Ensure that the criteria for supplementary feeding programmes (SFPs) allow for appropriate inclusion of individuals with disabilities and older people. Use blanket or targeted programmes depending on levels of malnutrition, the status of vulnerable groups and the risk of an increase in acute malnutrition.

N4.2 Consider the appropriateness of SFP rations and accessibility of distributions for people with disabilities and older people, and make adaptations to ensure equitable access. Pay special attention to inclusion and access for people with physical or visual mobility limitations, those with intellectual or psychosocial disabilities and those at particular risk of exploitation, abuse or neglect. In the design, implementation and monitoring of distributions:

- Consider the composition of SFP, how easy rations are to carry, the frequency, location, accessibility and means of distributions, the distances people have to travel to distribution points, the need for support with transport, and the availability of outreach services.
- Prioritise and/or create separate queues or distribution times for people with disabilities and older people. Ensure the availability of seating, shade, accessible and safe water and sanitary facilities at distribution sites.
- Consider the likelihood of sharing within the household and the associated risk of under-nutrition.

- Set up additional distribution mechanisms for people who cannot leave their homes or shelters or who have difficulty attending distributions.³⁷ Ask those who cannot access or use distribution points about how they want to receive assistance, and make arrangements for alternative collection (eg by a trusted 'proxy') or direct delivery through outreach services or trusted community members. Monitor the arrangements to ensure they are reliable and sustainable and that beneficiaries are receiving their full ration.

N4.3 Systematically monitor the coverage and acceptability of SFP rations among people with disabilities and older people to inform ongoing programme design and implementation.

N4.4 Adapt the criteria for closing down a targeted SFP depending on the percentage of people with disabilities and older people in the population (possibly as few as eight older beneficiaries could be used as a criterion).

N4.5 Set up outpatient sites for the management of MAM and SAM in safe locations, close to the targeted population, to reduce the risks, costs and difficulties of travelling long distances. People with disabilities and older people (or carers) should be less than a day's return walk away, including distribution time.

N4.6 Ensure that community-based management of severe acute malnutrition includes identification and treatment of SAM among people with disabilities and older people, through staff training and programme design. Make sure that referral systems for nutritional assessment and hospital- or community-based therapeutic care include children and adults with disabilities and older people. Ensure that all individuals with disabilities or older people, including those with a chronic illness, have equal access to therapeutic nutrition if they meet the criteria for admission. Make sure that children with disabilities with severe acute malnutrition are treated appropriately within paediatric nutrition programmes.

37. For example, some blind people, people with severe learning disabilities, or lone carers of people with multiple disabilities and SAM.



Example of good practice:

TREATMENT OF SEVERE ACUTE MALNUTRITION IN OLDER PEOPLE IN REFUGEE CAMPS IN SOUTH SUDAN

Refugees fleeing the conflict in Blue Nile arrived in Maban County in South Sudan in November 2012, where Médecins Sans Frontières (MSF Belgium) had a nutrition and health programme in two camps. A large number of adults as well as children were suffering from malnutrition after having travelled in the bush for a long period without access to proper food. It was decided to include adults in a therapeutic feeding programme. Criteria for admission were based on MUAC and presence of oedema, and clinical condition decided whether they would be admitted as outpatients or inpatients. Very rapidly, many older people were admitted, particularly as inpatients. At the beginning of their treatment, older people complained about the therapeutic milk, which was difficult to digest and

caused diarrhoea. This improved after a few days, with the transition to the rehabilitation phase and the introduction of solid food (RUTF). While RUTF was generally well accepted, it appeared that being transferred to outpatient care was a problem for a number of older people who were isolated and without community support. Others improved their nutrition status but still had medical conditions. After discharge from inpatient care, they continued to be monitored by home visitors who were sent to provide the RUTF and who organised a system of donkey carts to pick them up for a monthly visit to the ambulatory feeding centre. This project showed that older people can be successfully treated in a therapeutic programme, and highlighted the importance of social support, home visiting, and the need for palliative care, as a large number of older people were approaching the end of their life.

Source: MSF Belgium, 2012; cited in HelpAge International, 2013, p.32

**RECOMMENDED DOCUMENTS
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Brice Blonde/Handicap International



SHELTER, SETTLEMENT AND NON-FOOD ITEMS (NFIs)³⁸

Have you read the
Key Inclusion Standards?

SHELTER, SETTLEMENT AND NFIs STANDARD 1:

People with disabilities and older people, and their carers, are included in the design, implementation, monitoring and evaluation of shelter/settlement programmes, and they participate in relevant needs assessments.

SHELTER, SETTLEMENT AND NFIs STANDARD 2:

Information relating to shelter and settlement assistance and essential NFI distributions is fully available and accessible to people with disabilities and older people.

SHELTER, SETTLEMENT AND NFIs STANDARD 3:

People with disabilities and older people have safe and equitable access to shelter and settlement facilities that are appropriate, adequate and safe for them to use.

SHELTER, SETTLEMENT AND NFIs STANDARD 4:

People with disabilities and older people, and their carers, are included in the design, implementation and monitoring and evaluation of NFI programmes, and they participate in relevant needs assessments.

SHELTER, SETTLEMENT AND NFIs STANDARD 5:

Cash and voucher and NFI distributions are designed, targeted and implemented in ways that ensure dignity and minimise exclusion or marginalisation and other risks for people with disabilities and older people.

38. NFIs might be referred to as essential household items, as they should include items that are essential for daily living for many people with disabilities and older people, such as mobility or other assistive devices (eg hearing aids and batteries, spectacles, etc) and items for special WASH, food or health needs (eg commodes, drinking straws, etc).



**SHELTER, SETTLEMENT AND
 NFIs STANDARD 1:**

People with disabilities and older people, and their carers, are included in the design, implementation, monitoring and evaluation of shelter/settlement programmes, and they participate in relevant needs assessments.

▶ ACTIONS TO MEET THE STANDARD

S1.1 Ensure that all data collected to inform the design, implementation (including targeting), and evaluation of shelter/settlement programmes is disaggregated by sex, age and disability. When conducting multi-sectoral assessments, include questions on the needs and capacities of people with disabilities and older people (see **Key Inclusion Standard 1**).

S1.2 Train shelter staff and partners in disability- and age-awareness and inclusion, and to recognise the specific shelter needs of people with disabilities and older people (see **Key Inclusion Standard 8**).

S1.3 Consult and involve people with disabilities and older people, and their carers, in decisions on all aspects of shelter/settlement programmes (see **Key Inclusion Standard 4**). For example, by:

- Selecting locations for temporary and longer-term shelters or settlements which are safe and close to essential facilities.
- Identifying priority shelter needs, and the assistance needed for shelter construction.
- Designing new shelters and buildings or adapting/renovating existing buildings.

- Arranging distribution of shelter materials.
- Monitoring and evaluating the coverage, accessibility, suitability, impartiality and outcomes of shelter and settlement programmes for people with disabilities and older people.
- Making sure that people with disabilities and older people (women and men) are fully represented in local shelter/settlement committees.
- Considering the shelter needs of older people who care for children (eg grandparents) and people with disabilities who have children.
- Taking into account particular vulnerabilities to extreme temperatures (hot and cold weather).

S1.4 Identify the risks and barriers to accessing safe and appropriate shelter for people with disabilities and older people (consider those that are specific to women, girls, boys and men), applying a gender analysis. Pay attention to those with mobility-related or visual impairments, those who are isolated or unable to engage in construction activities, and those who are unable to leave their homes or reach essential services easily.

SHELTER, SETTLEMENT AND NFIs STANDARD 2:

Information relating to shelter and settlement assistance and essential NFI distributions is fully available and accessible to people with disabilities and older people (see Key Inclusion Standard 4).

SHELTER, SETTLEMENT AND NFIs STANDARD 3:

People with disabilities and older people have safe and equitable access to shelter and settlement facilities that are appropriate, adequate and safe for them to use.

► **ACTIONS TO MEET THE STANDARD**

S2.1 Ensure that people with disabilities and older people, and their carers, have access to all the information they need relating to shelter/settlement and NFI programmes. This includes information about:

- Registration, assessment, selection processes and entitlements for shelter assistance.
- Distributions, and how to access grants, materials or other support.
- Tenure, housing, land, property and inheritance rights and legal services.
- Instructions on the use of shelter materials and NFIs.

S2.2 Use a range of communication methods and channels to ensure that important information (eg about cash and voucher transfer explanations) reaches, and is understood by, the people who need it. Make special arrangements for those who may have difficulty accessing or comprehending information they need.

► **ACTIONS TO MEET THE STANDARD**

S3.1 Make sure that accommodation in temporary shelters is designed to protect the dignity and safety of people with disabilities and older people, eg with appropriate partitions/separation of sleeping areas, accessible latrines and washing areas and, if needed, space for assistance with personal care. Ensure that women and girls do not have to share accommodation with men who are not members of their immediate family.

S3.2 Ensure that at least 15 per cent of shelters are accessible to all.³⁹ This can be achieved by:

- Locating dwellings used by those with physical or visual disabilities or restricted mobility close to essential facilities and services, with safe and well-lit access routes (and, if necessary, accessible evacuation routes).
- Adapting or constructing dwellings for use by people with mobility limitations to be accessible (eg level and/or ramped access, flooring with dark and light colour combinations, doorway wide enough for a wheelchair, handrails, grab bars, guide ropes, non-slip floors).
- Designing and constructing new temporary or permanent shelters to be universally accessible, using universal design principles (see **Key Inclusion Standard 2**). If necessary, seek advice from specialist disability/older people’s organisations to ensure that shelters are accessible.

39. The percentage should be based on participatory needs assessments and SADDD. Where there is no reliable local data, 15 per cent is recommended, based on WHO global estimates. See www.who.int/mediacentre/factsheets/fs352/en/



S3.3 Adapt or build all essential facilities (including schools, health centres, water and distribution points and sanitary facilities) so that all people can access and use them. Identify and remove significant physical obstacles. Budgets need to include specific costs for accessibility – estimate 0.5-1 per cent for buildings.⁴⁰

S3.4 Ensure that the accessibility of shelters is maintained when sub-contracting construction work to local companies, eg by establishing contracts and monitoring processes which specify that users with mobility limitations are considered.

S3.5 Encourage and support people with disabilities and older people to participate in construction activities (eg with instructions and training, childcare or child-, women- and age-friendly spaces, selection of non-physical tasks); and involve men and women equally. Ensure that people who do not have the opportunity (eg because of caring responsibilities) or the capacity to participate (eg because of frailty, a physical or visual limitation, or a learning disability) have access to additional resources based on their needs. Identify service providers who can offer outreach assistance to people with additional support needs.

S3.6 Where people with disabilities and older people are dependent on others for support with shelter construction, minimise the risk of sexual exploitation through consultation, monitoring and organised shelter construction assistance where necessary.

SHELTER, SETTLEMENT AND NFIs STANDARD 4:

People with disabilities and older people, and their carers, are included in the design, implementation and monitoring and evaluation of NFI programmes, and they participate in relevant needs assessments.

► **ACTIONS TO MEET THE STANDARD**

S4.1 Ensure that older people and people with disabilities (women, girls, boys and men), and their carers, are involved in decisions about the provision and distribution of the essential NFIs they need, and in the monitoring and evaluation of NFI programmes. Train all staff undertaking monitoring and evaluation in disability- and age-awareness and use inclusive and gender-sensitive methods of consultation that safeguard people’s dignity.

S4.2 Using community or outreach services, identify those with specific needs and the most vulnerable (eg older people with frailty and those with multiple disabilities or incontinence) and their carers. Ensure that their needs are met, eg requirements for extra blankets in cold and wet weather, mattresses, additional clothing or underwear, appropriate footwear, additional sanitary or hygiene materials (such as incontinence pads or catheter bags) and special utensils for eating and drinking.

40. DFID 2013 'DFID Policy on Standards of Accessibility for Disabled People' notes that incorporating accessibility through Universal Design is cost-effective, accounting for less than 1 per cent of total construction costs. The cost of making adaptations after a building is completed is far greater. www.gov.uk/government/uploads/system/uploads/attachment_data/file/273923/DFID-Policy-standards-accessibility-disabled-people_.pdf

SHELTER, SETTLEMENT AND NFIs STANDARD 5:

Cash and voucher and NFI distributions are designed, targeted and implemented in ways that ensure dignity and minimise exclusion or marginalisation and other risks for people with disabilities and older people.

▶ ACTIONS TO MEET THE STANDARD

S5.1 Include disability and age in selection criteria and ensure the participation of people with disabilities and older people in selection processes at a camp/ community level. Wherever possible, include an outreach component in registration procedures to maximise the inclusion of people who are unable to leave their homes.

S5.2 In consultation with people with disabilities and older people, adapt NFI, cash and voucher distribution methods to ensure safe, dignified and equitable access, particularly for those with frailty or who have mobility-related limitations or who are at risk of exploitation, abuse or neglect.

S5.3 Consider how easy NFIs are to carry, the frequency, location, accessibility and means of distributions, the distances people have to travel to distribution points, the need for support with transport, and the availability of outreach services.

S5.4 Arrange prioritised or separate queues or distribution times for people with disabilities and older people, and adequate seating, shade, water and sanitary facilities at distribution sites.

S5.5 Ensure safe and equal access to cash and voucher transfer programmes for older people and people with disabilities.⁴¹ They should not be unfairly marginalised by lack of access to distribution means (eg mobile phones, bank accounts or ATMs), or by lack of information about, or understanding of, the programme. Compensate for communication difficulties and assist those with little or no literacy or who lack understanding of banking systems, cash and voucher assistance and associated technology.

Keep distribution lists updated and use programme monitoring to ensure that beneficiaries are receiving their full grant and are not exposed to increased risks by cash or voucher programmes.

S5.6 Arrange additional distribution mechanisms for people who have difficulty attending distributions (with or without assistance). Ask these people how they want to receive assistance, and make arrangements for alternative collection (eg by a trusted ‘proxy’) or direct delivery of NFIs or cash grants/vouchers with support of outreach services or trusted community members. Implement ongoing monitoring of individuals or households to ensure the sustainability of these arrangements.

S5.7 Where necessary, partner with other organisations or specialised agencies to provide specialised items or equipment.

S5.8 Carry out post-distribution monitoring, including:

- Checks on the rate that different age and disability groups access supplies.
- Continuous checks on the safety of distribution points and access routes.
- Detection of exploitation, extortion, violence or other discrimination or abuse affecting people with disabilities and older people.
- Attention to people who are particularly at risk of exclusion from NFI programmes (eg widows, adolescent girls with disabilities, children and adults with multiple disabilities and their carers, etc).

41. Note that there is currently a lack of evidence-based guidance on inclusive cash programming, so the safe and equitable inclusion of people with disabilities and older people in cash programming requires further attention than it has received to date.

Example of good practice:**HANDICAP INTERNATIONAL IN BANGLADESH**

The emergency shelter in Alekdia (a village on the Bangladesh coast) was constructed following a cyclone in 1991 that killed 120 people. In 2011, Handicap International (HI) conducted an accessibility audit which showed that the shelter was not accessible. HI and its partner Young Power in Social Action carried out adaptations to remove obstacles at the entrance and constructed a ramp with handrails to reach the ground floor. Pathways and doors to reach the toilets were widened. Toilet chairs, grab bars and accessible water flushing were installed. The Cyclone Shelter Management Committee, which includes people with disabilities, helped decide which adaptations should be implemented. Before, people with disabilities had avoided the shelter, or only evacuated at the last moment, due to the lack of accessibility. Mock drills and visits by people with disabilities to see the changes have helped build awareness and confidence in using the shelter in the event of a disaster.

Source: Handicap International, CBM and IFRC, 2015

RECOMMENDED DOCUMENTS FOR FURTHER GUIDANCE:

CBM International (ND) *Inclusive post-disaster reconstruction: Building back safe and accessible for all*, 16 minimum requirements for building accessible shelters. Retrieved from: www.cbm.org/article/downloads/54741/16-minimum-requirements-for-building-accessible-shelters.pdf

Handicap International (2006) *Disability Checklist for Emergency Response*. Paris: Handicap International. Retrieved from: reliefweb.int/report/world/disability-checklist-emergency-response

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Handicap International (2014) *Conduct an accessibility audit in low- and middle-income countries*. Lyon: Handicap International. Retrieved from: www.hiproweb.org/uploads/tx_hidrtdocs/AccessibilityAudit_PG13.pdf

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IFRC, CBM and Handicap International (2015) *All Under One Roof: Disability-inclusive shelter and settlements in emergencies*. Retrieved from: www.cbm.org/article/downloads/54741/All_Under_One_Roof_-_Disability-inclusive_shelter_and_settlements_in_emergencies.PDF

The Sphere Project (2010) *The Sphere Handbook (Minimum standards in shelter, settlements and non-food items)*. Retrieved from: www.spherehandbook.org

UN High Commissioner for Refugees (UNHCR) (2011a) *Working with persons with disabilities in forced displacement*. Need to Know Guidance 1. Geneva: UNHCR. Retrieved from: www.unhcr.org/4ec3c81c9.pdf

Women's Refugee Commission (2008) *Disabilities Among Refugees and Conflict-Affected Populations. Resource Kit for Fieldworkers*. New York: WRC. Retrieved from: www.asksourc.info/resources/disabilities-among-refugees-and-conflict-affected-populations-resource-kit-field

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BASR



HEALTH

Have you read the
Key Inclusion Standards?

HEALTH STANDARD 1:

People with disabilities and older people, and their carers, affected by crisis are fully included in multisectoral and specific health assessments and in the design, implementation and monitoring of health programmes and services.

HEALTH STANDARD 2:

Healthcare staff are trained and sensitised on disability and age and associated healthcare needs, and in how to respectfully communicate with people with disabilities and older people.

HEALTH STANDARD 3:

People with disabilities and older people affected by crisis have access to comprehensive health services and health information.

HEALTH STANDARD 4:

People affected by crisis, including people with disabilities and older people, have access to trauma/injury care during humanitarian crises to prevent avoidable morbidity, mortality and disability, and people with injuries or disabilities have access to rehabilitation services and assistive aids and devices to help reduce the disabling impacts of injuries or impairments.

HEALTH STANDARD 5:

People with disabilities and older people have access to essential therapies to reduce morbidity and mortality due to chronic health conditions.

HEALTH STANDARD 6:

Children with disabilities have full access to child health services.

HEALTH STANDARD 7:

People with disabilities and older people have full access to sexual and reproductive health services.

HEALTH STANDARD 8:

People with disabilities and older people have access to preventive, diagnostic and therapeutic health services for communicable diseases on an equal basis with others.

HEALTH STANDARD 9:

People affected by crisis, including people with disabilities and older people, have access to mental health services that prevent or reduce emergency-related and pre-existing mental health conditions and associated impaired functioning.



HEALTH STANDARD 1:

People with disabilities and older people, and their carers, affected by crisis are fully included in multisectoral and specific health assessments and in the planning, design, implementation and monitoring of health programmes and services.

► **ACTIONS TO MEET THE STANDARD**

- H1.1** Ensure that health data – including data on communicable and non-communicable diseases (NCDs), injuries and impairments – is systematically disaggregated by sex, age and disability in order to clarify the health needs of adults and children and provide a continuum of care for all ages and people with disabilities. (Recommended minimum age disaggregation: >5, 5 to 59, 60-79, 80 and above.) Apply gender analysis to key health data collected. At community level, use registers (eg those held by community health workers) to identify people with disabilities and older people and their health needs.
- H1.2** Carry out multisectoral and specific health needs assessments to ensure the priority health needs of adults and children of all ages and people with disabilities are met.
- H1.3** Ensure that people with disabilities and older people, and their carers, participate in the development of health strategies. Use accessible and gender-sensitive consultation methods in the design, implementation, monitoring and evaluation of inclusive health programmes and services to improve the quality, coverage and accessibility of the health services (see **Key Inclusion Standard 4**).
- H1.4** Partner with appropriate organisations to guarantee that the most vulnerable adults and children with disabilities and older people are identified, including those living in institutions. Ensure that assessment of protection-related health needs (eg exposure to violence or abuse) is undertaken only by staff who are trained in protection monitoring and assessment (including confidentiality, safe recording and handling of information, and reporting and referral procedures).

HEALTH STANDARD 2:

Healthcare staff are trained and sensitised on disability and age and associated healthcare needs, and in how to respectfully communicate with people with disabilities and older people.

► **ACTIONS TO MEET THE STANDARD**

- H2.1** Provide ongoing training in disability- and age-awareness for health staff, and training on the additional or specific health needs of adults and children with disabilities and older people (eg higher prevalence of NCDs, or complications during pregnancy and childbirth for some women with disabilities).
- H2.2** Put in place codes of conduct, ethical guidelines and procedures for health staff, to support safe and appropriate provision of healthcare for people with disabilities and older people, including their right to impartial needs-based healthcare, and procedures for obtaining informed consent for services.
- H2.3** Make health staff aware of the increased risk of sexual violence faced by people with disabilities (women and girls, but also boys and men) and train them in the safe identification and care of people with disabilities who have experienced sexual violence, respecting their confidentiality.

HEALTH STANDARD 3:

People with disabilities and older people affected by crisis have access to comprehensive health services and health information.

▶ ACTIONS TO MEET THE STANDARD

H3.1 Locate and arrange health services to ensure optimal accessibility and coverage for all, including adults and children with disabilities and older people.

H3.2 Identify and address the physical, financial, security and/or social barriers preventing older people and people with disabilities from accessing essential health services, for example, by:

- Ensuring the physical accessibility of health facilities (eg facilitating transport, installing ramps, etc) and of essential services within health facilities (eg latrines and breastfeeding areas) and costings included in budget plans.
- Using health outreach services.
- Organising specific schedules for people with disabilities and older people to access medical or nursing consultations.
- Providing appropriate mobility aids (wheelchairs, crutches, etc) and other assistive devices (hearing aids, glasses, etc).
- Identifying and addressing significant social barriers affecting access for these groups, including discrimination and stigma.

H3.3 Ensure that the overall health response includes access to: injury care and rehabilitation services; appropriate mobility aids and other assistive devices; mental health and psychosocial support services; and essential medication, equipment and services for the treatment of chronic health conditions.

H3.4 Maintain a continuum of care for people with disabilities and older people by establishing partnerships and referral pathways between health services (including access to specialised services and rehabilitation).

H3.5 Use a range of communication channels and methods (see **Key Inclusion Standard 4**) to ensure that all people with disabilities and older people, and their carers, have access to health prevention and promotion information, and are equally informed about health services.

HEALTH STANDARD 4:

People affected by crisis, including people with disabilities and older people, have access to trauma/injury care during humanitarian crises to prevent avoidable morbidity, mortality and disability, and people with injuries or impairments have access to rehabilitation services and assistive aids and devices to help reduce the disabling impacts of injuries or impairments.

▶ ACTIONS TO MEET THE STANDARD

H4.1 Refer people with serious or catastrophic injuries to the most appropriate medical facility available to provide specialised surgical and medical care, including emergency/corrective surgery if necessary, regardless of their age or disability. Implement procedures for identifying people with injuries, including those who remain within their homes or shelters. Ensure that transportation to treatment facilities is available for injured people and people with disabilities.

H4.2 Make arrangements for referral to post-operative rehabilitation services. At a community level, provide support for home-based nursing and rehabilitative care.

H4.3 Provide appropriate assistive devices and/or rehabilitation services for people with pre-existing physical or sensory impairments in partnership, where possible, with community-based rehabilitation (CBR) programmes, and disabled people’s and older people’s organisations.



HEALTH STANDARD 5:

People with disabilities and older people have access to essential therapies to reduce morbidity and mortality due to chronic health conditions.

▶ ACTIONS TO MEET THE STANDARD

- H5.1** Ensure that emergency health kits include medications to treat NCDs and other chronic health conditions (including diabetes, cardiovascular disease, hypertension, chronic obstructive pulmonary disease, and epilepsy).
- H5.2** Offer people with disabilities and older people continuous access to the diagnosis and treatment of NCDs through appropriate health services. Ensure there is no charge for essential diagnostic equipment, tests and drugs for chronic health conditions.
- H5.3** Make treatment for eye conditions available and accessible for people with visual impairments.

HEALTH STANDARD 6:

Children with disabilities have full access to child health services.

▶ ACTIONS TO MEET THE STANDARD

- H6.1** Ensure that children with disabilities have full access to required medical treatments, including medicines for treating epilepsy and juvenile diabetes; prevention and treatment programmes; and nutrition services (see **Nutrition Standards 1 and 4**).
- H6.2** Structure immunisation programmes to take account of the possibility that some older children with disabilities may have escaped both previous vaccination campaigns and measles.
- H6.3** Make health workers aware of the higher risk of malnutrition and of mortality caused by malnutrition among children with disabilities compared with children without disabilities.
- H6.4** Inform children with disabilities and their parents/guardians/carers of available health facilities, and make sure that children’s health facilities are accessible for those with different disabilities. Ensure that staff working at these facilities have an understanding of the spectrum of childhood disabilities and links with secondary complications and different diseases.



HEALTH STANDARD 7:

People with disabilities and older people have full access to sexual and reproductive health services.

▶ ACTIONS TO MEET THE STANDARD

H7.1 Use a range of communication channels and methods to maximise coverage and inclusion of people with disabilities and older people (see **Key Inclusion Standards 1** and **4**).

H7.2 Ensure and monitor the inclusion of people with disabilities (women, girls, boys and men, including adolescents) and older people in sexual and reproductive health programmes. For example, by:

- Including people with disabilities and older people in contraceptive distribution, awareness-raising activities on contraception and family planning, GBV prevention and response, HIV/AIDS and sexually-transmitted disease (STD) prevention programmes.
- Including people with disabilities and older people in community mobilisation interventions on sexual and reproductive health and rights.

H7.3 Make arrangements for people with disabilities and older people to have full access to sexual and reproductive health services. For example, by providing older women and men, and women, girls, boys and men with disabilities with full access to services that assist survivors of GBV or other violence and abuse, including psychosocial assistance.

- Making emergency obstetric care, post-abortion care and newborn care services available and accessible for girls and women with disabilities, and meeting additional requirements in childbirth for women with disabilities.

HEALTH STANDARD 8:

People with disabilities and older people have equal access to preventive, diagnostic and therapeutic health services for communicable diseases.

▶ ACTIONS TO MEET THE STANDARD

H8.1 Ensure that public health education messages (including messages about communicable diseases) reach all people with disabilities and older people, and their carers.

H8.2 Make primary healthcare services accessible, and organise outreach/mobile clinics to ensure that people with disabilities and older people, and their carers, at risk of contracting or transmitting communicable diseases are identified.

H8.3 Make treatment sites physically accessible so that people who require isolation and treatment of infectious diseases, for example cholera or ebola, can be accommodated.

H8.4 Address disability- or age-related considerations while providing care for communicable diseases, eg management of pressure sores, and/or prevention of contractures for individuals who are unable to move from their beds.



HEALTH STANDARD 9:

People affected by crisis, including people with disabilities and older people, have access to mental health services that prevent or reduce emergency-related and pre-existing mental health conditions and associated impaired functioning.

► **ACTIONS TO MEET THE STANDARD**

H9.1 Make mental healthcare accessible and available for a broad range of emergency-related and pre-existing mental health conditions through clinical healthcare, community-based mental health services and community-based social support. For example:

- Provide psychological first aid and other forms of psychosocial support for people suffering from psychological stress. Make sure this can be accessed by adults and children with disabilities and older people, and their carers (see **Protection Standard 2**).
- Ensure that people with severe mental disorders (including dementia) and other mental and neurological disabilities have access to clinical and community-based care, and set up referral systems between community-based and tertiary services.
- Offer continued treatment for individuals who were receiving mental health treatment before the crisis.

H9.2 In liaison with local and/or national authorities and the institutions concerned, ensure that psychiatric hospitals and other residential institutions are identified and visited regularly,⁴² because the risk of severe neglect or abuse of people in institutions is extremely high. Ensure that basic psychiatric/ psychosocial care and other basic healthcare is provided to patients/residents.

Example of good practice:

IMPROVING ACCESS TO HEALTH SERVICES FOR OLDER PEOPLE IN DARFUR, SUDAN

By 2011, the Darfur emergency of 2003/4 had become a protracted humanitarian crisis, with as many as 2 million people becoming internally displaced – many living in camps throughout Darfur. Of these, an estimated 8 per cent of the camp population were made up of older people. In 2005/6, HelpAge International carried out a series of assessments and surveys to consult older people about their vulnerabilities and health and nutrition needs. Results showed that, for a number of reasons, older people in Darfur were not accessing health services, despite clinics being available. HelpAge established a roster of community health workers to visit older people who were unable to leave their homes/ shelters, providing care and referral as required. They also introduced a donkey cart ambulance to transport older people to clinics for emergency care. Another initiative involved distributing supplementary food baskets to older people at risk of malnutrition, or who were caring for multiple dependants. Meanwhile, HelpAge staff advocated that medical NGOs should set aside specific clinic times each week as priority referral times for older people. When the clinic was unable to source or deliver drugs, HelpAge did this directly, to ensure that older people were accessing the medication they needed. These interventions had a range of positive outcomes. The older people became more willing to access health services on their own, and reported higher levels of wellbeing.

Source: HelpAge International, 2012d

42. Including also residential homes for older people, orphanages, special schools for children with disabilities, detention centres and prisons.

**Example of good practice:****MANAGEMENT OF CHRONIC DISEASES
AMONG SYRIAN REFUGEES IN LEBANON**

A study conducted in 2013 looking at older Syrian refugees in Lebanon found that many were affected by non-communicable diseases (NCDs). For example 60 per cent had hypertension, 47 per cent diabetes and 30 per cent cardio-vascular diseases. With poverty increasing and minimal access to services and assistance, 66 per cent reported deterioration in their health status since they arrived in Lebanon.⁴³ The reported barriers to NCD treatment included difficult access to healthcare, lack of regular access to medication, high cost of healthcare and medication and lack of laboratory tests.⁴⁴ In response, in August 2014, HelpAge International and partners launched a project to contribute to the decrease in morbidity and mortality linked to chronic diseases among Syrian refugees and host communities, by improving the management of diabetes and hypertension at primary healthcare level. The project was implemented in seven health facilities located in poor, under-served areas of Lebanon. All people coming to these centres, run by the Lebanese NGO Amel, were screened for diabetes and hypertension.

Those affected or at risk were offered a package of comprehensive services including clinical examination, laboratory tests, necessary chronic medication and patient education. Health facilities were equipped with the necessary material and Amel staff assessed and trained on WHO guidelines for the management of hypertension and diabetes, by the Lebanese diabetes and cardiology societies. Training was also conducted on medication use and management, as well as data collection. In 6 months, 2,447 people were screened; 63 per cent were found affected and 14 per cent at risk or undiagnosed. More than 90 per cent of enrolled patients had baseline laboratory tests and around 40 per cent of the patients had medical follow up visits. Patients also received health education, including advice on healthy diets and lifestyle. The project thus provided much-needed access to NCD care for patients otherwise unable to afford it, and built capacity of health centre staff to identify and manage these conditions – thus providing more inclusive healthcare.

Source: HelpAge International Lebanon

43. Health status and health needs of older refugees from Syria in Lebanon *Conflict and Health* (2015) 9:12, doi: 10.1186/s13031-014-0029-y

44. HelpAge International and Handicap International (2014) “Hidden victims of the Syrian crises: disabled, injured and older refugees”, & UNHCR (2014) “Health access and utilisation survey among non-camp Syrian refugees.” Available at data.unhcr.org/syrianrefugees/download.php?id=6029



RECOMMENDED DOCUMENTS FOR FURTHER GUIDANCE:

Handicap International (2006) *Disability Checklist for Emergency Response*. Paris: Handicap International. Retrieved from: reliefweb.int/report/world/disability-checklist-emergency-response

Handicap International (2013) *Mental health and psychosocial support interventions in emergency and post-crisis settings*. Lyon: Handicap International. Retrieved from: www.hiproweb.org/uploads/tx_hidrtdocs/PG10Psychosocial.pdf

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World Health Organization (2009) 'Persons with disabilities particularly vulnerable to HIV/AIDS'. Podcast transcript: 10 June 2009, hosted by Veronica Riemar. Retrieved from: www.who.int/mediacentre/multimedia/podcasts/2009/disabilities_hiv_20090610/en

World Health Organization (2013) *Guidance Note on Disability and Emergency Risk Management for Health*. Geneva: WHO. Retrieved from: apps.who.int/iris/bitstream/10665/90369/1/9789241506243_eng.pdf

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J. Mc Geoury/Handicap International



EMERGENCY EDUCATION

Have you read the
Key Inclusion Standards?

EDUCATION STANDARD 1:

The participation of girls and boys and young people with disabilities in education is systematically assessed and monitored, and barriers to participation are identified to inform inclusive education responses.

EDUCATION STANDARD 2:

Parents and guardians of children and young people with disabilities, and girls and boys with disabilities, participate in needs assessments and in the design, implementation, monitoring and evaluation of education services and interventions. Humanitarian actors actively promote an inclusive community environment that is supportive of including girls and boys with disabilities in education.

EDUCATION STANDARD 3:

Girls and boys with disabilities have full access to quality and relevant education opportunities.

EDUCATION STANDARD 4:

People with disabilities and older people have full access to vocational training, skills training and adult literacy classes.



EDUCATION STANDARD 1:

The participation of girls and boys and young people with disabilities in education is systematically assessed and monitored, and barriers to participation are identified to inform inclusive education responses.

► **ACTIONS TO MEET THE STANDARD**

E1.1 Use relevant national or other population data to inform the initial education response; give consideration to the likelihood that official data on children with disabilities may be inaccurate. Use registration processes to screen for children with disabilities and use sex-, age- and disability-disaggregated data to inform the planning and implementation of emergency education programmes (see **Key Inclusion Standard 1**).

E1.2 Use additional sources of information to improve data collection of children with disabilities (eg nutrition and health programmes) and develop and establish protocols to ensure the confidential sharing of data and referral processes. Ensure that education programme planning is flexible and responsive to changes in the estimated percentages of children with disabilities attending or not attending school.

E1.3 Include children and young people with disabilities in all assessments on protection and education monitoring. Make sure that household and other surveys collect data specifically relating to these groups. Directly consult girls and boys with disabilities, and their families/carers, using inclusive communication methods (see **Key Inclusion Standard 4**).

E1.4 Consult key informants (eg teachers from the community and representatives of disabled people’s organisations) about the participation of children with disabilities in school education. Ensure that data on school enrolment is disaggregated by age, sex and disability, and that data on the main disability types is collected and analysed using standardised questions/criteria (see **Key Inclusion Standard 1**).

E1.5 Use child protection rapid assessments to identify vulnerable or excluded children with disabilities. Anticipate that children with disabilities, who may not be visible in initial assessments, need to be included as project plans develop (eg children concealed within homes and those in residential special schools).

E1.6 Analyse the participation and education needs of children with disabilities. Take into consideration the overall percentage of children with disabilities in the community, their previous inclusion and/or exclusion from education, and any gender- or disability-specific, protection-related or social/cultural barriers to access.

E1.7 Continuously assess and monitor participation of children with disabilities, to demonstrate an increase in their participation rates into educational activities. Set up a reporting structure for schools, paying particular attention to the enrolment, retention and outcomes for vulnerable learners, including children and young people with disabilities.



EDUCATION STANDARD 2:

Parents and guardians of children and young people with disabilities, and girls and boys with disabilities, participate in needs assessments and in the design, implementation, monitoring and evaluation of education services and interventions. Humanitarian actors actively promote an inclusive community environment that is supportive of including girls and boys with disabilities in education.

► ACTIONS TO MEET THE STANDARD

- E2.1** Remove barriers to participation relating to gender, disability, or age in the development of education programmes. Ensure that people with disabilities and/or disabled people’s organisations and parents and guardians of children with disabilities are represented in community-level education committees and in all key forums where decisions are made that affect education.
- E2.2** Invite people with disabilities to participate in the construction, adaptation and maintenance of the learning environment. When identifying sites and (re)constructing education facilities, involve and consult parents and guardians of children and young people with disabilities and disabled people’s organisations.
- E2.3** Conduct community awareness-raising and information campaigns to sensitise teachers, parents and guardians, students, community leaders and the wider community about disability issues. Use the relevant range of communication channels to maximise coverage (see **Key Inclusion Standard 4**). Emphasise the importance of education and access to school for all children with disabilities.
- E2.4** Actively address information barriers to school attendance for children with disabilities. Take steps to ensure that key information about education is accessible to people with disabilities (see **Key Inclusion Standard 4**).

EDUCATION STANDARD 3:

Girls and boys with disabilities have full access to quality and relevant education opportunities.

► ACTIONS TO MEET THE STANDARD

- E3.1** Make sure the education response is designed with dedicated budget lines to allow for continuing assessment and reasonable adjustments to support the inclusion of children and young people with disabilities (eg adapted tables and chairs in school and classroom, transport to and from school or provision of learning aids such as magnifiers).
- E3.2** Provide training for teachers, volunteers and students, as well as their parents and guardians, on how to challenge attitudes and perceptions which create barriers to inclusive education.
- E3.3** Encourage teachers, community groups, disabled people’s organisations and other relevant actors to identify girls and boys with disabilities who are not at school and to address their exclusion.
- E3.4** Address barriers caused by distance, security and practicalities of travel to and from school, specifically for girls. Consult children and young people with disabilities, and their families, about how to overcome these obstacles. Provide assistance with transport, accompanied travel, or itinerant teaching programmes for those who need them.
- E3.5** Ensure the accessibility of school buildings and facilities for children and young people with disabilities. Provide mobility devices (eg wheelchairs) and assistive devices (eg hearing aids and batteries) as required (in partnership with disabled people’s organisations or specialised agencies if necessary). Ensure the accessibility of latrines (separate ones for boys and girls). Allocate specific budgets for accessibility in programme planning.
- E3.6** Address enrolment barriers, particularly for those children and young people with disabilities who have not been registered at birth and lack identity documents.
- E3.7** Relax school uniform and other material requirements for attending school.



E3.8 Ensure that teaching is accessible for children and young people with disabilities, with staff training, teaching methods, curriculum and additional support and adjustments in place to maximise the inclusion of children with disabilities.⁴⁵ Consult children and young people, and their families, directly about their individual access and learning needs. Organise special classes/sessions to prepare children with disabilities to access mainstream education.

E3.9 Ensure the safety of the school environment for girls and boys and young people with disabilities. This includes:

- Giving consideration to the potentially higher risks for children and young people with disabilities to sexual or other violence, abuse or exploitation.
- Implementing safeguarding policies to ensure protection of children and young people with disabilities.
- Ensuring children and young people with disabilities can access essential information relating to their safety and protection (eg sexual and reproductive health education, and where to report any abuse or exploitation).

E3.10 Consider other models of education at community level, eg setting up home-based schooling and specialised units to children with specific needs, such as communication and developmental learning needs.

E3.11 Train education staff to recognise signs of psychosocial and mental disorders, such as behavioural disorders and anxiety-related conditions. Set up referral protocols with psychosocial and other health services to ensure effective treatment and follow up.

E3.12 Promote and actively support inclusive staffing and volunteering policies in schools and other education activities, including active support for the involvement of women and men with disabilities and older women and men.

EDUCATION STANDARD 4:

People with disabilities and older people have full access to vocational training, skills training and adult literacy classes.

► **ACTIONS TO MEET THE STANDARD**

E4.1 Include older women and men and people with disabilities of all ages in assessments of education and training needs. Ensure they participate in the design of non-formal education programmes, eg literacy, numeracy or vocational or skills (life and technical) training for those who are illiterate or may not have completed their schooling.

E4.2 Enlist community workers and disabled people's and older people's organisations to help identify the skills and training needs of people with disabilities and older people and encourage these people to participate in vocational and other training opportunities.

E4.3 Make all non-formal education programmes fully accessible to women, men, girls and boys with disabilities and to older women and men. Adapt communication methods and other accessibility arrangements as necessary.

E4.4 Design monitoring systems to identify and support responses to any form of discrimination (intentional or unintentional) in non-formal education affecting people with disabilities and older people.

45. see INEE Access and Learning Environment Standard 1 and Teaching and Learning Standard 3 (INEE, 2010a)



Examples of good practice:

SAVE THE CHILDREN SWEDEN IN PAKISTAN

In Pakistan in 2005, after widespread displacement caused by the Kashmir earthquake, Save the Children Sweden set up community education councils linked to rehabilitation schools. Each school council included at least two children who were asked to report who was not in school and why they thought these children were absent. The school councils found that often girls and children with disabilities were kept at home because their families thought that going to school was not safe, or their children wouldn't benefit from education, or because they feared their children might get injured or get lost. This reluctance to send disabled children to school could have been interpreted as traditional resistance to inclusion rather than stemming from practical concerns. Once identified, the community education council developed plans to make it easier for them to come to school and to have a positive experience once there.

Source: INEE, 2009.

WOMEN'S REFUGEE COMMISSION IN NEPAL AND THAILAND

The Women's Refugee Commission (WRC) reports how in refugee camps in Nepal and Thailand, early childhood intervention programmes were put in place to identify children with disabilities and help them to integrate into mainstream schools. Classroom support was provided for refugee children with severe educational needs and there was on-going training of support teachers as well as mainstream teachers to help support inclusive education. Teaching aids and appropriate curricula were developed and children with severe educational needs were provided with mobility aids and learning accessories, such as Braille text books to support their learning. In general, WRC found that inclusive education could be a good entry point for people with disabilities to access other services. For example, through early childhood intervention programmes, refugee children with disabilities could be referred to appropriate health services, and parent support groups were a positive starting point to provide psychosocial support to parents of children with disabilities.

Sources: R. Reilly, 2010; Women's Refugee Commission, 2014



RECOMMENDED DOCUMENTS FOR FURTHER GUIDANCE:

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ANNEX I: DISAGGREGATION OF DATA BY SEX, AGE AND DISABILITY (SADDD)

The collection and use of data that is disaggregated by sex, age and disability, is essential for shaping an inclusive response to a humanitarian crisis. Methods for collecting sex- and age-disaggregated data (SADD), including older age groups, are now well-established (if not always implemented) as an accepted standard across the humanitarian system. The Standards recommend disaggregating data for females and males according to the following cohorts: 0-5; 6-12; 13-17; 18-49; 50-59; 60-69; 70-79; and 80+.⁴⁶

The systematic disaggregation of data by disability presents a greater challenge to humanitarian organisations, due to the technical nature of identification and classification of disability. There are several tools currently available, a number of which are identified below:

1. The Washington Group Questions: The Washington Group Questions have been adopted by the UN's Washington Group on Disability Statistics. The Washington Group Questions aim to identify limitations in areas of basic activity functioning that are found universally, are most closely associated with social exclusion, and which occur most frequently. A 'Short Set' of six questions seek to identify people with functional limitations that have the potential to limit their independent participation in society. Responses are categorised on a scale of severity of the difficulty experienced (ie no difficulty, some difficulty, a lot of difficulty, and cannot do at all).

The questions are:

1. Do you have difficulty seeing, even if wearing glasses?
2. Do you have difficulty hearing, even if using a hearing aid?
3. Do you have difficulty walking or climbing steps?
4. Do you have difficulty remembering or concentrating?
5. Do you have difficulty (with self-care such as) washing all over or dressing?
6. Using your usual (customary) language, do you have difficulty communicating, (for example understanding or being understood by others)?

46. The Sphere Project (2010) The Sphere Handbook. Retrieved from: www.spherehandbook.org Core Standard 3: Assessment

The categories allow for multiple disability scenarios to be described depending on the domain of interest (eg seeing, hearing) and the level of severity at which the term 'disability' is defined. The Washington Group recommends that all those with at least one domain that is coded as "a lot of difficulty" or "cannot do it at all" is identified as a person with disability. An 'Extended Set' of questions is also available.⁴⁷ www.cdc.gov/nchs/washington_group/wg_questions.htm

2. The Australian Information Matrix: This tool, which has been used in the Australian census since 2006, seeks to identify the population with actual or potential long-term health problems. A number of data elements are used together to assess the functional status of a person across a range of life areas. This leads to a classification of 'Activity limitation' which takes into account both the level of activity/participation, and also the need for assistance. meteor.aihw.gov.au/content/index.phtml/itemId/505770

3. The UNHCR Heightened Risk Identification Tool: contains a number of specific questions on older people and people with disabilities, amongst other vulnerable groups. The tool is available at www.refworld.org/cgi-bin/telex/vtx/rwmain?docid=4c46c6860 and its user guide at www.refworld.org/cgi-bin/telex/vtx/rwmain?docid=46f7c0cd2

4. WHODAS: This is a generic assessment instrument for assessing health and disability. It aims to be applicable in both clinical and general population settings to produce standardised disability levels and profiles, applicable across cultures, and in all adult populations. It is directly linked to concepts used by the International Classification of Functioning, Disability and Health (ICF). www.who.int/classifications/icf/whodasii/en/

47. The Washington Group and UNICEF have also have a survey module to measure child functioning and disability: www.un.org/disabilities/documents/events/UNICEF_side_event_LOEB.pdf

ANNEX II: GAPS IN EXISTING STANDARDS AND GUIDANCE REQUIRING ATTENTION BY HUMANITARIAN ACTORS

Through the process of developing these Minimum Standards, a number of specific gaps in existing literature relevant to the inclusion of people with disabilities and older people in humanitarian response have been identified as requiring further attention and development:

- Across all sectors, there is currently a lack of systematic consideration of the needs and participation of carers, both as regards their role in ensuring that the needs of the people they care for are met (eg accessing food or other assistance for people that they care for), and as regards their own specific needs and vulnerabilities as carers (eg where caring responsibilities make it difficult or impossible to access assistance and services). Children who are carers of siblings or adults with disabilities, older carers of people with disabilities, and older people who care for children, have little visibility in the majority of relevant humanitarian standards and guidance documents. While these Standards include attention to carers, this is an area that nevertheless demands further development.
- There is a paucity of standards and guidance in either specialist or mainstream literature on meeting the needs of people in residential institutions, including care homes, special schools, orphanages, psychiatric institutions, detention centres and prisons, where the proportion of people with disabilities and older people among residents may be significantly higher than in the general population.
- Much of the existing disability- and age-centred standards and guidance literature assumes application in situations where humanitarian organisations have considerable control over the physical environment and good access to affected populations, such as camps located in rural areas. More attention needs to be given to the development, applicability and associated indicators for more challenging environments, such as remote and/or insecure rural areas and conflict-affected urban areas.
- Given that cash programming is becoming increasingly important across the humanitarian system, there is an urgent need to look at how people with disabilities and older people can be safely and equitably included in cash-based interventions of different kinds, as this challenge appears not to have yet received the attention it deserves.
- The human resource requirements associated with inclusive programming need closer attention and relevant standards need to be further developed accordingly.
- Although international child protection standards are now widely recognised and applied across the humanitarian system, gaps remain in how these have been picked up within emergency education standards and guidance, particularly in relation to children with disabilities.
- The inclusion of people with disabilities (including children with disabilities) in nutrition programmes has received very little attention to date, and consequently, the nutrition standards developed in this pilot version are derived principally from guidance developed on nutrition support for older people. This area requires urgent and close attention, particularly in light of the potentially higher risks of malnutrition among children and other people with disabilities compared with the general population.⁴⁸ The hygiene and water needs of people with disabilities in crisis contexts have also received little attention compared with inclusive WASH programming in development contexts.
- People with multiple disabilities (including children) and their carers, and people with severe learning and/or psychosocial disabilities may be acutely vulnerable in situations of crisis, but there is little specific guidance to support inclusive humanitarian assistance and protection for these groups.

48. See Groce et al, 2013.

ANNEX III: ACRONYMS

CBO	Community-based organisation
CBR	Community-based rehabilitation
CFS	Child-friendly space
CHS	Core Humanitarian Standard on Quality and Accountability
GBV	Gender-based violence
IDP	Internationally displaced person
MAM	Moderate acute malnutrition
MUAC	Middle-upper arm circumference
NCD	Non-communicable disease
NFIs	Non-food items
NGO	Non-governmental organisation
RUTF	Ready-to-use therapeutic foods
SADDD	Sex-, age- and disability disaggregated data
SAM	Severe acute malnutrition
SFP	Supplementary feeding programme
SOP	Standard operating procedures
STD	Sexually transmitted disease
UN	United Nations
UNHCR	Office of the United Nations High Commissioner for Refugees
WASH	Water, sanitation and hygiene
WHO	World Health Organization

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A man having just received emergency relief items, Concepcion, Panay Island, the Philippines after typhoon Haiyan, November 2013.

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