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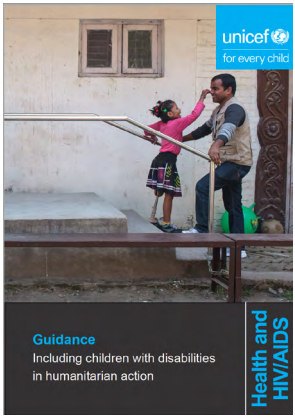
for every child

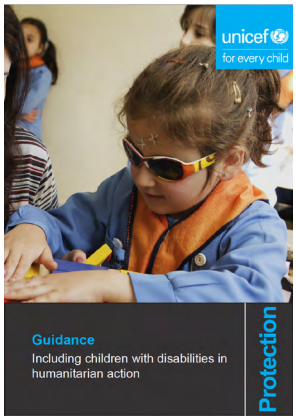
Guidance

Including children with disabilities in humanitarian action

Nutrition

Series of guidance consists of six booklets:





Including Children with Disabilities in Humanitarian Action

Preparedness
Response and early recovery
Recovery and reconstruction

Nutrition

UNICEF in collaboration with Handicap International prepared *Guidance on Including Children with Disabilities in Humanitarian Action: Nutrition*. 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 to Besan AbdelQader, Victor Aguayo, Dina Al Jamal, Kate Alley, France Begin, Jaya Burathoki, Anna Burlyaeva, Stanley Chitekwe, David Clark, Begna Edo, Anne Filorizzo, Jumana Haj-Ahmed, Diane Holland, Sunita Kayastha, Muhammad Rafiq Khan, Marie Leduc, Jennifer Leger, Asma Maladwala, Aline Mandrilly, Jane Mwangi, Maureen Njoki, Beth Ann Plowman, Cristina Roccella, Tamara Rusinow, Lieve Sabbe, Yukiko Sakurai, Cecilia Sanchez Bodas, Midori Sato, Betsy Sherwood, Frederic Sizaret, Pauline Thivillier, Juliet Young and Nurten Yilmaz for their valuable contributions, including expert input, advice and insight.

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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.

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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.

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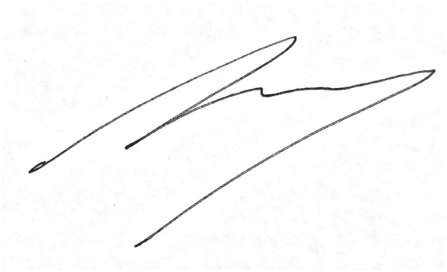

Manuel Fontaine
Director, Office of Emergency Programmes
UNICEF

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 organization of persons with disabilities)
HIV	Human Immunodeficiency Virus
ISO	International Standardization Organization
MICS	Multiple Indicator Cluster Survey
MUAC	mid-upper arm circumference
NGO	non-government organization
RECU	reach, enter, circulate and use
SitRep	situation report
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 insights 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 practical 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 nutrition 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 nutrition 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, social workers, case managers and child-friendly space facilitators may find useful when engaging directly with children with disabilities and their families such as during case management or in designing messages for affected populations.

The guidance comprises six booklets on how to include children 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 nutrition interventions, a right of all persons with disabilities. While *preventing* disabilities is also a matter of nutrition and 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 175 countries as of November 2017, the CRPD underscores that children and adolescents with disabilities have the right to receive essential nutrition services and to reach their highest attainable standard of health.[1]

[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 http://www.ohchr.org/EN/HRBodies/CRPD (UN, 2006).

- Undernutrition in infants and children, including those with disabilities, can lead to poor health outcomes; missing or delays in reaching developmental milestones; acquiring avoidable secondary conditions; stunting and wasting; and, in extreme circumstances, death (Groce et al., 2013a).

- Children with disabilities are more likely to be malnourished as malnutrition can cause disabilities and disability can also lead to malnutrition, creating a cycle (Groce et al., 2013a):

  - Children who are malnourished may develop developmental delays and are at greater risk of illness (Groce et al., 2013a).

  - At the same time, children with disabilities may become malnourished due to difficulties swallowing and feeding,[2] frequent illness, difficulties absorbing nutrients, caregiver's lack of knowledge on feeding and neglect (CBM et al., 2014a).

  - Malnourishment can also result from stigma and discrimination. Mothers may be encouraged to not breastfeed their infants with disabilities and children and adolescents with disabilities may be fed less, denied food or provided less nutritious food than siblings without disabilities (UNICEF, 2013).

- This cycle is often exacerbated during humanitarian crises due to food shortages or food aid not being accessible (CBM et al., 2014a); and in the aftermath of a disaster, children with disabilities may lose or become separated from caregivers who support their nutrition (WHO, 2010).[3]

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[2] Children with disabilities may require more time and assistance to eat due to difficulties suckling, swallowing, sitting up or holding spoons. These factors also lead to an increased risk of aspiration (*see Glossary, Section 11*) and/or choking.

[3] Some children and adolescents with physical or intellectual disabilities may have difficulties feeding themselves or need assistance from caregivers to eat (UNICEF, 2013).

- Studies suggest that girls with disabilities are more likely to be underweight than boys with disabilities (Groce et al., 2014).[4] While little research exists, it is likely that food scarcities in emergency contexts could further exacerbate these inequities (Leonard Cheshire Disability, UNICEF and Spoon Foundation, 2014).

- Access to nutritious food for pregnant women with disabilities is consistently overlooked in both disability and nutrition sectors, placing them at increased risk of malnutrition (Groce et al., 2013a).

- Caregivers with disabilities may experience additional barriers in humanitarian contexts, particularly when the physical environment changes as in an earthquake or tsunami.

    - For example, a mother who is blind may find it difficult to perform household tasks, such as cooking in a shelter after a natural disaster.

[4] Based on a study of children with cerebral palsy in Turkey.

Binda feeds rice to her 3-year-old son outside a UNICEF-provided medical tent in Dolakha, Nepal. Her children were injured when they were buried beneath rubble during the earthquake of 12 May 2015. It took Binda an hour to dig her children out and another three hours to reach medical care.

- Food distribution sites and health facilities that provide nutrition interventions (e.g., micronutrient supplements, severe acute malnutrition treatment, infant and young child feeding programmes) may be located in sites that are inaccessible to children and caregivers with disabilities.

- Some children and adolescents with physical disabilities may not be identified as malnourished as current measurement methods (mid-upper arm circumference) may be misleading where the upper arm muscle has built up (such as for some wheelchair users) and no guidelines exist for such instances (Sphere, 2011).

- Health and nutrition professionals may not be able to communicate effectively with persons with disabilities (Shakespeare et al., 2009).

- Caregivers of children with disabilities who need to provide additional support for their children may not be able to join food distributions, food-for-work or livelihoods programmes, reducing their access to food (CBM et al., 2014a).[5] Additional barriers further compound this when the caregiver is also a person with a disability.

- Food rations and supplies are not adapted for children with disabilities who may require a modified food consistency (*see Glossary, Section 11*) such as smooth pureed food that is easier to swallow (Novita Children's Services, 2011d), additional nutrients and adapted utensils (WRC, 2008).

- Children with disabilities are less likely to be included in school-based nutrition and food security programmes as they are often not in school, including in emergency education settings[6] (CBM et al., 2014b).

[5] Based on a study in Turkana region, Kenya.

[6] See Education Booklet at http://training.unicef.org/disability/emergencies/education.html.

- Stigma and discrimination can lead to emergency and nutrition workers excluding children with disabilities (particularly those with visible disabilities) believing that the preservation of the life of a child with a disability is of lower priority than that of a child who is not disabled (Groce et al., 2013a).

- Children with disabilities disproportionately make up the populations of institutions and orphanages, which food programmes often overlook (Leonard Cheshire Disability, UNICEF and Spoon Foundation, 2014).

4.1 UNICEF's Core Commitments for Children in Humanitarian Action

UNICEF's Core Commitments for Children in Humanitarian Action (CCCs), a global framework to guide UNICEF and partners in emergencies, outline commitments and benchmarks related to nutrition interventions in humanitarian action. They include the establishment of nutritional assessments and surveillance systems, access to infant and young child feeding, management of acute malnutrition, and access to micronutrients and relevant information about nutrition (UNICEF, 2010). All nutrition core commitments are applicable for children with disabilities. (*See Annex for specific inclusive actions for each nutrition commitment.*)[7]

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 ensure accountability. The Sphere Project sets both a humanitarian charter and minimum standards for WASH, food security and nutrition, shelter, settlement and non-food items and health. The rights of persons with disabilities are a cross-cutting theme within the Sphere Handbook, both in mainstreamed and targeted actions (Sphere Project, 2011).

4.3 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

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

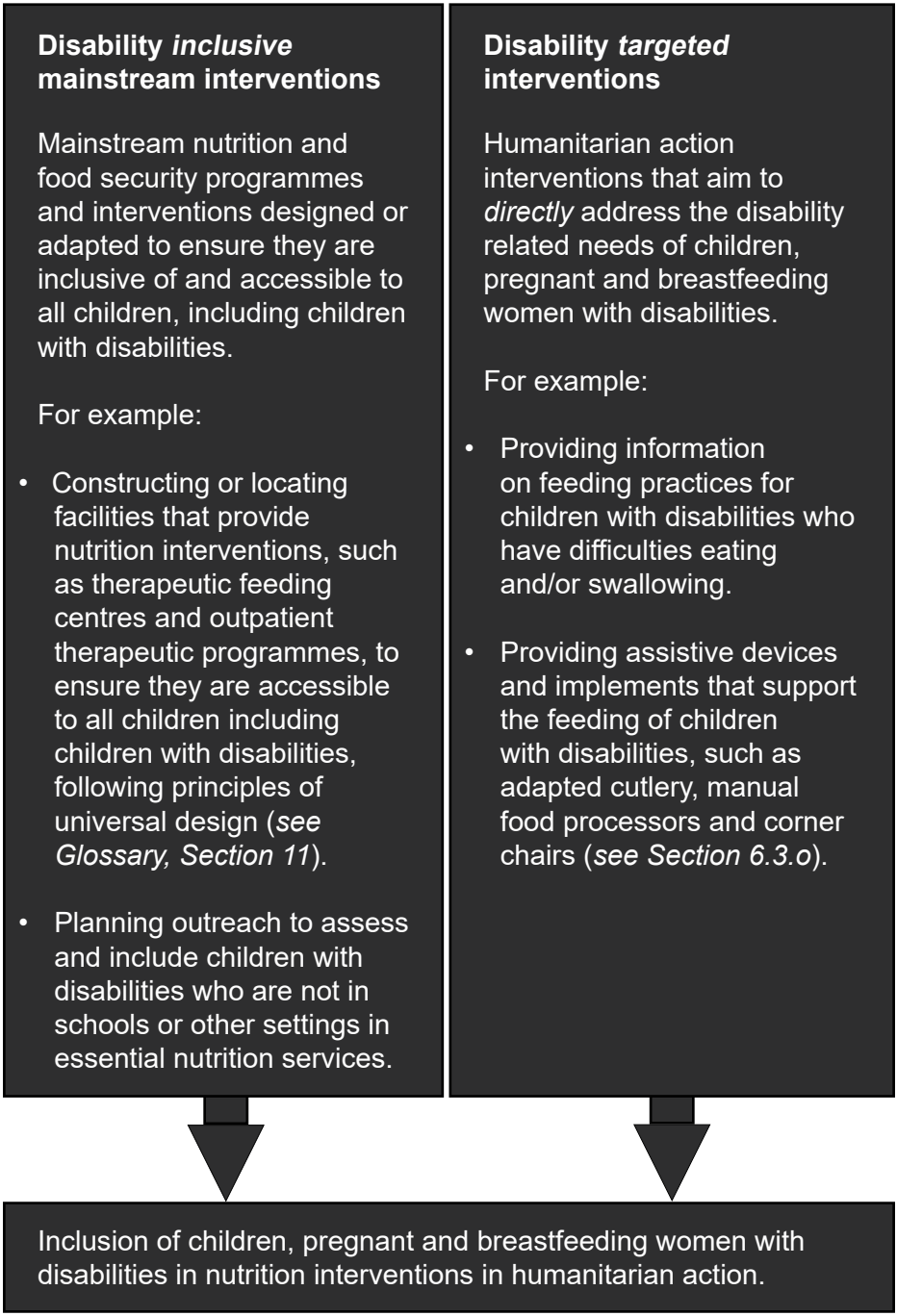
States, United Nations agencies, civil society organizations and organizations of persons with disabilities (DPOs) to make humanitarian action inclusive of persons with disabilities, lift barriers to accessing humanitarian services and ensure the participation of persons with disabilities. The Charter has been widely endorsed.[8]

4.4 Twin-track approach

The twin-track approach strengthens the inclusion of children with disabilities in nutrition interventions (*see Figure 1*).

[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 nutrition 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 actions 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 (e.g., 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.

In the former Yugoslav Republic of Macedonia, 11-year-old Rida, from the Syrian Arab Republic, rests after receiving a warm coat, food and water in a UNICEF child-friendly space at a refugee and migrant transit centre.

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 nutrition (e.g., in clusters or 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 social welfare, education and health, NGOs and DPOs).

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* (2013), which provides advice on reaching and identifying children with disabilities and working with their parents and caregivers and 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: Jordan coordination mechanism – disability task force

In 2015, a disability task force, co-chaired by UNHCR and Handicap International, was established in Jordan under the protection cluster (UNHCR, 2015a). The task force developed technical guidelines for providing services for refugees and vulnerable host populations with disabilities in camp and non-camp settings and strengthened disability data collection. The guidelines included information on nutritional support for persons with disabilities (UNHCR, 2015b and 2016).

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 reference 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 expertise and resources available for children and adolescents with disabilities;
- Coordinating with national and humanitarian service providers (including health and food security) to establish clear referral mechanisms based on up-to-date mapping and assessments;
- Working with health, food security, WASH, education and shelter, camp coordination and camp management mechanisms (clusters) to plan accessibility for key humanitarian interventions (e.g., health facilities, baby-friendly spaces, food distribution sites, food shops, information on vouchers and food transfers).

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 nutrition and food security interventions.

a. During preparedness stages, find and gather the best available data on children with disabilities within populations at risk of food scarcity and undernutrition.[13]

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; Health Management Information Systems; education departments; beneficiary registers for social protection schemes for children with disabilities. Previous household surveys, such as UNICEF's Multiple Indicator Cluster Survey (MICS), may have used the child functioning module (*see Box 4*).[14]

[13] For more information on risks and causes of undernutrition, see UNICEF Nutrition in emergencies, Lesson 2.5 Causes and most vulnerable to undernutrition: https://www.unicef.org/nutrition/training.

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

Box 3: Identifying children with disabilities from existing sources continued

- 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 underreport the number of children and adults with disabilities (WHO and UNESCAP, 2008).
- The World Health Organization (WHO) 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 of 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.[15]

[15] 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.

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.[16]
    - 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.[17]
- 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 larger surveys (e.g., UNICEF's MICS).
- Disaggregate by disability in information management systems, such as Health Management Information Systems and Nutrition Information Systems.

[16] 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.

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 and pregnant and breastfeeding women with disabilities in assessments related to nutrition, such as when collecting information on feeding practices (*see Glossary, Section 11*).

e. Map existing nutrition programmes, interventions and services that are accessed by children with disabilities and pregnant and breastfeeding women with disabilities, such as inclusive and special schools, disability inclusive baby-friendly spaces and child-friendly spaces.

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.[18]

- 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.

[17] 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). 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.

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

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

Programme monitoring and evaluation

g. When establishing systems and procedures that measure the nutrition interventions to 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) to collect relevant information on services related to disability (*see Section 6.2.e*).[19] 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, national nutrition databases, and nutrition monitoring and reporting templates (e.g., national nutrition surveillance and monitoring systems) is a longer-term investment in national capacity for monitoring humanitarian responses.

6.3 Planning

As part of planning, consider the following:

Service provision

a. Review nutrition and food security policies and programmes to assess if they consider children with disabilities.

[19] 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.

b. Highlight this information in trainings for nutrition 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 accessing health and nutrition services and determine whether they are inclusive and address the needs of children with disabilities.

d. Determine if a system of disability identity cards exists.[20] 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 women and children with disabilities (e.g., cash and food transfers).[21]

f. Develop nutrient-dense and culturally appropriate recipes that can be adapted for children with disabilities (e.g., modifying food consistency).[22]

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

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

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[20] Disability identity cards are often used as eligibility criteria for accessing services.

[21] For more information on *Nutrition and Social Protection*, see FAO (2015) Nutrition and Social Protection, www.fao.org/3/a-i4819e.pdf.

[22] For instance, see *Combating Malnutrition among Children with Disabilities in Twelve Countries: Development of culturally appropriate texture-modified foods* (SPOON, no date), www.ohsuwelcome.com/xd/education/schools/school-of-medicine/academic-programs/graduate-programs-human-nutrition/about/community-outreach/upload/SPOON_Poster.pdf

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 nutrition coordination, data collection, assessments, baby-friendly space interventions and communication materials preparation.

DPOs are organizations representing persons with disabilities at the community, national, regional and global levels. Some are specific to a type of disability such as the National Federations of the Blind, while 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 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 women and girls with disabilities.
- To find a DPO, review the member list of the International Disability Alliance.[23]
- Contact a regional DPO if a country-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. When a flood is coming, we have to prepare: we store dry food and firewood. We make a list of doctors with their phone numbers; we use that list during the flood if needed."[24] (Plan International, 2013).

Human resources

i. Identify and create lists of existing personnel with expertise working with children with disabilities, such as rehabilitation doctors, nutritionists, midwives, early childhood development specialists, sign language interpreters, physiotherapists, occupational therapists, speech and language therapists, social workers, and special educators for children with intellectual and psychosocial disabilities or who are deaf or blind.

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

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

l. Mobilize disability expertise and experience to inform inclusive nutrition programmes and interventions (*see Box 8*).

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

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

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

Procurement and supplies

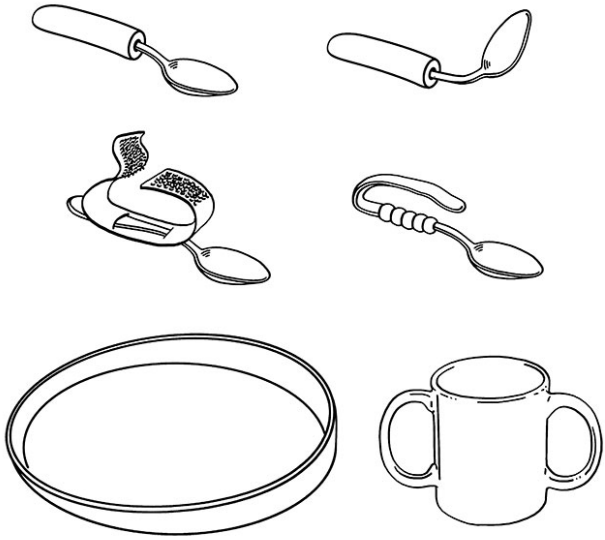
n. Identify regular supplies that benefit all children and improve access to and use of nutrition services and facilities for children and women with disabilities. These include mattresses, wedge pillows, ramps, toilet chairs and grab rails for toilets in nutrition-related facilities.

o. Identify targeted supplies that respond to children's disability related needs. These include assistive devices and implements to support the feeding of children with disabilities, such as manual food processors, corner chairs (*see Figure 2*) and adapted cutlery (*see Figure 3*).

Figure 2: Corner chairs support children with disabilities during mealtimes

Source: Adapted from Handicap International, 2010

Figure 3: Adapted cutlery can support independent feeding



Source: Adapted from Handicap International, 2010

p. 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 for assistive devices accordingly and collaborate with organizations that work on the provision of assistive devices.

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

r. 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.

s. 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.

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

Funding and budgeting

t. Allocate budgets (proportionate to funding availability) for actions listed in this booklet[26] such as conducting awareness campaigns on disability, constructing or modifying nutrition facilities for accessibility, producing accessible materials for baby-friendly spaces, developing accessible communication materials and mobilizing outreach teams.

u. Allocate budget for service providers who can address the nutrition needs of children with disabilities, such as occupational therapists, physiotherapists, social workers with experience working with children with disabilities 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 (e.g., cluster approach awareness trainings), programming and nutrition processes and tools (e.g., harmonize training package)[28] and to government coordination structures for emergency response. This will encourage DPOs to contribute to nutrition 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 (buildings 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.

[28] For more information on Nutrition training packages, see http://nutritioncluster.net/trainings.

c. Develop a disability awareness session and training module to be used in nutrition in emergency training programmes,[29] covering:

   - Data collection on children with disabilities and identification of their nutritional needs;
   - Nutrition needs of children with disabilities through a comprehensive package of care[30] (*see Section 7.4*);
   - Infant care and feeding practices for breastfeeding women with disabilities (*see Section 7.4.i and r*);
   - Nutrition risks and barriers faced by children with disabilities and ways to mitigate them through mainstream inclusive approaches;
   - Communicating with children with disabilities (*see Section 9.2*) and adapting information (*see Section 9.3*).

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

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

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[29] Awareness sessions aim to create interest and change attitudes towards disability, while the objective of 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; see www.unicef.org/disabilities/66434.html.

[30] Comprehensive package of care includes meeting specific nutrition needs of children with disabilities and inclusive infant and young child feeding, management of severe acute malnutrition and micronutrient supplementation.

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 has developed a resource, *Strengthening the Role of Women with Disabilities in Humanitarian Action: A facilitator's guide*. Its purpose is to support women leaders in training members, colleagues and partners about humanitarian action. The training enhances the capacity of women with disabilities to advocate effectively on women's and disability issues, including those related to food security, within humanitarian forums at national and regional levels (WRC, 2017).

6.5 Accessible infrastructure

a. When assessing and pre-identifying buildings and facilities that could be used for nutrition and food security in emergency interventions (e.g., food distribution points, health care facilities, baby-friendly spaces, therapeutic feeding centres, outpatient therapeutic programmes), look for infrastructure that is already accessible or requires only minor modifications.

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

c. When relevant, plan and budget for necessary modifications to make nutrition-related facilities accessible. Consider accessibility in the establishment of temporary nutrition facilities (e.g., baby-friendly spaces, therapeutic feeding centres and outpatient therapeutic programmes).

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

[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).

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 needs of children with disabilities, including:

- Easy-to-understand information on existing nutrition services such as baby-friendly spaces, infant and young feeding programmes, and outreach programmes;
- Information on the nutrition needs of children with disabilities such as modifying food consistency (*see Glossary, Section 11*) and use of assistive devices for feeding such as adapted spoons and corner chairs (*see Section 6.3.o*);
- Information on breastfeeding infants with disabilities (*see Section 7.4.p–r*) and providing complementary foods for children with difficulties swallowing, chewing or eating independently (*see Section 7.4.s–y*);
- Information in at least two different formats (e.g., written and audio) on breastfeeding and child nutrition for pregnant and breastfeeding women with disabilities (*see Section 7.4.i and r*);
- Messages on the right to food and nutrition services for all girls and boys with disabilities.

b. Include positive images of children and women with disabilities in communication materials (e.g., women with disabilities as

[32] For accessibility specifications for buildings and facilities, see www.unicefinemergencies.com/downloads/eresource/docs/Disability/annex12_technical cards for accessible construction.pdf.

mothers or pregnant women) 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, using at least two means of gathering feedback such as written and verbal (*see Section 9.2*).

Example: Disability targeted nutrition communication campaign

In the Lao People's Democratic Republic, specific messages on disability in the Lao language were included in the World Food Programme nutrition awareness campaigns. In addition to messages on the importance of nutrition for mothers and babies to prevent disabilities, the following messages were included:

- A mother with a disability can also breastfeed and has enough milk for her baby;
- Village health volunteers should ensure that all mothers with a disability or mothers of children with a disability receive assistance (World Food Programme).

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 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/nutrition.html.

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

Do nutrition 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 and women with disabilities been mapped (e.g., disability inclusive baby-friendly spaces and child-friendly spaces, provision of assistive devices or rehabilitation centres)?	☐ Planned ☐ In progress ☐ Completed
Notes:	
Planning	
Have issues related to children with disabilities been included in nutrition 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 nutrition activities?	☐ Planned ☐ In progress ☐ Completed
Notes:	
Has a budget for services and supplies to address the nutrition 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 nutrition supply planning considered products relevant to children with disabilities (e.g., assistive devices, adapted cutlery)?	☐ Planned ☐ In progress ☐ Completed
Notes:	
Is disability accessibility a criterion for identification and selection of nutrition-related facilities in emergencies (e.g., health clinics, baby-friendly spaces, therapeutic feeding centres and outpatient therapeutic programmes)?	☐ Planned ☐ In progress ☐ Completed

Notes:	
Capacity development	
Have nutrition humanitarian staff received training on inclusion of children with disabilities (e.g., how to make nutrition interventions inclusive, communicating with children with disabilities and adapting information)?	☐ Planned ☐ In progress ☐ Completed
Notes:	
Behaviour change communication and communication for development	
Are communication materials developed as part of preparedness programmes in at least two formats (e.g., written and audio)?	☐ Planned ☐ In progress ☐ Completed
Notes:	

Halima, 9, lives with cerebral palsy. Halima lives in Somalia and has a wheelchair and access to rehabilitation from Handicap International.

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

7.1 Coordination

a. Establish a disability focal point,[33] a focal agency or a task force to represent disability issues in humanitarian nutrition coordination mechanisms (e.g., clusters, working groups).

b. Form links between government authorities and clusters on critical issues to support coordinated and inclusive nutrition services.

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

- Education, health and protection clusters to:
  - Map and implement inclusive nutrition programmes through existing facilities (e.g., health clinics, schools, temporary learning spaces, child-friendly spaces);
  - Establish community outreach to identify and screen children and women with disabilities in need of nutritional support through trained community health workers, home-based educators or social workers;
  - Create and implement referral mechanisms for the prevention and treatment of undernutrition due to neglect within the family/household or institutions.[34]
- Health cluster to:

[33] The disability focal point may benefit from participating in disability related training planned in the country or region.

[34] Children with disabilities are often overrepresented in institutions (UNICEF, 2017a) and may be at increased risk of undernutrition due to the limited time and skills of caregivers in these facilities (Groce et al, 2013b).

- Provide management of malnutrition in children and women with disabilities (including the management of newborns with difficulties breastfeeding);
- Enable access to antenatal care for pregnant women with disabilities;
- Facilitate the provision of assistive devices to support feeding of children and adolescents with disabilities (*see Section 7.4.s–y*).

- Food security cluster to:
  - Facilitate access to food security interventions (e.g., considering the accessibility of food distribution sites, markets, shops, information on cash and voucher transfers);
  - Design and distribution of food rations that can be transported and used by persons with disabilities (e.g., packages with less weight and easy to use handles/lids for persons with limited mobility).
  - Facilitate access to livelihoods programmes for households with children and women with disabilities (including income-generating activities and employment for women with disabilities).

d. When mapping humanitarian services as in a 5W database (*see Section 6.2.h*), collect information from the ministry or department responsible for disability issues, organizations that provide services accessed by children and adolescents with disabilities, and those that provide targeted services (e.g., assistive devices, rehabilitation centres).

e. Identify gaps and advocate for adapting services that are currently not inclusive of children with disabilities following the guidance in this booklet. Examples of services that are not inclusive are nutrition-related facilities that lack ramps or baby-friendly spaces without staff trained on including children and breastfeeding and women with disabilities in interventions.

7.2 Assessment, monitoring and evaluation

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

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

c. Collect data on children with disabilities at all levels – 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 nutrition programmes and determine the extent to which children and women with disabilities are accessing services, such as infant and young child feeding, treatment of severe and acute malnutrition and micronutrient deficiencies.

Example: Data collection on flood-affected persons with disabilities in Pakistan

During the response and recovery phases following the 2010 floods in Pakistan, the Special Talent Exchange Program and Sightsavers established the Information Resource Center on Disability – a database using national identity card information on flood-affected people with disabilities in Nowshera and Charsaddah districts. This web-based resource, with data on approximately 650 people with disabilities as of 2011, links to the central Crisis Centre of Red Crescent Society of Pakistan. The database is used to reach people with disabilities and their families for coordinated service provision and dissemination of information on food distribution systems, medical services, distribution of cash and food grants and cash-for-work programs (Ageing and Disability Task Force, 2011).

Humanitarian needs assessments

e. Incorporate issues related to children with disabilities into mainstream humanitarian needs assessments, such as multi-cluster or multi-sector initial rapid assessment[35] and post-disaster needs assessments.

f. For instruments that collect information on individuals (e.g., anthropometric status, micronutrient status, infant and young child feeding, maternal care practices), adapt tools to collect disaggregated data by disability, age and sex (*see Box 4*).

g. Identify the nutritional needs related to the child's age and disability:

   - Feeding practices for infants and children with disabilities; for example, children with difficulties breastfeeding or requiring mealtime support or modified food consistency (*see Glossary, Section 11*) such as soft pureed foods and thicker drinks (*see Section 7.4.s–y*).

h. In malnutrition measurement, mid-upper arm circumference (MUAC) measurements for malnutrition may be misleading in cases where upper arm muscle might build up for children who use their upper bodies to aid mobility (e.g., manual wheelchair users).

   - Alternatives to MUAC measures could be visual assessment, skin fold, length, arm span, demi-span or lower leg length measurements (Sphere Project, 2011).

i. Observe the accessibility of nutrition services and facilities such as baby-friendly spaces and health facilities to see whether children, pregnant and breastfeeding women with disabilities are present and participating in humanitarian activities (*see Section 10*).

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

j. In participatory assessments, organize focus group discussions and key informant interviews to gather information on nutrition risks and access to nutrition services for women, 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*).

- 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 food utilisation (*see Glossary, Section 11*) such as denial of food, information or services;

  - Difficulty reaching services (including food distributions) due to distance or lack of transport;

  - Lack of nutrition-related information in formats that can be understood by pregnant and breastfeeding women with disabilities (e.g., information on breastfeeding or fortified rations);

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

  - Lack of knowledge and support in feeding practices from humanitarian workers and caregivers;

  - Lack of suitable food and supplies for children and women with disabilities (e.g., adapted cutlery, corner chairs).

k. 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*).

l. Encourage children's participation.[36] Children are often aware of who is excluded from schools and child-friendly spaces and why (UNESCO, 2010). Use art and play as a way for children with disabilities to express their views about their needs and preferences in key informant interviews and focus group discussions.[37]

   - 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 and highlight findings in further reporting.

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

Programme monitoring and evaluation

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

   - Number of children with disabilities with severe acute malnutrition receiving treatment.

   - Number of women with disabilities receiving skilled breastfeeding counselling.

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

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

[37] 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.

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

q. Include questions on whether children, pregnant and breastfeeding women with disabilities are accessing nutrition 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, pregnant and breastfeeding women with disabilities access baby-friendly spaces?"

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 nutrition interventions relevant to the specific needs of children, pregnant and breastfeeding women with disabilities?
- How efficiently were interventions and services delivered to children and pregnant and breastfeeding women with disabilities in emergency settings?
- To what extent did nutrition 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 nutrition needs of children, pregnant and breastfeeding women with disabilities?

Box 6 continued: Assessing inclusion of children with disabilities

- To what extent was information on children, pregnant and breastfeeding women with disabilities from needs assessments used to inform programming?
- To what extent were ongoing programmes on disability connected with the humanitarian response?
- Have there been lasting or sustained benefits as a result of connecting ongoing programming on disabilities with the humanitarian response?

r. Analyse information gaps in assessments and bottlenecks in implementation of inclusive nutrition humanitarian programmes (e.g., through workshops with partners or the development of a paper).

s. Document and share lessons learned on inclusion of children with disabilities in humanitarian nutrition interventions such as through case studies (*see Section 8.2*).

t. 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, pregnant and breastfeeding women with disabilities and include them in the response (*see Section 9.2*).

b. When developing or providing feedback on emergency plans (e.g., Inter-Agency Humanitarian Response Plans, Regional

Response Plans and UNICEF humanitarian work plans), include the nutrition needs of girls and boys with disabilities, identify barriers to accessing nutrition interventions and add activities that include children with disabilities.

c. Include children, pregnant and breastfeeding 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 and women with disabilities;
   - Targets and prioritized indicators to track the extent to which children and women 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 nutrition needs of children with disabilities and barriers to accessing services, identify this as an information gap and initiate actions to address it.

Example: Disability as targeting and vulnerability criteria in Afghanistan

In Afghanistan, disability in the household is specifically included among the vulnerability criteria for World Food Programme's assistance. The criteria, endorsed by the Food Security Cluster, were developed in 2016 following the surge of Afghan returnees from Pakistan. They acknowledge that households that are either headed by or host persons with disabilities, and those with chronic illnesses and the elderly face extreme barriers in accessing livelihoods and income-generating activities (World Food Programme).

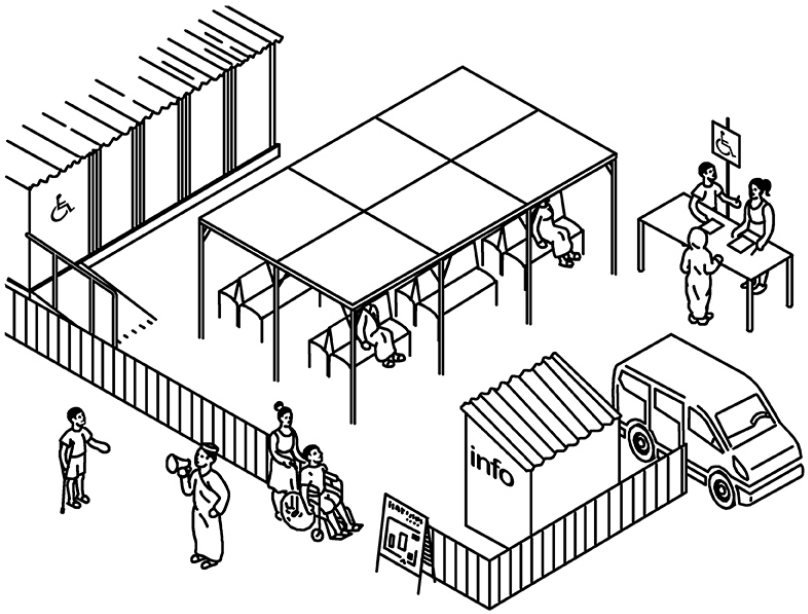
7.4 Making nutrition interventions inclusive and accessible

Food distributions and micronutrient services

a. Set up fast tracks (*see Glossary, Section 11*) or prioritization processes[38] for food distributions, registration and nutrition services in health facilities, therapeutic feeding centres and outpatient therapeutic programmes.

b. Provide covered seating to enable people to rest while queuing (*see Figure 4*). This assists not only persons with disabilities, but also the elderly and pregnant women.

Figure 4: Inclusive and accessible waiting areas



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

[38] 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.

c. Organize simplified registration processes and provide dedicated cards to households with children, pregnant and breastfeeding women with disabilities for easy identification and inclusion in nutrition services such as breastfeeding counselling, infant and young child feeding, therapeutic feeding and provision of micronutrient supplements and fortified foods.

d. Provide training to nutrition and health staff (including community health workers) on how to identify[39] and communicate with children with disabilities in need of nutrition support (*see Section 9.2*).

e. Train nutrition staff to identify the family's capacity to care for a child with a disability such as providing stimulation and mealtime support or modifying food consistency (*see Glossary, Section 11*). Refer to rehabilitation services if required.

   - The assessment process should strengthen the relationship between child and family.

f. Plan and supervise accessibility compliance in construction, reconstruction and repair of nutrition-related infrastructure, including sites for nutrition and food security–related services and distribution. Ensure accessibility for children and adults with different types of disabilities, considering location, access, and use of temporary and permanent facilities (*see Section 10*).

g. Provide transport assistance or allowances for caregivers with disabilities and caregivers of children with disabilities as needed to enable them to reach nutrition and food security services.

[39] Households with children with disabilities can be identified through data collection processes such as household surveys, refugee registration and services records (*see Box 3*).

Example: World Food Programme prioritizing people with disabilities in food distributions in Bangladesh and Afghanistan

The World Food Programme in Bangladesh gives priority to people with disabilities, pregnant women and the elderly during its food distributions to prevent long waiting times in queues. The World Food Programme also pays for porters or transport to deliver food rations to those unable to attend.

When working in Afghanistan, the World Food Programme's cooperating partners identify highly vulnerable people, including people with disabilities, and support them through the distribution process by accompanying them to the front of the line and assisting through the verification and distribution process (World Food Programme).

Baby-friendly spaces

h. Arrange for volunteers (e.g., parents, community members, DPOs) and professionals (e.g., sign language interpreters, occupational therapists) to support mothers with disabilities in baby-friendly spaces.

i. Invite mothers with disabilities and caregivers of infants with difficulties feeding to attend mother and infant groups.

j. During breastfeeding and infant feeding counselling, provide information and support to caregivers of infants and children with developmental delays and disabilities (*see Section7.4.p–y*).

k. Equip baby-friendly spaces with clean, washable mats and wedged pillows and corner chairs for children with difficulties sitting (*see Figure 2*).

l. Support caregivers to establish a distraction-free environment

during mealtimes in baby-friendly spaces, outpatient therapeutic programmes or in the household.

- It is difficult for children with disabilities who need to concentrate on the process of eating and drinking if people are moving around or doing other tasks nearby.

m. Plan and supervise accessibility compliance in construction, reconstruction and repair of baby-friendly spaces. Choose accessible locations for temporary and permanent nutrition-related facilities for children and adults with different types of disabilities (*see Section 10*).

n. Signs that provide information, including the location of baby-friendly spaces, can be made accessible (*see Section 10*).

Outreach mechanisms

o. Develop outreach mechanisms (e.g., ambulatory therapeutic feeding centres) to provide nutrition services to children, pregnant and breastfeeding women with disabilities 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.[40]

Breastfeeding

p. Encourage mothers of infants with developmental delays and disabilities and mothers with disabilities to breastfeed.

- Breastfeeding can be the best feeding technique for some children with disabilities such as those with certain cleft lips and palates (Dalben et al., 2003) and a good way of facilitating mother-child bonding.

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

q. Train nutrition workers to identify signs that indicate difficulties breastfeeding, such as fatigue during breastfeeding, muscle weakness/stiffness, cleft lip or palate and tongue-tie.

- Different breastfeeding positions can help attachment. Upright and semi-upright positions are recommended with babies with cleft lip, cleft palate and babies with low muscle tone (*see Figure 5*).

- Alternative methods such as breastmilk via cup or spoon are preferable to any other breast milk substitute (ABM, 2013).

Figure 5: Alternative positions to support attachment

Source: Adapted from Handicap International, 2010.

r. Train health and nutrition staff to support women with disabilities to breastfeed by suggesting different positions and techniques (e.g., sitting in a chair, wheelchair or bed to support her back and arms; using pillows or a rolled-up cloth under the baby; lying on her side with her baby beside her supported by pillows or a rolled-up cloth).

- Women who cannot use their arms and upper body can breastfeed with help from family members or friends.[41]

Box 7: Feeding infants affected by Zika

- Children born with congenital Zika syndrome[42] often experience difficulties in breastfeeding due to reduced muscle tone, seizures and difficulties swallowing, which may lead to gagging and aspiration (*see Glossary, Section 11*).
- Provide breastfeeding support to initiate and sustain breastfeeding to mothers with suspected, probable or confirmed Zika virus infection during pregnancy and postnatally following recommendations from WHO.[43]
- As required, refer mothers of infants with congenital Zika syndrome to psychosocial support services (*see Child Protection booklet*[44]).

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41 For more information on breastfeeding for women with disabilities, see Hesperian Foundation (2007) *A Health Handbook for Women with Disabilities*, Chapter 12, 'Breastfeeding the baby,' http://en.hesperian.org/hhg/A_Health_Handbook_for_Women_with_Disabilities:Breastfeeding_the_baby.

42 For more information on congenital Zika syndrome, see https://www.cdc.gov/zika/hc-providers/infants-children/zika-syndrome-birth-defects.html.

43 WHO (2016) 'Infant Feeding in Areas of Zika Virus Transmission', http://apps.who.int/iris/bitstream/10665/204473/1/WHO_ZIKV_MOC_16.5_eng.pdf.

44 See http://training.unicef.org/disability/emergencies/protection.html.

Complementary foods[45]

s. Train nutrition workers to identify:

- Signs of difficulties eating and drinking (such as poor muscle control in the face, mouth and tongue; drooling or poor saliva control; pocketing of food in the sides of the mouth).

- Other factors that can contribute to risks of aspiration (*see Glossary, Section 11*) and choking such as level of consciousness, difficulties sitting upright to eat or feeding inappropriate foods and liquids (Novita Children's Services, 2011a).

- To reduce the risk of aspiration and choking, refer children with difficulties eating or drinking to rehabilitation services.[46]

t. Train nutrition workers to modify food and fluid consistencies (*see Glossary, Section 11*) to prevent the risk of aspiration and choking; lump-free pureed foods are easier to eat and thicker fluids easier to control (Novita Children's Services, 2011c).

u. If the child eats a reduced quantity of food due to difficulties swallowing, increase the energy of foods by adding oil or cream (Novita Children's Services, 2011d) and supplemental or fortified foods.

v. Train nutrition workers to use assistive devices and implements to support children with disabilities feeding. Examples include:

- Mortars, food mills, blenders and other manual food processors can make soft pureed foods.

- A stable, upright position with support for eating and drinking is one of the most important factors for safe swallowing (Novita Children's Services, 2011b). Wedged pillows or corner chairs

[45] *See Glossary, Section 11*.

[46] See Health booklet at http://training.unicef.org/disability/emergencies/health-and-hivaids.html.

(*see Figure 2*) – made by local carpenters – can support a child in a stable, upright position during mealtimes.

- Spoon and forks with a fold and/or thicker handle (e.g., using plastic or rubber) are easier for children to hold and bring food to their mouths (*see Figure 3*).

- A plate with steep sides makes eating easier for children who are blind or have mobility limitations as the edges assist to push the food on to the spoon or fork (*see Figure 3*).

- Communication boards can be used to talk about food (*see Figure 8*).

w. Provide first aid skills to nutrition workers, volunteers and parents/caregivers, teaching them what to do in case of air obstruction and choking.

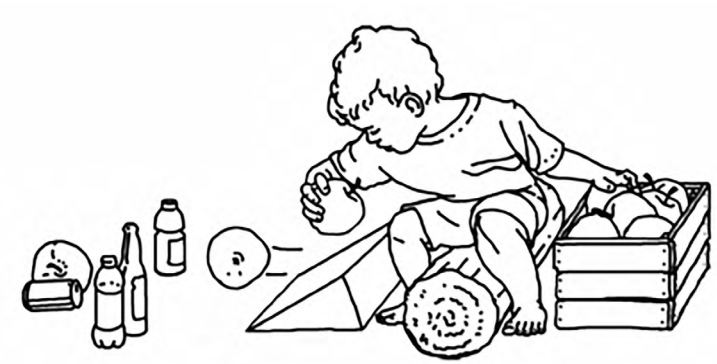
x. Train health and nutrition staff to support women with disabilities to provide complementary foods, when appropriate, to young children (e.g., sitting to the side of the baby to feed her/him without having to lean forward).

- If the mother cannot feed her baby by herself, she can talk to her baby while someone else feeds him/her. This will facilitate mother-child bonding.[47]

y. Games and play can stimulate and strengthen motor skills related to feeding and support the child to establish a positive link with food and nutrition (*see Figure 6*).

[47] For more information on women with disabilities, see Hesperian Foundation (2007) *A Health Handbook for Women with Disabilities*, Chapter 12, 'Feeding an older baby', http://en.hesperian.org/hhg/A_Health_Handbook_for_Women_with_Disabilities:Feeding_an_older_baby.

Figure 6: Game to strengthen motor skills



Source: Adapted from Handicap International, 2010.

Example: Supporting malnourished children with developmental delays in South Sudan

In 2014 during a coordinated assessment conducted by Handicap International in Médecins Sans Frontières' health clinics and ambulatory therapeutic feeding centres in a refugee camp in Maban, South Sudan, 177 displaced children with developmental delays were identified among 447 children with severe acute malnutrition. The identified children were included in play-based stimulation group sessions with their caregivers. The sessions included community awareness on child development and the impact of malnutrition and parent-infant bonding. Family counselling also was provided.

Additionally, Handicap International organized capacity-building sessions for 14 representatives of four nutrition-focused humanitarian partners in the area (Médecins Sans Frontières, Goal, International Medical Corps and Samaritan Purse). The training highlighted play-based stimulation and psychosocial support activities for malnourished children with developmental delays (Handicap International).

Social protection[48]

z. 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, food and assistive devices; and loss of income due to caring for a family member with a disability.

aa. Identify existing social protection programmes for persons with disabilities (e.g., disability allowances, pensions, free transport passes, special needs education grants, food subsidy coupons, food transfers) and consider using or modifying them to reach children with disabilities.

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

Example: UNICEF supported cash transfers providing access to food in Nepal

As part of the 2015 earthquake response in Nepal, UNICEF supported the Government in instituting a cash transfer initiative that included disability as one of the five criteria. Some 13,000 persons with disabilities received a small top-up cash grant in addition to their regular monthly social security allowances. "The extra money that our parents received from UNICEF was very helpful as our home was completely destroyed during the earthquake. At least they didn't have to worry about not having enough to eat," says 18-year-old Rajendra, who is blind and lives in Nuwakot district (UNICEF Nepal).

Partnerships

ac. Disability expertise can be mobilized through existing partnerships or by establishing new partnerships with

[48] See Glossary, Section 11.

government agencies (e.g., ministries of education or social welfare), DPOs, disability specific NGOs and by recruiting short-term consultants (*see Box 8*).

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

7.5 Human resources

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

Box 8: Disability expertise

- While developing humanitarian rosters, identify personnel with expertise on children with disabilities by adding 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 nutrition-related positions (e.g., nutritionists, midwives, nurses, early childhood development specialists), 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.[49]

[49] 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 for 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

- Reach out to disability networks and DPOs to share recruitment information and identify persons with disabilities who have relevant technical expertise.
- Develop disability related terms of reference for consultancies or partnerships to engage disability experts (e.g., engineers, technicians with experience in accessibility and universal design) when relevant.

Example: UNICEF promotes 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).

7.6 Procurement and supplies

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

b. For the provision and distribution of assistive devices, collaborate with health actors and include information on the devices' use and ongoing maintenance.[50]

7.7 Funding and budgeting

a. In fundraising documents (e.g., flash appeals, Humanitarian Action for Children appeals,[51] fundraising brochures and infographics):

   - Introduce information on nutritional needs and priority actions for children with disabilities. For example, a flash appeal could state: "Children with disabilities are more at risk of becoming malnourished and face significant food security in humanitarian crises. Particular attention will be given to the nutritional needs of children 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 facility construction, repair and reconstruction, capacity development, assistive devices, awareness-raising, training and related costs.

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

[50] For more information on the provisioning of assistive devices, see Health and HIV/AIDS booklet: http://training.unicef.org/disability/emergencies/health-and-hivaids.html.

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

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

- Disability is included in the needs assessment;
- Data are disaggregated by sex, age and disability;
- Planned and budgeted activities, as well as related indicators and outcomes, consider the nutrition needs of children with disabilities or are specifically directed towards them (*see Section 7.4*).
- Track funding and projects dedicated to responding to the nutritional needs of children with disabilities (e.g., in financial tracking systems or country pooled funds).[52]

7.8 Capacity development

a. Identify scheduled training opportunities or request partners to conduct training on inclusion of children and adults with disabilities[53] and nominate staff to attend.

b. Conduct training on inclusion of children, pregnant and breastfeeding women with disabilities for nutrition staff, 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 nutrition coordination personnel, data collection teams, nutritionists, early childhood development specialists and community health workers.

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

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

d. Engage adults and youth 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 nutrition services for children with disabilities in baby-friendly spaces, parenting groups and in queues to receive supplements and food.

b. Provide nutrition-related 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 result from targeted interventions (e.g., cash grants, assistive devices) 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, such as transport allowances and assistive devices distributions (*see Section 4.1*).

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 with disabilities in response and early recovery. 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/nutrition.html.

Considerations for including children with disabilities in response and early recovery	
Coordination	
Does the nutrition working cluster/working group have a disability focal point or focal agency?	☐ Planned ☐ In progress ☐ Completed
Notes:	
Have issues related to children with disabilities been included in nutrition 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, special schools, residential facilities, NGOs, DPOs)?	☐ Planned ☐ In progress ☐ Completed
Notes:	
Are data on nutrition programmes disaggregated by disability (e.g., data on anthropometric status, micronutrient status, infant and young child feeding, maternal care practices)?	☐ Planned ☐ In progress ☐ Completed
Notes:	

Do nutrition-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:	
Do nutrition-related monitoring, reporting and evaluations (SitReps, dashboards, real-time monitoring and evaluations, joint evaluations) capture information on access to nutrition services and challenges faced by children with disabilities?	☐ Planned ☐ In progress ☐ Completed
Notes:	
Are children with disabilities, 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., disability inclusive baby-friendly spaces and child-friendly spaces, provision of assistive devices or rehabilitation centres)?	☐ Planned ☐ In progress ☐ Completed
Notes:	
Inclusive and accessible WASH interventions	
Do nutrition measurement and breastfeeding counselling provide needed support and accommodations for children, pregnant and breastfeeding women with disabilities (e.g., sign language interpreters)?	☐ Planned ☐ In progress ☐ Completed
Notes:	
Do nutrition activities take into account inclusion and accessibility requirements of children, pregnant and breastfeeding women with disabilities (e.g., in baby-friendly spaces, feeding practices)?	☐ Planned ☐ In progress ☐ Completed

Notes:	
Does the provision of skilled breastfeeding support consider requirements of children and breastfeeding women with disabilities?	☐ Planned ☐ In progress ☐ Completed
Notes:	
Have supplementary and complementary food been adapted to girls and boys with disabilities of different ages, feeding capacities and energy demands?	☐ Planned ☐ In progress ☐ Completed
Notes:	
Have inclusive nutrition programmes been planned both in centres (e.g., health facilities, baby-friendly spaces) and through community outreach (e.g., ambulatory therapeutic feeding)?	☐ Planned ☐ In progress ☐ Completed

Notes:	
Have caregivers of children with disabilities accessed parent support programmes (e.g., early childhood development skills, infant and children with disabilities feeding skills)?	☐ Planned ☐ In progress ☐ Completed
Notes:	
Have collaborations/partnerships been established with agencies/organizations with expertise on disability (e.g., NGOs working on disability, DPOs, rehabilitation centres, special schools)?	☐ Planned ☐ In progress ☐ Completed
Notes:	

Human resources	
Have existing nutrition 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, brochures, proposals)?	☐ Planned ☐ In progress ☐ Completed
Notes:	
Capacity development	
Have nutrition staff received training on inclusion of children with disabilities (e.g., adapting services to be inclusive, communicating with children with disabilities, providing guidance on food quantity, quality and texture)?	☐ 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 and implements)?	☐ Planned ☐ In progress ☐ Completed
Notes:	
Behaviour change communication and communication for development	
Are communication materials developed as part of nutrition programmes in at least two formats (e.g., written and audio)?	☐ Planned ☐ In progress ☐ Completed
Notes:	

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

Sadaf, 4, a boy with a disability, is helped by his mother during a UNICEF-supported nutrition survey by the Rapid Nutrition Assessment Team at Netrokona, Bangladesh.

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 women 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 and women with disabilities initiated during the response phase and further consolidate as part of recovery planning.

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

c. Incorporate data and information on services and resources relevant to disability generated during the response and early recovery phase into existing government and international mechanisms so they can be available for future use.

d. Work with partners (relevant government departments, disability related NGOs, DPOs, 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*).

Example: Inclusive self-help group recovers from food crisis in Kenya

In 2011, CBM and partners responded to the resulting food crisis of the Horn of Africa drought. CBM initiated disability inclusive emergency and recovery projects, incorporating food security, livelihoods and WASH in Ethiopia and Kenya (CBM, 2013).

In Kenya, CBM and Services for the Poor in Adaptive Rehabilitation Kinship established food distribution clusters to provide food rations. The clusters evolved into self-help groups engaged in micro-enterprise and livelihood activities to strengthen food security (CBM and DiDRRN, 2013).

They encouraged mothers of children with disabilities and adults with disabilities to join the self-help groups and participate in activities on farming, animal husbandry, poultry rearing and advocacy. In Meru County, 391 households of persons with disabilities benefited (CBM, 2013).

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 and Nutrition 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 strengthen nutrition systems to include children with disabilities.[54]

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 the recovery of their environment and themselves (*see Section 7.2.I*).

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 nutrition programmes.

g. Conduct targeted surveys (e.g., Knowledge, Attitude, Practice or participatory assessments) focusing on households with children with disabilities to determine their access to nutrition services.

h. Include qualitative data collection activities (e.g., focus group discussions) that can record the impact and change in the lives of children and women 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 with disabilities have been underrepresented in programming.

j. Include access of children and women with disabilities to nutrition and food security services in all evaluations (*see Box 6*).

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

Example: Documenting lessons learned

The Ageing and Disability Task Force, established in Pakistan after floods in 2010, published a resource book that captured disability-inclusive interventions, lessons learned and case studies of the 10 international and local organizations that made up the task force. Some case studies highlight lessons on nutrition and food security (Ageing and Disability Task Force, 2011).[55]

8.3 Social protection[56]

a. 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.

8.4 Accessible infrastructure

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

a. Advocate for accessibility to be a key component in reconstruction plans (*see Section 10*).

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

[55] For full report, see *Ageing and Disability in Humanitarian Responses* (Ageing and Disability Task Force, 2011), https://www.cbm.org/article/downloads/74053/ADTF_Report.pdf.

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

8.5 Human resources

a. Work with relevant ministries, 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., nutritionists, speech therapists, occupational therapists, midwives, early childhood development specialists, health staff), advocating for sufficient numbers of qualified staff to address the needs of children with disabilities.

8.6 Procurement and supplies

a. Encourage health and nutrition departments and ministries to develop catalogues of assistive devices for a range of disabilities.[57]

b. Establish long-term agreements with suppliers of inclusive and accessible supplies, such as assistive devices (*see Section 6.3.n and o*).

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 for any unmet nutritional needs of children with disabilities in post-disaster needs assessment

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

reports and in 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, parent associations, experts, and children and adolescents with disabilities to help prioritize nutrition services and use financial resources better (*see Box 5 and Section 7.2.I*).

8.8 Capacity development

a. Work with government counterparts in relevant ministries or departments to mainstream training modules on disability into regular nutrition training.

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

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

8.9 Policies

a. Review national nutrition-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:

- Developing community-based nutrition programmes and social protection benefits for households with children with disabilities.

- Provision of disability identity cards to access health benefits, assistive devices and rehabilitation, medication, and health and nutrition follow-up.

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 with disabilities in recovery and reconstruction. 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/nutrition.html.

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

Have issues related to children with disabilities been included in nutrition recovery plans?	☐ Planned ☐ In progress ☐ Completed
Notes:	
Do plans to strengthen health and nutrition systems include provisions for children with disabilities?	☐ Planned ☐ In progress ☐ Completed
Notes:	
Assessment, monitoring and evaluation	
Do nutrition 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 nutrition-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?	☐ Planned ☐ In progress ☐ Completed
Notes:	

Accessible infrastructure	
Does reconstruction of nutrition-related 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 and nutrition-related government and service providers for the provision of assistive devices for children with disabilities?	☐ Planned ☐ In progress ☐ Completed
Notes:	
Human resources	
Have collaborations/partnerships been established with agencies/organizations with expertise on disability (e.g., NGOs working on disability, DPOs, rehabilitation centres, special schools)?	☐ Planned ☐ In progress ☐ Completed

Notes:	
Do nutrition-related databases and rosters capture information on nutrition staff and personnel with expertise on disability?	☐ Planned ☐ In progress ☐ Completed
Notes:	
Funding and budgeting	
Do nutrition recovery and reconstruction budgets include funding for accessible facilities and services for children with disabilities?	☐ Planned ☐ In progress ☐ Completed
Notes:	

Capacity building	
Does nutrition-related training include components on how to respond to the rights and needs of children with disabilities (e.g., training for nutritionists, midwives, early childhood development specialists, health staff)?	☐ Planned ☐ In progress ☐ Completed
Notes:	
Policies	
Do national health and nutrition policies and standards related to infrastructure and services integrate components of disability that align with international standards?	☐ Planned ☐ In progress ☐ Completed
Notes:	

A girl from Atfaluna (‘Our Children’) Society for Deaf Children, a local NGO in Gaza, State of Palestine. The organization offers education and vocational training, as well as free health care and psychosocial services.

This section is a reference for humanitarian nutrition officers, nurses, doctors, midwives, early childhood development specialists and baby-friendly space facilitators when engaging directly with children and adolescents with disabilities and their families including caregivers with disabilities (e.g., during nutrition services or designing messages for affected populations).

9.1 Terminology[58]

The terminology used to address children and adolescents 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' rather than '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).[59]

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

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

[59] 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 persons and an abbreviation denies that.

9.2 Communicating with children and adolescents with disabilities[60]

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 and early childhood specialists, can support caregivers to communicate and interact with their child or adolescent with a disability.

e. Allow the child or adolescent to see or hear that it is mealtime, show them where the food and utensils are and introduce tasks progressively (e.g., holding the spoon, spoon to mouth). Provide cues and reminders about safe eating.

f. 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 who can lip-read, keep eye contact and do not cover the mouth.

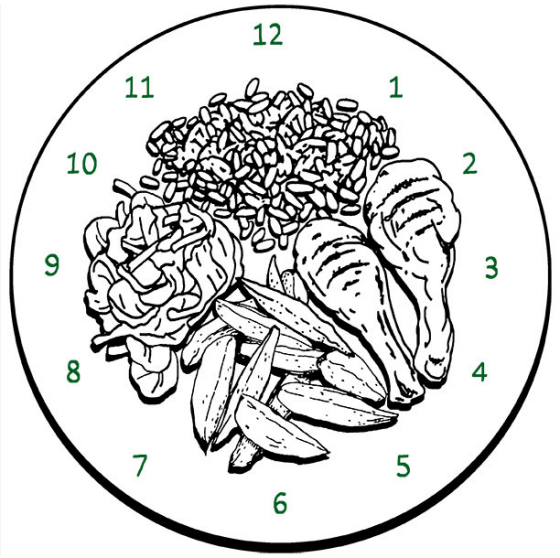
g. For children and adolescents with visual disabilities (blind or low vision):

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

- Describe surroundings (e.g., food, utensils) and introduce people present.

- Use the 'clock method' (*see Figure 7*) to help older children and adolescents locate people and items (e.g., on the plate, the rice is between 11 and 1 o'clock and the potatoes are at 6 o'clock).

Figure 7: The clock method



Source: UNICEF Disability Section, 2017

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

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

h. If the child or adolescent has difficulty communicating or understanding messages, use clear verbal communication and consider the following:[61]

[61] Adapted from Novita Children's Services, *Mealtime Routines* and *Alternative and Augmented Communication* factsheets.

- Use objects that represent different activities (e.g., eating) to support the child's understanding and ability to anticipate what will come next and help build routine.

- Children and adolescents with disabilities can also use objects to ask for things (e.g., a spoon or a dish to announce a meal or ask for food).

- Support children and adolescents to develop a book, a board or cards with pictures or drawings related to mealtime routines, handwashing, feelings and responding to questions (*see Figure 8*). This can be used to communicate about issues, food and mealtimes (Novita Children's Services, 2007).[62]

Figure 8: Communication boards and books

Source: Adapted from Novita Children's Services, 2017.

[62] 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 do not want, I see, I hear, I feel, It is). This allows the learner to use full sentences even if they have no speech.

- Seeing, smelling, hearing and touching food and food items can help stimulate the appetite and prepare the body for eating.

- 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 with food, full, thirsty).

- Smartphones and tablets can use applications that provide voice output when picture symbols are pressed. There are also devices that can be used as voice output communication aids.[63]

9.3 Adapting information for persons with disabilities[64]

Produce nutrition information in different formats. This will help ensure that children, adolescents and caregivers with physical, intellectual, hearing and visual disabilities have access to and can understand information.

a. Formats that are accessible for people with visual disabilities (blind and low vision) include large print, text messages (most smartphones have free voiceover application), 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 hearing disabilities (deaf and low hearing) include print, text messages, captions and sign language interpretation for meetings or television announcements.

[63] For examples of voice output communication aids, see https://www.nationalautismresources.com/speech-communication/aac-devices/.

[64] For information on adapting information for persons with disabilities, see the UNICEF Inclusive Communications Module at www.unicef.org/disabilities/index_90418.html.

d. Formats that are accessible for people with intellectual disabilities include simple plain language and visual signs, such as pictograms, drawings, pictures and photos on printed materials.[65]

e. Organize workshops to engage DPOs, other disabilities groups, and children and adolescents with various disabilities in the design, review and dissemination of communication materials such as radio programmes run by adolescents with disabilities (*see Box 5 and Section 7.2.I*).[66]

9.4 Developing messages inclusive of children with disabilities[67]

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 humanitarian action and development can be disability inclusive.

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

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

c. Portray children with disabilities and their caregivers actively participating in activities (e.g., parents feeding children, children playing or attending baby-friendly spaces).

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[65] For an example of an easy-to-read version of the Convention on the Rights of Persons with Disabilities, see https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/345108/easy-read-un-convention.pdf.

[66] For an example of accessible communication for people with various kinds of disabilities, see UNDP's inclusive communication on Ebola in Sierra Leone: https://www.youtube.com/watch?v=M015lGIF1MA.

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

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

- UNICEF Communication for Humanitarian Action Toolkit.[68]

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

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

Liban, 8, awaits a food distribution at a feeding centre for people with disabilities, in Mogadishu, Somalia. He lost his leg when a bomb exploded in the city centre.

People with disabilities experience different barriers to accessing nutrition services, food security 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 nutrition-related infrastructures accessible and can apply to any facility that provides nutrition services (e.g., food distributions, baby-friendly spaces, health clinics, food shops and markets).

Education, food security and health sector colleagues may need encouragement to ensure that all facilities providing nutrition services are accessible to all. Toilets, handwashing, showers and water points within any nutrition-related facility should be accessible and usable by people with different types of disabilities.[70]

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

a. Review national standards for accessibility. If there are no national standards, use international standards.[71]

b. Accessibility is built around the RECU principle: persons with any type of disability can reach, enter, circulate and use any nutrition-related facility in a continuous movement (e.g., without facing barriers).

c. Consider the location of all nutrition facilities – are they easy to reach? Are buildings accessible for people with different types of disabilities?

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

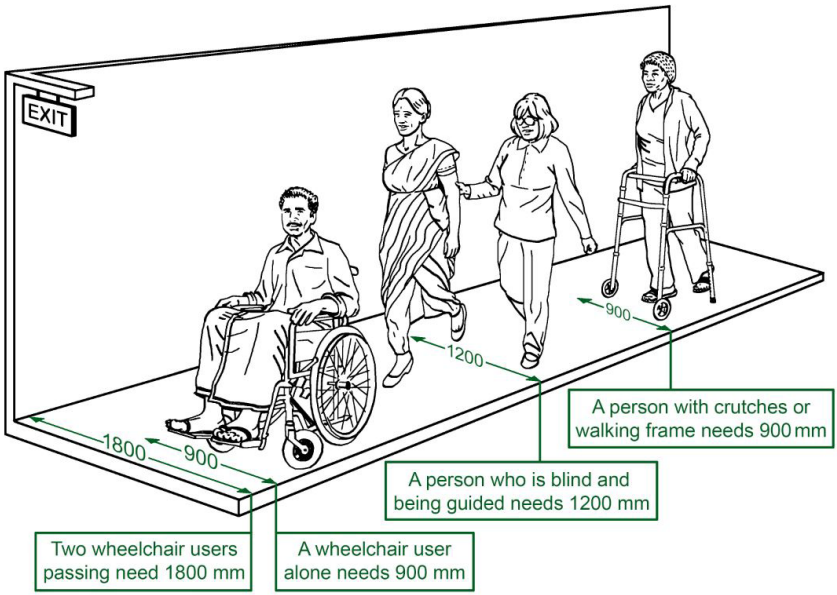
[70] See WASH booklet at http://training.unicef.org/disability/emergencies/wash.html.

[71] 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.

d. Where possible, select locations that are already accessible or will be easy to modify (e.g., door widths are 800 mm,[72] 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 9*). Paths should be firm and even.

Figure 9: Paths should be minimum 900 mm to accommodate different users

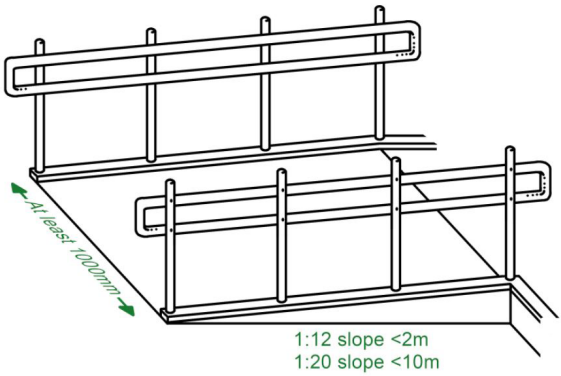


Source: Adapted from Oxley, 2002, by DFID and TRL, 2004 (UNICEF, 2016b)

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 or drainage crossings (*see Figure 10*).

[72] After construction, doors are difficult to retrofit and modify to make wider for wheelchairs to enter the buildings or rooms.

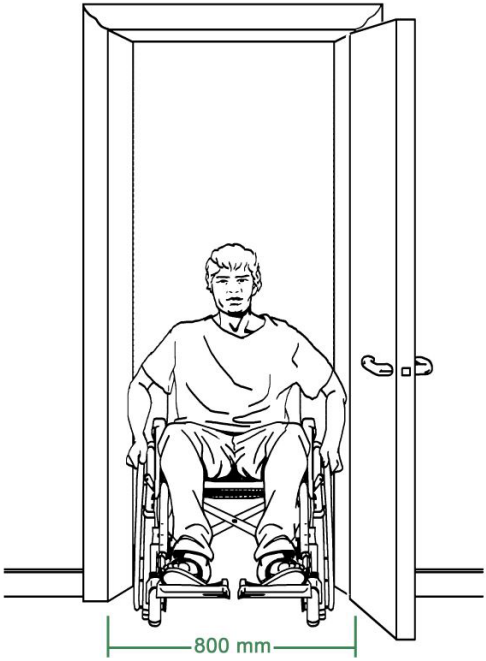
Figure 10: Ramps



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

g. Entrances and door openings should be a minimum of 800 mm wide (*see Figure 11*) with no thresholds or barriers on the ground.

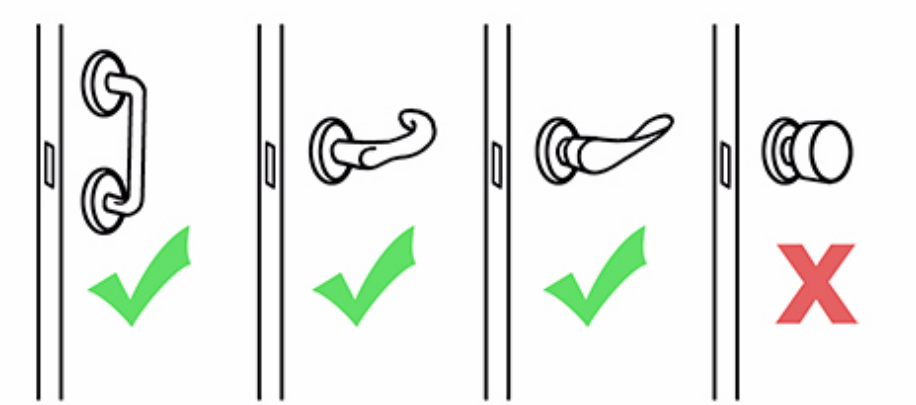
Figure 11: Doors should be a minimum of 800 mm wide



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 12*).

Figure 12: Easy-to-use door handles



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

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

j. Allow for adequate circulation space within facilities.

k. Make signage related to nutrition services accessible:

- Install well-lit maps showing the location of available services and arrows for better orientation (e.g., entrance to baby-friendly space, clinics).
- 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.
- Uses simple language, pictures, colour contrast, pictograms and tactile elements.

Accessibility audits

l. Conduct accessibility audits of nutrition 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 with 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.

Aspiration: Inhalation of foreign material such as food and liquid. It can lead to serious medical complications such as lung infections or choking (Novita Children's Services, 2011a).

Assistive devices: Any external product (including devices, equipment, instruments or software), especially produced or generally available of which the primary purpose 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.[73]

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

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.[74]

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, 2010).

Complementary foods: Foods consumed between 6 months and 2 years of age, ideally complementing a breastmilk-based diet. The 18-month period between 6 months and 2 years is referred to as the complementary feeding period (UNICEF, 2017b).

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).

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 disabil-

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73 For more information, see https://www.unicef.org/cbsc.

74 Ibid.

ities 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).

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.

Food consistency: Degree of density, firmness or viscosity of food provided to children with difficulties eating to assist with the chewing or swallowing process. The main categories of food consistency are: unmodified regular foods; soft foods (e.g., banana); minced and moist food (e.g., coarsely minced meats and sauce); and smooth pureed food blended in a food processor (Novita Children's Services, 2011c).

Food utilization: Food is properly used through appropriate food processing and storage practices and adequate health and sanitation services. Some agencies also consider how food is shared within the household compared with each person's nutrient requirements. Utilization also refers to biological use of food at the individual level linked to a person's health (Nutrition Cluster, 2014).

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).

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, 2017a).

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).

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The table, derived from the programmatic actions outlined in this document, lists key actions under each Nutrition Core Commitment for Children in Humanitarian Action[75] that enhance inclusion of children and adolescents with disabilities.

Commitment 1: Effective leadership is established for nutrition cluster inter-agency coordination, with links to other cluster/sector coordination mechanisms on critical inter-sectoral issues.
Actions to include children with disabilities
Coordination mechanisms, including nutrition clusters and working groups, have a disability focal point or focal agency.
Issues related to children and women with disabilities are included in nutrition cluster and working group plans.
Links made between the nutrition cluster and other clusters for critical inter-sectoral actions to include children with disabilities (e.g., with the education and protection clusters to ensure nutrition interventions in schools, child-friendly spaces and baby-friendly spaces include children and women with disabilities).
Commitment 2: Timely nutritional assessment and surveillance systems are established and/or reinforced.
Actions to include children with disabilities
Data collected in nutritional assessments and surveillance systems are disaggregated by sex, age and disability.
The nutritional needs of children, adolescents and women with disabilities have been identified to inform response.
Commitment 3: Support for appropriate infant and young children feeding is accessed by affected women and children.
Actions to include children with disabilities
Nutrition programmes are planned in both centres (e.g., schools, clinics and baby-friendly spaces) and through community outreach to children and women with disabilities not in these settings.

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

Caregivers of children with disabilities and caregivers with disabilities have accessed parent support programmes (e.g., early childhood care and development skills, infants and children with disabilities feeding skills).
Children with disabilities have been provided with assistive devices and implements to improve their nutrition and feeding practices.
Commitment 4: Children and women with acute malnutrition access appropriate management services.
Actions to include children with disabilities
Nutrition actors have received support (information and training) on adapting malnutrition treatment and management to meet the needs of children and women with disabilities (e.g., guidance on appropriate supplemental food for children and women with difficulties eating, tube feeding, use of assistive devices).
Commitment 5: Children and women access micronutrients from fortified foods, supplements or multiple-micronutrient preparations.
Actions to include children with disabilities
Supplementary food has been adapted to children and women with disabilities of different ages, feeding capacities and energy demands.
Food distribution mechanisms have been adapted for households with children and caregivers with disabilities (e.g., registering these households, fast-track mechanisms for distributions, transport support).
Commitment 6: Children and women access relevant information about nutrition programme activities.
Actions to include children with disabilities
Nutrition-related information is developed and disseminated to affected populations in at least two different formats (e.g., brochures, audio announcements).
Positive images of children and women with disabilities included in nutrition materials (e.g., pregnant women with disabilities or women with disabilities breastfeeding).

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:

Danielle, 19 years old, mother of Thalles, who was born with microcephaly, in Recife, Brazil.

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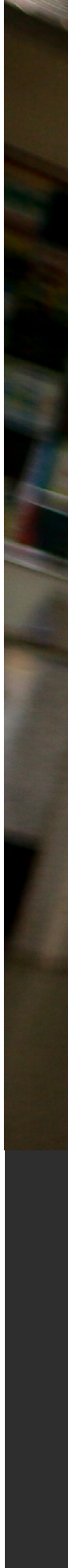

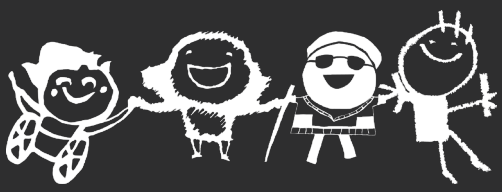

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