unicef
for every child

Guidance

Including children with disabilities in humanitarian action

Health and HIV/AIDS

Series of guidance consists of six booklets:

Including Children with Disabilities in Humanitarian Action

Preparedness
Response and early recovery
Recovery and reconstruction

Health and HIV/AIDS

Acknowledgements

UNICEF in collaboration with Handicap International prepared *Guidance on Including Children with Disabilities in Humanitarian Action: Health and HIV/AIDS.* The core team included Ricardo Pla Cordero, Gopal Mitra and Megan Tucker. The booklets were developed under the supervision of Rosangela Berman Bieler, Senior Advisor and Chief, Disability Section, UNICEF.

Colleagues from UNICEF country offices, regional offices and headquarters as well as external experts also made substantial contributions to the development of this booklet. Thanks go Besan AbdelQader, Dina Al Jamal, Kate Alley, Jaya Burathoki, Anna Burlyaeva, Dick Chamla, Begna Edo, Anne Filorizzo, Jumana Haj-Ahmed, Ettie Higgins, Sunita Kayastha, Muhammad Rafiq Khan, Marie Leduc, Jennifer Leger, Chewe Luo, Asma Maladwala, Aline Mandrilly, Jane Mwangi, Maureen Njoki, Heather Papowitz, Luwei Pearson, Stefan Swartling Peterson, Beth Ann Plowman, Hendrikus Raaijmakers, Cristina Roccella, Jessica Rodrigues, Tamara Rusinow, Lieve Sabbe, Yukiko Sakurai, Cecilia Sanchez Bodas, Midori Sato, Betsy Sherwood, Frederic Sizaret, Peter Skelton, Pauline Thivillier, Nurten Yilmaz and Juliet Young and for their valuable contributions, including expert input, advice and insight.

The guidelines were validated in Jordan and Nepal, with sincere thanks to all participants in the validation workshops (a list of workshop participants is available on the website). Special thanks go to Isabella Castrogiovanni, Kendra Gregson, Ettie Higgins, Tomoo Hozumi, Doreen Mulenga and Alok Rajouria for their support.

Special thanks go to UNICEF colleagues from the Division of Communication for providing guidance on the publishing of this booklet: Angus Ingham, Catherine Langevin-Falcon, Timothy Ledwith, Christine Nesbitt, David Ohana, Charlotte Rutsch and Samantha Wauchope.

UNICEF does not necessarily share or endorse the examples from external agencies contained in this publication.

The six booklets, accompanying materials and information (such as posters, presentations, checklists, etc.) can be found at training.unicef.org/disability/emergencies.

In addition to the print and PDF versions, the guidance is also available in a range of accessible formats, including EPUB, Braille-ready file and accessible HTML formats. For more information, please contact disabilities@unicef.org.

Editor: Christine Dinsmore
Copy editor: Timothy DeWerff
Fact checker: Hirut Gebre-Egziabher
Layout and graphic design: Jason Robinson
Illustrator: Frank Barbara

An estimated one in every 10 children has a disability. Armed conflict and disasters further increase disabilities among children. Within any crisis-affected community, children and adults with disabilities are among the most marginalized, yet they often are excluded from humanitarian assistance.

The UNICEF Core Commitments for Children in Humanitarian Action are a framework to deliver humanitarian assistance to all children, regardless of their status or context. Children with disabilities are first and foremost children, requiring the same basic services to survive and thrive: nutrition, health care, education, safe water and a protective environment. They have additional needs owing to their disability, such as accessible environments and assistive devices.

UNICEF was one of the first organizations to endorse the Charter on Inclusion of Persons with Disabilities in Humanitarian Action, launched at the World Humanitarian Summit. This further demonstrates our commitment to addressing the rights and needs of children with disabilities.

Including children with disabilities requires a better understanding of the challenges they face in humanitarian crises. It is also essential to know how to tailor humanitarian programmes to meet their needs and to partner with organizations that have expertise on issues related to disability.

UNICEF's humanitarian programmes around the world are increasingly reaching out to children with disabilities. The number of UNICEF country offices reporting on disability inclusive humanitarian action increased fivefold over the last five years. This guidance, developed through extensive consultation with UNICEF staff, provides practical ways to make humanitarian programmes more disability inclusive. We hope it will support humanitarian practitioners to make humanitarian action more equitable and inclusive of children with disabilities.

Ted Chaiban
Director, Programme Division
UNICEF

Manuel Fontaine
Director, Office of Emergency Programmes
UNICEF

Contents

5W	who does what, where, when and for whom
AIDS	Acquired Immunodeficiency Syndrome
CCC	UNICEF Core Commitments for Children in Humanitarian Action
CRPD	Convention on the Rights of Persons with Disabilities
DPO	Disabled Persons Organization (also known as an organization of persons with disabilities)
HIV	Human Immunodeficiency Virus
ISO	International Standardization Organization
MHPSS	Mental Health and Psychosocial Support
MICS	Multiple Indicator Cluster Survey
NGO	non-government organization
RECU	reach, enter, circulate and use
SitRep	situation report
SRH	sexual and reproductive health
UNDP	United Nations Development Programme
UNHCR	United Nations High Commissioner for Refugees
WASH	water, sanitation and hygiene
WHO	World Health Organization
WRC	Women's Refugee Commission

The purpose of *Including Children with Disabilities in Humanitarian Action* is to strengthen the inclusion of children and women with disabilities and their families in emergency preparedness, response and early recovery, and recovery and reconstruction. This series of booklets provides insight into the situation of children with disabilities in humanitarian contexts, highlights the ways in which they are excluded from humanitarian action, and offers practical actions and tips to better include children and adolescents with disabilities in all stages of humanitarian action.

The booklets were created in response to UNICEF colleagues in the field expressing a need for a resource to guide their work. The information and recommendations are based on evidence and good practices gathered from literature and field staff experiences.

Box 1: Target audience

All health and HIV/AIDS humanitarian staff can contribute significantly to the inclusion of children with disabilities, even if not an expert or specialist on issues related to disability. This booklet provides practical tips and entry points to start the process.

While primarily for UNICEF field staff including health and HIV/AIDS humanitarian field officers, coordinators, specialists and advisors, the guidance can also be useful for UNICEF partners and other stakeholders. All staff can play an active role in ensuring that children with disabilities are included in humanitarian interventions.

'Practical tips' (*see Section 9*) contains hands-on advice that humanitarian officers, doctors, nurses, rehabilitation staff and community health workers may find useful when engaging directly with children with disabilities and their families (e.g., when providing health services, HIV testing or in designing messages for affected populations).

The guidance comprises six booklets on how to include children and adolescents with disabilities in humanitarian programmes: 1) general guidance; 2) child protection; 3) education; 4) health and HIV/AIDS; 5) nutrition; 6) water, sanitation and hygiene (WASH). Each booklet is a stand-alone resource with sector-specific humanitarian actions for embracing children, adolescents and families with disabilities.

The actions and practical tips are relevant across various humanitarian contexts:

- Rapid-onset disasters, such as flood, earthquake, typhoon or tsunami;
- Slow-onset disasters, such as drought or famine;
- Health emergencies, such as Ebola;
- Forced displacement, including refugees and internally displaced persons;
- Armed conflict, including protracted crisis.

This guidance is focused on the *inclusion* of children with disabilities in emergency health interventions, a right of all persons with disabilities. While *preventing* disabilities is also a matter of public health (including in humanitarian contexts), it is outside the scope of the guidance.

Feedback and comments: This resource is a living document that will be updated and adapted as UNICEF's work to include children with disabilities in humanitarian action develops and the resource is applied in the field. UNICEF colleagues and partners can send feedback to disabilities@unicef.org.

Box 2: Children and adolescents with disabilities

According to the Convention on the Rights of Persons with Disabilities (CRPD), adults, adolescents and children with disabilities include those who have:

- Long-term physical, mental, intellectual or sensory impairments, and
- Barriers that may hinder their full and effective participation in society on an equal basis with others (UN, 2006).

Ratified by 174 countries as of June 2017, the CRPD underscores that children and adolescents with disabilities have the right to reach their highest attainable standard of health and to attain and maintain maximum independence.[1] This includes equal access to sexual and reproductive health care, HIV information, prevention, care and treatment, and comprehensive rehabilitation services and programmes (*see Glossary, Section 11*).

[1] Countries that have ratified the CRPD must report on progress to meet the commitments outlined in the Convention, including those related to Article 11 on humanitarian situations. For the list of countries that have ratified the CRPD, country reports and concluding observations on these reports by the CRPD Committee, see www.ohchr.org/EN/HRBodies/CRPD (UN 2006).

- Disasters and conflict can have catastrophic consequences on the health of children and adolescents with disabilities, including the following:
  - Increased risk of childhood illnesses such as influenza, diarrhoea and pneumonia, for which access to health care services is required[2] (UNICEF and WHO, 2012).
  - Increased risk of secondary conditions such as pressure sores and urinary tract infections in children with physical disabilities (WCPT, 2016) and opportunistic infections for HIV positive children with disabilities (IASC, 2004).
  - Increased risk of new disabilities due to untreated chronic diseases (Handicap International and HelpAge International, 2014).
  - Onset of psychosocial conditions[3] such as situational anxiety and post-traumatic stress disorder, as well as worsening of pre-existing conditions such as schizophrenia and depression (Reinhardt et al., 2011).
  - In humanitarian contexts, children with disabilities are more likely than their peers without disabilities to experience psychological distress due to separation from caregivers, breakdown of routine, high risk of abuse, etc. (UNICEF, 2013).

- Girls with disabilities are particularly vulnerable to sexual violence, especially in conflict-affected contexts, increasing injuries and risk of exposure to HIV and other sexually transmitted infections[4] (Oxford University, 2010).

- Girls with disabilities may also be exposed to violence and human rights violations as a result of their disability and gender, such as forced or coerced sterilization, withholding of assistive devices for mobility and communication, and denial of assistance for personal hygiene and/or daily tasks (Human Rights Council, 2012).

---

[2] Children with disabilities are significantly more likely to experience serious illness compared to their peers without disabilities in the 12 months after an emergency (UNHCR and Reach, 2014).

[3] Psychosocial conditions are a type of disability. *See the Glossary, Section 11* for more information on the different types of disabilities.

[4] As shown in a study in conflict-affected Northern Uganda.

- A significant number of traumatic injuries and acquiring of new disabilities can result from disasters (e.g., earthquakes) (Reinhardt, 2011) and armed conflict, both in children with and without existing disabilities.
  - Compared to adults, children are disproportionately affected by explosive remnants of war. In 2013, children made up 46 per cent of global explosive remnants of war casualties; however, in some countries, such as the Democratic Republic of Congo (DRC), this percentage is as high as 90 per cent (Landmine and Cluster Munition Monitor, 2014).

- Persons with disabilities also have higher mortality rates in disasters – for instance, in the 2011 earthquake and tsunami in Japan the mortality rate among persons with disabilities was double that of the rest of the population (IFRC, Handicap International and CBM, 2015).

Marmane, 8, looks over her shoulder as she sits in a wheelchair at a rehabilitation centre run by the international NGO Médecins Sans Frontières, in Port-au-Prince, Haiti. She was struck in the neck by a stray bullet while playing in the schoolyard and is now paralysed from the waist down.

- Reliable, detailed and disaggregated data on the prevalence of disability and health conditions associated with disability are rarely collected in health information systems (Reinhardt, 2011).

- Health care services for psychosocial conditions are often unavailable in humanitarian contexts (WRC, 2013b).

- Health care staff are not trained to treat and communicate with children and adolescents with disabilities (WHO, CBM et al., 2013).

- Low- and middle-income countries often have poorly resourced rehabilitation services, which are quickly overwhelmed after a disaster (WCPT, 2016), restricting access for children with pre-existing and newly acquired disabilities.

- Incorrect perceptions that children with disabilities do not need vaccinations may prevent their access to Expanded Programmes on Immunization.

- Erroneous beliefs that adolescents with disabilities do not (or should not) engage in sexual relations may result in denial or exclusion from sexual and reproductive health information and services, including those related to HIV (UNICEF, 2013).

- Health-related information, including information on sexual and reproductive health, HIV and emergency health services may not be in formats that children, adolescents and caregivers with disabilities can understand.

- Research amongst Syrian refugees in Iraq found temporary health centres and clinics in humanitarian settlements are often hard to reach, overcrowded, not accessible and do not provide priority or alternative access for persons with disabilities, such as home-based or outreach care (UNHCR and Reach, 2014).

- Children and adolescents with disabilities may lose their assistive devices (*see Glossary, Section 11*) in humanitarian

crises and disruption in health services may prevent or delay their replacement. This reduces their ability to access services (WRC, 2013a), including HIV prevention and treatment such as antiretroviral treatment, post-exposure prophylaxis and prevention of mother-to-child transmission.

4.1 UNICEF's Core Commitments for Children in Humanitarian Action

UNICEF's Core Commitments for Children in Humanitarian Action (CCC), a global framework to guide UNICEF and partners in emergencies, outline commitments and benchmarks related to health and HIV/AIDS interventions in humanitarian action. They include provision of malaria prevention, essential household items, Expanded Programme on Immunization, obstetric care and continuation of antiretroviral treatment including for the prevention of mother-to-child transmission (UNICEF, 2010). All health and HIV/AIDS core commitments are applicable for children with disabilities. (*See Annex for specific inclusive actions for each health and HIV/AIDS commitment*).[5]

The CCCs advocate the 'Do no harm' principle in humanitarian action. The principle addresses the specific needs of the most vulnerable groups of children and women – including children with disabilities – and develops targeted programme interventions, stressing to avoid causing or exacerbating conflict between groups of people (UNICEF, 2010).

4.2 Sphere Humanitarian Charter and Minimum Standards

Initiated in 1997 by humanitarian non-government organizations (NGOs) and the International Red Cross and Red Crescent Movement, the Sphere Project aims to improve the quality of actions during disaster response and to ensure accountability. The Sphere Project sets both a humanitarian charter and a set of minimum standards for WASH, food security and nutrition, shelter, settlement and non-food items and health. The rights of persons with disabilities are cross-cutting themes within the Sphere handbook, both in mainstreamed and targeted actions (Sphere Project, 2011).

[5] For more information on the UNICEF CCCs, see www.unicef.org/emergencies/index_68710.html.

4.3 Minimum Standards for Emergency Medical Teams

Emergency Medical Teams are an important part of the global health workforce and have specific roles. Any doctor, nurse or paramedic team coming from another country to practice health care in an emergency must be a member of a team. The minimum standards for foreign medical teams in sudden-onset disasters discuss the principles and core standards of how registered Emergency Medical Teams must function and declare their operational capabilities,[6] while the minimum technical standards and recommendations for rehabilitation set the standards for rehabilitation in emergencies.[7]

4.4 Charter on Inclusion of Persons with Disabilities in Humanitarian Action

The Charter was launched at the World Humanitarian Summit in Istanbul, Turkey, on 23 and 24 May 2016. It commits endorsing States, United Nations agencies, civil society organizations and organizations of persons with disabilities (DPOs) to make humanitarian action inclusive of persons with disabilities, lift barriers to accessing humanitarian services and ensure the participation of persons with disabilities. The charter has been widely endorsed.[8]

4.5 Twin-track approach

The twin-track approach strengthens the inclusion of children with disabilities in health and HIV/AIDS interventions (*see Figure 1*).

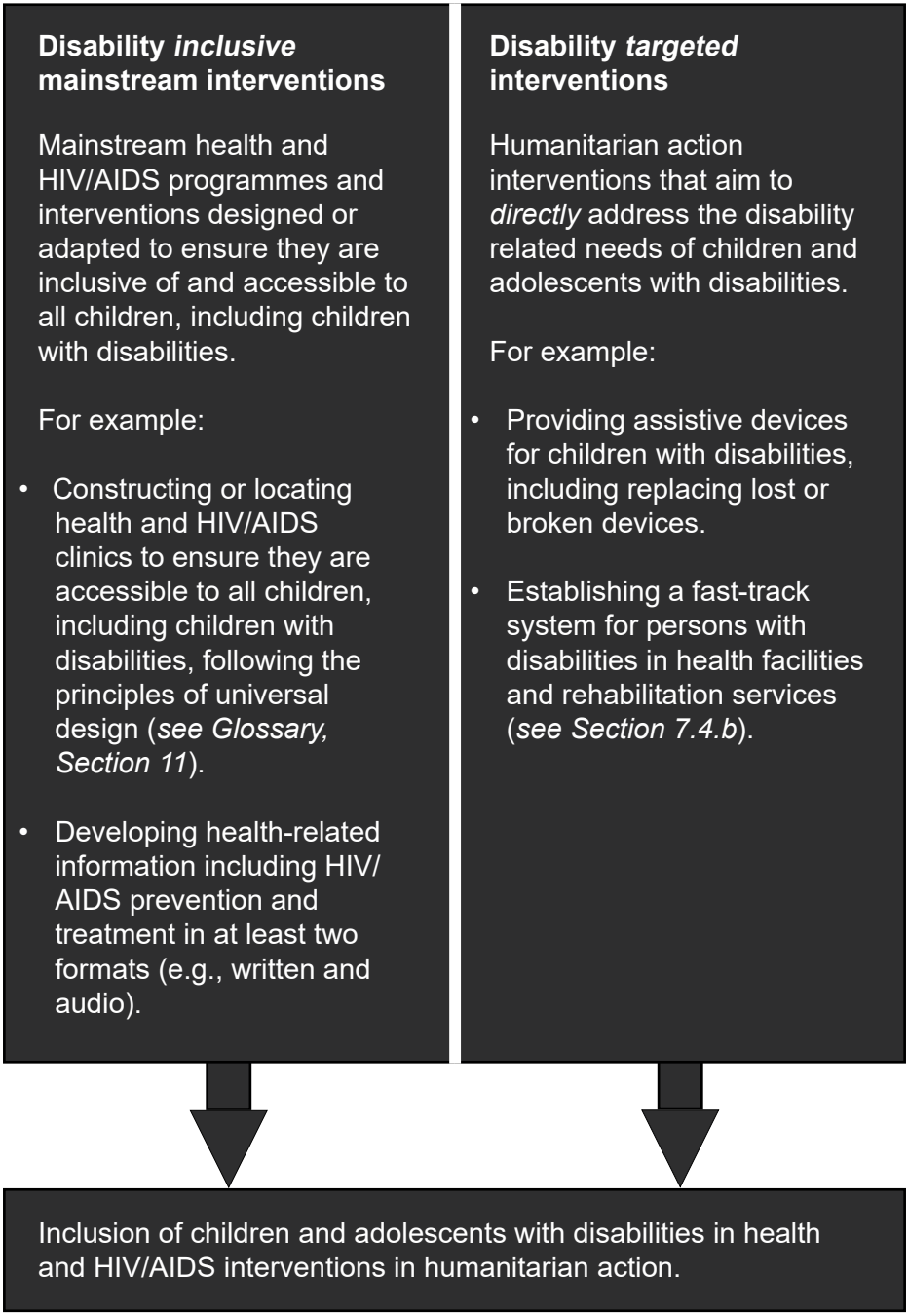
---

[6] For more information on Emergency Medical Teams, see www.who.int/hac/techguidance/preparedness/emergency_medical_teams/en and for minimum standards, see www.who.int/hac/global_health_cluster/fmt_guidelines_september2013.pdf?ua=1.

[7] For more information on rehabilitation standards, see https://extranet.who.int/emt/content/minimum-technical-standards-and-recommendations-rehabilitation.

[8] For the list of endorsees including States, United Nations agencies and NGOs, see http://humanitariandisabilitycharter.org.

Figure 1: **Twin-track approach**



There is a range of actions outlined below to make health and HIV/AIDS interventions more inclusive of children and adolescents with disabilities in all phases of the humanitarian action programme cycle: preparedness; response and early recovery; and recovery and reconstruction. These actions are entry points that can be prioritized based on the country context, recognizing that not all actions are applicable in all settings. Some are better suited for protracted crises while others are applicable in sudden-onset emergencies. While this guidance organizes actions according to humanitarian phases, it is important to recognize that these phases are interlinked and can overlap. In some contexts, especially conflict settings, the phases are not distinct.

During major emergencies (such as Level 2 or 3 emergencies),[9] these guidelines can be considered alongside UNICEF's *Simplified Standard Operating Procedures*.[10]

[9] For more information, see http://unicefinemergencies.com/procedures/level-2.html.

[10] For more information, see www.unicefinemergencies.com/procedures/index.html.

Prosthetic legs arrayed on a shelf at an orthopedic centre in Kabul, Afghanistan.

Including children with disabilities in preparedness is crucial not only to reduce risk and build resilience in children with disabilities and their families, but also to establish capacity, resources and plans for an inclusive response and recovery. Whenever children and adolescents participate in any initiative, children and adolescents with disabilities also need to be included.[11] If actions undertaken in preparedness are not inclusive, actions in later phases will need to be adapted.

Interventions in this section can also support inclusion of children with disabilities in risk-informed planning. Some actions are also relevant in the recovery and reconstruction phases.

6.1 Coordination

a. Establish a disability focal point, focal agency or task force to represent disability issues in coordination mechanisms for health and HIV/AIDS (e.g., in clusters and working groups).[12]

b. Within the working group or task force, engage actors with experience in addressing the needs of children with disabilities (e.g., government ministry responsible for disability, departments and organizations that provide services to children with disabilities such as rehabilitation, social welfare, education, DPOs, other disability groups, NGOs).

c. When establishing cluster or sector capacity, identify, create and foster partnerships with government stakeholders and civil society organizations that have expertise on disability, including NGOs, disability service providers and DPOs (*see Box 5*).

[11] Refer to UNICEF's *Take Us Seriously! Engaging children with disabilities in decisions affecting their lives*, which provides advice on reaching and identifying children with disabilities and working with their parents and caregivers, along with practical steps to engage children and measure the effectiveness of their participation; see www.unicef.org/disabilities/files/Take_Us_Seriously.pdf.

[12] In many cases, the disability focal point would benefit from participating in disability related training planned in the country or region.

Example: Nepal coordination mechanism – Injury and rehabilitation sub-cluster

After the 2015 earthquakes in Nepal, the Ministry of Health and Population and the World Health Organization (WHO) established an 'injury and rehabilitation sub-cluster' within the cluster system. The sub-cluster coordinated mapping of available rehabilitation and other specialist services, data collection, referral networks and tasking of international teams. National emergency trauma guidelines, including rehabilitation developed prior to the earthquake, were distributed to arriving medical and rehabilitation teams (Handicap International).

d. Actions at the coordination level for the disability focal point, focal agency or task force may include:

- Adding components on disability inclusion in terms of references developed by working groups, clusters or other relevant coordination mechanisms (actions in this booklet can inform the terms of reference);
- Supporting the collection of available data on children and adolescents with disabilities in humanitarian data collection processes, such as field monitoring systems, needs assessments, partner reports and humanitarian needs overviews;
- Assessing and mapping existing expertise and resources available for children and adolescents with disabilities;
- Coordinating with national and humanitarian service providers to establish clear referral mechanisms based on the most up-to-date mapping and assessments;
- Working with WASH, nutrition, shelter, camp coordination and camp management mechanisms (clusters) to plan accessibility for key humanitarian interventions (e.g., health facilities, including WASH facilities).

6.2 Assessment, monitoring and evaluation

By collecting data on children with disabilities, it is possible to identify them, assess their needs and monitor the outcomes of health and HIV/AIDS interventions.

a. During preparedness stages, find and gather the best available data on children with disabilities within populations at risk of disease, health status deterioration, violence and HIV transmission.

b. Data on children with disabilities can be collected at any level including community, district and national.

Identification of children with disabilities and disaggregation of data

Box 3: Identifying children with disabilities from existing sources

- Data on children with disabilities are available from a variety of sources: disability related ministries or departments; education departments; beneficiary registers of social protection schemes for children with disabilities or education grants or recipients of assistive devices. Previous household surveys, such as UNICEF's Multiple Indicator Cluster Survey (MICS), may have used the child functioning module (*see Box 4*).[13]
- Special schools for children with disabilities, DPOs and NGOs working with children with disabilities or implementing community-based rehabilitation programmes (*see Glossary, Section 11*) often have data on children with disabilities, particularly at the community level.
- If data on children with disabilities are limited, an estimate can be used for planning purposes. Be aware that national surveys or censuses often under-report the number of children and adults with disabilities (WHO and UNESCAP, 2008).
- The World Health Organization estimate that "15% of the world population lives with a disability" (WHO, 2011) can be used to calculate an approximate number of adults with disabilities in any given population.
- An estimate for the number of children with disabilities can be calculated based on 10 per cent of the population of children and young people in any given population (UNICEF, 2007).
- Estimates should consider that the proportion of persons with disabilities may be higher in conflict-affected areas.[14]

Box 4: Collecting disability disaggregated data

- Surveys, censuses and registration systems can use two modules (sets of questions) to identify children and adults with disabilities and to disaggregate data by disability:
    - The Washington Group Short Set of questions identifies adults with disabilities through questions related to difficulties performing six activities: walking, seeing, hearing, cognition, self-care and communication.[15]
    - The Washington Group/UNICEF Survey Module on Child Functioning is a set of questions to identify children aged 2 to 17 years old who have difficulties across 14 domains including seeing, hearing, mobility, communication and comprehension, learning, relationships and playing.[16]
- Disaggregating data by disability (in addition to age and sex) is important in activities across all phases, such as in needs assessment and programme monitoring.
- Include the child functioning module within surveys (e.g., UNICEF's MICS).
- Disaggregate by disability in Health Management Information Systems and medical record systems, such as immunization and health status.

[13] UNICEF's Multiple Indicator Cluster Survey (MICS) is the largest household survey on children's well-being worldwide and has been conducted in 107 countries. For more information, see http://mics.unicef.org.

[14] For instance, a survey of Syrian refugees living in camps in Jordan and Lebanon found that 22 per cent have a disability (Handicap International and HelpAge, 2014). This is higher than the global estimated prevalence of 15 per cent.

Needs assessments

c. Consider disaggregation by disability when establishing a rapid assessment mechanism by inserting the Washington Group Short Set of Questions or the Child Functioning Survey Module into the questionnaire (*see Box 4*).

d. Identify the specific needs of children with disabilities in assessments related to health and HIV/AIDS.

e. Map existing programmes, interventions and services that are accessed by children with disabilities, such as inclusive and special schools, disability inclusive child-friendly spaces, psychosocial health, mine risk education programmes, provision of assistive devices or rehabilitation centres.

f. DPOs and NGOs working with children with disabilities and implementing community-based rehabilitation programmes often have data on children with disabilities, particularly at the community level.[17]

- Such data can provide rich information on the situation, vulnerabilities and needs of children with different disabilities as well as the local capacities available to address them.

- DPO and community-based rehabilitation workers can also be useful resources in the process of collecting data on persons with disabilities.

---

[15] The Washington Group was established by the United Nations Statistics Commission to improve comparable data on disability. For the set of questions, see www.washingtongroup-disability.com/washington-group-question-sets/short-set-of-disability-questions.

[16] The Survey Module on Child Functioning is recommended for children (aged 2 to 17) as it is more sensitive to child development than the Washington Short Set. It is not possible to collect reliable information on children with disabilities below the age of 2 in a population survey. Due to the transitional nature of child development, development delays in children this age are not necessarily indicative of a disability (UNICEF, 2016a).

Programme monitoring and evaluation

g. When establishing systems and procedures that measure which health and HIV/AIDS services will be delivered, who will receive services and achieved results, disaggregate data by disability, sex and age.

h. Review and adapt existing mechanisms like 5W mapping systems ('who does what, where, when and for whom')[18] and Health Resources Availability Mapping Systems to collect relevant information on services related to disability (*see Section 6.2.e*). These data will also be useful at the evaluation stage.

i. Consider strengthening disaggregation by disability when developing information management systems that include sex- and age-disaggregated data and gender and disability responsive information. Including data disaggregated by disability in systems such as Health Management Information Systems is a longer-term investment in national capacity for monitoring humanitarian responses.

For more information, see https://data.unicef.org/topic/child-disability/child-functioning-module and www.washingtongroup-disability.com/washington-group-question-sets/child-disability.

[17] Data from the community level can provide information on the needs and vulnerabilities of children and adolescents with disabilities, which can inform planning and programming.

[18] The purpose of 5W is to outline the operational presence by sector and location within an emergency. For more information, see https://www.humanitarianresponse.info/en/applications/tools/category/3w-who-does-what-where.

6.3 Planning

As part of planning, consider the following:

Service provision

a. Review health and HIV/AIDS legislation, policies and programmes (including those related to primary health care and sexual and reproductive health) to assess if they consider children with disabilities.

b. Highlight this information in trainings for health and HIV/AIDS colleagues and in behaviour change communication and communication for development materials (*see Glossary, section 11*).

c. Examine health registration systems, identification cards and other documents essential for social protection and health and HIV/AIDS services provision (e.g., health insurance) and determine whether they are inclusive and address the needs of children with disabilities.

d. Determine if a system of disability identity cards exists.[19] Consider ways to simplify procedures to issue identity cards and replace lost cards.

e. Gather information on social protection programmes (*see Glossary, Section 11*) and benefits to support households with children with disabilities (e.g., cash transfers for essential health services, access to assistive devices[20]).

f. Use outreach mechanisms and collaborate with DPOs to reach children with disabilities who may not be in school or are isolated in their homes.

---

[19] Disability Identity Cards are often used as eligibility criteria for accessing services.

[20] For more information, see www.who.int/mediacentre/factsheets/assistive-technology/en.

g. Support children with disabilities and their caregivers to participate in preparedness and disaster risk-reduction activities; support may include transport assistance or allowances for caregivers to accompany or help children with disabilities during activities.

h. Develop standardized treatment protocols – according to national or international guidelines[21] – for disabilities that may result from or could be exacerbated by emergencies (WHO, CBM et al., 2013).

i. Develop patient education leaflets in accessible formats (*see Glossary, Section 11*) for the prevention and treatment of disability related conditions such as epilepsy, pressure sores (*see Glossary, Section 11*) and the management of disaster-related injuries such as fractures, amputations and spinal cord injury.

Example: Mass casualty management protocols in Nepal

The Nepal Ministry of Health and Population, together with Handicap International, WHO, Oxfam and Save the Children, implemented an Earthquake Preparedness Programme (2011–2014) with a focus on mass casualty management in the case of a major disaster. They developed protocols and trainings on trauma management and patient education materials. Topics included complex fractures, spinal cord injury, burns and head trauma. For the first time, health professionals from various disciplines (doctors, nurses and physical therapists) came together on an integrated approach. The management included primary/emergency interventions as well as acute and long-term rehabilitation. The system was in place and contributed to an effective national response to the earthquake in April 2015 (WCPT, 2016).

[21] For example, WHO (2016) *Classification and Minimum Standards for Foreign Medical Teams in Sudden Onset Disasters* and WHO (2016) *Minimum Technical Standards and Recommendations for Rehabilitation.*

Box 5: Engaging persons with disabilities and DPOs

Persons with disabilities can be staff, consultants, advisors, volunteers and partners across all phases of humanitarian action. Their experience and perspective can inform health coordination, data collection, assessments, provision of assistive devices, sexual and reproductive health information and services and communication materials preparation.

DPOs are organizations representing persons with disabilities at community, national, regional and global levels. Some are specific to a type of disability such as the National Federation of the Blind; others are geographical such as the African Disability Forum.

- To ensure full participation, ask persons with disabilities their preferred format for information (*see Section 9.3*) and consider the accessibility of meeting venues (*see Section 10*).

- If possible, cover any additional expenses for persons with disabilities, such as transportation or the cost of a companion.

- Establish partnerships with DPOs and other organizations with expertise in the inclusion of children with disabilities. Mobilize existing partnerships in humanitarian activities to utilize the capacity and experience of persons with disabilities.

- In some regions, women's DPOs are active and well informed on the unique needs and rights of girls with disabilities.

Box 5 continued: Engaging persons with disabilities and DPOs

- To find a DPO, review the member list of the International Disability Alliance.[22]
- Contact a regional DPO if a county-level DPO is unavailable.

Example: Young woman with a disability leading disaster committee

In Bangladesh, Kazol, a young woman who uses a wheelchair, is the president of the Ward Committee on Disaster and leader of a sub-committee on cleanliness during floods. "I have to help people understand how to keep food clean so that it is not affected by germs. We have an early warning system, and make sure a person with a speech or hearing impairment knows how the warning system is working for them. We make a list of doctors with their phone numbers; we use the list during the flood if needed. We also plan how to rescue people with disabilities during a flood."[23] (Plan International, 2013)

[22] For member list, see www.internationaldisabilityalliance.org/content/ida-members.

[23] For a video on Kazol, see www.cbm.org/video/My-story-Kazol-Rekha-386717.php.

Human resources

j. Identify and create lists of existing personnel with expertise working with children with disabilities, such as sign language interpreters, physiotherapists, occupational therapists, speech and language therapists, and special educators for children with intellectual and psychosocial disabilities or those who are deaf or blind.

k. Develop sample job descriptions for disability related personnel, so they can be mobilized swiftly during response phase.

l. Consult and recruit persons with disabilities in all preparedness processes, as they contribute first-hand expertise on issues faced by children and adults with disabilities (*see Box 5*).

m. Mobilize disability expertise and experience to inform inclusive health and HIV/AIDS programmes and interventions (*see Box 8*).

n. Consider nominating and resourcing a disability focal point within the organization or agency.

Example: Physical therapist roster to respond to emergencies

Physical therapists working in the United Kingdom are recruited by the UK Emergency Medical Team to join the emergency response register. Those with the appropriate experience undergo pre-deployment training, including safety, security, humanitarian principles and specialized clinical rehabilitation trauma training. The training also includes sessions on psychological first aid,[24] establishing an emergency wheelchair service and clinical practical days to practice new skills. Those likely to be deployed undergo additional training in a field hospital environment. Physical therapists from the register have since been deployed in response to emergencies in Gaza, Nepal and the Philippines (WCPT, 2016).

Procurement and supplies

o. Identify regular supplies that benefit all children, including children with disabilities. These include potties, pans, grab rails for toilets, transportable jerry cans and plastic mattress covers.

p. Identify targeted supplies that respond to children's disability related needs. These include assistive devices and other implements that support children and adolescents with disabilities, such as mobility devices (wheelchairs, crutches, tricycles), communication boards/books, hearing aids and batteries and white canes (*see Box 7*).

q. Identify and ensure a sufficient supply of medical supplies and medications to treat and support chronic conditions, including those related to psychosocial health (e.g., catheters, adolescent size diapers, tube feeding materials, and medications for diabetes, cardiovascular diseases, schizophrenia, chronic obstructive pulmonary disease and epilepsy).

r. Without pre-existing data on children and adults with disabilities, estimate that 3 per cent of the population needs assistive devices (UNICEF and WHO, 2015). Plan budgets and supplies of assistive devices accordingly.

s. Conduct assessments to identify and evaluate children for assistive devices needs and collaborate with organizations that work on the provision of assistive devices (*see Box 7*).

t. The WHO list of priority assistive products can inform the planning and procurement of assistive devices.[25]

u. Some devices can be developed and made locally with basic resources. DPOs, families of children with disabilities and health workers may assist in locating, designing or adapting items.

[24] For psychological first aid manual, see www.who.int/mental_health/publications/guide_field_workers/en.

[25] For the full list and more information, see www.who.int/phi/implementation/assistive_technology/EMP_PHI_2016.01/en.

v. When establishing basic supply chain requirements, such as location of relief stocks, suppliers and logistics, identify local suppliers of assistive devices and share this information with humanitarian partners.

Funding and budgeting

w. Allocate a budget (proportionate to funding availability) for actions listed in this booklet,[26] such as training health and HIV/AIDS workers to identify and address the needs of children with disabilities; conducting awareness campaigns on disability; building or modifying health facilities for accessibility; providing assistive devices; recruiting outreach health and rehabilitation teams; and producing accessible communication materials.

x. Allocate a budget for service providers to address the health needs of children with disabilities, such as rehabilitation doctors, physical or occupational therapists, speech and language therapists and sign language interpreters.

6.4 Capacity development

a. Identify training opportunities on the inclusion of children and adults with disabilities and nominate staff to attend.[27]

b. Invite DPOs to trainings organized on humanitarian issues to familiarize them with the humanitarian system, programming and health processes and tools, and also invite them to government coordination structures for emergency response. This will encourage DPOs to contribute to health and HIV/AIDS coordination mechanisms, risk analysis, monitoring, preparedness and response actions.

[26] *The Minimum Standards for Age and Disability in Humanitarian Action* recommends budgeting an additional 0.5–1 per cent for physical accessibility (building and latrines) and 3–4 per cent for specialized non-food items and mobility equipment (Age and Disability Consortium, 2015).

[27] Often NGOs working with persons with disabilities, DPOs or government ministries and departments organize trainings to address the needs of children with disabilities in the country or region.

c. Develop a disability awareness session and training module to be used for health and HIV/AIDS in emergencies training,[28] covering:

- Data collection on children with disabilities;
- How to recognize and, where relevant, refer for further assessment and rehabilitation services, different types of disabilities in children (*see Glossary, Section 11*);
- Health needs of children and adolescents with disabilities, including child and newborn health, immunization, rehabilitation and HIV/AIDS prevention and treatment;
- Health risks and barriers faced by children and adolescents with disabilities to accessing health and HIV/AIDS services and ways to mitigate them through mainstream inclusive approaches;
- Psychosocial support including psychological first aid and case management for children with disabilities (*see Glossary, Section 11 and Protection booklet*[29]);
- Communicating with children with disabilities (*see Section 9.2*) and adapting health and HIV/AIDS information to be accessible (*see Section 9.3*).

d. Include trainers with experience in disabilities when developing a pool of trainers (e.g., DPO and NGO staff who work on issues related to children with disabilities and government).

[28] Awareness sessions aim to create interest and change attitudes towards disability, while the objective of a training is to improve practical and professional skills for the inclusion of children with disabilities. The UNICEF Disability Orientation video provides an introduction to disability, why it is important to include children with disabilities and UNICEF's approach to disability inclusion. Available in English, French and Spanish at www.unicef.org/disabilities/66434.html.

[29] See http://training.unicef.org/disability/emergencies/protection.html.

e. Conduct systematic and relevant training that includes components on children with disabilities in mainstream humanitarian and health workshops. Use the module (*see Section 6.4.c*) to carry out specific training on disability and health and HIV/AIDS in humanitarian action.

Example: Inclusive training on disaster preparedness first aid

In 2006, the Emmanuel Hospital Association in India established the Disaster Management and Mitigation Unit. Supported by CBM,[30] the project has developed disability inclusion in disaster preparedness in eight states. Three thousand community volunteers and professionals were trained in first aid and basic disaster response. The association's first aid guide was published in Braille; persons with disabilities were included in first aid training; and for the first time, a Village Disaster Management Plan was developed that provided for the needs of persons with disabilities in the community (CBM and DiDRRN, 2013).

6.5 Accessible infrastructure

a. When assessing and pre-identifying buildings and facilities that could be used for health and HIV/AIDS in emergency interventions (e.g., primary health clinics, hospitals, rehabilitation centres), look for infrastructure that is already accessible or requires minor modifications.

b. Include accessibility in assessment criteria or standards used to select health-related buildings and facilities.

c. Where relevant, plan and budget for necessary modifications to make health-related facilities accessible. Consider accessibility in the establishment of temporary health facilities.

[30] CBM is a faith-based international development NGO focused on persons with disabilities.

d. Planning for accessibility from the outset – starting from the planning and design stage – is far less expensive than modifying existing infrastructure.[31]

e. For tips on constructing, reconstructing or modifying buildings and facilities for accessibility, see 'Accessible infrastructure tips' (*Section 10*).[32]

6.6 Behaviour change communication and communication for development

a. Involve communication colleagues in the development of inclusive and accessible information (*see Sections 9.2 and 9.3*) and in campaigns on the health needs of children and adolescents with disabilities, including:

- Health education leaflets on disability related topics for children with disabilities, such as glaucoma, epilepsy, juvenile diabetes, and how to avoid secondary complications, such as pressure sores prevention and management.
- Easy-to-understand information about the use and maintenance of assistive devices.
- Sexual, reproductive health and HIV/AIDS prevention and treatment information in accessible formats (e.g., written and audio).
- Messages on the right to health services, including sexual reproductive health and HIV/AIDS for all girls and boys with disabilities.

[31] For example, the cost of making a school latrine accessible is less than 3 per cent of the overall costs of the latrine, and can be less than 1 per cent if planned from the outset (WEDC, 2010).

[32] For accessibility specifications for buildings and facilities, see www.unicefinemergencies.com/downloads/eresource/docs/Disability/annex12technical cards for accessible construction.pdf.

b. Include positive images of children and women with disabilities in communication materials (e.g., women with disabilities as mothers or pregnant) to help transform attitudes towards persons with disabilities and reduce stigma and discrimination.

c. When using feedback and complaint mechanisms as part of accountability and community engagement processes, consider accessibility for persons with different types of disabilities; for instance, by using at least two means of gathering feedback such as written and verbal (*see Section 9.2*).

Example: Developing inclusive communication materials with refugees with disabilities

The Syrian Disability Representatives project, supported by Handicap International, aimed at developing self-help groups for Syrian refugees with disabilities in Jordan and Lebanon in 2016. The self-help groups produced communication materials (posters, postcards, images, videos) in Arabic and English to reduce stigma towards persons with disabilities. The materials illustrated CRPD articles, for example, Article 25 on the right to health and Article 26 on rehabilitation[33] (Handicap International).

6.7 Checklist for preparedness

The checklist, derived from the programmatic actions outlined in this document, can help plan and assess whether key actions include children and adolescents with disabilities in preparedness. To complete the checklist, discussions may be required with other colleagues and stakeholders. Completing the checklist in a team or coordination meeting would be helpful. Additional printable copies of the checklist can be found at http://training.unicef.org/disability/emergencies/health-and-hivaids.html.

[33] For the materials, see http://training.unicef.org/disability/emergencies/resources.html.

Considerations for including children with disabilities in preparedness	
Coordination	
Has a disability focal point, focal agency or task force been identified in health and HIV/AIDS-related coordination mechanisms (including clusters)?	☐ Planned ☐ In progress ☐ Completed
Notes:	
Assessment, monitoring and evaluation	
Have available data on children with disabilities been compiled (e.g., from departments of health, social welfare, institutions, NGOs, DPOs)?	☐ Planned ☐ In progress ☐ Completed
Notes:	

Do health and HIV/AIDS needs assessments, admission and referral forms, clinical records, and monitoring and reporting tools identify the health needs of children with disabilities and disaggregate data by disability (*see Box 4*)?	☐ Planned ☐ In progress ☐ Completed
Notes:	
Have existing services and programmes for children with disabilities been mapped (e.g., psychosocial health services, mine risk education programmes, provision of assistive devices and rehabilitation centres)?	☐ Planned ☐ In progress ☐ Completed
Notes:	
Planning	
Have issues related to children with disabilities been included in health and HIV/AIDS preparedness plans, including in plans developed by coordination mechanisms or inter-ministry/ inter-department working groups?	☐ Planned ☐ In progress ☐ Completed
Notes:	

Have children with disabilities, their families and DPOs been consulted and involved in preparedness-related health and HIV/AIDS activities?	☐ Planned ☐ In progress ☐ Completed
Notes:	
Has a budget for services and supplies to address the health and HIV/AIDS needs of children with disabilities been allocated?	☐ Planned ☐ In progress ☐ Completed
Notes:	
Have collaborations/partnerships been established with agencies/organizations with expertise on disability (e.g., government departments providing services to children with disabilities, NGOs working on disability and providing assistive devices, DPOs, rehabilitation centres)?	☐ Planned ☐ In progress ☐ Completed
Notes:	

Has health and HIV/AIDS supply planning considered products relevant to children with disabilities (e.g., assistive devices, potties, bed pans, grab rails for toilets)?	☐ Planned ☐ In progress ☐ Completed
Notes:	
Is disability accessibility a criterion for identification and selection of health facilities in emergencies (e.g., sites for vaccination campaigns, health clinics, outreach services)?	☐ Planned ☐ In progress ☐ Completed
Notes:	
Capacity development	
Have humanitarian health and HIV/AIDS staff received training on inclusion of children with disabilities (e.g., how to make health and HIV/AIDS interventions inclusive, communicating with children with disabilities and adapting information)?	☐ Planned ☐ In progress ☐ Completed
Notes:	

Behaviour change communication and communication for development	
Are health and HIV/AIDS materials developed as part of preparedness in at least two formats (e.g., written and audio)?	☐ Planned ☐ In progress ☐ Completed
Notes:	

Ahmad, 12 years old, receives physical therapy at Za'atari refugee camp, Jordan. Ahmad has cerebral palsy.

Check preparedness actions and adapt them to response and early recovery actions accordingly.

7.1 Coordination

a. Establish a disability focal point,[34] a focal agency or a task force to represent disability issues in humanitarian health and HIV/AIDS coordination mechanisms (e.g., clusters, working groups).

b. Form links between government authorities and cluster on critical issues to support coordinated and inclusive health and HIV/AIDS services.

c. Create referral pathways through inter-sectoral connections to effectively identify and respond to the needs of children with disabilities:

- With the education cluster to coordinate the distribution of assistive devices to support the learning of children and adolescents with disabilities and ensure coverage of children with disabilities in child health and immunization programmes (including vaccination campaigns) in temporary learning spaces (*see Education booklet*[35]).

- With the nutrition cluster to create and implement referral mechanisms for the management of malnutrition in children and women with disabilities (including the management of newborns with difficulties breastfeeding) and coordination for the provision of assistive devices to support feeding of children, adolescents and pregnant women with disabilities (*see Nutrition booklet*[36]).

- With the WASH cluster to address water and hygiene needs of children and adolescents with disabilities (e.g., pressure

[34] The disability focal point may benefit from participating in disability related training planned in the country or region.
[35] See http://training.unicef.org/disability/emergencies/education.html.
[36] See http://training.unicef.org/disability/emergencies/nutrition.html.

sores management, menstrual hygiene management), for the provision of toileting assistive devices (e.g., commodes) for inclusive prevention and treatment of water- and hygiene-related diseases, and for the construction and reconstruction of accessible WASH facilities in temporary and permanent health centres and clinics (*see WASH booklet*[37]).

- With the protection cluster to ensure coverage of children with disabilities in child health and immunization programmes (including vaccination campaigns) in child-friendly spaces and to refer any unaccompanied hospitalized children and adolescents with disabilities to family reunification services (*see Protection booklet*[38]).

- With the HIV/AIDS sub-cluster or working group (where they exist) to ensure referral mechanisms for children and women with disabilities who are survivors of sexual violence to HIV prevention and treatment information (in accessible formats) and services (including post-exposure prophylaxis).

d. When mapping health and HIV/AIDS humanitarian services as in a 5W database (*see Section 6.2.h*) and Health Resources Availability Mapping Systems, collect information from the ministry or department responsible for disability issues, organizations that provide inclusive services for children and adolescents with disabilities, and those that provide targeted services (e.g., the provision of assistive devices and rehabilitation centres).

e. Identify gaps and advocate for adapting health and HIV/AIDS services that are currently not inclusive of children with disabilities following the guidance in this booklet. Examples of services that are not inclusive include primary health clinics that lack ramps that would enable access for children and adults with disabilities, or health clinics without staff trained on communicating with children with disabilities.

[37] See http://training.unicef.org/disability/emergencies/wash.html.
[38] See http://training.unicef.org/disability/emergencies/protection.html.

7.2 Assessment, monitoring and evaluation

a. Review and use any data collection tools that were developed or adapted during preparedness to include children with disabilities.

b. If data collection tools have been developed, review and adapt them as required to include children with disabilities (*see Section 6.2*).

c. Collect data on children with disabilities at all levels – including household, community, district and national.

Identification of children with disabilities and disaggregation of data

d. The identification of children with disabilities (*see Box 3*) and disaggregation of data by disability (*see Box 4*) can inform design of inclusive health and HIV/AIDS programmes and determine the extent to which children with disabilities are accessing services, such as vaccination campaigns.

Humanitarian needs assessments

e. Incorporate issues related to children and women with disabilities into mainstream humanitarian needs assessments, such as multi-cluster or multi-sector initial rapid assessment[39] and post-disaster needs assessments.

f. For instruments that collect information on individuals (e.g., Health Management Information Systems, Injury Surveillance Systems, HIV/AIDS surveillance mechanisms, medical records), adapt tools to collect disaggregated data by disability, age and sex (*see Box 4*).

g. Observe the accessibility of health and HIV/AIDS services and

[39] For more information, see Humanitarian Programme Cycle/Needs assessment: https://www.humanitarianresponse.info/en/programme-cycle/space.

facilities such as primary health clinics, to see whether children with disabilities are present and participating in humanitarian activities (*see Section 10*).

h. In participatory assessments, organize focus group discussions and key informant interviews to gather information on health risks and access to health and HIV/AIDS services for girls and boys with disabilities.

- Interview adults and youth with disabilities as key informants. Invite DPOs, local disability groups, and parents and caregivers with disabilities to focus group discussions (*see Box 5*).

- Identify general and disability specific health needs of children and women with disabilities.

  - General health needs include immunization, newborn and child health services, sexual and reproductive health, HIV/AIDS prevention and treatment.

  - Disability specific health needs include early rehabilitation (*see Glossary, Section 11*), physical and occupational rehabilitation, and assistive devices.

- Collect information on the barriers faced by children with disabilities and their caregivers to accessing humanitarian services and information, and consider this when establishing referral pathways. Barriers may include:

  - Discriminatory practices against girls with disabilities in accessing reproductive health information (e.g., denial of information or services);

  - Difficulty reaching services due to distance or lack of transport;

  - Inaccessible health facilities (e.g., health clinics with stairs and no ramp, toilets in health clinics that are not wheelchair-accessible);

- Lack of knowledge and support from humanitarian workers to provide health services to children and women with different disabilities; and

- Lack of suitable supplies for children with disabilities (e.g., appropriate-sized wheelchairs, crutches and hearing aids, lack of specific medication for psychosocial conditions or chronic diseases).

i. When collecting data directly from children with disabilities, appropriate support may be required to communicate, give consent and maintain confidentiality. Such support includes alternative communication or sign language interpretation (*see Section 9.2*).

j. Encourage child participation.[40] Children often are aware of who is excluded from schools and child-friendly spaces and why (UNESCO, 2010). Use art and play for children with disabilities to express their views about their needs and preferences in key informant interviews and focus group discussions.[41]

   - Establish a target to ensure that at least 10 per cent of all consulted children are children with disabilities.

   - Consider organizing separate focus group discussions with women and girls with disabilities to identify specific discriminatory practices and barriers. Highlight findings in further reporting.

k. Use existing data or data collected in assessments to inform humanitarian needs overviews and humanitarian response plans. Share such data with relevant agencies.

---

[40] When engaging children in data collection, ensure that ethical standards are upheld. See https://www.unicef.org/supply/files/ATTACHMENT_IV-UNICEF_Procedure_for_Ethical_Standards.PDF and https://www.unicef-irc.org/publications/849.

[41] For information on the participation of children with disabilities, refer to UNICEF's *Take Us Seriously! Engaging children with disabilities in decisions affecting their lives*, www.unicef.org/disabilities/files/Take_Us_Seriously.pdf.

Example: Assessment of Syrian refugees with disabilities in Iraq

In 2013, the REACH initiative[42] in partnership with UNHCR set out to identify all Syrian refugees with disabilities in the camps in the Kurdistan Region of Iraq. The disability assessment also sought to identify gaps in the humanitarian response, encourage targeted service provision, and understand the specific needs and challenges faced by refugees with disabilities. They conducted key informant interviews, followed by interviews of all Syrian refugee households in the identified camps during the assessment. A large proportion of the refugees with disabilities were children under the age of 18 (41 per cent). Almost every person with a disability (99 per cent) reported that they had difficulties accessing essential services, with 74 per cent experiencing difficulties accessing health care (UNHCR and Reach, 2014).

Programme monitoring and evaluation

l. Develop prioritized disability specific indicators to monitor progress in reaching and meeting the needs of children with disabilities. Indicators may include:

- Percentage of health facilities that are disability accessible.
- Percentage of community health workers who have received training on disability.

m. Disaggregate monitoring data related to beneficiaries by disability, sex and age.

[42] Created in 2010, REACH is a joint initiative of international NGOs – ACTED and IMPACT – and the United Nations Operational Satellite Applications Programme that aims to strengthen evidence-based decision-making by aid actors through emergency data collection, management and analysis.

n. Document and report progress made on reaching children with disabilities and meeting their health and HIV/AIDS needs in humanitarian monitoring and reporting (e.g., in SitReps, humanitarian dashboards, six-monthly or annual reports).

o. Include questions on whether children and women with disabilities are accessing health and HIV/AIDS services and facing any challenges, in real-time monitoring using mobile phones and text messages, joint monitoring with partners, post-distribution monitoring and assessment. Ask questions such as, “Did children with disabilities access vaccination campaigns?”

Box 6: Assessing inclusion of children with disabilities

In humanitarian evaluations, consider disability inclusion as an evaluation criterion and include such questions as:

- To what extent were health and HIV/AIDS interventions relevant to the specific needs of children with disabilities?
- How efficiently were interventions and services delivered to children with disabilities in emergency settings?
- To what extent did health and HIV/AIDS interventions, both mainstreamed and targeted, achieve the expected results?
- To what extent did the interventions have unexpected effects?
- To what extent did needs assessments identify the specific health needs of children with disabilities?
- To what extent was information on children with disabilities from needs assessments used to inform programming?
- To what extent were ongoing programmes on disability connected to the humanitarian response?

Box 6 continued: Assessing inclusion of children with disabilities

- Have there been lasting or sustained benefits as a result of connecting ongoing programming on disabilities with the humanitarian response?

p. Analyse information gaps in assessments and bottlenecks in implementation of inclusive humanitarian programmes (for instance, through workshops with partners or the development of a paper).

q. Document and share lessons learned on inclusion of children with disabilities in humanitarian health and HIV/AIDS interventions such as through case studies (*see Section 8.2*).

r. See Section 6.6.c for accessible complaint and feedback mechanisms

7.3 Planning

a. Despite the urgency of a humanitarian response, there are ways to draw on the abilities and unique experience of children, adolescents and adults with disabilities and include them in the response (*see Section 9.2*).

b. When developing or providing feedback on emergency plans (such as Inter-Agency Humanitarian Response Plans, Regional Response Plans and UNICEF humanitarian work plans), include the health needs of girls and boys with disabilities, identify barriers to accessing health and HIV/AIDS interventions and add activities that include children with disabilities.

c. Include children, adolescents and women with disabilities as a

specific category of people to be reached in response plans by developing:

- A strategy that articulates prioritized actions for reaching children with disabilities;

- Targets and prioritized indicators to track the extent to which children with disabilities are reached.

d. Consider children with disabilities when setting beneficiary selection criteria based on situation analysis, taking into account barriers and risks they face.

e. If data are not available on sex, age, disability and health needs of children with disabilities and barriers to accessing services, identify this as an information gap and initiate actions to address it.

7.4 Making health and HIV/AIDS interventions inclusive and accessible

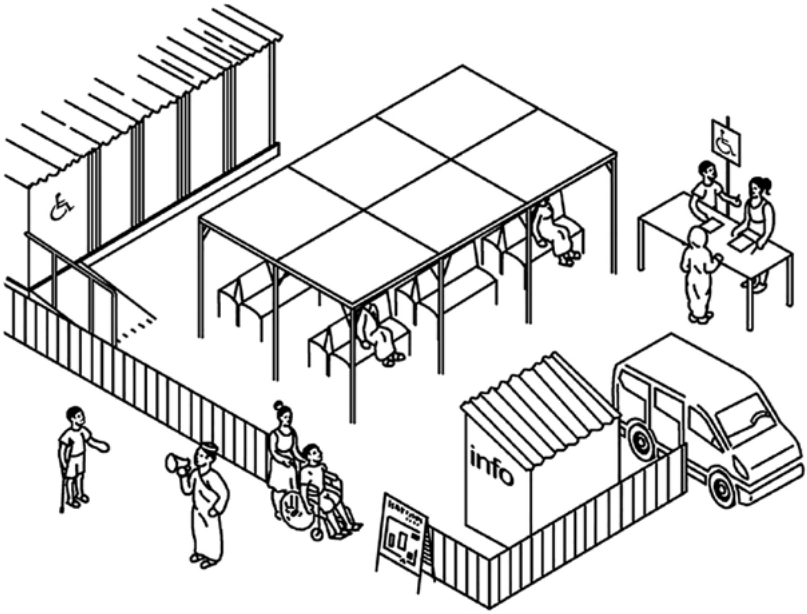
Patient registration

a. Set up fast tracks (*see Glossary, Section 11*) or prioritization processes for patient admission, registration and access services[43] (e.g., immunizations, newborn and child health) in health facilities, temporary learning spaces, schools and essential household items distributions.

b. Provide covered seating to enable people to rest while queuing (*see Figure 2*). This assists not only persons with disabilities, but also the elderly and pregnant women.

[43] A prioritization process could include trained health workers identifying children with disabilities in health registration waiting areas, giving them and their caregivers support in completing medical forms and priority for registration.

Figure 2: Inclusive and accessible waiting areas



Source: Adapted from IFRC, Handicap International and CBM, 2015.

c. Organize simplified registration processes and provide dedicated cards to households with children with disabilities for easy identification and inclusion in health services (e.g., immunization campaigns, essential household items distributions).

d. Provide training to health staff involved in patient admission and clinical assessment on how to identify and communicate with children with disabilities in need of assistance (*see Section 9.2*).

Accessible infrastructure and transport

e. Plan and supervise accessibility compliance in construction, reconstruction and repair of health-related infrastructure, including WASH facilities and sites for health campaigns and distributions.

f. Ensure accessibility for children and adults with different types of disabilities, considering the choice of location, access, and use of temporary and permanent facilities (*see Section 10*).

g. Provide transport assistance or allowances for children or caregivers with disabilities as needed to enable them to reach health services.

Primary health care interventions

h. Train doctors, nurses and community health workers on how to communicate with children with disabilities to ensure access to essential health services for children and adolescents with disabilities, such as maternal and newborn health, measles vaccination, vitamin A, deworming medication or control of communicable diseases (*see Section 9.2*).

i. Train health staff to identify the family's capacity to care for a child with a disability (e.g., providing stimulation, mealtime support, adapting food). Refer to rehabilitation services if relevant.

   - Assessment should be done in a manner that strengthens the relationship between child and family.

j. Develop outreach mechanisms to provide health services to children and adolescents with disabilities and their caregivers who are isolated in their homes and institutions, especially for children with intellectual and psychosocial disabilities. Girls and young women with disabilities may be more isolated and less likely to access services than their male peers.[44]

[44] Girls and women with disabilities may have less power and status in society due to social norms relating to age, gender and disability.

Example: Mobile rehabilitation clinics in Pakistan

After the earthquake in Pakistan in 2005, 600 people were affected by spinal cord injury. The government appointed 100 physical therapists and established seven rehabilitation centres. In Rawalpindi, an International Committee of the Red Cross physical therapy and ortho-prosthetic team worked in a centre and, in an outreach effort, established mobile clinics to reach those unable to attend centres (WCPT, 2016).

Prevention of secondary conditions, rehabilitation and specialized medical care

k. Consult 5W databases and health resources availability mapping systems to identify and, where required, partner with organizations/agencies providing specialized medical care services such as emergency/corrective surgery for catastrophic injuries,[45] rehabilitation (*see Glossary, Section 11*), prosthetics and orthotics (s*ee Section 6.2.e*).

l. Establish referral systems with providers of specialized medical care, including early rehabilitation[46] (*see Glossary, Section 11*), rehabilitation[47] (*see Glossary, Section 11*), prosthetics, orthotics and assistive devices (*see Box 7*).

m. Develop behaviour change communication/communication for development campaigns (see Section 6.6) and train health workers, including community health workers, on how to prevent and treat secondary conditions for people with disabilities (e.g., prevention and treatment of pressure sores [*see Glossary, Section 11*]).

---

[45] Catastrophic injuries include spinal cord injury, traumatic brain injury and severe burns (WHO, CBM et al., 2013).

[46] Early rehabilitation is provided in hospitals and step-down facilities (*see Glossary, Section 11*) and aims to increase survival, reduce length of hospital stays and improve the recovery of children with catastrophic injuries at risk of developing permanent impairments.

Example: Rehabilitation after the earthquake in Nepal

After the 2015 Nepal earthquake, Kathmandu University's physiotherapy classes were postponed and volunteers were enlisted from among the physiotherapy students. Each physiotherapist working at Kathmandu University's Dhulikhel Hospital supervised several students to meet rehabilitation needs (WCPT, 2016). The Hospital and Rehabilitation Centre for Disabled Children was also part of the earthquake emergency response as a referral centre for children requiring inpatient post-operative support or rehabilitation. The Hospital and Rehabilitation Centre for Disabled Children with the Nepal Youth Foundation operated a 'step-down' facility (*see Glossary, Section 11*) for people with injuries (WHO, 2015b).

Mental Health and Psychosocial Support (MHPSS)[48]

n. Establish MHPSS interventions at centre and community levels that consider the needs of children with disabilities and their family members and caregivers.

- Raise awareness among health and MHPSS staff (including psychologists and community/psychosocial support workers) about psychosocial and psychological conditions associated with post-traumatic stress disorder and depression and how they impact children with disabilities (WHO, CBM et al., 2013).

[47] Rehabilitation services run by DPOs and as part of community-based rehabilitation programmes (*see Glossary, Section 11*) ensure ongoing continuity of rehabilitation care and support. Rehabilitation does not end at inpatient discharge (WCPT, 2016)

[48] For more information, see Handicap International (2013) *Mental Health and Psychosocial Support Interventions in Emergency and Post-Crisis Settings*, http://mhpss.net/?get=176/1384534052-PG10Psychosocial.pdf.

- Train MHPSS, protection and education workers on psychological first aid for children (Save the Children, 2015), on how to communicate with children with disabilities (*see Section 9.2*), and establish a referral mechanism to ensure identification and referral of children with psychosocial disabilities to MHPSS services.

- Ensure access to mental health medication and treatment for children with psychosocial disabilities by including this medication in pre-positioning of supplies (*see Section 6.3.o–v*) and hiring psychologists and psychiatrists with expertise in working with children with disabilities.

- Consider the psychosocial support needs of children and adolescents with newly acquired impairments and their family members and caregivers.

Sexual and reproductive health interventions (SRH)[49]

o. When planning SRH programmes and services for adolescents and youth, including sex education, consider delivering in special schools and residential facilities.

p. Consider outreach activities to reach adolescent girls with disabilities with SRH information and services (*see Section 7.4.j*) as they may not be accessing education spaces (e.g., temporary learning spaces, schools) and health facilities.

q. Train SRH staff and volunteers on how to communicate with adolescents with disabilities (*see Section 9.2*), especially on acceptable touching and protection strategies for adolescents with intellectual impairments (WRC, 2014).

r. Review and adapt contraception distribution mechanisms considering the accessibility of distribution points (*see Section 10*) and providing contraception-related information in at least two different formats, such as written and audio (*see Section 9.3*).

HIV/AIDS interventions[50]

s. Provide HIV screening services, contraceptive methods (including post-exposure prophylaxis), prevention of mother-to-child transmission programmes and antiretroviral medication in accessible locations (*see Section 10*) and ensure that information is in accessible formats (*see Section 9.3*).

t. Raise awareness and provide training for health workers on the increased risk of sexual violence that people with disabilities face in humanitarian contexts, and the safe and confidential care and treatment for people with disabilities who have experienced sexual violence, including referrals to psychosocial support (WHO, CBM et al., 2013).

Box 7: Assistive devices for children and adolescents with disabilities[51]

Assistive devices include products, equipment, instruments and software (*see Glossary, Section 11*).

- WHO has published a Priority Assistive Products List.[52] Examples of assistive products include:

[49] For more information on SRH and disability, see WHO and UNFPA (2009) *Promoting Sexual and Reproductive Health for Persons with Disabilities,* http://apps.who.int/iris/bitstream/10665/44207/1/9789241598682_eng.pdf.

[50] For more information on HIV and disability, see UNICEF (2012) *Towards an AIDS-Free Generation: Promoting community-based strategies for and with children and adolescents with disabilities*, www.unicef.org/disabilities/files/Disability_HIV_Towards_an_AIDS-Free_Generation.pdf.

[51] Adapted from UNICEF and WHO (2015) *Assistive Technology for Children with Disabilities: Creating opportunities for education, inclusion and participation – A discussion paper.*

[52] For the full list of Priority Assistive Products and more information, see www.who.int/phi/implementation/assistive_technology/EMP_PHI_2016.01/en.

Box 7 continued:

- **Mobility** – crutches, walking frames, wheelchairs, tricycles, artificial limbs, hand splints, clubfoot braces, corner chairs, standing frames, adapted cutlery.
- **Vision** – balls that emit sound, eyeglasses, magnifiers, white cane, Braille equipment for reading and writing, screen-reading software for computer.
- **Hearing** – headphones, hearing aids, hearing loop.
- **Communication** – communication cards with texts, communication board with letters, symbols or pictures.
- **Cognition** – tasks lists, picture schedule and calendar, picture-based instructions, adapted toys and games.

- To ensure proper use and reduce risks, assistive products should be accompanied by appropriate services such as referral, prescription, fitting/adjusting of the product to the child, training on its use, follow-up, maintenance and repairs. Therefore, 'one-off' distribution of assistive devices should be avoided.
- In the case of amputations and other severe acquired impairments, rehabilitation services and psychological support should ideally be provided prior to or at the same time as surgery, and always with the provision of assistive products (WCPT, 2016).
- Train and inform children and caregivers on the use and maintenance of assistive devices by providing user guides in accessible formats (*see Section 9.3*).
- Set up referral systems for obtaining assistive devices and other implements (*see Section 6.3.o–v*). Plan outreach distributions to facilitate access.

Example: Provision of wheelchairs

In 2013, after Typhoon Haiyan in the Philippines, an international organization planned to provide wheelchairs. Due to advocacy by local physical therapists to follow WHO guidelines, the organization decided to outsource the wheelchair distribution. It resulted in trained local physical therapists assessing and prescribing the wheelchairs, checking the fit and training users on their use, maintenance and repair. Following the assessments, appropriate wheelchairs were procured from a local manufacturer (WCPT, 2016).

Social Protection (*see Glossary*)[53]

u. While designing social protection programmes, consider that households with persons with disabilities may face financial hardship in emergencies due to disruption of services and social protection benefits, additional costs of health services and assistive devices and loss of income due to caring for a family member with a disability.

v. Cash transfers can enable vulnerable households affected by crises, including households with disabilities, to access medical items such as assistive devices (e.g., to replace lost glasses and hearing devices, wheelchairs) and services (e.g., rehabilitation and health care).

w. Add disability as a criterion for recipient selection in cash-based programming to reach households with disabilities.

Partnerships

x. Disability expertise can be mobilized through existing partnerships or by establishing new partnerships with government agencies (e.g., ministries of health, education, social welfare), DPOs,

[53] Learn more about social protection and humanitarian action at https://www.unicef.org/socialpolicy/index_socialprotection.html.

disability specific NGOs, and by recruiting short-term consultants (*see Box 5*).

Box 8: Disability expertise

- While developing humanitarian rosters, identify personnel with expertise on children with disabilities by including this skill to the experience column.
- Identify team members with previous experience working either directly with children with disabilities or on disability related issues.
- In job descriptions for health and HIV/AIDS positions (e.g., doctors, nurses, rehabilitation staff), designate experience working with children with disabilities or on related issues as a desirable asset.
- Encourage men and women with disabilities to apply for staff, consultancies and volunteer positions.[54]
- Reach out to disability networks and DPOs to share recruitment information and identify persons with disabilities who have relevant technical expertise.

[54] UNICEF has an Executive Directive on Employment of Persons with Disabilities. There is also a Disability Accommodation Fund, which provides support to staff members with disabilities with different types of individual accommodations. In 2016, UNICEF also established a Greening and Accessibility Fund to support UNICEF offices to make premises disability accessible.

Box 8 continued: Disability expertise

- Develop disability related terms of references for consultancies or partnerships to recruit disability experts (e.g., speech and language therapists, physical and occupational therapists, sign language interpreters) when relevant.

- Establish registers of disability related professionals (e.g., psychologists, physical and occupational therapists, prosthetists, orthotists), who can conduct training and field exercises during preparedness and be called upon in an emergency (WCPT 2016).

Example: A woman's leadership in humanitarian coordination

Having professionals with disabilities as part of a humanitarian response team can help ensure children with disabilities are included in humanitarian programming. UNICEF deployed Cara Elizabeth Yar Khan as its first woman with a severe disability in an active crisis setting. In the aftermath of the 2010 earthquake in Haiti, Ms. Yar Khan served as a member of the UNICEF Haiti Team in 2011. In her role as a Resource Mobilization Specialist, she brought her lived experience as a woman with a disability, taking on the additional role of Disability Focal Point for the UNICEF Haiti Country Office. She was able to advocate for actions that promoted the inclusion of children with disabilities in various sectors. Ms. Yar Khan's work illustrated how women with disabilities bring both expertise and critical awareness on key issues that affect girls and boys with disabilities in humanitarian settings (WRC, 2016).

y. Civil society organizations, such as women's rights and human rights associations, may have expertise in cross-cutting issues of disability, gender, age and other factors that make children with disabilities more at risk in emergencies.

7.5 Human resources

a. Consult and recruit persons with disabilities in response and early recovery processes, adding first-hand expertise on issues faced by children and adults with disabilities (*see Box 5*).

b. An emergency health programme should ideally include rehabilitation professionals as part of the team to work with the health coordinator. A psychologist with experience working with children and adolescents with disabilities would also be an asset to the team.

7.6 Procurement and supplies

a. During the procurement and planning of supplies, consider whether products can be used by children with various disabilities (*see Section 6.3.o–p*).

b. Reach out to government departments (e.g., health, education, social welfare), DPOs and organizations working with persons with disabilities for products and information related to disability, such as assistive products (*see Box 7*).

c. Distribute the supplies planned and procured in a health contingency plan (*see Section 6.3.o–v*). Update items and quantities based on the findings of needs assessments and surveys.

d. For the provision and distribution of assistive devices, collaborate with other clusters such as WASH, nutrition, education and protection, ensuring information is also provided on the devices' use and ongoing maintenance (*see Box 7*).

Example: Supplies in the UNICEF response to the earthquake in Nepal

As part of its immediate response to the 2015 earthquake in Nepal, UNICEF mobilized Female Community Health Volunteers to identify children with disabilities and to refer them to services such as rehabilitation and the distribution of assistive devices. UNICEF supported the provision of assistive devices[55] in partnership with the Hospital and Rehabilitation Centre for Disabled Children[56] and the Karuna Foundation.[57] UNICEF also provided tents and medicines to Hospital and Rehabilitation Centre for Disabled Children, which had been damaged by the earthquake, to allow its staff to treat and support adults and children with disabilities (UNICEF Nepal).

7.7 Funding and budgeting

a. In fundraising documents (e.g., flash appeals, Humanitarian Action for Children appeals,[58] fundraising brochures and infographics):

   - Introduce information on health needs and priority actions for children with disabilities. For example, a flash appeal could state: "In humanitarian crises, children with disabilities are at increased risk of illness and secondary conditions. Particular

[55] Provided assistive devices included hearing aids, crutches, walkers and toilet chairs

[56] The Hospital and Rehabilitation Center for Disabled Children is located on the outskirts of Kathmandu in Banepa and provides medical services outreach and community-based rehabilitation to adults and children with disabilities. UNICEF has worked in partnership with the hospital since 2014.

[57] The Karuna Foundation is an NGO that works to improve the quality of life of children with disabilities by strengthening health care systems and empowering communities.

[58] UNICEF's Humanitarian Action for Children sets out the organization's annual appeal and its goals in providing children with access to safe water, nutrition, education, health and protection across the globe.

attention will be given to address the health needs of children who are most at risk, including children with disabilities."

- Use positive language to refer to children with disabilities (*see Section 9.1*).

b. When developing proposals, allocate dedicated budgets for human resources, accessible health facility construction, repair and reconstruction, supplies, including assistive devices, health information in different formats and other related costs.

c. When evaluating proposals from humanitarian actors, assess and provide feedback on the extent of inclusion of children and adolescents with disabilities, encouraging organizations to demonstrate how their activities, monitoring and results are disability inclusive.

d. Identify and fund projects that include children with disabilities and their families. Consider the following criteria when selecting projects:

- Disability is included in the needs assessment;
- Data are disaggregated by sex, age and disability;
- Planned and budgeted activities, as well as indicators and outcomes, consider the health needs of children with disabilities or are specifically directed towards them (*see Section 7.4*).

e. Track funding and projects dedicated to responding to the health needs of children with disabilities (e.g., in financial tracking systems or country pooled funds).[59]

[59] For more information, see Humanitarian Programme Cycle/Resource mobilization: https://www.humanitarianresponse.info/programme-cycle/space/page/resource-mobilization.

[60] NGOs working with persons with disabilities, DPOs or government ministries or departments organize trainings on the needs of children with disabilities in their country or region.

7.8 Capacity development

a. Identify scheduled training opportunities or request partners to conduct training on inclusion of children and adults with disabilities[60] and nominate staff to attend.

b. Conduct training on inclusion of children and adolescents with disabilities for staff involved in health and HIV/AIDS interventions, utilizing the training resources identified and modules developed during the preparedness phase (*see Section 6.4.c*).

c. Where possible, conduct training at different levels for health and HIV/AIDS coordination personnel, data collection teams, doctors, nurses, psychologists and community health workers.

d. Engage adults and young people with disabilities as outreach team members and community volunteers. Allocate training resources to develop their capacity in identifying children with disabilities and providing information and referrals.

7.9 Behaviour change communication and communication for development

a. Share information on existing health and HIV/AIDS services for children with disabilities in health facilities through parenting groups and during health campaigns.

b. Provide health and HIV/AIDS information in at least two different formats, such as posters, banners or signs for services, text message campaigns, and audio announcements on radio or community loudspeakers (*see Section 9.3*).

c. Include positive images of children, adolescents and women with disabilities in materials to ensure communication campaigns help transform attitudes and reduce stigma and discrimination towards people with disabilities.

d. Mitigate stigma, myths or jealousy that may arise from targeted interventions (e.g., distribution of assistive devices or cash

grants) through communication for development interventions. For example, hold open-discussion meetings with local communities and host populations to explain humanitarian activities and disability targeted interventions (*see Section 4.1*).

Example: Reaching people with disabilities in the Ebola outbreak

In Sierra Leone, the social mobilization pillar – the coordination platform for the Ebola response – set up a subcommittee focused on vulnerable groups. Led by Handicap International, this subcommittee works to "ensure that specific support is provided to special groups, including people with disabilities." DPOs from Sierra Leone form part of the subcommittee. In order to adapt messages to be accessible, specific media were used for different groups: text messages and one-to-one sensitization at home (for people with restricted mobility); radio, Braille and large print (for people with visual impairments); and pictograms and television with sign language interpretation (for people with hearing impairments)[61] (Handicap International).

e. Develop accessible feedback and complaint mechanisms as part of accountability and community engagement processes (*see Section 6.6.c*).

7.10 Checklist for response and early recovery

The checklist, derived from the programmatic actions outlined in this document, can help plan and assess whether key actions include children and adolescents with disabilities in response and early recovery. To complete the checklist, consultations may be required with other colleagues. Completing the checklist in a team or coordination meeting would be helpful. Additional printable copies of the checklist can be found at training.unicef.org/disability/emergencies/health-and-hivaids.html.

[61] See video of the adapted communication used in the Ebola campaign (in English with French subtitles): https://www.youtube.com/watch?v=M015lGIF1MA.

Considerations for including children with disabilities in response and early recovery	
Coordination	
Do health and HIV/AIDS coordination mechanisms (such as clusters and working groups) have a disability focal point, focal agency or task force?	☐ Planned ☐ In progress ☐ Completed
Notes:	
Have issues related to children with disabilities been included in health and HIV/AIDS cluster/ working group plans?	☐ Planned ☐ In progress ☐ Completed
Notes:	
Assessment, monitoring and evaluation	
Have available data on children with disabilities been compiled (e.g., from government departments related to disabilities, health and social welfare, institutions, NGOs, DPOs)?	☐ Planned ☐ In progress ☐ Completed

Notes:	
Do health and HIV/AIDS-related needs assessments consider the needs of children with disabilities (e.g., in multi-cluster initial rapid assessment, post-disaster needs assessments)?	☐ Planned ☐ In progress ☐ Completed
Notes:	
Are data on health and HIV/AIDS programmes disaggregated by disability (e.g., data on SRH, primary health care, HIV/AIDS treatment)? (*See Box 4.*)	☐ Planned ☐ In progress ☐ Completed
Notes:	
Do humanitarian-related health and HIV/AIDS monitoring, reporting and evaluations (SitReps, dashboards, real-time monitoring and evaluations, joint evaluations) capture information on access to humanitarian services and challenges faced by children with disabilities?	☐ Planned ☐ In progress ☐ Completed

Notes:	
Are children with disabilities and their families and DPOs included while consulting affected populations?	☐ Planned ☐ In progress ☐ Completed
Notes:	
Planning	
Have current services and programmes for children with disabilities been mapped (e.g., rehabilitation, assistive devices, corrective surgery, prosthetics and orthotics)?	☐ Planned ☐ In progress ☐ Completed
Notes:	

Inclusive and accessible interventions	
Are persons with disabilities able to access humanitarian-related health infrastructure and facilities?	☐ Planned ☐ In progress ☐ Completed
Notes:	
Have outreach mechanisms been established for the identification and inclusion of children with disabilities in campaigns such as measles vaccination, insecticide-treated nets, vitamin A and deworming medication?	☐ Planned ☐ In progress ☐ Completed
Notes:	
Has a fast-track system for essential household items collection been set up for households with persons with disabilities?	☐ Planned ☐ In progress ☐ Completed
Notes:	

Are children with disabilities accessing specialized services (e.g., MHPSS, physical/ occupational therapy, assistive devices, pressure sores management, emergency/corrective surgery)?	☐ Planned ☐ In progress ☐ Completed
Notes:	
Have collaboration/partnerships been established with government agencies/organizations with disability expertise (e.g., Ministry of Health, NGOs working on disability, DPOs, community-based rehabilitation organizations, rehabilitation centres)?	☐ Planned ☐ In progress ☐ Completed
Notes:	
Have collaborations been established with providers of specialized services to address the needs of children with disabilities (e.g., providers of emergency/corrective surgeries, MHPSS services, rehabilitation services, assistive devices)?	☐ Planned ☐ In progress ☐ Completed
Notes:	

Human resources	
Have existing health and HIV/AIDS staff and personnel with expertise on disability related issues been identified?	☐ Planned ☐ In progress ☐ Completed
Notes:	
Funding and budgeting	
Are children with disabilities visible and their issues and needs highlighted in fundraising documents (e.g., flash appeals, Humanitarian Action for Children appeals, brochures, proposals)?	☐ Planned ☐ In progress ☐ Completed
Notes:	
Capacity development	
Have health and HIV/AIDS staff received training on inclusion of children with disabilities (e.g., adapting services to be inclusive, communicating with children with disabilities)?	☐ Planned ☐ In progress ☐ Completed

Notes:	
Procurement and supplies	
Have collaborations been established with government departments, DPOs and NGOs on products and supplies for children with disabilities (e.g., assistive devices)?	☐ Planned ☐ In progress ☐ Completed
Notes:	
Behaviour change communication and communication for development	
Are communication materials developed as part of health and HIV/AIDS programmes in at least two formats (e.g., written and audio)?	☐ Planned ☐ In progress ☐ Completed
Notes:	

Are children with disabilities visible in health and HIV/AIDS-related communication campaigns and messaging (e.g., photos of children with disabilities included in materials)?	☐ Planned ☐ In progress ☐ Completed
Notes:	

Twelve-year-old Monel, supervised by a health worker, walks with the aid of newly issued crutches, at a field hospital set up after the earthquake, Port-au-Prince, Haiti.

Recovery from a humanitarian crisis provides an opportunity to institutionalize and sustain the disability inclusive processes and interventions introduced during the response phase and to ensure ongoing advancement of the rights of children and adolescents with disabilities. Recovery and reconstruction phases affect preparedness interventions. Therefore, some actions below are also relevant for preparedness.

8.1 Coordination and planning

a. Identify ministries and departments with services for children with disabilities initiated during the response phase that could be further consolidated as part of recovery planning (e.g., provision of assistive devices, rehabilitation services).

b. Work with government counterparts to include disability inclusive practices established in the response and early recovery phase into relevant mainstream health programmes and training plans (*see Section 8.8*), partnerships and ongoing support, and as part of health system strengthening.

Example: Physical therapy in earthquake recovery and reconstruction

In March 2011, a year after the Haiti earthquake that injured 300,000, CBM transitioned their earthquake response from emergency relief to recovery and reconstruction. Prior to the disaster, rehabilitation in the country was poorly developed and under-resourced; however, the impairments that resulted from the earthquake created high demand for physical rehabilitation. As part of their recovery phase, over a two-year period CBM worked with partners to develop a rehabilitation centre. The centre was staffed by national physical therapists, rehabilitation assistants, and community and social workers. It was included within a local referral network and connected to a CBM-supported local community-based rehabilitation centre (WCPT, 2016).

c. Incorporate data, information on services and resources relevant to disability generated during the response and early recovery phase into existing government and international mechanisms so they are not lost and can be available for future use.

d. Work with partners (relevant government departments, disability related NGOs, DPOs and private sector) to facilitate access to assistive devices for the most vulnerable families (e.g., through grants, health insurance or social protection benefits and by streamlining procurement).

e. Establish long-term partnerships with disability related organizations including DPOs and NGOs working on issues related to disability (*see Box 5*).

8.2 Assessment, monitoring and evaluation

Identification of children with disabilities and disaggregation of data

a. Advocate for the adoption of disability disaggregated data in national information systems and other administrative data collection mechanisms such as Health Management Information Systems (*see Box 4*).

b. See Box 3 for identification of children with disabilities.

Needs assessment

c. Engage in recovery-related assessments and planning processes, such as post-disaster needs assessments, to influence both data collection and key policy and planning discussions, which will provide opportunities to increase access to health services for children with disabilities.[62]

[62] Post-disaster needs assessments are often conducted by the European Union, the World Bank and the United National Development Programme (UNDP).

d. Collect and present data on children and adolescents with disabilities in post-disaster needs assessments and related reporting, addressing any identified information gaps (*see Box 4*).

e. In targeted surveys and other participatory assessments, dedicate time and space for children with disabilities to express their views on their priorities for their recovery and that of their environment (*see Section 7.2.j*).

Programme monitoring and evaluation

f. Capture good practices (what worked and why) that promote the inclusion of children with disabilities (e.g., through lessons-learned exercises) and use findings to provide recommendations for ongoing health and HIV/AIDS programmes.

g. Conduct targeted surveys (such as knowledge, attitude and practice or participatory assessments) focusing on households with children with disabilities to assess their access to health and HIV/AIDS services.

Example: Documenting lessons learned

The Ageing and Disability Task Force, established in Pakistan after floods in 2010, published a resource book of inclusive practices that captured disability inclusive interventions, lessons learned and case studies from the 10 international and local organizations that make up the task force. The Light for the World case study highlights the establishment of an emergency eye care unit in 2009 to respond to the influx of internally displaced persons in Mardan District due to conflict. The unit performed 730 cataract surgeries and examined 12,931 patients. Additionally, the task force provided assistive devices and established mobile health clinics after the floods in 2010 (Ageing and Disability Task Force, 2011).[63]

[63] For full report, see www.cbm.org/article/downloads/54741/ADTF_Report.pdf.

h. Include qualitative data collection activities (e.g., focus group discussions) that can record the impact and changes in the lives of children and adolescents with disabilities and describe lessons and challenges in evaluations and reporting.

i. Study other factors, such as gender, age and type of disability, to see which groups of children and adolescents have been under-represented in programming.

j. Include access of children with disabilities to health and HIV/AIDS services in all evaluations (*see Box 6*).

8.3 Social protection[64]

a. The affordability of health care is a key issue in most countries (ILO, 2008). Social protection can play an important role in transforming relief interventions into long-term recovery programmes. For instance, cash in emergencies can evolve into predictable medium- or long-term social protection mechanisms, such as social health insurance for persons with disabilities.

b. Consider converting cash transfer programmes for households with children with disabilities into provision of assistive devices and rehabilitative care when relevant (*see Section 7.4.u–w*).

Example: Health insurance for children with disabilities

In 2016, the Government of the Philippines endorsed a national insurance benefit package for 5 million children with disabilities supported by UNICEF. The package offers assessments, assistive devices and rehabilitation services and is a major step towards providing innovative and inclusive services at a national scale (UNICEF Philippines).

[64] For more on social protection and humanitarian action, see https://www.unicef.org/socialprotection/framework/index_61912.html.

8.4 Accessible infrastructure

Reconstruction and rehabilitation of health facilities offer the opportunity to build back better, safer and more accessible.

a. Advocate for accessibility to be a key component in reconstruction plans, including WASH in primary health clinics and hospitals (*see Section 10*).

b. Promote accessibility in national building codes and standards and other relevant policies.

8.5 Human resources

a. Work with relevant ministries and departments and civil society organizations to develop databases and rosters of persons who have disability related training and experience (*see Box 8*).

b. Support local government in reviewing human resources (e.g., community health workers, rehabilitation doctors, physical and occupational therapists, prosthetics and orthotics specialists), advocating for sufficient numbers of qualified staff to address the health needs of children with disabilities.

8.6 Procurement and supplies

a. Encourage health departments and ministries to develop catalogues of assistive devices for a range of disabilities.[65]

b. Establish long-term agreements with suppliers of inclusive and accessible supplies, such as assistive devices (*see Box 7*).

[65] For the full list of WHO priority assistive products and more information, see www.who.int/phi/implementation/assistive_technology/EMP_PHI_2016.01/en.

c. Map other agencies that procure and provide assistive devices. Bulk procurement can reduce costs.

d. Support local and national governments in integrating inclusive supplies (e.g., portable ramps for health facilities, assistive devices) into their procurement processes, including basic training modules and information on safe use and maintenance.

8.7 Funding and budgeting

a. Specify the funding required to address any unmet health needs of women, children and adolescents with disabilities in post-disaster needs assessment reports and final cluster and country reporting.

b. Support local and national governments to develop inclusive and participatory planning and budgetary processes, engaging in focus group discussions with DPOs, other disability groups, parents associations, experts and children and adolescents with disabilities to help prioritize health and HIV/AIDS services and to use financial resources more efficiently (*see Box 5 and 7.2.k*).

- An example is advocating for the establishment of rehabilitation units for long-term rehabilitation provision while ensuring the delivery of community-based rehabilitation (WHO, 2010a).

8.8 Capacity development

a. Work with government counterparts in relevant ministries or departments to mainstream training modules on disability into regular health and HIV/AIDS training.

b. Conduct awareness-raising sessions on the rights and health needs of children with disabilities for local authorities and humanitarian staff.

c. Support DPOs to strengthen their capacity and engage them both in recovery planning and disaster-risk reduction.

Example: Training women with disabilities on humanitarian action

The Women's Refugee Commission (WRC) in collaboration with organizations of women with disabilities in Africa and South Asia developed a resource, *Strengthening the Role of Women with Disabilities in Humanitarian Action: A facilitator's guide.*[66] Its purpose is to support women leaders in providing training to members, colleagues and partners on humanitarian action. The training is intended to enhance the capacity of women with disabilities to effectively advocate for women's and disability issues, including those related to health, within relevant humanitarian forums at national and regional levels (WRC, 2017).

8.9 Policies

a. Review national health-related policies and frameworks to determine whether they consider disability.

b. Based on the review, provide recommendations and advocacy messages for the amendment of existing policies or the development of new policies inclusive of children with disabilities. Policy recommendations may include:

- Provision of disability identity cards to access health benefits, assistive devices and rehabilitation, medication and health follow-up.
- Health insurance for children with disabilities.

[66] See https://www.womensrefugeecommission.org/populations/disabilities/research-and-resources/1443-humanitarian-facilitators-guide.

8.10 Checklist for recovery and reconstruction

The checklist, derived from the programmatic actions outlined in this document, can help plan and assess whether key actions include children and adolescents with disabilities in recovery and reconstruction. To complete the checklist, discussions may be required with other colleagues. Completing the checklist in a team or coordination meeting would be helpful.

Additional printable copies of the checklist can be found at http://training.unicef.org/disability/emergencies/health-and-hivaids.html.

Considerations for including children with disabilities in recovery and reconstruction	
Coordination and planning	
Are collaborations with ministries and departments that provide health and HIV/AIDS services for children with disabilities sustainable in the long term?	☐ Planned ☐ In progress ☐ Completed
Notes:	

Have issues related to children with disabilities been included in health and HIV/AIDS recovery plans?	☐ Planned ☐ In progress ☐ Completed
Notes:	
Do plans to strengthen health systems include provisions for children with disabilities?	☐ Planned ☐ In progress ☐ Completed
Notes:	

Assessment, monitoring and evaluation	
Do health needs assessments related to recovery and reconstruction reflect the needs of children with disabilities and include disaggregated data by disability?	☐ Planned ☐ In progress ☐ Completed
Notes:	
Do health and HIV/AIDS-related monitoring, reporting and evaluations capture information on access to services and challenges faced by children with disabilities?	☐ Planned ☐ In progress ☐ Completed
Notes:	

Are children with disabilities, their families and DPOs consulted as part of recovery and reconstruction efforts?	☐ Planned ☐ In progress ☐ Completed
Notes:	
Accessible infrastructure	
Does reconstruction of health infrastructure (e.g., hospitals, community health clinics) have disability accessibility as a criterion?	☐ Planned ☐ In progress ☐ Completed
Notes:	

Procurement and supplies	
Have partnerships been established with health-related government and service providers for the provision of assistive devices for children with disabilities?	☐ Planned ☐ In progress ☐ Completed
Notes:	
Human resources	
Do health and HIV/AIDS-related databases and rosters capture information on staff and personnel with expertise on disability?	☐ Planned ☐ In progress ☐ Completed
Notes:	

Do health and HIV/AIDS reconstruction budgets include funding for accessible facilities and services for children with disabilities?	☐ Planned ☐ In progress ☐ Completed
Notes:	
Capacity building	
Does health and HIV/AIDS-related training include components on how to respond to the rights and needs of children with disabilities (e.g., training for community health workers, doctors, nurses)?	☐ Planned ☐ In progress ☐ Completed
Notes:	

Policies	
Do national health and HIV/AIDS policies and standards related to infrastructure and services include components on disability?	☐ Planned ☐ In progress ☐ Completed
Notes:	

A boy is assessed by a health worker at Atfaluna (‘Our Children’) Society for Deaf Children, a local NGO in Gaza City, State of Palestine.

This section is a reference for humanitarian officers, doctors, nurses, rehabilitation staff and community health workers when engaging directly with children and adolescents with disabilities and their families, including caregivers with disabilities (e.g., during consultations, when visiting health facilities, providing health services or designing messages for affected populations).

9.1 Terminology[67]

The terminology used to address children, adolescents and women with disabilities or to talk about them in materials can either diminish or empower them.

a. Use person-first terminology (e.g., 'child with a disability', not 'disabled child'; 'girl who is blind' or 'girl with a vision impairment', not 'blind girl').

b. Do not use terms that have negative connotations, such as suffer, suffering, victim or handicapped. Say 'wheelchair user', rather than 'wheelchair bound' or 'confined to a wheelchair'.

c. Use 'persons without disabilities', rather than 'normal' or 'regular' persons.

d. Do not use acronyms to refer to children with disabilities (CWD) and persons with disabilities (PWD).[68]

e. Use appropriate terminology for different types of disabilities: physical, visual/vision, hearing, intellectual and psychosocial impairments (*see Glossary, Section 11*).

---

[67] For more information on terminology related to disabilities, see the UNICEF Inclusive Communications Module: www.unicef.org/disabilities/index_90418.html.

[68] The Convention on the Rights of Persons with Disabilities uses the terminology 'children with disabilities' and 'persons with disabilities'. As a response to the long-standing stigma and discrimination faced by children and adults with disabilities, they prefer to be referred to as children and people and an abbreviation denies that.

9.2 Communicating with children and adolescents with disabilities[69]

a. When possible, talk to and try to get information directly from the child or adolescent with a disability and not only through their caregivers.

b. Be patient. Do not make assumptions. Confirm understanding what the child has expressed.

c. Where required, identify community members who can facilitate communication with children with disabilities (e.g., sign language interpreters, DPOs, inclusive education or special education teachers, other caregivers of children with disabilities, speech and language therapists).

d. Trained or specialist staff working with children with disabilities, such as speech and language therapists, can support caregivers to communicate and interact with their child or adolescent with a disability about their health.

e. Children and adolescents with hearing disabilities (deaf or hard of hearing) often use sign language. If the child or caregiver does not know sign language, use body language, visual aids or key words, and speak slowly and clearly.

   - When speaking to a child that can lip-read, maintain eye contact and do not cover the mouth.

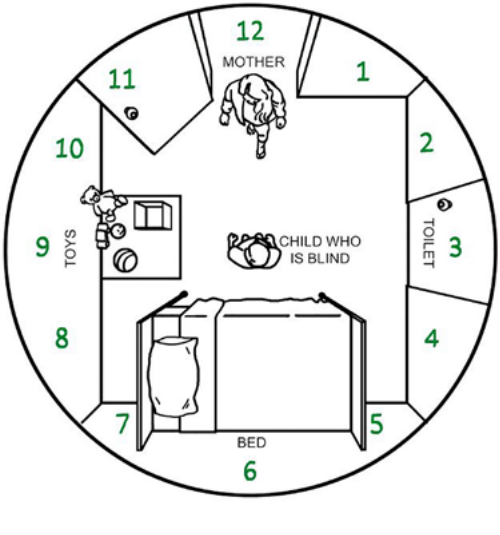
f. For children and adolescents with visual disabilities (blind or low vision):

   - Describe surroundings (e.g., any medical equipment being used or medicines being discussed) and introduce people present.

[69] For more information on communicating with children with disabilities, see the UNICEF Inclusive Communications Module: www.unicef.org/disabilities/index_90418.html.

- Use the 'clock method' (*see Figure 3*) to help older children and adolescents locate people and items (e.g., 'the toilet is at 3 o'clock' if directly to their right or 'the toys are between 8 and 10 o'clock' if they are on the left).

Figure 3: The clock method



Source: UNICEF Disability Section, 2017

- Touching and feeling different objects can support learning and help identify objects such as food or cutlery.

- Ask permission if offering to guide or touch the child or their assistive devices, such as wheelchairs or white canes.

g. If the child or adolescent has difficulty communicating or understanding messages, use clear verbal communication and consider the following:

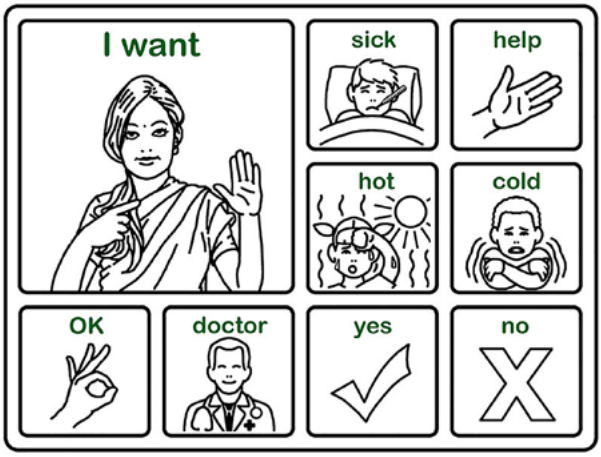
- Use objects to represent different activities to support the child's or adolescent's understanding and ability to anticipate what will come next and to build routine.

- Children and adolescents with disabilities can also use items

to ask for things (e.g., soap to announce a bath or spoon to indicate they are hungry).

- Support children and adolescents in developing a book, a board, or cards with pictures or drawings related to feelings and responding to questions, such as whether they are feeling hot/cold/sick (s*ee Figure 4*). This can be used to communicate about health, food, self-care routines or play (Novita, 2007).[70]

Figure 4: Communication boards and books



Source: Adapted from Novita, 2017.

- Train parents and caregivers to observe and learn the subtle facial expressions or body movements used by the child or adolescent to show their feelings (e.g., uncomfortable, happy, in pain, full, hungry or thirsty).

- Smartphones and tablets can use applications that provide voice output when picture symbols are pressed. There are

[70] If the child is able, more-complex books can be developed with picture symbols arranged in different categories per page (e.g., food, kitchen items, clothes, school items). The same initial sentence starters can be used (e.g., I want, I don't want, I see, I hear, I feel, It is). This allows the learner to use full sentences even if they have no speech.

also devices that can be used as voice output communication aids.[71]

9.3 Adapting information for persons with disabilities[72]

Produce health and HIV/AIDS information in different formats. This will help ensure that children, adolescents and caregivers with physical, intellectual, hearing and visual disabilities can access and understand the information.

a. Formats that are accessible for people with visual disabilities (blind and low vision) include large print, text messages on phones (most smartphones have free voiceover applications), Braille, radio and audio announcements.

b. People with screen-reading software on their computers can also access electronic information (e.g. emails, word formats).

c. Formats that are accessible for people with intellectual disabilities include simple language and visual signs, such as pictograms, drawings, pictures and photos on printed materials.

d. Formats that are accessible for children with hearing disabilities (deaf and low hearing) include print, text messages, captions and sign language interpretation for meetings or television announcements.

e. Organize workshops to engage DPOs, other disability groups, and children and adolescents with different types of disabilities in the design, review and dissemination of communication materi-

[71] For examples of voice output communication aids, see https://www.nationalautismresources.com/speech-language/assistive-technology/.

[72] For more information on adapting information for persons with disabilities, see the UNICEF Inclusive Communications Module: www.unicef.org/disabilities/index_90418.html, and for an example of communication that is accessible to people with different types of disabilities, see the UNDP's inclusive communication on Ebola in Sierra Leone: https://www.youtube.com/watch?v=M015lGIF1MA.

als such as radio programmes run by adolescents with disabilities (*see Box 5 and Section 7.2.k*).

Example: Accessible formats in tsunami response

Following the March 2011 earthquake and tsunami that hit Japan, radio broadcasts and vans with loudspeakers were used to reach the affected populations. These announcements were inaccessible for persons who are deaf or have difficulty hearing. After the disaster struck, a private company, PLUSVoice, initiated a service to provide free sign language interpretation via video calls for residents of Iwate, Miyagi and Fukushima prefectures. This remote communications support provided persons with hearing disabilities access to emergency-related information and warnings (IFRC, Handicap International and CBM, 2015).

9.4 Developing messages inclusive of children with disabilities[73]

The way information portrays children with disabilities can help reduce stereotypes and prejudices and promote awareness of their needs and capabilities. All communication related to both humanitarian action and development can be disability inclusive.

a. Represent community diversity through pictures of children with disabilities in health information both related and unrelated to disability.

b. Depict children with different types of disabilities among groups of children, rather than by themselves or separated from the group.

c. Portray children with disabilities and their caregivers actively

[73] For information on developing inclusive messages, see the UNICEF Inclusive Communications Module: www.unicef.org/disabilities/index_90418.html.

participating in activities (e.g., parents feeding children, children playing or attending child-friendly spaces, temporary learning spaces, receiving health services).

d. Adapt existing communication tools to raise awareness on disability.

- UNICEF Communication for Humanitarian Action Toolkit.[74]

- UNICEF communication for development: Provide a voice for children and adolescents with disabilities through social mobilization; involve them in communication campaigns as main actors; focus on positive images of disability with the aim of transforming social norms and reducing stigma and discrimination.

[74] See https://www.adelaide.edu.au/accru/projects/effectivecomms/6-C4D-CHAT_Proof-2.pdf.

With the help of their siblings, Marva, 12, and Mahar, 11 (left and right, in wheelchairs) make their way home in the Za'atari camp for Syrian refugees in Jordan. Their family (including their father, who has the same disability, and 6 children) fled Syria to escape the violence affecting their neighbourhood.

People with disabilities experience various barriers to accessing health and HIV/AIDS services and related information. These accessibility tips relate to identifying and overcoming physical barriers in the environment and infrastructure. The actions are minimum standards for making health and HIV/AIDS-related infrastructure accessible and can apply to any facility that provides health services (e.g., child-friendly spaces, temporary learning spaces and schools that support vaccination campaigns, hospitals, temporary health clinics).

Education, protection and WASH colleagues may need encouragement to ensure that all facilities providing health and HIV/AIDS services are accessible to all. Toilets, handwashing areas, showers and water points within any health facility should be accessible and usable by people with different types of disabilities (*see WASH booklet*[76]).

Where available, accessibility consultants can assist in assessing, planning, supervising and auditing the construction and reconstruction of accessible health facilities.[77]

a. Review national standards for accessibility. If there are no national standards, international standards can be used.[78]

b. Accessibility is built around the RECU principle: persons with any type of disability can Reach, Enter, Circulate and Use any distribution point or health facility in a continuous movement (e.g., without facing barriers).

---

[75] All provided specifications are taken from the UNICEF resource *Accessible Components for the Built Environment: Technical guidelines embracing universal design*, www.unicefinemergencies.com/downloads/eresource/docs/Disability/annex12 technical cards for accessible construction.pdf (unpublished UNICEF 2016 document).

[76] See http://training.unicef.org/disability/emergencies/wash.html.

[77] A database of qualified accessibility consultants in many countries and all regions is maintained by GAATES on behalf of UNICEF. Information can be obtained by emailing disabilities@unicef.org.

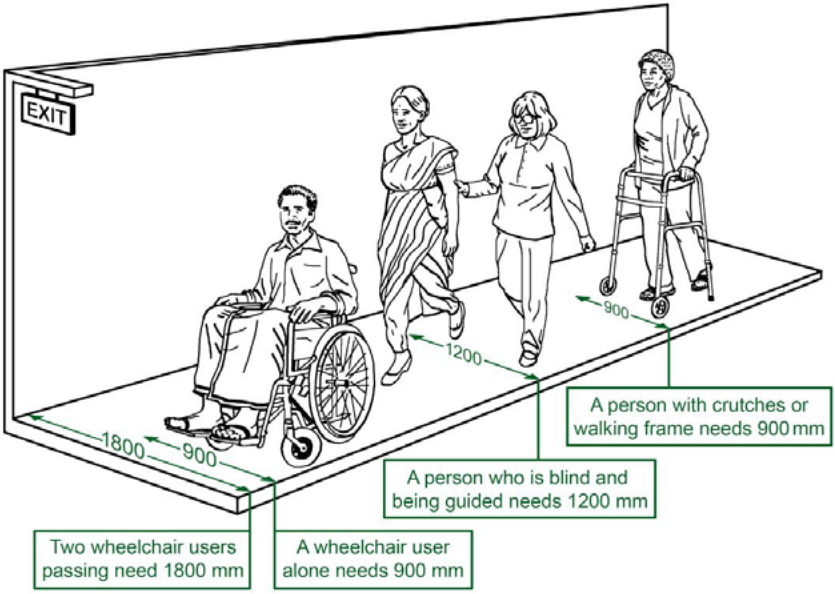
[78] *Refer to Building Construction: Accessibility and usability of the built environment* (2011) by the International Standardization Organization (ISO). UNICEF colleagues can access this from Supply Division.

c. Consider the location of health facilities: Are they easy to reach? Are buildings accessible for people with different types of disabilities?

d. Where possible, select locations and facilities that are already accessible or will be easy to modify (e.g., door widths are already 800 mm,[79] ramp can be added to the main entrance).

e. Pathways should have a minimum width of 900 mm, with the ideal being 1800 mm to allow two wheelchair users to pass each other (*see Figure 5*). Paths should be firm and even.

Figure 5: Paths should be minimum 900 mm to accommodate different users

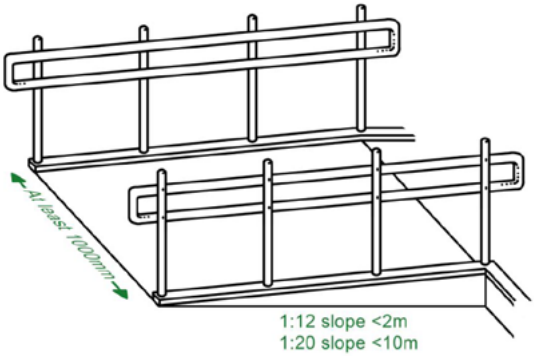


Source: Adapted from Oxley, 2002, by DFID and TRL, 2004 (UNICEF, 2016b)

[79] After construction, doors are difficult to retrofit and modify to make wider for wheelchair users to enter buildings or rooms.

f. Ramps are the only practical solution for people who cannot use steps or stairs. They should have a minimum width of 1000 mm, with handrails recommended for slopes steeper than 1:20, for stairs for drainage crossings (*see Figure 6*).

Figure 6: Ramps



Source: Adapted from IFRC, Handicap International and CBM, 2015

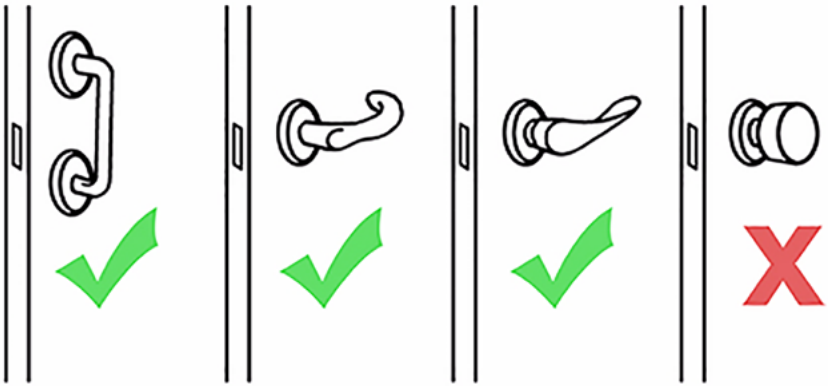
g. Entrances and door openings should be a minimum of 800 mm wide (*see Figure 7*) with no thresholds or barriers on the ground.

Figure 7: Doors should be a minimum of 800 mm wide

Source*:* Adapted from UNESCO, 1990, ISO, 2011 (UNICEF, 2016b)

h. Door handles should be mounted 800–900 mm above the floor; D-lever handles are preferred (*see Figure 8*).

Figure 8: Easy to use door handles



Source: Adapted from IFRC, Handicap International and CBM, 2015

i. Reduce barriers inside health facilities by levelling floors and thresholds.

j. Allow for adequate circulation space within facilities.

k. Make signage related to health facilities accessible:

- Install well-lit maps showing the location of available services with arrows for better orientation (e.g., entrance to clinics, food distributions, temporary learning spaces, child-friendly spaces).
- Install all signage addressed to children at child's height and ensure that parents and caregivers are aware of the information to inform their children.
- Use simple language, pictures, color contrast, pictograms and tactile elements.

Accessibility audits

l. Conduct accessibility audits of health facilities.

m. Involve children, adolescents and caregivers with disabilities in accessibility audits. Move through the environment and facilities with children with different types of disabilities to identify obstacles and elicit their suggestions for improvements.

Accessibility: Persons with disabilities accessing, on an equal basis as others, the physical environment, transportation, information and communications, including information and communications technologies and systems, and other facilities and services open or provided to the public, both in urban and rural areas (UN, 2006). Physical accessibility is the provision of buildings or parts of buildings for people, regardless of disability, age or gender, to be able to gain access to them, into them, to use them and exit from them (ISO, 2011).

Accessible formats: Information available to people with different types of disabilities including displays of text, Braille, tactile communication, large print, accessible multimedia, written, audio, plain-language, human-reader, and augmentative and alternative modes, means and formats of communication, including accessible information and communication technology (UN, 2006).

Accessible signage: Signage designed to inform and orientate all people, including persons with disabilities. All signs should be visible, clear, simple, easy to read and understand, have tactile elements and be properly lit at night.

Assistive devices: Any external product (including devices, equipment, instruments or software) especially produced or generally available, the primary purpose of which is to maintain or improve an individual's functioning and independence, and thereby promote their well-being. Assistive products are also used to prevent impairments and secondary health conditions (WHO, 2016).

Behaviour change communication: A research-based consultative process for addressing knowledge, attitudes and practices. It provides relevant information and motivation through well-defined strategies, using a mix of media channels and participatory methods. Behaviour change strategies focus on the individual as a locus of change to encourage and sustain positive and appropriate behaviours.[80]

Caregiver: The term 'parent' or 'caregiver' is not limited to biological parents, but extends to any guardian providing consistent care to the

[80] For more information, see https://www.unicef.org/cbsc.

child. Caregivers include fathers, mothers, siblings, grandparents and other relatives, as well as child care providers who play a significant role in caring for infants and young children (UNICEF, 2014).

Case management: The process of helping individual children and families through direct social-work support and managing information[81] (CPWG, 2012) and referral to other needed services,[82] and the activities that case workers, social workers or other project staff carry out in working with children and families in addressing their protection concerns (Save the Children, 2011).

Communication for development: A two-way process for sharing ideas and knowledge using a range of communication tools and approaches that empower individuals and communities to take actions to improve their lives. It involves engaging communities and listening to adults and children as they identify problems, propose solutions and act upon them.[83]

Community-based rehabilitation: A multi-sectoral approach working to improve the equalization of opportunities and social inclusion of people with disabilities while combating the perpetual cycle of poverty and disability. Community-based rehabilitation is implemented through the combined efforts of people with disabilities, their families and communities, and relevant government and non-government health, education, vocational, social and other services (WHO, 2010b)

Disability: Long-term impairments that affect the functioning of a person and which in interaction with attitudinal and environmental barriers hinder the person's full and effective participation in society on an equal basis with others (UN, 2006).

---

[81] Direct support involves the time case workers spend with children and families, discussing how they can address their concerns and simply providing support through their presence and attention. It also involves family tracing, medication and follow-up monitoring following family separation and reunification.

[82] Other services are those that are not or cannot be provided directly by the case worker to which the child or family is referred. Such services may include medical, legal, educational or livelihood support provided by another agency or government body.

[83] For more information, see https://www.unicef.org/cbsc.

Disability inclusion: An approach that aims to address barriers faced by persons with disabilities, support their specific needs and ensure their participation.

Disabled People Organizations (DPOs), also known as organization of persons with disabilities: Associations of people with disabilities and/or their representatives, including self-help groups, federations, networks and associations of parents of children with disabilities. An organization is considered a DPO if a majority of its board and members are persons with disabilities (PWDA, 2016).

Early rehabilitation: Immediate assessment and rehabilitative interventions after a traumatic event, ensuring greater possibilities of recovering to previous levels of function before the injury or illness and of reaching a more independent life (Handicap International, 2010).

Fast track: Mechanisms that aim to identify and prioritize certain groups such as persons with disabilities, allowing prioritized access to services. Examples of fast-track mechanisms include separate lines, token systems, beneficiary numbers or identification/beneficiary cards.

Impairment: A significant deviation or loss in body functioning or structure (WHO, 2002). Impairments may be either temporary or permanent and people may have multiple impairments. There are five broad categories of impairments:

- Hearing impairments (sensory) – deafness and hearing loss;
- Visual impairments (sensory) – blindness and low vision;
- Psychosocial impairments – mental health issues that can cause difficulties in communicating, attention deficit and uncontrolled behaviours (e.g., attention deficit hyperactivity disorder, depression, post-traumatic stress disorder);
- Developmental and intellectual impairments – varying degrees of limitations on intellectual functions that can affect ability to learn, memorize, focus attention, communicate, and develop social autonomy and emotional stability (e.g., Down syndrome);
- Physical impairments – partial or total limitations in mobility, including the upper and/or lower body.

Inclusion: A process that aims to ensure that the most vulnerable people are taken into account equally and that they participate in and benefit from development and humanitarian programmes.

Persons with disabilities (children, adolescents and adults): Persons who have long-term physical, mental, intellectual or sensory impairments, which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others (UN, 2006).

Pressure sores: Occur when the body cuts off the blood circulation over a bony area, causing the skin and underlying flesh to die and sores to form. They usually form on parts of the body that have lost feeling and in persons with reduced mobility (Werner, 1997).

Rehabilitation: A set of measures that enables people with disabilities to achieve and maintain optimal functioning in their environments. Rehabilitation services range from the basic to the specialized and are provided in many different locations, including hospitals, homes and community environments (WHO, 2010c).

Social protection: A set of public actions that address not only income poverty and economic shocks but also social vulnerability, thus taking into account the inter-relationship between exclusion and poverty. Through income or in-kind support and programmes designed to increase access to services (e.g., health, education and nutrition), social protection helps realize the human rights of children and families (UNICEF, 2017).

Step-down facility: A transitional health facility providing essential rehabilitation care to lighten the workload of in/outpatient services (WHO, 2015a).

Universal design: The design of products, environments, programmes and services to be usable by all people, to the greatest extent possible, without the need for adaptation or specialized design. Does not exclude assistive devices for particular groups of persons with disabilities where needed (UN, 2006).

Handicap International (2011) *Training of Trainers Manual on Disability-Inclusive HIV Services and Disability-Inclusive Sexual and Reproductive Health for Health Workers*, www.asksource.info/resources/training-trainers-manual-disability-inclusive-hiv-services-and-disability-inclusive-sexual.

WCPT (2016) T*he Role of Physical Therapists in Disaster Management*, www.wcpt.org/sites/wcpt.org/files/files/resources/reports/WCPT_DisasterManagementReport_FINAL_March2016.pdf.

WHO, CBM et al. (2013) *Guidance Note on Disability and Emergency Risk Management for Health*, http://apps.who.int/iris/bitstream/10665/90369/1/9789241506243_eng.pdf?ua=1.

WHO (2009) *Disability and HIV Policy Brief*, www.who.int/disabilities/jc1632_policy_brief_disability_en.pdf.

WHO (2016) *Priority Assistive Products List: Improving access to assistive technology for everyone, everywhere*, www.who.int/phi/implementation/assistive_technology/global_survey-apl/en.

WHO (2016) *Minimum Technical Standards and Recommendations for Rehabilitation*, https://extranet.who.int/emt/content/minimum-technical-standards-and-recommendations-rehabilitation.

UNICEF (2014) *Disability Orientation Video*, www.unicef.org/disabilities/66434.html.

UNICEF (2016) *Inclusive Communication Module*, www.unicef.org/disabilities/index_90418.html.

Age and Disability Consortium (2015) *Minimum Standards for Age and Disability Inclusion in Humanitarian Action: Pilot version.*

Ageing and Disability Task Force (2011) *Ageing and Disability in Humanitarian Response: A resource book of inclusive practices.* CBM.

CBM and Disability Inclusive DRR Network for Asia and Pacific (2013) *Disability Inclusive Disaster Risk Management: Voices from the field & good practices.*

Child Protection Working Group (CPWG) (2012) *Minimum Standards for Child Protection in Humanitarian Action.*

DFID and TRL (2004) *Overseas Road Note 21: Enhancing the mobility of disabled people – Guidelines for practioners.*

Handicap International (2010) *Early Rehabilitation Protocols for Victims of Natural Disaster.*

Handicap International and HelpAge International (2014) *Hidden Victims of the Syrian Crisis: Disabled, injured and older refugees.*

Human Rights Council (2012) *Thematic Study of the Issue of Violence against Women and Girls with Disabilities*, A/HRC/20/5, 30 March 2012.

Inter-Agency Standing Committee (IASC) (2004) *Guidelines for Addressing HIV in Humanitarian Settings.*

International Federation of the Red Cross and Red Crescent Societies (IFRC), Handicap International and CBM, *All under One Roof: Disability-inclusive shelter and settlements in emergencies*. IFRC, 2015.

ILO (2008) *Social Health Protection: An ILO strategy towards universal access to health care.*

ISO (2011) *Building Construction: Accessibility and usability of the built environment*. International Standard ISO 21542.

Landmine and Cluster Munition Monitor (2014) *Factsheet: The impact of mines/ERW on children*, www.the-monitor.org/index.php/content/view/full/25198.

Novita Children's Services (2007) *Alternative and Augmented Communication Factsheets.*

Novita Children's Services (2017) *Augmentative and Alternative Communication (ACC)*.

Oxford University (2010) 'Disability and Displacement', *Forced Migration Review*, Issue 35.

Oxley, P. (2002) *Inclusive Mobility: A guide to best practice on access to pedestrian and transport infrastructure*, London: Department of Transport.

Plan International (2013) *Because I Am a Girl: The State of the World's Girls 2013 – In double jeopardy: adolescent girls and disasters.*

PWDA [People with Disability Australia] (2016), www.pwd.org.au/student-section/disabled-people-s-organisations-dpos.html.

Reinhardt, J. D., et al. (2011) 'Disability and Health-Related Rehabilitation in International Disaster Relief', *Global Health Action*, 4, p. 7191.

Save the Children (2011) *Case Management Practice within Save the Children Child Protection Programmes*.

Save the Children (2015) *Psychological First Aid Training Manual for Child Practitioners*.

Sphere Project (2011) *Humanitarian Charter and Minimum Standards in Humanitarian Response*.

UN (2006) *Convention on the Rights of Persons with Disabilities*.

UNESCO (1990) *Handbook of Design Guidelines for Easy Access to Educational Building by Physically Handicapped Persons*.

UNESCO (2010) *Guidebook for Planning Education in Emergencies and Reconstruction*.

UNHCR and Reach (2014) *Disability Assessment Report: Syrian refugees in Northern Iraq*.

UNICEF (2007) *Promoting the Rights of Children with Disabilities*. Innocenti Digest No. 13.

UNICEF (2010) *Core Commitments for Children: Health*.

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

UNICEF (2014) *A Systematic Review of Parenting Programmes for Young Children in Low- and Middle-Income Countries*.

UNICEF (2016a) *UNICEF/ Washington Group on Disability Statistics Child Functioning Module.* Concept Note, https://data.unicef.org/wp-content/uploads/2016/11/UNICEF-WG-Child-Functioning-Module-Concept-Note-October-2016-FINAL.pdf.

UNICEF (2016b) *Accessible Components for the Built Environment: Technical guidelines embracing universal design*. Unpublished document, www.unicefinemergencies.com/downloads/eresource/docs/Disability/annex12 technical cards for accessible construction.pdf.

UNICEF (2017) *Children with Disabilities and Learning Difficulties: Central and Eastern Europe/Commonwealth of Independent States*, https://www.unicef.org/ceecis/education_13373.html.

UNICEF and WHO (2012) *Early Childhood Development and Disability*.

UNICEF and WHO (2015) *Assistive Technology for Children with Disabilities: Creating opportunities for education, inclusion and participation – A discussion paper*.

WCPT (2016) *The Role of Physical Therapists in Disaster Management*.

WEDC (2010) *Inclusive Design of School Latrines: How much does it cost and who benefits?*

Werner, D. (1997) *Nothing about Us without Us: Developing innovative technologies for, by and with disabled persons*. Chapter 27.

WHO (2002) Towards a Common Language for Functioning, Disability and Health ICF, www.who.int/classifications/icf/en.

WHO (2010a) *Community-Based Rehabilitation: CBR guidelines – Supplementary Book*.

WHO (2010b) *Community-Based Rehabilitation: CBR guidelines – Introductory booklet*, http://apps.who.int/iris/bitstream/10665/44405/9/9789241548052_introductory_eng.pdf

WHO (2010c) *Community-Based Rehabilitation: CBR guidelines – Health booklet.*

WHO (2011) *World Report on Disability*.

WHO (2015a) 'Nepal Health Cluster Bulletin 2, 11 May', www.searo.who.int/entity/emergencies/crises/nepal/health_cluster_bulletin_12_may_2015.pdf.

WHO (2015b) 'Health Cluster Bulletin 4, 27 May, Nepal Earthquake Response'.

WHO (2016) *ICF Browser – Environmental factors – Chapter 1, Products and Technology*, http://apps.who.int/classifications/icfbrowser.

WHO and UNESCAP (2008) *Training Manual in Disability Statistics*.

WHO, CBM et al. (2013) *Guidance Note on Disability and Emergency Risk Management for Health*.

WRC (2013a) *Disability Inclusion in the Syrian Refugee Response in Lebanon*.

WRC (2013b) *Disability among Refugees and Conflict-Affected Populations*.

WRC (2014) *The Intersection of Sexual and Reproductive Health and Disability Research from Kenya, Uganda and Nepal*.

WRC (2016) *"Working to Improve Our Own Future": Inclusion of women and girls with disabilities in humanitarian action.*

WRC (2017) *Strengthening the Role of Women with Disabilities in Humanitarian Action: A facilitator's guide.*

The tables, derived from the programmatic actions outlined in this document, list key actions under each health and HIV/AIDS Core Commitment for Children in Humanitarian Action[84] that enhance inclusion of children and adolescents with disabilities.

Health Core Commitments for Children in Humanitarian Action

Commitment 1: Inter-agency coordination mechanisms in the health sector (e.g., cluster coordination) are supported and enhanced with links to other cluster/sector coordination mechanisms on critical inter-sectoral issues.
Actions to include children with disabilities
Coordination mechanisms, including health clusters and working groups, have a disability focal point or focal agency.
Issues related to children with disabilities included in health cluster and working group plans.
Links made between the health and other clusters for critical inter-sectoral actions to include children with disabilities (e.g., with the education cluster to ensure that health campaigns in schools and temporary learning spaces include children with disabilities).
Commitment 2: Children and women access life-saving interventions through population- and community-based activities (e.g., campaigns and child health days).
Actions to include children with disabilities
Outreach mechanisms established for the identification and inclusion of children with disabilities in campaigns such as measles vaccination, insecticide-treated nets, vitamin A and deworming medication.
Commitment 3: Children, adolescents and women equitably access essential health services with sustained coverage of high-impact preventive and curative interventions.

[84] For more information on the UNICEF Core Commitments for Children, see www.unicef.org/emergencies/index_68710.html.

Actions to include children with disabilities
Health outreach and facility-based staff trained on identification and referral of children, adolescents and women with disabilities, including to rehabilitation services.
Collaboration established with providers of specialized services to address the needs of children with disabilities (e.g., children who have suffered catastrophic injuries, including emergency/corrective surgeries, rehabilitation services and provisioning of assistive devices).
Health humanitarian staff have been trained on the inclusion of children with disabilities (e.g., making SRH and MHPSS interventions inclusive, communicating with children with disabilities).
Humanitarian-related health infrastructure and facilities are able to be accessed and used by persons with disabilities (e.g., accessible location and building, information in different formats).
Commitment 4: Women and children access behaviour-change communication interventions to improve health-care and feeding practices.
Actions to include children with disabilities
Key health messages developed and disseminated to affected populations in at least two different formats (e.g., brochures, audio announcements).
Positive images of children with disabilities included in health materials (e.g., children with disabilities playing with other children).
Commitment 5: Women and children have access to essential household items.
Actions to include children with disabilities
Households with persons with disabilities identified, registered and provided with identification cards for the provision of essential household items.
Fast-track or prioritization system set up for essential household items to households with persons with disabilities.

HIV/AIDS Core Commitments for Children in Humanitarian Action

Commitment 1: Children, young people and women have access to information regarding prevention, care and treatment.
Actions to include children with disabilities
Information on HIV prevention, care and treatment, including where HIV/AIDS services are available, developed and disseminated in at least two different formats (e.g., written and audio).
Staff working on HIV trained on how to communicate with people with disabilities (e.g., basic tips on communicating with people who are deaf, blind or have intellectual disabilities).
Commitment 2: Children, young people and women access HIV/AIDS prevention, care and treatment during crisis.
Actions to include children with disabilities
HIV services, both facility- and community-based, are accessible for persons with disabilities (e.g., in accessible locations and buildings with accessible signage).
Children with disabilities are accessing HIV/AIDS prevention and treatment campaigns (in schools and/or through outreach).
Data on access to HIV/AIDS services are disaggregated by disability.
Commitment 3: Prevention, care and treatment services for children, young people and women are continued.
Actions to include children with disabilities
Persons with disabilities previously on HIV-related care and treatment continue to receive antiretroviral treatment, which may require outreach as after an emergency they may be isolated and unable to attend clinics.

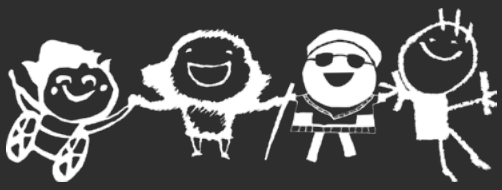
The six booklets of the guidance are available from:
training.unicef.org/disability/emergencies

In addition to the print and PDF versions, the guidance is also available in a range of accessible formats: EPUB, Braille-ready file and accessible HTML formats

Cover photo:

Nirmala (left, with physiotherapist Jay) and Khembro (right, with physiotherapist Sudan Rimal) receive prosthesis and rehabilitation sessions after being injured in the Nepal earthquake.

Photo credit: © Lucas Veuve/Handicap International



unicef

for every child