WOMEN'S COMMISSION
for refugee women & children

DISABILITIES AMONG REFUGEES AND CONFLICT-AFFECTED POPULATIONS

Resource Kit for Fieldworkers

Women's Commission for Refugee Women and Children
June 2008

Cover photograph: Boy making a reed basket at the UNHCR-supported vocational training program for the blind and disabled at the Blind Association, Jalalabad, Afghanistan. (UNHCR/S. Schulman)

The Women's Commission for Refugee Women and Children works to improve the lives and defend the rights of refugee and internally displaced women and children.

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RESOURCE KIT FOR FIELDWORKERS

Improving Services for Displaced Persons with Disabilities: Lessons Learned and Ideas for Action

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EXECUTIVE SUMMARY

The World Health Organization (WHO) estimates that between 7 and 10 percent of the world's population live with disabilities. As such, it can be assumed that between 2.5 and 3.5 million of the world's 35 million displaced persons also live with disabilities. Among displaced persons who have fled civil conflict, war or natural disasters, the number with disabilities may be even higher.

Yet persons with disabilities remain among the most hidden, neglected and socially excluded of all displaced people today. People with disabilities are often literally and programmatically "invisible" in refugee and internally displaced persons (IDP) assistance programs. They are not identified or counted in refugee registration and data collection exercises; they are excluded from or unable to access mainstream assistance programs as a result of attitudinal, physical and social barriers; they are forgotten in the establishment of specialized and targeted services; and they are ignored in the appointment of camp leadership and community management structures. Disabled persons' potential to contribute and participate is seldom recognized: they are more often seen as a problem than a resource. Moreover, traditional community coping mechanisms, including extended families, neighbors and other caregivers, often break down during displacement. The loss of caregivers can leave persons with disabilities extremely vulnerable and exposed to protection risks.

Disabilities Among Refugees and Conflict-Affected Populations, the companion report to this resource kit, is the culmination of a six-month project commissioned by the Women's Commission for Refugee Women and Children and co-funded by the United Nations High Commissioner for Refugees (UNHCR) to address the rights and needs of displaced persons with disabilities, with a particular focus on women (including older women), children and youth. Based on field research in five refugee situations, as well as global desk research, the Women's Commission sought to map existing services for displaced persons with disabilities, identify gaps and good practices and make recommendations on how to improve services, protection and participation for displaced persons with disabilities. The objective of the project was to gather initial empirical data and produce a resource kit that would be of practical use to UN and nongovernmental organization (NGO) field staff working with displaced persons with disabilities.

While refugees and IDPs with disabilities face enormous challenges, the research was not wholly negative. The Women's Commission found examples of innovative and successful programs for refugees with disabilities, particularly in the areas of inclusive and special needs education, vocational and skills training, community health care and outreach programs and prosthetics and physical rehabilitation (especially for land mine survivors). We found situations where refugees with disabilities and their families were highly organized and had formed their own self-help support groups. The Women's Commission also found examples of positive disability awareness programs. Given an accessible physical environment, heightened disability awareness, both within their community and the local host community, and an inclusive approach by agencies assisting them, displaced persons with disabilities can live independent lives, participate fully in public affairs and make positive contributions to their communities.

The research found that, in general, services and opportunities for refugees with disabilities were better in refugee camps than in urban settings. Due to the more geographically and socially cohesive nature of refugee camps, it is easier to identify refugees with disabilities, adapt programs to be more inclusive and set up specialized services. It is also easier to effect attitudinal and programmatic change in refugee camps. Urban refugee communities are more dispersed and less physically cohesive. Many urban refugees are undocumented and lack any legal status. They are often afraid of the authorities and prefer to remain "hidden." This makes it much harder to identify persons with disabilities or to integrate them into mainstream or specialized services.

The study showed that less information and fewer services were available for people with mental disabilities than those with physical and sensory disabilities. Refugees with mental disabilities tended to be more "invisible" and "hidden" from public view than those with physical disabilities. They were less likely to be identified in registration and data collection exercises and tended to be more excluded from both mainstream and targeted assistance programs. They were less likely to be included in decision-making processes or in leadership and program management structures.

Collecting reliable and accurate data on the number and profile of displaced persons with disabilities was one of the weakest aspects of all the programs surveyed for the report. In many cases, data on the number of displaced persons with disabilities was simply not available from the government, UNHCR or its implementing partners. Where

data did exist, it was often inconsistent or inaccurate. One of the reasons for this was differences in the terminology and categories used to classify different types of disabilities and reasons for disabilities. In addition, concepts of "impairment" and "disability" can differ enormously among different cultures and societies. Data collection staff also lacked the technical expertise to identify and categorize different types of disabilities.

Almost all the countries surveyed identified problems with the physical layout and infrastructure of camps or settlements, and lack of physical access for persons with disabilities. Refugees with disabilities noted the physical inaccessibility of shelters, food distribution points, water points, latrines and bathing areas, schools, health centers, camp offices and other community facilities. Problems of physical accessibility were often worse for refugees living in urban areas, where the opportunities to adapt or modify physical infrastructure were much more limited, than in camps. Difficulties with physical access affected all aspects of disabled refugees' daily lives, especially those with physical and visual impairments. Unable to leave their homes, or move around easily, many refugees with disabilities faced greater levels of isolation than before their displacement.

Nearly all the field studies reported that refugees with disabilities did not receive additional or special food rations, nor were they prioritized in food distribution systems. In all the countries surveyed, participants pointed out that the food and nonfood distribution points were far from people's homes and the long, crowded lines made it difficult for many persons with disabilities to receive their rations.

All the field surveys cited the lack of specialized health care, psychosocial support and counseling services for persons with disabilities. There were no specialized doctors, no specialist therapy and a lack of specialized medicines and treatments. Moreover, there were generally no referrals to specialist services outside the camps. Nearly all the refugees surveyed said that health clinics were often physically inaccessible for persons with disabilities and that they had to line up for long periods and were not given priority treatment. Many disabled people and their families said that they were suffering from increased levels of isolation, depression and mental health problems since becoming refugees, but there were no or very limited psychosocial services available. A positive finding in all the countries' situations surveyed was that women with disabilities had access to reproductive health care. There were also positive examples of community health care and outreach programs (especially in refugee camps).

Access to education for children with disabilities was one of the most successful areas in all the countries surveyed. All the field studies showed that children with disabilities had access to schools and no cases were found of children with disabilities being actively excluded from school. The field surveys identified many successful examples of inclusive education programs for children with disabilities, including early childhood intervention programs; ongoing training of special needs support teachers and mainstream teachers in special needs education; the development of special teaching aids, appropriate curriculum and teaching resources; home support and liaison programs; parent support groups; and, where necessary, the establishment of separate schools, or learning environments, for children with particular needs (e.g., schools for blind or deaf children).

In some settings, although children with disabilities were not actively excluded from mainstream schools, they were not actively encouraged to attend either and dropout rates were high. This was due to various factors, including the lack of special needs support staff or training for mainstream teachers in special needs education; the lack of appropriate teaching aids or flexible curriculum; and the physical inaccessibility of school buildings and facilities. The field studies also found some incidents of gender disparity in school attendance rates for children with disabilities (more boys than girls with disabilities were attending school), although the reasons for this were not entirely clear from the research.

Access to vocational and skills training, income generation and employment opportunities for refugees with disabilities varied considerably. There were some examples of very successful vocational and skills training programs that were specially geared for persons with disabilities and had helped them to learn useful skills and subsequently either find employment or set up their own small business. In other settings, vocational training courses had not been adapted to meet the needs of persons with disabilities and the teachers were not specially trained. Elsewhere, persons with disabilities were either actively excluded from vocational training or given no encouragement to attend. In all the countries surveyed, persons with disabilities said that they were keen to learn new skills and wanted to find jobs. However, they faced huge social, attitudinal and legal barriers in finding employment,

not only because of their disability, but also because of their status as refugees and outsiders. The field research demonstrated that it was easier for refugees with disabilities in camps to find work or set up their own small businesses than it was for refugees in urban areas, where they were competing on the open market.

Nearly all the refugees with disabilities interviewed during the field studies said that they would like to be more involved in community affairs, camp management and decision-making processes. However, opportunities for *formal* participation of refugees with disabilities in camp management and program planning, implementation and management were very few, even in those situations where there were high levels of disability awareness. There were a few isolated examples of persons with disabilities being included in strategic planning processes and participatory assessments, and a few examples of NGOs with positive employment policies for persons with disabilities. In the absence of *formal* opportunities to participate in community management and decision-making, there were some positive examples of refugees with disabilities forming their own organizations and self-help groups.

Opportunities for community participation among refugees with disabilities in urban areas were even more limited. In all the countries surveyed, there was little to no contact between refugees with disabilities and local disabled persons' organizations (DPOs) and no attempts by local DPOs to integrate refugees with disabilities into their activities. A positive outcome of the field surveys, however, was a building of alliances between local disability service providers and local DPOs and refugees with disabilities in several countries.

Involvement in the field research exposed local DPOs to the needs of refugees with disabilities and motivated them to include refugees in their programs. It also helped increase awareness of national disability services among refugee relief agencies.

In general, the quality of information on protection risks faced by refugees with disabilities was poor. Respondents in the field studies cited a range of protection problems, but gave few concrete examples. Almost without exception, everyone interviewed mentioned discrimination, stigmatization, harassment, neglect and exclusion of persons with disabilities as major protection concerns, both within their own communities and in the host communities. In several countries, the field studies found that women with disabilities were at risk of sexual violence, domestic abuse and physical assault, although again, few concrete examples were given. In one country, nearly all the respondents mentioned that older persons with disabilities were doubly discriminated against and were at risk of neglect and possible abandonment, especially when they became, or were perceived as having become, a burden for their families. The same country also highlighted physical abuse against children with disabilities.

The lack of available information about protection risks faced by persons with disabilities does not imply that refugees and IDPs with disabilities do not face protection risks, but rather highlights weaknesses in protection reporting and response and a general failure to address the protection needs of persons with disabilities during routine protection monitoring. The research also found that there were no clear policies or information about durable solution options for refugees with disabilities, in particular in third country resettlement.

This resource kit is a companion piece to the report *Disabilities among Refugees and Conflict-Affected Populations*, published by the Women's Commission for Refugee Women and Children in June 2008.

For a copy of the full report, go to www.womenscommission.org/special/disabilities.php or contact:

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RESOURCE KIT FOR FIELDWORKERS

Improving Services for Displaced Persons with Disabilities: Lessons Learned and Ideas for Action

If invisibility, exclusion and powerlessness are common themes emerging from the experience of older people, then consultation, inclusion and empowerment through partnership have emerged as the primary indicators for good practice.*

This resource kit is intended for United Nations (UN), nongovernmental organization (NGO), community-based organization (CBO) and disabled persons' organization (DPO) field staff working with refugees, asylum seekers and internally displaced persons (IDPs) with disabilities. It is intended to provide practical ideas on how to improve services and protection for people with disabilities and enhance their inclusion and participation in community affairs. It is based on the findings of five country field studies, as well global desk research into other refugee and IDP programs and an analysis of existing international policies and practices relating to displaced persons with disabilities. The resource kit is a compilation of lessons learned and ideas for action. It is not intended as authoritative guidelines. It is an initiative that the Women's Commission hopes will be built on and developed over time, with input from a broad range of humanitarian actors, CBOs, DPOs and displaced persons with disabilities themselves. References to relevant international guidelines are given after each section.

* HelpAge International, *Older People in Disasters and Humanitarian Crises: Guidelines for Best Practice* (London: HelpAge International, 2000)

GUIDING PRINCIPLES

The following principles should guide all actions on behalf of refugees and IDPs with disabilities:

> **Rights-based approach.** All humanitarian action targeting persons with disabilities should be informed by the human rights principles and standards codified in the UN Convention on the Rights of Persons with Disabilities (CRPD). These include principles of nondiscrimination; respect for the inherent dignity, autonomy and independence of the individual; gender equality; respect for difference and diversity; and respect for the rights of women and children. The objective of all humanitarian programs should be to promote the full and equal enjoyment of all human rights and fundamental freedoms by *all* persons, *including* people with disabilities, and respect for their inherent dignity.

> **Inclusive approach.** Humanitarian actors should promote the full and effective *participation and inclusion* of displaced persons with disabilities in all community activities and address all social, attitudinal, informational and physical barriers that impede people with disabilities from participating fully in everyday life and decision-making.

> **Accessibility.** Humanitarian actors should ensure that the physical environment, all facilities, services, shelters, schools, health services, organizations and information are accessible to displaced persons with disabilities.

> **Independent living.** Action should be taken to ensure that displaced persons with disabilities can live as independently as possible and participate as fully as possible in all aspects of life.

> **Age, gender and diversity awareness.** Special attention should be paid to the rights of displaced women, children and older persons with disabilities and their particular situation. Often these groups may be doubly, or triply, discriminated against—not only on the basis of their disability, but also due to their age, gender and status. Humanitarian actors should make special efforts to ensure full age and gender equality in their programs to promote the full inclusion and participation of women, children and older people with disabilities in decision-making processes.

Resources:

Ad Hoc Committee on a Comprehensive and Integral International Convention on the Protection and Promotion of the Rights and Dignity of Persons with Disabilities. (2006). Final report, *Convention on Rights of Persons with Disabilities*. http://www.un.org/disabilities/convention/conventionfull.shtml.

IASC. (2007). *Guidelines on mental health and psychosocial support in emergency settings*. Geneva: Inter-Agency Standing Committee.

UNHCR. (2007). *A community-based approach in UNHCR operations*. Geneva: UNHCR.

OPERATIONAL GUIDELINES

It may be necessary to differentiate between various stages of a refugee or displacement emergency when implementing these guidelines. In the very early stages of an emergency, attention should be paid to site selection and the planning and design of camp infrastructure, services and facilities to ensure *minimum* standards of accessibility to mainstream services for all persons with disabilities (e.g.,10 percent of latrines in a camp should be physically accessible and appropriately designed for people with disabilities). At later stages of emergencies, when services and infrastructure are well-established (i.e., during "care and maintenance" phases), attention should be paid to increasing coverage and improving access to mainstream services, as well as designing targeted services that more specifically meet the needs of persons with disabilities.*

* E-mail communication with Valérie Scherrer (Emergency Coordinator, Christian Blind Mission (CBM)), April 23, 2008.

DATA COLLECTION / IDENTIFICATION / REGISTRATION

Objective: *To improve the collection of data on refugees and IDPs with disabilities in all displacement situations. To gather disaggregated data on the number, age, gender and profile of displaced persons with disabilities in order to enhance their assistance and protection. To safeguard confidentiality and avoid misuse of data.*

> Identify a responsible organization and standardized system for registration and data collection in each displacement situation, to ensure consistency of data.

> Ensure that questions on disability are included in all screening of new arrivals and subsequent data collection, population census or registration exercises.

> Ensure that confidentiality safeguards are included in all data collection systems to avoid misuse of information.

> Ensure that standard disability definitions/terminology are used in each displacement situation.

> Disaggregate data on disability by age/gender/type of disability and, where relevant, cause of disability (e.g., congenital, as a result of childbirth, due to accident or injury, due to illness, malnutrition, trauma). Indicate whether the disability preceded displacement, was a result of the conflict or natural disaster that caused the displacement or was a result of the displacement itself.

> Where the disability preceded displacement, collect basic data on what services/assistance were available to individuals prior to displacement (see Assessments section below for further information).

> Include details about family/support networks for displaced persons with disabilities and identify people with disabilities who are living alone.

> Use registration and data collection exercises to identify family members of people with disabilities who may have been separated during flight and facilitate family reunification as soon as possible.

> Wherever possible, the UNHCR data collection software, ProGres, should be used in all operations to facilitate the collection of globally comparative data on refugees with disabilities.

> The disability definitions included in the ProGres Standardized Specific Needs Codes should be amended to avoid confusion between "mental disability" and "mental illness." All other UNHCR identification and registration tools (e.g., the Heightened Risk Identification Tool) should be harmonized to use the same disability definitions as ProGres to ensure consistency in data.

> Use multiple sources/networks of different organizations to gather baseline information on displaced persons with disabilities (e.g., teachers/health workers/community workers/social workers/camp management committee/parents).

> Provide sensitization and training on disability issues to staff responsible for registration/data collection—in particular on terminology and definitions; how to identify, classify and register people with disabilities; and communication strategies.

> Encourage data collection staff to work alongside trained and qualified disability workers in order to accurately identify and record the number and profile of people with disabilities within a displaced population.

> Take into account local perceptions/concepts/definitions of disability when organizing data collection exercises.

Resources:

Norwegian Refugee Council (NRC). (2004). *Camp management toolkit.* Oslo: NRC.

UNHCR. (2007). *Handbook for emergencies*, 3rd ed. Geneva: UNHCR.

UNHCR. (2007). *Heightened Risk Identification Tool.* Geneva: UNHCR.

See also, information on UNHCR's data collection software package ProGres (Profile Global Registration System), developed in 2004 to standardize UNHCR registration procedures and improve the quality and accuracy of data collected (e.g., UNHCR. (2007). "Guidance on the use of standardized specific needs odes." IOM/028/FOM/030. Geneva: UNHCR).

ASSESSMENTS

Objective: *To conduct initial, rapid response, community-based assessments and, at a later stage, more comprehensive individual assessments to ascertain the assistance needs, protection risks, skills and capacities of displaced persons with disabilities.*

COMMUNITY ASSESSMENTS

> Analyze registration data to assess the number, profile, specific needs and protection risks of people with disabilities within the community.

> Include people with all types of disabilities and of all ages and gender in community-based, participatory assessments.

> Identify specific protection risks, including possible physical or sexual abuse, exploitation, trafficking, discrimination, marginalization, neglect and exclusion, of people with disabilities within the community.

> Identify existing community mechanisms to protect and support people with disabilities in the community; identify potential new protection mechanisms.

> Identify the extent to which people with disabilities are participating in community management and decision-making; identify who is excluded and why.

> Identify existing skills/resources/capacities among people with disabilities in the community.

> Identify what services/facilities were available to people with disabilities in their countries of origin/home community.

> Identify what services/facilities exist locally in the host community and what services are provided in camps or settlements.

> Identify the extent to which people with disabilities are able to access mainstream services and how many people with disabilities are benefiting from specialized services in the camp/settlement or local community.

> Make priority lists for distribution of basic equipment/mobility devices and other assistive devices (e.g., wheelchairs, walking aids, hearing aids) based on rapid, group-based needs identification.

> Identify any existing self-help groups or organizations among people with disabilities and their families.

> Identify local DPOs in the host community and assess their capacity to incorporate displaced persons with disabilities into their programs.

> Community workers/humanitarian agencies should familiarize themselves with national disability strategies in the country of asylum, including national legislation, national services, inter-agency responsibilities (e.g., which government ministries are responsible for disabilities, which UN agencies, international NGOs, NGOs and CBOs are engaged) and how displaced persons with disabilities can access national services and protection.

INDIVIDUAL ASSESSMENTS

> Once persons with disabilities have been identified and registered, steps should be taken by trained disability workers to conduct individual assessments in order to provide necessary follow-up and care.

> Provide training to disability workers on how to conduct assessments and on early intervention and prevention strategies.

> Implement early intervention and prevention strategies, especially for children and older people. Identify people with disabilities who are living alone or who need additional community support to live independently or need more institutionalized care.

> Identify people with disabilities (including mental disabilities) who were previously living in institutions. Assess their immediate protection and basic needs and determine whether these can be adequately and appropriately met within the family/community.

> Where possible, promote community-based care for people with disabilities. In cases where disabled people were previously living in institutions and have very high-intensity needs that cannot be met within the family/community, identify local institutions that can provide adequate and appropriate care. Ensure regular monitoring and follow-up for people referred to institutions, in particular to monitor the quality of care and respect for their human rights.

> Conduct independent living assessments to identify what additional assistance people with disabilities require to live independently (e.g., house modifications/assistive devices/mobility aids).

> Identify what mobility aids and other assistive devices (e.g., prostheses, orthotics, wheelchairs, walking aids, hearing aids, eyeglasses, etc.) individuals with disabilities had access to in their countries/communities of origin. Assess how many, and what kind, of assistive devices need to be replaced and/or repaired and how many additional devices are required by people who did not have access to them before.

> Conduct medical assessments to identify medical needs of people with disabilities and care required, and make necessary medical referrals.

> Conduct educational/vocational training assessments to identify educational needs of children with disabilities/vocational training needs of young people and adults with disabilities and make necessary referrals to schools/colleges/training centers.

> Conduct livelihood/employment assessments of people with disabilities to identify skills and abilities and make necessary referrals to income generation activities.

> Provide disability certification where necessary (i.e., if this will help people with disabilities access locally available services and facilities).

Resources:

IASC. (2007). *Guidelines on mental health and psychosocial support in emergency settings.* Geneva: Inter-Agency Standing Committee.

UNHCR. (2008). *A community-based approach in UNHCR operations.* Geneva: UNHCR.

UNHCR. (1996). *Assisting disabled refugees: A community-based approach,* 2nd ed., rev. Geneva: UNHCR.

UNHCR. (2007). *Heightened Risk Identification Tool.* Geneva: UNHCR.

UNHCR. (2006). *Mainstreaming age, gender and diversity summary report.* Geneva: UNHCR.

UNHCR. (2005). *The UNHCR tool for participatory assessment in operations.* Geneva: UNHCR.

ACCESS TO INFORMATION

Objective: *To ensure that people with disabilities have full and unhindered access to information in a manner that is accessible and appropriate to different kinds of disabilities.*

> Ensure that displaced persons with disabilities have full access to a range of resources regarding information about their legal rights and entitlements as refugees, asylum seekers or IDPs and as persons with disabilities.

> Ensure that displaced persons with disabilities have full access to accurate information about emergency relief efforts, as well as national services for persons with disabilities.

> Ensure that persons with disabilities have full access to accurate information about conditions in their country/region of origin, and about the range of durable solutions available to them, including resettlement policies for refugees with disabilities.

> Devise community-based strategies and communication channels for ensuring that people with disabilities are informed about community affairs and developments.

> Involve DPOs in information dissemination.

> Ensure that information is provided in a format that is accessible, easy to understand (i.e., by 12-year-olds) and appropriate to different kinds of disabilities (e.g., camp radio broadcasts; Braille news-sheets and large-print media; loudspeaker announcements; messages passed through disability community workers—including in sign language; street drama, songs, etc.).

> Use information campaigns to raise awareness and understanding about disability issues among displaced and local communities. Public awareness-raising campaigns can be used to counter prejudices and negative attitudes toward people with disabilities and to promote the rights of people with disabilities to participate fully in their community.

> Conduct public information campaigns on the UN Convention on the Rights of Persons with Disabilities (CRPD) and how it applies in displacement situations.

> Identify members of the refugee/IDP or local community who are skilled in using Braille, sign language and other methods of communication and facilitate training for community leaders, UN and NGO service providers (e.g., doctors/health workers/teachers/community workers) in these methods.

Resources:

Ad Hoc Committee on a Comprehensive and Integral International Convention on the Protection and Promotion of the Rights and Dignity of Persons with Disabilities. (2006). *Convention on Rights of Persons with Disabilities* (Articles 9 and 21). http://www.un.org/disabilities/convention/conventionfull.shtml.

IASC. (2007). *Guidelines on mental health and psychosocial support in emergency settings.* Geneva: Inter-Agency Standing Committee.

CAMP LAYOUT / INFRASTRUCTURE

Objective: *To ensure that camps, settlements and urban living areas are accessible for people with disabilities and designed in such a way as to enable displaced persons with disabilities to live independently and to participate fully in all aspects of life.*

> The needs of people with disabilities should be addressed at *the start* of any refugee/IDP emergency during site selection and the planning and design of camp layout and infrastructure.

> Site design and camp construction may start before a detailed registration and profiling of the camp population has taken place. Nevertheless, site planners should work on the assumption that 7-10 percent of *any* population will have disabilities and the number may likely be higher among populations displaced by war, conflict or natural disaster (in particular the number of physical disabilities). Camp infrastructure and facilities should be designed accordingly (e.g., 10 percent of latrines should be physically accessible and appropriately designed for people with disabilities).

> Site planners, architects and construction engineers should receive basic training and sensitization on disability issues. The principle of "Universal Design" should guide all site planning and design—this means that infrastructure and facilities should be designed to be usable by all people, to the greatest extent possible, without the need for adaptation or specialized design.

> The needs of people with disabilities should be taken into consideration when designing all aspects of camp life. Minimum accessibility standards should be applied to ensure that camp buildings and facilities are accessible to people with disabilities (e.g., shelters, latrines and bathing areas, water points, schools, health services, food and nonfood-item distribution points, community centers, camp offices).

> Site planners and construction engineers should also ensure that refugee and IDP settlements are safe for people with disabilities to avoid accidents and injuries.

> Where refugees or IDPs are not accommodated in purpose-built camps or settlements but are living in urban areas, humanitarian organizations should provide assistance to displaced persons and their families to make whatever alterations and modifications are necessary to make their living areas and physical environment more accessible. These include:

- house modifications (e.g., widening doors for wheelchair access, installing ramps and handrails)
- provision of assistive devices (e.g., wheelchairs, crutches, walking sticks, motorized or manual three-wheelers)
- assistance with transportation to enable people with disabilities to leave their homes (e.g., a minibus to take people with disabilities to local health clinics, workplace, schools; or financial assistance, where necessary, to buy bus/train tickets)

> Where more structural change is required to the local physical environment, humanitarian organizations should collaborate with local government authorities. It should be noted that improvements to the local infrastructure will benefit not only displaced persons with disabilities, but also older people and people with disabilities among the local population. These include:

- constructing sidewalks (pavements)
- installing ramps and handrails and widening doors in public buildings
- paving and repairing roads

> Principles of "reasonable accommodation" should guide efforts to make living environments and urban infrastructure more accessible. This means making any necessary and appropriate modifications and adjustments to ensure that persons with disabilities can live independently and participate fully in all aspects of life.

Resources:

Ad Hoc Committee on a Comprehensive and Integral International Convention on the Protection and Promotion of the Rights and Dignity of Persons with Disabilities. (2006). *Convention on Rights of Persons with Disabilities* (Preamble, Articles 9 and 21). http://www.un.org/disabilities/convention/conventionfull.shtml.

Norwegian Refugee Council (NRC). (2004). *Camp management toolkit.* Oslo: NRC.

The Sphere Project. (2004). Chap. 4, Shelter, settlement and non-food items. In *The Sphere Project: Humanitarian charter and minimum standards in disaster response,* rev. ed. London: Oxfam Publishing. http://www.sphereproject.org/content/view/27/84.

UNHCR. (2007). *Handbook for emergencies*, 3rd ed. Geneva: UNHCR.

ACCESS TO MAINSTREAM SERVICES: CHECKLISTS

Objective: *To ensure that displaced persons with disabilities have full and equal access to all mainstream services available to the rest of the displaced population and that mainstream services are accessible and inclusive.*

The checklists below provide suggestions on how humanitarian organizations can improve access to mainstream services for displaced persons with disabilities. They include steps to improve physical access to all mainstream services and facilities; steps to make mainstream services more appropriate for people with disabilities; and steps to improve the training and orientation of humanitarian workers in different sectors, so they can be more sensitive to the needs of people with disabilities.

SHELTER / ACCOMMODATION

> Are shelters physically accessible for people with disabilities (e.g., are they built on flat land; are ramps/handrails provided; are doors wide enough for wheelchair access)?

> Are kitchens/cooking areas accessible for people with disabilities?

> Are sleeping arrangements/beds accessible and comfortable for people with disabilities (e.g., raised bed/provision of mattress or padded sleeping mat)?

> Are shelters for people with disabilities located close to essential services and facilities (e.g., water, latrines and bathing areas, health centers, schools, food and nonfood distribution points, fuel collection, community centers, camp offices)?

> Are people with disabilities provided with necessary assistance and materials to build their shelters?

> Do living arrangements provide sufficient privacy to people with disabilities, in particular women?

> Are shelters in a safe location, especially for women and those with limited mobility?

> Are people with disabilities involved in decision-making regarding the design and location of shelters? (N.B.: especially those with limited mobility who will spend extended periods in shelters.)

> In cold climates, are shelters sufficiently warm and insulated for people with disabilities, particularly older people and those who are less mobile and may suffer more from the cold?

Resources:

HelpAge International. (2000). *Older people in disasters and humanitarian crises: Guidelines for best practice.* London: HelpAge International.

IASC. (2007). *Guidelines on mental health and psychosocial support in emergency settings.* Geneva: Inter-Agency Standing Committee.

Norwegian Refugee Council (NRC). (2004). *Camp management toolkit.* Oslo: NRC.

The Sphere Project. (2004). Chap. 4, Shelter, settlement and non-food items. In *The Sphere Project: Humanitarian charter and minimum standards in disaster response,* rev. ed. London: Oxfam Publishing. http://www.sphereproject.org/content/view/27/84.

UNHCR. (2007). *Handbook for emergencies*, 3rd ed. Geneva: UNHCR.

WATER AND SANITATION

> Have people with disabilities, including women, participated in the planning, design and location of latrines, water points and bathing areas?

> Do people with disabilities have easy access to latrines (i.e., next to house or very close to house)?

> Are latrines physically accessible (i.e., on flat ground/no steps/wide enough doors/correct height/assistive aids such as handrails)?

> Can people with disabilities living alone access latrines on their own?

> Do people with disabilities have easy access to water for washing?

> Do latrines and bathing areas provide sufficient privacy and security to people with disabilities, especially women?

> Do women with disabilities have access to private areas where they can wash/dispose of menstrual cloths (according to local customs)?

> Do people with disabilities have easy access to water points (i.e., close to house)?

> Are water points physically accessible (i.e., on flat ground/no steps/correct height)?

> Are there systems in place to ensure assistance for people with disabilities who cannot fetch their own water?

Resources:

IASC. (2007). *Guidelines on mental health and psychosocial support in emergency settings.* Geneva: Inter-Agency Standing Committee.

Norwegian Refugee Council (NRC). (2004). *Camp management toolkit.* Oslo: NRC.

The Sphere Project. (2004). Chap. 2, Minimum standards in water supply, sanitation and hygiene promotion. In *The Sphere Project: Humanitarian charter and minimum standards in disaster response,* rev. ed. London: Oxfam Publishing. http://www.sphereproject.org/content/view/27/84.

UNHCR. (2007). *Handbook for emergencies*, 3rd ed. Geneva: UNHCR.

FOOD AND NUTRITION

> Are people with disabilities able to participate in the design of food distribution systems?

> Are food distribution points easily and physically accessible for people with disabilities (i.e., close to house/on flat ground/no steps)?

> Are systems in place to ensure that people with disabilities are given priority during food distributions (i.e., do not have to line up for long periods; can receive food first; "fast track" lines)?

> Are systems in place to ensure that people with disabilities, including older people, have equal access to food and are not discriminated against (e.g., checks to ensure that people with disabilities receive their full food ration and are not cheated or robbed of their ration during food distribution, or forced to use their food ration to pay for the transportation of the food back to their homes)?

> Is transport provided to enable people with disabilities to reach food distribution points and to transport food to their homes?

> Is food packaged in a way that is easy to transport (e.g., smaller food packages for people with disabilities or older people)?

> Are systems in place to assist persons with disabilities who are unable to collect their food ration themselves (e.g., can other family members, neighbors or community workers collect their food ration)?

> Are there mobile food distribution services for people with disabilities who are housebound or immobile?

> Do food-for-work programs exclude people with disabilities, including older people? Are there alternative programs for people unable to work?

> Are kitchens physically accessible and appropriate for people with disabilities (e.g., can people with disabilities enter kitchens; are stoves at correct height, easy to use)?

> Are systems in place to ensure that people with disabilities who live alone and cannot prepare their own food are assisted by other family members, neighbors or community workers?

> Is food nutritionally appropriate/easy to eat and digest for people with disabilities (e.g., children with cerebral palsy/children with cleft palates/older people missing teeth or with digestive problems)?

> Is there supplementary feeding for children and older people with disabilities?

> Do people with disabilities have easy and equal access to cooking fuel or firewood?

> Are systems in place to assist people with disabilities to collect cooking fuel or firewood if they are unable to do so themselves (e.g., other family members, neighbors or community workers)?

Resources:

HelpAge International. (2000). *Older people in disasters and humanitarian crises: Guidelines for best practice.* London: HelpAge International.

IASC. (2007). *Guidelines on mental health and psychosocial support in emergency settings.* Geneva: Inter-Agency Standing Committee.

Norwegian Refugee Council (NRC). (2004). *Camp management toolkit.* Oslo: NRC.

The Sphere Project. (2004). Chap. 3, Minimum standards in food security, nutrition and food aid. In *The Sphere Project: Humanitarian charter and minimum standards in disaster response,* rev. ed. London: Oxfam Publishing. http://www.sphereproject.org/content/view/27/84.

UNHCR. (2007). *Handbook for emergencies*, 3rd ed. Geneva: UNHCR.

NONFOOD-ITEM DISTRIBUTION

> Are nonfood distribution points easily and physically accessible for people with disabilities (i.e., close to house/on flat ground/no steps)?

> Are systems in place to ensure that people with disabilities are given priority during nonfood distributions (e.g., do not have to line up for long periods; can receive items first)?

> Are systems in place to ensure that people with disabilities, including older people, have equal access to nonfood items and are not discriminated against (e.g., checks to ensure that people with disabilities receive their entitlement and are not cheated/robbed of their assistance during nonfood distribution)?

> Is transport provided to enable people with disabilities to reach nonfood distribution points and to transport nonfood items to their homes?

> Are systems in place to assist people with disabilities who are unable to collect nonfood items themselves (e.g., can other family members, neighbors or community workers collect their nonfood assistance)?

> Are there mobile nonfood distribution services for people with disabilities who are house-bound or immobile?

> Are people with disabilities provided with additional nonfood items if necessary (e.g., blankets, clothing, bathing and laundry soap, cooking utensils, mattresses or raised beds)?

> Are people with disabilities provided with necessary assistive devices and mobility aids during nonfood distributions (e.g., special cooking utensils, smaller pots and water containers, tools, hearing aids and batteries, crutches, etc.)?

> Are women with disabilities provided with menstrual cloths?

Resources:

HelpAge International. (2000). *Older people in disasters and humanitarian crises: Guidelines for best practice.* London: HelpAge International.

Norwegian Refugee Council (NRC). (2004). *Camp management toolkit.* Oslo: NRC.

The Sphere Project. (2004). Chap. 4, Shelter, settlement and non-food items. In *The Sphere Project: Humanitarian charter and minimum standards in disaster response,* rev. ed. London: Oxfam Publishing. http://www.sphereproject.org/content/view/27/84.

UNHCR. (2007). *Handbook for emergencies*, 3rd ed. Geneva: UNHCR.

HEALTH SERVICES (INCLUDING MENTAL HEALTH SERVICES)

> Do people with disabilities, regardless of their type of disability, age or gender, have full and equal access to health services?

> Are health services easily and physically accessible for people with disabilities (i.e., close to houses/on flat ground/no steps/wide doors)?

> Do people with disabilities and mothers of children with disabilities have priority access to health services (e.g., are they seen first by doctors; do not have to wait in long lines)?

> Do doctors and health staff receive training and sensitization on disability issues and communication methods (e.g., Braille/sign language)?

> Is public health information provided in accessible formats for people with disabilities (e.g., notices in Braille and large print)?

> Are appropriate medicines available in camps or urban settlements for people with disabilities (such as anti-epileptic, anti-convulsant, anti-depressant and other psychiatric drugs); if not, can they be acquired elsewhere?

> What mental health services are available in the camp or settlement? Are people with the most severely disabling neuropsychiatric problems (e.g., psychosis, epilepsy, severe depression) receiving care? Are special mental health services provided for people with disabilities? If not, can people with disabilities access mental health services elsewhere?

> Do women with disabilities have access to reproductive health services? Are there any special health services for women with disabilities?

> Are systems in place to ensure that when people with disabilities are sick they can receive medical care (e.g., who do they inform—family members, disability workers, social workers, etc.)? Are there daily home visits for people with disabilities who live alone to check on their health and well-being?

> Are systems in place to help people with disabilities get to health clinics if they are unable to do so alone (e.g., with the help of family members, neighbors or community workers)?

> Is transport provided to assist people with disabilities to get to health services that are outside the camp or settlement, or are far away from their homes (e.g., local forms of transport in refugee camps (wheelbarrows, carts, donkey carts, tricycles) or buses/carts/tricycles for urban refugees)?

Resources:

HelpAge International. (2000). *Older people in disasters and humanitarian crises: Guidelines for best practice.* London: HelpAge International.

IASC. (2007). *Guidelines on mental health and psychosocial support in emergency settings.* Geneva: Inter-Agency Standing Committee.

The Sphere Project. (2004). Chap. 5, Minimum standards in health services. In *The Sphere Project: Humanitarian charter and minimum standards in disaster response,* rev. ed. London: Oxfam Publishing. http://www.sphereproject.org/content/view/27/84.

UNHCR and International Save the Children Alliance. (2001). Action for the rights of children resource pack: *Critical issues: Disability.* London: International Save the Children Alliance. http://www.savethechildren.net/arc/files/main.html.

PHYSICAL REHABILITATION SERVICES

> Are there physical rehabilitation centers close to the refugee or IDP camps?

> Do people with physical impairments living in urban areas have access to physical rehabilitation services?

> Are physical rehabilitation services physically accessible and available equally to, and designed to meet the particular needs of, women, men, girls and boys and older persons?

> Do physical rehabilitation centers provide a full range of services (e.g., assistive devices, appropriate therapy, follow-up, etc.)?

> Are systems in place to help people with disabilities get to physical rehabilitation centers if they are unable to do so alone (e.g., with the help of family members, neighbors or community workers)?

> Is transport provided to assist people with disabilities get to physical rehabilitation services that are outside the camp or settlement, or are far away from their homes (e.g., local forms of transport in refugee camps (wheel-barrows, carts, donkey carts, tricycles) or buses/carts/tricycles for urban refugees)?

EDUCATION

> Do children with disabilities have full and equal access to pre-schools, primary and secondary schools?

> Do girls and boys with disabilities have equal access to educational opportunities?

> Are schools easy to get to and physically accessible for children with disabilities (i.e., close to homes; on flat ground; wide doors for wheelchair access; ramps instead of stairs)?

> Are facilities in schools physically accessible for children with disabilities (e.g., are latrines accessible and appropriate; are classrooms and classroom furniture appropriate and accessible; can children with disabilities reach water points; are playgrounds safe and appropriate)?

> Is transport provided to help children with disabilities get to schools that are at a distance from their homes (e.g., local forms of transport in refugee camps (wheelbarrows, carts, donkey carts, tricycles) or buses/carts/tricycles for urban refugees)?

> Is the school environment welcoming and supportive for children with disabilities?

> Are there sufficient and appropriate teaching aids, and play and stimulation materials for children with disabilities?

> Are there opportunities for children with disabilities to join in with mainstream social, cultural and sporting activities (e.g., sports lessons/cultural events/field trips)?

> Do children with disabilities have access to play areas and child-friendly spaces in displacement camps or settlements that are physically accessible and appropriate for their needs?

> Are there school/home liaison teachers who can build links with the school and children's homes; advise families on children's progress; identify children with disabilities in the community and promote their inclusion in mainstream schools or attendance at special schools?

> Is there an early childhood intervention program to help identify children with disabilities, conduct assessments, provide training and support to families and link children to available services?

> Are there opportunities for children with disabilities to continue with higher education? Is higher education promoted for children with disabilities?

> Are schools utilized to serve broader community needs, for example, as a place where parents with children with disabilities can meet and form support groups?

Resources:

Inter-Agency Network for Education in Emergencies. (2006). Good practice guides: *Inclusive education of children at risk*. http://ineesite.org/page.asp?pid=1060.

UNHCR and International Save the Children Alliance. (2001). Action for the rights of children resource pack: *Critical issues: Disability*. London: International Save the Children Alliance. http://www.savethechildren.net/arc/files/main.html.

VOCATIONAL TRAINING / SKILLS TRAINING / ADULT EDUCATION

> Do people with disabilities, including older people, have access to existing vocational training, skills training and adult literacy classes?

> Are there special vocational training or adult education programs geared toward people with disabilities, including older people?

> Are the needs and skills of people with disabilities taken into account when planning vocational training courses?

> Are vocational training classes physically accessible for people with disabilities (e.g., are centers near homes; are they on flat ground; wide doors; no steps)?

> Is transport provided to help people with disabilities attend vocational training courses?

> Do vocational trainers receive any training or sensitization on disability issues, including communication methods (e.g., sign language/Braille/other forms of communication)?

> Can community workers help identify the skills and training needs of people with disabilities in the community and encourage them to participate in vocational training courses?

> Are vocational training courses linked to possible job opportunities?

> Is there a market for the skills learned/products made during vocational training courses?

> Are vocational training courses regularly evaluated on the basis of attendance rates, progress of participants and ability to find jobs and/or sell products at the end of the course? Are participants with disabilities included in course evaluations?

Resources:

HelpAge International. (2000). *Older people in disasters and humanitarian crises: Guidelines for best practice.* London: HelpAge International.

UNHCR. (1996). *Assisting disabled refugees: A community-based approach,* 2nd ed., rev. Geneva: UNHCR.

INCOME GENERATION / EMPLOYMENT OPPORTUNITIES / LIVELIHOODS

> Are there income generation/job opportunities for people with disabilities in refugee camps and settlements or outside in the community?

> Are there opportunities for people with disabilities to set up small businesses in camps/settlements?

> Are people with disabilities, including older people, included in existing income generation/livelihood projects? Are income generation projects designed to take into account the needs/skills/wage-earning capacities of people with disabilities?

> Can people with disabilities, including older people, access existing microcredit/self-reliance schemes? Are there special microcredit schemes for people with disabilities to set up small businesses? Are they provided with tools, seeds and other material inputs?

> Do cash-for-work programs discriminate against or exclude people with disabilities, including older people? Are there alternative schemes for people unable to work?

> Do UN agencies/NGOs/CBOs promote the employment of people with disabilities in the management and implementation of assistance programs? Do humanitarian agencies have equal opportunity employment policies?

> Do UN agencies/NGOs work with local employers to promote the employment of people with disabilities?

Resources:

HelpAge International. (2000). *Older people in disasters and humanitarian crises: Guidelines for best practice.* London: HelpAge International.

UNHCR. (1996). *Assisting disabled refugees: A community-based approach,* 2nd ed., rev. Geneva: UNHCR.

PSYCHOSOCIAL PROGRAMS

> Are people with disabilities included in existing psychosocial/counseling and support programs?

> Are there specially trained counselors/community workers to work with people with disabilities and their families? Are they trained in sign language/Braille/other forms of communication?

> Can community workers make referrals to locally available psychosocial services for people with disabilities?

Resources:

IASC. (2007). *Guidelines on mental health and psychosocial support in emergency settings.* Geneva: Inter-Agency Standing Committee.

SPECIALIZED SERVICES FOR PEOPLE WITH DISABILITIES

Objective: *To provide targeted services specifically geared to meet the needs of people with disabilities.*

As well as improving disabled persons' access to mainstream services, there may also be a need to set up specialized services and infrastructure that are specifically geared to meet the needs of displaced persons with disabilities. There is some overlap between the sectors covered below and those dealt with under mainstream services in the section above. However, this section of the Resource Kit provides guidance to humanitarian workers on how to plan and design educational, health, psychosocial, skills training and other programs that specifically target the needs of persons with disabilities. It also includes advice on how to plan and design facilities and infrastructure (such as water and sanitation and food distribution systems) to specifically meet the needs of people with disabilities. The following suggestions are drawn from the field studies and country programs reviewed by this project, as well as guidance from specialist organizations in different sectors.

WATER AND SANITATION

A leader in water supply and sanitation programs in emergencies, Oxfam has considerable experience in designing appropriate water supply and sanitation for people with disabilities. The following ideas are drawn from Oxfam good practice in the field and technical briefs that Oxfam has prepared for its staff.

> Involve people with disabilities, including women, and, where necessary, their caregivers, at all stages of planning, design and location of latrines, water points and bathing areas to ensure that they are accessible, convenient, safe and appropriate.

> Design latrines, water points and bathing areas with the aim of ensuring that people with disabilities can access them independently and be as self-reliant as possible.

> Where independent access is not possible, design latrines and bathing areas to accommodate caregivers who will accompany people with disabilities.

> Ensure easy access to water close to the latrine.

> Consider the following features when designing latrines and bathing facilities for disabled access:
  - Build individual family latrines for people with disabilities or disabled units within communal latrine blocks.
  - Ensure that individual latrines and/or communal latrines are close to the homes/shelter of people with disabilities.
  - Install an easy access pathway, using ramps rather than steps, to the latrines, water points and bathing areas.
  - Ensure that the entrance to the latrine block and doors of the disabled units are wide enough to accommodate a wheelchair/crutches.
  - Ensure that disabled units are large enough to accommodate and maneuver a wheelchair, plus a caregiver, and that the door can be shut when the user is inside.
  - Install handrails/ropes/vertical poles to assist the user to move into the latrine, to help move from standing to sitting/squatting position and to provide added stability while sitting/squatting.
  - Install handrails on the door, or a pulley system, to enable people with disabilities to easily open and close the door from inside the latrine; a doorstop will also prevent the door from swinging too far if it opens outward.
  - Install raised, strong, easily cleanable seats for people with disabilities (fixed or movable) (N.B.: seats should be designed to enable a disabled person to move from his/her wheelchair to the seat and back again).
  - Public health promotion should emphasize the importance of keeping disabled units/family latrines clean and hygienic.
  - Hand-washing units should be easy to access and at an appropriate height for children and people with disabilities.
  - Bathing facilities should be close to the latrines, easily accessible and with enough room for the user and caregiver (including wheelchair); a washable, drainable chair or bench can be useful (e.g., a metal framed bench with woven rubber strips).

> For those disabled people who are housebound, consider the following options:
  - a commode chair (made of wood or metal with a removable pot)
  - bedpans or potties

> For disabled people who are housebound, ensure that there is sufficient privacy within shelters (e.g., a screen or separate area within the shelter) and easy access to water and soap for washing the commode pots or bedpans.

Resources:

Jones, H. and R. A. Reed. (2005). *Water and sanitation for disabled people and other vulnerable groups.* Leicestershire, UK: WEDC.

Oxfam Technical Brief No. 1. (2007). *Excreta disposal for people with physical disabilities in emergencies.* London: Oxfam Publishing.

Oxfam Technical Brief No. 2. (2007). *Vulnerability and socio-cultural considerations for PHE in emergencies.* London: Oxfam Publishing.

FOOD AND NUTRITION

The Sphere Project Handbook provides the following guidance on providing nutritionally appropriate food for people with disabilities.

> Ensure that people with disabilities, and their caregivers, are given priority in food distribution systems and have easy access to food supplies.

> Ensure that systems are in place to bring food to the homes of people with disabilities who have restricted mobility and/or have lost caregivers and family support during the crisis.

> Provide food that is nutritionally adequate and appropriate and easy to eat and digest for people with disabilities (including older people and children) (N.B.: this will depend on specific nutritional requirements).

> Provide people with disabilities with energy-dense foods that are easy to prepare, consume and digest (N.B.: this will depend on specific needs).

> Provide supplementary feeding for people with disabilities (especially children and older people) with specific nutritional requirements.

> Provide special aids to assist with food preparation and feeding (e.g., special seats, spoons, straws, cooking utensils and necessary adaptations to cooking areas—e.g., raised stoves).

> Ensure that the needs of caregivers are also taken into account when planning feeding programs (e.g., lack of time to access and prepare food due to caring role; lack of community support mechanisms due to stigma and marginalization; the time consumed maintaining higher standards of hygiene and feeding a person with disabilities may mean caregivers miss out on meals themselves; lack of available assets to exchange for food due to costs of treatment).

Resources:

HelpAge International. (2000). *Older people in disasters and humanitarian crises: Guidelines for best practice.* London: HelpAge International.

The Sphere Project. (2004). Chap. 3, Minimum standards in food security, nutrition and food aid. In *The Sphere Project: Humanitarian charter and minimum standards in disaster response,* rev. ed. London: Oxfam Publishing. http://www.sphereproject.org/content/view/27/84.

HEALTH SERVICES (INCLUDING MENTAL HEALTH SERVICES)

The following ideas have been gathered from the field studies, as well as several other countries whose disability programs were reviewed.

> Set up regular, specialized health clinics for different impairments (e.g., a regular eye clinic or prosthetics clinic once a week or once a month).

> Arrange for visiting specialist doctors and health professionals to run the clinics (e.g., once a week/once a month).

> Set aside specific hours and/or days for children, adults and older people with disabilities to visit health clinics to avoid long waits to see doctors.

> Ensure that health staff have a good knowledge of locally available clinics/health services for people with disabilities and are able to make referrals where appropriate (N.B.: this also means providing the funding for referrals to outside clinics).

- Establish outreach care and home visiting programs. Encourage community health workers, including mental health workers, to regularly visit the homes of people with disabilities in order to:
  - carry out early identification of impairments
  - conduct physical and mental health assessments
  - disseminate information on public health, disease prevention and basic hygiene
  - provide rehabilitative care, physical therapy and support
  - reduce drop-out once treatment is initiated (e.g., ensuring that people with severe mental disorders adhere to treatment and return to their mental health care provider for follow-up visits)
  - make referrals where necessary
- Provide appropriate mobility aids and assistive devices through the health services (e.g., walking sticks, crutches, wheelchairs, tricycles, hearing aids, eyeglasses) to people with disabilities.
- Provide home-based respite care for children with disabilities (e.g., for children with cerebral palsy), to give their families or caregivers a break.
- Protect and promote the rights of patients with disabilities, such as patient confidentiality; ensure privacy, especially for women; informed consent by patient, or guardian (in the case of children or people with severe mental disabilities).

Resources:

HelpAge International. (2000). *Older people in disasters and humanitarian crises: Guidelines for best practice.* London: HelpAge International.

IASC. (2007). *Guidelines on mental health and psychosocial support in emergency settings.* Geneva: Inter-Agency Standing Committee.

The Sphere Project. (2004). Chap. 5, Minimum standards in health services. In *The Sphere Project: Humanitarian charter and minimum standards in disaster response,* rev. ed. London: Oxfam Publishing. http://www.sphereproject.org/content/view/27/84.

PHYSICAL REHABILITATION SERVICES

- Where physical rehabilitation centers exist in close proximity to refugee or IDP camps, set up a referral system and provide assistance to enable refugees and IDPs with physical impairments to access these services. Assistance may include: covering the cost of treatment (if needed); the cost of transportation; and, if the person has to stay at the center for a long time, the cost of accommodation and food.
- Ensure that physical rehabilitation centers close to camps can provide a complete range of services, including surgical and post-operative care, prostheses, orthotics, wheelchairs, walking aids and other assistive mobility devices, physical therapy and follow-up.
- Where there is no physical rehabilitation center close to the refugee or IDP camp, explore the possibility of a team from a nearby center visiting the camp on a regular basis to provide physical rehabilitation services.
- If this option is chosen, community workers should be trained (by the center) to provide basic physical therapy to ease the appropriation of the devices and to perform basic repairs.
- For urban refugees and IDPs, set up a referral system and provide assistance to enable refugees and IDPs with a physical disability to have access to services. This may include: covering the cost of treatment (if needed); the cost of transportation; and, if the person has to stay for a long time, the cost of accommodation and food.
- Ensure that physical rehabilitation centers for urban refugees can provide a complete range of services, including surgical and post-operative care, prostheses, orthotics, wheelchairs, walking aids and other assistive mobility devices, physical therapy and follow-up.
- If none of the above options are possible, consider establishing a physical rehabilitation center (or workshop) within the camp or settlement. This will require using trained personnel (prostheses and orthotics technicians and physiotherapists) to set up the center and provide the services. Staff could be expatriate specialists, trained personnel from the host country or, if available, trained personnel from the refugee or IDP population.
- Set up workshops and provide training for refugees and displaced persons, including amputees, to make and repair prosthetics/mobility aids/assistive devices within camps or urban settlements.

Resources:

Handicap International. http://www.handicap-international.org/.

ICRC. http://www.icrc.org.

ICRC Special Fund for the Disabled. http://www.icrc.org/fund-disabled.

Mae Tao Clinic, Thailand. http://www.maetaoclinic.org/.

See also, Landmine Survivors Network. http://www.landminesurvivors.org. This website can be used to download the following documents:

Prosthetics and orthotics project guide: Supporting P&O services in low-income settings: A common approach for organizations implementing aid projects

Prosthetics and orthotics programme guide: Implementing P&O services in low-income settings: A guide for planners and providers of services for persons in need of orthopaedic devices

PSYCHOSOCIAL PROGRAMS

The IASC *Guidelines on Mental Health and Psychosocial Support* provide a wealth of ideas about how to promote mental health and psychosocial well-being. The following ideas are drawn from the IASC guidelines, the HelpAge International guidelines and from the case studies reviewed for this project.

> Encourage home visits by social workers/disability workers to people with disabilities and their families or caregivers to provide counseling and psychosocial support.

> Help set up support groups for families or caregivers of children and adults with disabilities (e.g., mothers' support groups/older persons' support groups).

> Set up safe places/centers within the camp or settlement where people with disabilities/older people/parents of disabled children can meet and socialize.

> Provide ongoing training for mothers and/or caregivers of children with disabilities (e.g., training and support for mothers of children with mental disabilities or cerebral palsy).

> Consider providing additional material and social assistance to households that care for disabled family members.

> Provide respite care for families and/or caregivers of children or adults with disabilities (e.g., to give them a break; enable them to attend a training course or a regular support group).

> Promote full and inclusive participation of people with disabilities in decision-making, planning, design, management and implementation of camp activities as a key strategy toward ensuring psychosocial well-being.

Resources:

HelpAge International. (2000). *Older people in disasters and humanitarian crises: Guidelines for best practice.* London: HelpAge International.

IASC. (2007). *Guidelines on mental health and psychosocial support in emergency settings.* Geneva: Inter-Agency Standing Committee.

INCLUSIVE EDUCATION

Extensive literature exists on how to promote inclusive education for children with disabilities. The following suggestions are drawn from the INEE Handbook and Good Practice Guides and from the Action for the Rights of Children disability resource pack. Additional ideas come from the field studies and other country programs reviewed during this project.

> Ensure that children with disabilities have full and equal access to all educational opportunities.

> Wherever possible, promote the inclusion of children with special needs in mainstream schools and classes.

> Set up special units within mainstream schools or special schools for children who would benefit more from specialized teaching (e.g., schools/special units for children who are deaf, blind, severely mentally impaired or those with severe learning difficulties).

> Where necessary, facilitate referrals to special education facilities outside the camps/settlements for children who cannot attend mainstream schools and provide necessary funding and transport.

> Provide training and awareness raising for mainstream teachers on special needs and inclusive education.

> Provide ongoing training for special needs support teachers and special education assistants in schools.

> Provide training in sign language, Braille and other forms of communication for mainstream teachers and special needs support teachers.

> Develop a flexible learning environment and curriculum that takes into account the special needs of children with disabilities (e.g., arrange classrooms so children with visual impairment can see the blackboard or arrange for visual aids; arrange classrooms so children with hearing impairments can hear the teacher; adapt the curriculum for children with learning difficulties and mental disabilities).

> Provide specialized teaching aids and learning devices for children with disabilities (e.g., materials in Braille, large print books, talking books and talking calculators for the visually impaired; colored chalk and visual aids for the visually and hearing impaired; and special aids for literacy and numeracy for children with learning difficulties).

> Provide children with assistive devices and mobility aids to facilitate their inclusion in mainstream schools and maximize their learning (e.g., hearing aids, eyeglasses, magnifying glasses, wheelchairs, crutches, tricycles and special chairs).

> Set up workshops in the camps for making teaching aids, play materials and learning devices for children with disabilities with locally available resources.

> Conduct community awareness raising and information campaigns to sensitize teachers, parents, other students and the local community about disability issues. Stress the importance for *all* children with disabilities to have the opportunity to attend school, especially girls and children with mental disabilities.

> Conduct more research and analysis into why fewer girls with disabilities are attending school than boys with disabilities. Take immediate steps to encourage families to send girls with disabilities to school.

Resources:

Inter-Agency Network for Education in Emergencies (INEE). (2006). Good practice guides: *Inclusive education of children at risk.* http://ineesite.org/page.asp?pid=1060.

INEE. (2004). Handbook: *Minimum standards for education in emergencies, chronic crises and early reconstruction.* http://ineesite.org/page.asp?pid=1240.

UNHCR and International Save the Children Alliance. (2001). Action for the rights of children resource pack: *Critical issues: Disability.* London: International Save the Children Alliance. http://www.savethechildren.net/arc/files/main.html.

PROTECTION

PROTECTION MONITORING

Objective: *To improve the identification of and response to protection risks faced by displaced persons with disabilities.*

> Ensure that protection officers include people with disabilities in routine protection monitoring.

> Provide training for protection officers on the risks faced by people with disabilities, including people with mental disabilities and older people, and on appropriate communication methods (e.g., sign language/Braille).

> Put in place reporting mechanisms for people with disabilities, their families and neighbors to report protection risks/problems involving people with disabilities, and set up coordinated response mechanisms.

> Extend family tracing services to include people with disabilities and reunite disabled people with their families or, where this is not possible, with extended or "foster" families.

> Develop checklists of possible protection risks faced by people with disabilities (e.g., sexual violence, domestic abuse and physical abuse; abduction/separation from family members; exploitation; neglect, abandonment, concealment and intimidation; disappearance and trafficking; theft of medicines/food/ belongings/identification documents), but *also* look for other potential protection risks not included in checklists.

> Assess local capacities for responding to protection risks: how did the community cope in the past; what has changed in displacement; specifically, how has this affected people with disabilities (e.g., family separation; loss of caregivers, family members, etc.)?

> Ensure representation of people with disabilities/their family and/or caregivers in protection working groups (PWG).

> Provide training to members of PWG on specific protection risks faced by people with disabilities, appropriate responses and communication methods.

> Establish safe places where people with disabilities, including older people, can meet and share information/children can play; ensure that safe places established in camps are accessible to people with disabilities.

> Include specific guidance on respect for the human rights of people with disabilities in staff Codes of Conduct.

> Provide training and awareness raising on the UN Convention on the Rights of Persons with Disabilities (CRPD) and how it applies in displacement situations for people with disabilities and their families, community leaders and members of the community, teachers, health staff, community workers, humanitarian workers and local government officers.

> Ensure that people with disabilities have full and equal access to justice and legal representation and enjoy recognition before the law.

> Provide training for law enforcement officials and the judiciary on disability rights and the CRPD in relation to refugees and IDPs.

Resources:

Ad Hoc Committee on a Comprehensive and Integral International Convention on the Protection and Promotion of the Rights and Dignity of Persons with Disabilities. (2006). Final report, *Convention on Rights of Persons with Disabilities.* http://www.un.org/disabilities/convention/conventionfull.shtml.

IASC. (2007). *Guidelines on mental health and psychosocial support in emergency settings.* Geneva: Inter-Agency Standing Committee.

Norwegian Refugee Council (NRC). (2004). *Camp management toolkit.* Oslo: NRC.

UNHCR. (2008). *A community-based approach in UNHCR operations.* Geneva: UNHCR.

UNHCR. (2003). *Agenda for protection,* 3rd ed. Geneva: UNHCR.

PROTECTING WOMEN WITH DISABILITIES

Objective: *To improve the identification of and response to specific protection risks faced by displaced women with disabilities.*

> Include women with disabilities in all protection monitoring, in particular with a focus on identifying and preventing sexual and gender-based violence, domestic violence and abuse, physical abuse, trafficking, neglect, discrimination and stigmatization of women with disabilities. Note that disabled women who have lost family support during a crisis may be at heightened risk of sexual violence.

> Pay special attention to the specific protection risks faced by women with mental disabilities and learning difficulties, who may be at greater risk of sexual violence and abuse.

> Special attention should also be paid to the protection risks faced by mothers of children with disabilities, who may face abandonment, domestic violence and abuse, discrimination and stigmatization.

> Ensure that women with disabilities have adequate privacy both in the home and in public places (e.g., latrines/bathing/washing areas/health centers/adequate clothing) to protect their dignity and safety.

> Encourage disabled women to set up their own committees/support groups and to identify and report protection risks faced by women with disabilities in their community.

Resources:

IASC. (2005). *Guidelines for gender-based violence interventions in humanitarian settings.* Geneva: Inter-Agency Standing Committee.

IASC. (2007). *Guidelines on mental health and psychosocial support in emergency settings.* Geneva: Inter-Agency Standing Committee.

UNHCR. (2008). *Handbook for the protection of women and girls.* Geneva: UNHCR.

UNHCR. (2003). *Sexual and gender-based violence against refugees, returnees and internally displaced persons: Guidelines for prevention and response.* Geneva: UNHCR.

PROTECTING CHILDREN WITH DISABILITIES

Objective: *To improve the identification and response to specific protection risks faced by displaced children with disabilities.*

> Include children with disabilities in all protection monitoring, with a particular focus on identifying and preventing neglect, abandonment, concealment, physical restraint, isolation, physical and/or sexual abuse, exploitation, trafficking, discrimination and stigmatization of children with disabilities.

> Establish community child protection committees, with the involvement of children and young people themselves, that identify at-risk children, including children with disabilities, monitor risks, intervene where possible and refer cases to relevant protection staff or authorities as necessary.

> Promote the inclusion of children and young people with disabilities in children's and youth groups in the community. Encourage children and young people with disabilities to set up their own support groups, where necessary.

> Encourage the establishment of support groups for parents and family members of children with disabilities; set up mother and child groups or parent support groups where parents can meet and young children can play.

Resources:

IASC. (2007). *Guidelines on mental health and psychosocial support in emergency settings.* Geneva: Inter-Agency Standing Committee.

UNHCR. (2008). *Handbook for the protection of women and girls.* Geneva: UNHCR.

UNHCR. (1994). *Refugee children: Guidelines on protection and care.* Geneva: UNHCR.

REFUGEE STATUS DETERMINATION

Objective: *To ensure that refugees and asylum seekers with disabilities have full and equal access to refugee status determination (RSD) procedures and that RSD staff are trained appropriately and are sensitive to disability issues.*

> Ensure that refugees and asylum seekers with disabilities have full, fair and equal access to RSD procedures.

> Ensure that information about RSD procedures is provided in a format that is accessible and easily understood by people with disabilities (e.g., written communication in large print or Braille for visually impaired; information provided in simple language that could be understood by a 12-year-old).

> Ensure that RSD offices are physically accessible for refugees with disabilities (e.g., on flat ground; ramps instead of steps; wide doors for wheelchair access). Ensure that facilities at RSD offices are also physically accessible (e.g., toilets/latrines).

> Provide transport for refugees with disabilities to reach RSD offices where necessary.

> Prioritize hearings for refugees with disabilities to avoid long waits.

> Ensure that refugees with disabilities are provided with the necessary assistance to ensure a full and fair hearing of their asylum case (e.g., access to sign language interpreters for the hearing impaired; mentally disabled are accompanied by family members or companions to assist with interview as necessary).

> Ensure that RSD officers have access to medical certificates, or letters from doctors, to ascertain the nature of an individual's disability, where this is necessary/appropriate.

> Provide training and awareness raising for RSD officers on disability issues and rights and appropriate communication methods (e.g., sign language/Braille/presenting information in a simple, easily understood format).

> Conduct further research into how accessible and appropriate RSD procedures are for refugees with disabilities and what modifications and adaptations need to be made (according to specific disabilities).

COMMUNITY PARTICIPATION AND INCLUSION

Objective: *To ensure that displaced persons with disabilities, regardless of their type of disability, gender or age, are empowered and can participate fully and equally in all community affairs, decision-making and planning processes. To ensure that displaced persons with disabilities, regardless of their type of disability, gender or age, are represented at all levels of camp/community management and at all stages of program planning, design, implementation and management. To ensure that displaced persons with disabilities are able to form their own organizations and to participate in local disabled persons' organizations (DPOs).*

> Include people with disabilities, their families and caregivers and DPOs in all community-based participatory assessments.

> Provide training and awareness-raising programs to people with disabilities on their rights; provide training in public communication skills, management skills, etc., to empower them to participate in community affairs and decision-making processes.

> Promote the inclusion of people with all types of disabilities in camp management structures (e.g., camp committees) and in community leadership positions (e.g., through quotas/reserved seats/awareness raising).

> Set up systems to ensure that people with disabilities, regardless of their type of disability, gender or age, are represented and heard at all levels of camp/community life and during decision-making processes.

> Ensure that children and young people with disabilities are able to participate fully in community affairs and that systems are in place to consult with children and young people and to listen to their views.

> Involve people with disabilities at all stages of the project cycle (needs assessment, planning, design, implementation and management).

> Involve people with disabilities at all levels of project management and promote the employment of people with disabilities in humanitarian organizations, particularly at senior management levels.

> Work with traditional leaders/camp leaders to promote the inclusion of people with disabilities, regardless of the type of disability, gender or age, in community management and decision-making processes and to gain their support for change in communities where people with disabilities have traditionally been excluded from public life.

> Conduct ongoing awareness raising and information campaigns in the community about the rights of people with disabilities in order to promote tolerance, understanding and respect for people with disabilities and allay fears about "difference."

> Work with people with disabilities, their families and DPOs to counter fears, stigmatization and superstition surrounding particular disabilities (e.g., mental disabilities) through awareness raising and information campaigns.

> Provide ongoing training to community leaders and community workers on the rights of people with disabilities (including the CRPD), participatory approaches to working with people with disabilities and appropriate communication methods (e.g., sign language/Braille/other methods).

> Encourage and support people with disabilities of all ages and gender to set up their own organizations, self-help or support groups.

> Encourage the inclusion of children and young people with disabilities in community youth groups and activities.

> Encourage the inclusion of people with disabilities in other special focus groups (e.g., women's groups, older persons groups, adult literacy groups, livelihood activities (e.g., gardening, livestock, handicraft projects)).

> Provide safe spaces/community centers within camps or settlements where people with disabilities, their families and DPOs can meet and socialize.

> Build links between displaced persons with disabilities and people with disabilities in the local community; encourage local DPOs to integrate displaced persons into their activities. This is especially important for refugees and IDPs with disabilities living in urban areas, who may be more isolated and have access to fewer services than those living in camps.

> Ensure that services provided to displaced persons with disabilities are also made available to people with disabilities in the local community.

> Build the capacities of DPOs both within the refugee community and the local community. Meet and consult regularly with DPOs and include them at all levels of program planning, implementation and evaluation.

> Provide transport/assistance so that people with disabilities can attend support groups, community meetings and DPO meetings both within and outside the camp/settlement.

Resources:

Ad Hoc Committee on a Comprehensive and Integral International Convention on the Protection and Promotion of the Rights and Dignity of Persons with Disabilities. (2006). *Convention on Rights of Persons with Disabilities.* Final report. http://www.un.org/disabilities/convention/conventionfull.shtml.

HelpAge International. (2000). *Older people in disasters and humanitarian crises: Guidelines for best practice.* London: HelpAge International.

IASC. (2007). *Guidelines on mental health and psychosocial support in emergency settings.* Geneva: Inter-Agency Standing Committee.

Norwegian Refugee Council (NRC). (2004). *Camp management toolkit.* Oslo: NRC.

UNHCR. (2008). *A community-based approach in UNHCR operations.* Geneva: UNHCR.

UNHCR. (1996). *Assisting disabled refugees: A community-based approach,* 2nd ed., rev. Geneva: UNHCR.

DURABLE SOLUTIONS

Objective: *Ensure that refugees and displaced persons with disabilities have full and equal access to all durable solution options. Ensure that displaced persons with disabilities have full access to information about durable solutions options in an accessible format.*

> Ensure that people with disabilities have equal access to all durable solutions and are not discriminated against or excluded.

> Ensure that displaced persons with disabilities are fully informed about durable solution options through accessible communication strategies (e.g., camp radio broadcasts; Braille news-sheets and large-print media; loudspeaker announcements; messages passed through disability community workers—including in sign language; street drama, songs, etc.).

> Ensure that refugees with disabilities are not separated from family members or caregivers when seeking durable solutions and that efforts are made to reunite family members who become separated during return or resettlement operations. However, where persons with disabilities choose different durable solution options from other family members, ensure that appropriate arrangements are made to facilitate durable solutions that are in the best interests of the person with disabilities.

> Ensure that there is a proper handover of individual care management at the time of accessing durable solutions; ensure that all agencies have full information about the needs of refugees with disabilities (e.g., medical care, treatments and medicines; education and training needs; rehabilitation and palliative care; independent living; mobility and assistive devices, etc.).

> Ensure that appropriate arrangements are made to assist with the voluntary repatriation of refugees with disabilities and the return of IDPs to their own communities, including pre-departure counseling, medical care and special travel arrangements and that refugees with disabilities and their families have access to this information.

> Ensure that people with disabilities have full information about their rights as disabled persons to services and facilities available in their country or community of origin.

> Ensure that adequate support is provided to people with disabilities when they return to their own communities and that appropriate medical, educational, rehabilitation, training and employment services are provided for returnees with disabilities.

> Ensure that refugees who choose to integrate locally in their countries of asylum have equal access to national services for people with disabilities and receive full information about their rights as disabled persons, and information about services and facilities available.

> Ensure that refugees with disabilities have full and transparent information about resettlement policies (e.g., policies of different resettlement countries toward refugees with disabilities; resettlement selection criteria).

> Ensure that refugees with disabilities and their families have full and transparent information about family reunification for refugees with disabilities.

> Provide refugees with disabilities and their families with information about the national disability framework in resettlement countries, including information on their rights as disabled persons and what services and facilities are available nationally.

> Ensure that special procedures are in place for resettling refugees with disabilities, including pre-departure screening, counseling and special travel arrangements and that refugees with disabilities and their families have access to this information.

> Ensure that refugees with disabilities and their families are assisted on arrival in resettlement countries and given full information on how to access medical, educational, rehabilitation, training and employment services on arrival in the resettlement country.

> Review individual country resettlement policies to ensure that they do not discriminate against refugees with disabilities (e.g., by imposing discriminatory health criteria) and that they are in full compliance with the UN Convention on the Rights of Persons with Disabilities.

> Review and revise UNHCR's policy on the resettlement of refugees with disabilities as articulated in the 2004 Resettlement Handbook. In particular, provide additional guidance on policies and procedures for the individual and group resettlement of refugees with disabilities, including issues of family reunification, pre-departure screening, special travel arrangements and arrangements on arrival in the resettlement country.

Resources:

UNHCR. (2004). *Resettlement handbook.* Geneva: UNHCR. http://www.unhcr.org/cgi-bin/texis/vtx/protect?id=3d4545984.

UNHCR. (2003). *Agenda for protection,* 3rd ed. Geneva: UNHCR.

UNHCR. (1996). *Handbook: Voluntary repatriation: International protection.* Geneva: UNHCR. http://www.unhcr.org/publ/PUBL/3bfe68d32.pdf.

ACRONYMS AND ABBREVIATIONS

CBO	Community-based organization
DPO	Disabled persons' organization
IASC	Inter-Agency Standing Committee
ICRC	International Committee of the Red Cross
IDP	Internally displaced person
INEE	Interagency Network for Education in Emergencies
NGO	Nongovernmental organization
ProGres	Profile Global Registration System
RSD	Refugee status determination
UN	United Nations
UNHCR	United Nations High Commissioner for Refugees

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