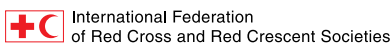
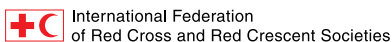




Guidance Note on Disability and Emergency Risk Management for Health



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Introduction

An estimated 15% of the world's population live with some form of disability (1), yet they are among the most vulnerable and neglected in any type of emergency (see Box 1 for definitions of relevant terms). Evidence gathered from previous events shows that people with disabilities are disproportionately affected and experience particularly high rates of mortality and morbidity (2). The United Nations *Convention on the Rights of Persons with Disabilities* (CRPD) Article 11 (on situations of risk and humanitarian emergencies) calls upon States Parties to take “all necessary measures to ensure the protection and safety of persons with disabilities in situations of risk, including situations of armed conflict, humanitarian emergencies and the occurrence of natural disasters” (3).

This guidance note is intended primarily for health actors working in emergency and disaster risk management (hereafter 'emergency risk management') at the local, national or international level, and in governmental or nongovernmental agencies. People with disabilities, those working in the disability sector and those working in other sectors that contribute to improved health outcomes related to emergency risk management, may also find this guidance note useful.

It is a short, practical guide that covers actions across emergency risk management such as risk assessment, prevention (including hazard and vulnerability reduction), preparedness, response, recovery and reconstruction. It outlines the minimum steps health actors should take to ensure that specific support is available for people with disabilities when needed and to ensure that disability is included in the development and implementation of general health actions in all emergency contexts, that is, natural and technological hazards, epidemic diseases and other biological hazards, and conflicts and other societal hazards. This dual strategy – of both mainstream and specific support – will help ensure that the long-term needs of the community are met (4).

Section 1 of this document provides an overview of the impact of emergencies on people with disabilities and describes the principles that should underpin practical action related to emergencies. Recognizing that disability is a multisectoral issue, Section 2 outlines the minimum actions required across sectors/clusters^a and specific disability-related actions that can be undertaken by health actors working in different areas of health care provision such as injury prevention and trauma care, mental health and psychosocial support, and child health to ensure inclusion of disability. The guidance note is supported by a series of annexes that provide further details and checklists to assist actors in conducting assessments and in the design and delivery of programmes and services that address the needs of people with disabilities who are at risk of emergencies.

^a International aid agencies commonly coordinate sectors according to the 'cluster' approach (5).



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1. Why programming for disability matters

Across the world, people with disabilities face widespread barriers to accessing services such as health, education, employment and transport. These barriers include inadequate policies and standards, lack of provision, lack of accessibility, negative attitudes, inadequate information and communication, inadequate funding, and lack of participation in decisions that directly affect their lives. As a result, people with disabilities have worse health and socioeconomic outcomes than people without disabilities, including poorer health, lower education achievements, less economic and social participation and higher rates of poverty (1).

While disability correlates with disadvantage, not all people with disabilities are equally disadvantaged. People with more severe impairments often experience greater disadvantage (1). In some contexts, women with disabilities, children, older people and people with mental health conditions and intellectual impairments experience more discrimination and exclusion than other people with disabilities (6,1). Emergencies in particular can increase the vulnerability of people experiencing disability. Statistics following the earthquake and tsunami in Japan in 2011 showed that the fatality rate for people with disabilities who were registered with the government was 2.06% while that for the general population was 1.03% (7).

People with visual, hearing and intellectual impairments and severe mental health conditions and those who are socially excluded or living in institutions may be unprepared for events that lead to emergencies, and may not know or understand what is happening. Inappropriate modes of communication for those who may have difficulties in hearing, seeing or understanding can exclude them from receiving critical information about emergencies. In emergency situations, people with disabilities may be less able to escape from hazards, may lose essential assistive devices such as spectacles, hearing and mobility aids and/or medications, or may be left behind when a community is forced to evacuate (2,8,9). They may also have greater difficulty accessing basic needs, including food, water, shelter, latrines and health-care services (8,9).

Emergencies may also reduce the capacity of caregivers and care settings such as residential homes to provide for and support people with disabilities. The vulnerability of children and older people with disabilities becomes even more acute during emergencies

when they are separated from their families, and traditional caring mechanisms in the community such as the extended family and neighbours break down (10). People with disabilities can also face higher risks associated with safety, protection and dignity; they may be particularly vulnerable to violence, exploitation and sexual abuse (11).

1.2 Emergencies can increase the number of people who experience disability

Emergencies also create a new generation of people who experience disability due to injuries, poor basic surgical and medical care, emergency-induced mental health and psychological problems, abandonment, and breakdown in support structures and preventive health care (9,15,16). Untreated or inadequately treated injuries can lead to unnecessary deaths and severe and long-lasting impairments (9,17). Estimates from some countries suggest that up to one quarter of disabilities may be associated with injuries and violence (18). It is estimated that for every child killed as a result of violent conflict, three are injured and permanently impaired (11). Natural disasters can lead to injuries due to buildings and other structures collapsing, flooding, dust, broken glass, electrocution and flying debris. Violence and conflict can lead to injuries from rape, torture and the use of weapons such as anti-personnel mines, and cluster munitions (19,20).

Box 1: Terminology

Disability

The *International Classification of Functioning, Disability and Health* (ICF) regards disability – or difficulties in functioning – as neither purely biological nor purely social, but instead the interaction between health conditions and environmental and personal factors (12). Disability can occur at three levels:

- impairment in body function or structure such as a cataract that prevents the passage of light and the sensing of form, shape, and size of visual stimuli;
- limitation in activity such as the inability to read or move around;
- restriction in participation such as exclusion from school.

People with disabilities

The United Nations *Convention on the Rights of Persons with Disabilities* states that “persons with disabilities include those who have long-term physical, mental,

intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others” (3). People with disabilities may include, for example, people who use wheelchairs, people who are blind or deaf, people with intellectual impairments or people with mental health conditions, as well as people who experience difficulties in functioning due to a wide range of health conditions such as chronic diseases, infectious diseases, neurological disorders, and as a result of the ageing process (1).

Emergencies

Emergencies are a type of event or incident that requires action, usually urgent and often non-routine. Emergencies are due to natural hazards (such as earthquakes, cyclones, forest fires, floods, heat waves and droughts), epidemic and pandemic diseases, transport crashes, building fires, chemical, radiological and other technological hazards, food insecurity, conflicts, and situations such as mass gathering events. Disasters can be considered large-scale emergencies that result in “a serious disruption of the functioning of a community or a society involving widespread human, material, economic or environmental losses and impacts, which exceeds the ability of the affected community or society to cope using its own resources” (13).

Emergency risk management

The term 'emergency risk management', sometimes called 'disaster risk management', refers to the systematic process of using administrative decisions, organization, operational skills and capacities to implement strategies, policies and coping capacities of the society and communities to lessen health consequences and improve health outcomes from hazards and related emergencies and disasters (13). Capacities encompass policies, legislation, human and financial resources, planning and coordination mechanisms, information management, risk assessment, infrastructure and logistics, service delivery, and capacity development for preventing hazards, reducing vulnerability, implementing emergency preparedness, response, recovery and rehabilitation of affected countries and communities (14). In order to simplify the guidance provided in this note, actions are described as follows:

- before: includes community and national emergency risk assessments, hazard and vulnerability reduction, and preparedness;

- during: the emergency response;
- after: covers recovery, rehabilitation, reconstruction and transition to comprehensive services, including actions to reduce the risk of future events.

Injuries resulting from natural disasters and conflict include: single, multiple or complex fractures; burns; wounds; spinal cord injuries; amputations; and traumatic brain injuries. These can result in physical and/or cognitive limitations due to neurotrauma; sensory impairments such as blindness and deafness; and mental and psychological problems such as depression, anxiety and post-traumatic stress disorders (18,21).

The impact of an increased number of people experiencing disability in the community can be long term and far reaching, creating overwhelming pressure on health and social sectors. Timely and appropriate health care can significantly reduce future disability. However, health care systems are often disrupted in an emergency and have a reduced capacity to provide continuity of care or treat people with both pre-existing chronic health conditions and acute health conditions that arise as a result of an emergency. Inadequate management of victims of emergencies can result in long-term detrimental physical, psychological, economic and social outcomes for individuals and their families (9).

1.3 How risks of emergencies are managed affects people with disabilities

Despite the increased risk and impact of disability, the basic and specific needs of people with disabilities are frequently ignored or overlooked in emergency risk management (11).

1.3.1 Identification

People with disabilities are often not identified before, during and after an emergency. Lack of disaggregated data and systematic identification of people with disabilities results in their 'invisibility' during risk and needs assessments, including those carried out during the recovery phase. This may be even more challenging for people with disabilities among evacuated or displaced communities. As a result they may not have the opportunity to participate in and benefit from vulnerability reduction and preparedness measures. If unidentified and unregistered, people with disabilities also fail to receive a range of services, including their basic entitlements to food, water, shelter and clothing (2,9,22–24).

1.3.2 Consultation or representation

People with disabilities are often not consulted or represented in emergency risk management, and are often excluded from community management and leadership structures (10). As a result they are often not consulted or represented in the design of emergency programmes, hence their needs are overlooked. In longer-term recovery and risk-reduction projects, people with disabilities are often excluded from mainstream rebuilding, livelihood and education programmes. Furthermore, coordination mechanisms lack disability representation and leadership, which also affects the sharing of information.

1.3.3 Specific supports

The needs of people with disabilities may not be met without consideration of specific support categories. In most instances people with disabilities have needs that are not necessarily related to their impairments and therefore require equitable access to the same services that are available to the general population, i.e. general health care services. However, in emergency contexts some people with disabilities may require specific types of support such as additional clothing or blankets for those who are vulnerable to the cold or unable to move, medical devices such as catheters for people with spinal cord injuries, and medicines to manage or treat health conditions such as epilepsy. Without appropriate allocation and provision of infrastructure, human resources and funding, the total needs of people with disabilities are unlikely to be met.

1.3.4 Knowledge and skills

Staff and volunteers are often uncertain about how to engage with people with disabilities. In addition, carers of people with disabilities may lack knowledge and information about the appropriate and effective actions they could take in emergency contexts to support people with disabilities, particularly in resource-poor settings. Field surveys have identified a lack of confidence and competence among emergency staff about how to appropriately identify, register, treat and engage people with different types of impairments, as well as communication difficulties between medical staff and people with disabilities (10). Negative attitudes toward people with disabilities may also significantly affect decisions about who is prioritized during emergencies when resources and time are scarce.

1.3.5 Engagement

Actively engaging people with disabilities in emergency risk management can significantly reduce their vulnerability and enhance the effectiveness of policies and practices (1,4,11,25). Opportunities exist to build on available disability-related resources, involve disabled people's organizations (DPOs), promote self-help and raise disability awareness, understanding, skills and confidence among all health actors (1,3,4,26–28).



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2. Programming for disability across all sectors with specific reference to health

Disability, emergency risk management and health are multisectoral issues. Annex 1 provides an overview of common functions and actions that need to be taken across all sectors/clusters to include, assist and support people with disabilities. These functions are relevant across the breadth of emergency risk management, and are organized according to the evolving global framework on emergency risk management for health (14), the WHO health system strengthening framework and other guidance (16). Core principles to guide multisectoral emergency risk management for people with disabilities are given in Box 2. The following section elaborates on these principles with more specific references to what health and disability actors need to do to increase the effectiveness of emergency risk management for people with disabilities, and influence their overall health outcomes.

2.1 Policies, legislation and strategies

Good governance is required before, during and after emergencies to ensure integrated action on disability and emergency risk management. Disability equality can be achieved by developing and strengthening national-level governance, accountability and oversight of disability in all relevant health and multisectoral policies, strategies, legal frameworks, capacity development plans, standards and services (30,31). Health actors can work with people with disabilities and DPOs to advocate for and contribute to the development and implementation of policies, laws, standards and programmes to prevent discrimination and promote disability equality across all sectors and in all aspects of emergency risk management for health.

Box 2: Core principles to guide disability-inclusive emergency risk management

The four principles listed below should be used to guide the design and implementation of all disability-inclusive emergency risk management measures. They are drawn from the principles outlined in the *Sphere Handbook* (29) and the United Nations *Convention on the Rights of Persons with Disabilities* (3).

Equality and non-discrimination

Emergency risk management should be inclusive of all those in need, particularly those who are most vulnerable, such as people with disabilities (29). Discrimination on the basis of disability “means any distinction, exclusion or restriction on the basis of disability which has the purpose or effect of impairing or nullifying the recognition, enjoyment or exercise, on an equal basis with others, of all human rights and fundamental freedoms. It includes all forms of discrimination, including denial of reasonable accommodation”^b.

Accessibility

People with disabilities should have “access, on an equal basis as others, to the physical environment, to transportation, to information and communications, including information and communications technologies and systems, and to other facilities and services open or provided to the public, both in urban and rural areas” (3).

Participation and dignity

People with disabilities have the right to participate in the assessment, design, implementation and monitoring of emergency programmes; make their own choices; and be recognized and respected as equal citizens and human beings with a contribution to make before, during and after an emergency.

b “Reasonable accommodation” means necessary and appropriate modification and adjustments not imposing a disproportionate or undue burden, where needed in a particular case, to ensure to persons with disabilities the enjoyment or exercise on an equal basis with others of all human rights and fundamental freedoms (3).

Resourcefulness and capacity

Many people with disabilities have existing resources and capacities to make meaningful contributions to emergency risk management. They also have the right to receive support and assistance to develop the skills, knowledge and capacities required to prepare and protect themselves from hazards, and to maximize their ability for survival and recovery following an emergency.

2.2 Resource management

2.2.1 Financial resources

Sustainable funding is required to maintain and increase access to health services for people with disabilities at the local level, and to support the development of disability-related policies and strategic frameworks at the national level.

Specific or additional measures for people with disability may be neglected unless dedicated funding is available for all aspects of emergency risk management. Planning based on disability-inclusive assessments before, during and after an emergency is required to ensure that funds are allocated for disability-related activities within budgets and emergency funding appeals.

Financing will be needed in all aspects of emergency risk management to provide:

- additional resources for risk assessments and needs assessments, including collecting disaggregated data on disabilities in the population-based assessments;
- specific medication, assistive devices and non-food items for people with disabilities;
- transport for people with disabilities to health facilities;
- referral services to specialist clinics and professionals;
- outreach activities in communities, shelters and camps;
- referral and hospital discharge planning, assistance and follow-up;
- community-based rehabilitation (CBR) services which should be planned and financed at an early stage;
- training and sensitization of staff, volunteers, community workers and DPOs;
- construction and reconstruction of structures that are accessible to people with disabilities before, during and after emergencies;
- innovation and research in the design of shelters, health facilities and other structures and services that are accessible to people with disabilities before, during and after emergencies.

2.2.2 Human resources

Lack of awareness about disability and uncertainty about effective actions are common among staff and volunteers from all sectors (6,11). People working in the area of disability may lack experience in emergency risk management, while emergency teams may lack knowledge about the rights of persons with disabilities, have limited staff who have the expertise to provide appropriate services for people with disabilities, or be unaware of local specialist disability services and therefore fail to make referrals (10). Increasing the disability knowledge and awareness of staff and volunteers across different sectors/clusters is best implemented during routine hazard and vulnerability reduction, emergency preparedness and early recovery programmes. However, even in the acute emergency phase, staff and volunteers can be briefly oriented and sensitized to priority disability issues and needs.

Before and after an emergency (in emergency risk management and ongoing health and disability programmes^c) it will be important to :

- create a development plan to increase disability knowledge, expertise and skills among staff, community workers and volunteers, e.g. training of mainstream staff and recruitment of specialist staff;
- ensure that the need to demonstrate disability-related experience is included in job descriptions and in performance evaluations;
- provide training for health staff and volunteers in core competencies for disability (see Box 3) and emergency risk management competencies.

Training curricula – new and existing – can be developed based on this guidance note and, wherever possible, supported by people with disabilities. Training could involve, for example, a half-day orientation on core disability competencies (see Box 3) and seminars for health personnel on protocols for specific disabling conditions that may result from or be exacerbated by emergencies (see Annex 4).

During an emergency it will be important to:

- include rehabilitation professionals in emergency teams as soon as possible to ensure that rehabilitation needs are identified and addressed as early as possible;
- recruit additional staff with expertise in disability to provide technical support on how to assist people with disabilities and adjust existing or new health services so that they are accessible to people with disabilities;

c This section is drawn from the WHO *Toolkit for assessing health-system capacity for crisis management*; the American Medical Association's *Core competencies for disaster medicine and public health*; and the Women's Refugee Commission's Resource kit for fieldworkers (10,30–32).

- provide a short orientation to all staff on disability, giving practical examples of how to support people with disabilities and ensure that health services are accessible to people with disabilities.

Box 3: Suggested core competencies for staff and volunteers regarding disabilities

- Demonstrate knowledge of the key risks and consequences of potential hazards and emergency situations faced by people with disabilities.
- Use accessible communication formats to disseminate information to people with disabilities.
- Demonstrate non-discriminatory attitudes and practices towards people with disabilities.
- Demonstrate an understanding of both the general and specific needs of people with disabilities.
- Deliver services using appropriate reasonable accommodations where required for people with disabilities.
- Demonstrate awareness of the resources available for people with disabilities, e.g. specialist clinics, and the referral systems in place to access these resources.
- Demonstrate knowledge and awareness of the rights of people with disabilities, e.g. in health care settings ensure privacy (especially for women), patient confidentiality, and informed consent by the patient or their guardian (in the case of children).

Training courses are unlikely to be possible during the acute phase of an emergency. However, even a short briefing can raise the awareness of staff and reduce risks to people with disabilities and may improve the quality of services provided. Briefings could include, for example, an outline of:

- access issues, e.g. physical access to facilities and accessible modes of communication;
- needs that may be specifically related to people with disabilities, e.g. the need for assistive devices, medication, appropriate positioning and bedding, and protection from violence such as sexual violence.

As soon as the situation has stabilized, further training as described above can begin.

2.3 Planning and coordination

The multisectoral and multidisciplinary nature of emergency risk management, disability and health requires leadership and coordination within and across sectors and government ministries at all levels – community, sub-national, national and international. The type of coordination mechanism will depend on the country context. The responsibility for disability in some countries may rest with the ministry of health, in others with the ministry of social welfare. Intersectoral emergency or disaster risk management committees and a disaster risk management agency are present at national, sub-national and local levels in most countries. Health sector coordination mechanisms and units are also required to coordinate health emergency risk management policies, assessment, planning and implementation and to facilitate interaction with other sectors. International coordination mechanisms typically address disability as a cross-cutting issue across the clusters and within funding mechanisms such as Consolidated Appeal Processes, including 'flash appeals' (33).

Coordination mechanisms must be in place to enable actors from different sectors to meet and coordinate disability-related plans and actions. In large-scale emergencies where a number of actors may have specific responsibility for disability, a single, intersectoral disability coordination group should be established with clear terms of reference. The leadership and membership of the coordination group should reflect the local organization of the disability sector. The lead agency should be knowledgeable about disability and skilled in inclusive coordination approaches to avoid dominance by a particular approach or sector. Intersectoral disability coordination group meetings would ideally be co-chaired by stakeholders from both health and social welfare/protection sectors and led by the relevant government ministry, or from community-level services with United Nations High Commissioner for Refugees in refugee situations.

In emergencies that are smaller scale, disability is usually an integrated component in various sectoral and individual agencies' responsibilities and therefore disability focal points should be established in each sector/cluster. Members of focal points can meet regularly and promote inclusion of disability issues within their given sectoral coordination mechanisms, and through processes to facilitate communication and referral across sectors.

2.4 Information and knowledge management

2.4.1 Health information management

Information management is a major challenge for both disability and emergency risk management. Therefore, established health information systems (HIS) at national,

sub-national and community levels, which have public health data on disability, can be advantageous to inform assessments and the design and delivery of programmes before and after emergencies, and to provide a foundation for information management during an emergency.

A disability-inclusive HIS should include, where feasible:

- protocols and procedures for the collection, analysis, interpretation and use of disability-related public health data (29);
- data on people with disabilities, disaggregated by age, sex and nature of disability (where possible, associated health conditions identified) and details of their location;
- an injury surveillance system based on relevant WHO injury classifications that include data markers to enable people with disabilities to be readily identified;
- mechanisms for sharing non-confidential public health data about disabilities in an accessible format with relevant government authorities, coordination groups and sectors.

Other important information to assist the planning and delivery of disability-inclusive health services in preparation for emergency situations might include data on the type and quantity of treatment, equipment (including assistive devices) and support that has been or is currently provided to people with disabilities. Information regarding issues that have arisen in previous emergency situations such as misdiagnosis and mistreatment of people with disabilities, unwarranted medical interventions such as amputations, and poor fracture care and wound management resulting in permanent impairments could also be used to improve the quality of care.

2.4.2 Assessments

Assessments across all phases of emergency risk management should consider disability issues. Despite progress in risk and needs assessments, there remains a serious deficit in data collection and analysis for both the health emergency risk management and the disability fields. Therefore, it is more realistic to assume that the guidance presented here is adapted to local circumstances than to expect that comprehensive disability-inclusive assessments can be implemented.

Coordination of assessments on disability is needed to:

- determine first what assessments have already been done on health and disability, compile information from existing assessments and carry out further field assessments on disability to fill key information gaps;

- plan what kind of information on disability should be collected, when, where, how and by whom;
- provide a common understanding of disability to make data comparable (see ICF in Box 1);
- compile data on different aspects of disability, which is typically collected by different organizations in a range of geographical areas;
- share analyses and outputs to provide a common basis for planning of actions by all organizations.

People with disabilities, their family members/caregivers and/or their representative organizations should be engaged in assessment processes at the earliest opportunity. The first-hand experience of people with disabilities can help to identify issues that are particularly relevant to them, reduce any negative impact the assessment/survey itself may have, and provide valuable advice on how to make data collection and related reports accessible to people with different types of impairments. These strategies can help to overcome the exclusion of people with disabilities in some communities that either do not include them or deny their existence.

Those who are responsible for coordination of assessments for disability should ensure as far as possible that the information outlined in Annex 2 is available for the areas at risk or affected by an emergency.

Before an emergency

National, sub-national and community emergency risk assessments are usually conducted as a multisectoral activity under the auspices of the entity responsible for coordination of emergency management in a particular jurisdiction, for example the national or local disaster management agency. The health sector usually participates in these assessments and may also conduct health emergency risk assessments. Risk assessment should be used as a basis to inform all actions in emergency risk management. Information on disability from routine health surveys and disability risk assessments (including people with disabilities and older people living in institutions), resource mapping and baseline studies should be utilized for emergency risk assessments. The use of participatory, community-based approaches is strongly encouraged: it is important to ensure that people with disabilities, their support persons, and/or representative organizations are included in national and sub-national disaster policy and decision-making processes, including risk assessments (4,6,34–36).

Pre-disaster multisectoral and health emergency risk assessments should include disability because they help to:

- identify people with disabilities in a community;
- identify pre-existing vulnerabilities, relevant resources and infrastructure in a given area and gaps in services for people with disabilities, as well as opportunities for strengthening capacities;
- identify the geographic areas, sub-populations and groups in which the risks to people with disabilities are the greatest;
- identify in advance the physical, social, economic and other barriers that increase risks for people with disabilities or affect their access to services in emergency contexts, and ways to minimize or overcome these;
- support and promote the knowledge and resources that people with disabilities have to reduce their vulnerabilities and risks, and increase their safety at an individual and community level;
- identify and facilitate the inclusion of people with disabilities in early warning mechanisms and response planning, increasing the appropriateness, inclusiveness and effectiveness of the plans;
- provide more detailed, disaggregated baseline data to inform assessments during an emergency when information is more difficult to obtain (where applicable, assessment should be integrated with health information systems);
- raise awareness and knowledge regarding disability among mainstream emergency and health actors and generate a shared commitment to inclusive practice (1,4,22–25,34,35,37).

Risk assessments should ensure that the risks for people with disabilities in migrant, mobile and hard-to-reach populations are also identified. Assessments will be aided by identifying those people with disabilities in registration systems for evacuees or displaced people at the source, in transit or at destination locations.

During an emergency

Emergency assessment guidance and tools have generally contained very little reference to disability (29); however, existing tools can be adapted to include disability-relevant information (see Annex 3). The development of any new tools should be inclusive of disability.

Assessments during the initial phase of an emergency situation must be as short as possible. They will rely on qualitative rather than quantitative data, and may have limitations in terms of:

- logistical constraints;

- time constraints;
- limited accessibility to affected areas;
- sampling method, which is usually purposive, hence preventing generalization of quantitative data.

Given the challenges with making rapid assessments, detailed information on disability may not always be collected and available to substantially influence programmes early in an emergency. In fact, most assessments that focus on disability are conducted several weeks or even months after a major sudden-onset emergency.

Where possible, key disability-related questions should be integrated into national and global multisectoral emergency rapid-assessment tools (see Annex 3). For example, questions related to people with disabilities are included in the global Inter-Agency Standing Committee's Multi-Cluster/Sector Initial Rapid Assessment (MIRA) (38) – a standardized intersectoral assessment tool used to: provide a rapid overview of emergency situations; help identify the impacts of the emergency; make initial assessments of need; and define priorities for action in the early weeks of the response. National tools are generally similar in scope and purpose to the MIRA and therefore could also be adapted to ensure that they are inclusive of disability. Disability should also be increasingly integrated in the more detailed assessments by sectors as the emergency evolves and population needs change.

After an emergency

Multisectoral and sectoral in-depth surveys may be carried out once essential high-priority responses have been implemented in order to adapt and improve an ongoing health response and to inform the design of early recovery and CBR programmes.^d A detailed, participatory understanding of the needs and capacities of people with disabilities can lead to, for example, health services and facilities designed for equal access, health information in accessible communication formats, inclusive policies, training and sensitization of doctors and health staff, public awareness and reduced discrimination (40).

Another tool at the global level that could be used and adapted is the Global Health Cluster's Health Resource Availability Mapping System (HeRAMS) (41), which supports the collection and analysis of data to promote good practice in mapping health resources and services. HeRAMS provides a health services checklist by level of care and by health sub-sector for health facility/mobile clinic/community-based services at each point of delivery.

Post-disaster and post-conflict needs assessments are required for longer-term recovery planning. They should also be inclusive of the needs of people with disabilities in order to

^d See also the Humanitarian emergency settings perceived needs scale (HESPER) (39).

maximize opportunities to strengthen systems and services for people with disabilities as well as measures to reduce their personal risks associated with future events (42).

2.4.3 Communication

The availability, accessibility and continuity of communication must remain a priority during all emergency risk management activities across all sectors and disciplines. All forms of communication, including risk communication, early warning, evacuation procedures and response plans, must be accessible to people with disabilities.

Communication mechanisms must be in place to provide information regarding the accessibility and availability of services before, during and after an emergency. The provision of these services prior to an emergency is critical, both as a place of support as well as an opportunity to raise awareness and facilitate organization and individual ownership in reduction of risks at community and individual levels.

All actors must ensure that communication formats are accessible and timely for people with a range of impairments, including visual, hearing and intellectual. Accessible communication formats may include sign language, pictures, plain language, speaking slowly, demonstrating actions rather than describing them, audio, Braille and large print.

2.5 Infrastructure and logistics

2.5.1 Health facilities, shelters and settlements

People with disabilities often experience barriers that inhibit their access to appropriate health care facilities and shelters before, during and long after an emergency. Appropriate planning, design and development is required to ensure that health facilities shelters and settlements are accessible to people with disabilities, and contribute to meeting their health, safety, security and social participation needs.

Often access barriers that exist prior to an emergency are further exacerbated after an emergency. Therefore, where feasible, the design of new and modification of existing health facilities and shelters should be done prior to the onset of an emergency. When planning for health facilities and both permanent and temporary shelters, universal design features should be considered and incorporated to the maximum extent possible to facilitate access by all people experiencing disability, including elderly people.

The design, reconstruction and replacement of health facilities after emergencies provides an opportunity to ensure that they are “built back better” to facilitate access for people with disabilities for both routine care and emergency situations.

2.5.2 Health supplies and logistics

Routine procedures for the provision of essential drugs and medical supplies can be adapted to ensure that items required by people with disabilities, including older people and people with chronic diseases, are included in essential medicine and equipment lists, emergency health kits and stockpiles. More specifically, the following actions can be taken:

- Include supplies that may be required by people with disabilities in national and international lists and kits, such as standardized essential medicines and equipment lists, and emergency health kits. For example, relevant items for people with disabilities could be included in the *WHO Essential Emergency Equipment List*.^e
- Identify requirements for health supplies in emergencies based on a needs assessment that includes the needs of people with disabilities.
- Check that health supplies are available in sufficient quantities for both routine and surge requirements during an emergency. These should include, for example, medication for health conditions such as juvenile diabetes, hypertension, heart failure, epilepsy, psychosis and depression; non-food items such as bed sheets, cushions, mattresses, mirrors, hygiene kits and adapted cooking and eating utensils; and equipment such as assistive devices, bed pans and catheters.
- Establish a safe interim/emergency supplies depot for essential medications, non-food items and equipment.

2.6 Service delivery

Not all the health needs of people with disabilities relate to their impairments. While they may have specific needs associated with their disability, like everyone else they also have general health needs for which they require access to the same services that are available to the general population. People with disabilities are also a heterogeneous group with a range of capacities and needs that may require different types and amounts of support to ensure their inclusion (29).

Services should reach people with disabilities where they reside – in evacuation shelters, camps, houses, institutions and residential schools. A variety of approaches can be used within mainstream settings to overcome the barriers (e.g. physical, communication and information barriers) that people with disabilities may experience when trying to access these services. Reasonable accommodation as defined in Article 2 of the CRPD (3) is one common approach.

e See WHO's *Integrated management for emergency and essential surgical care toolkit* (17).

Annex 4 provides an overview of the actions that health actors can take to ensure that health services in emergency risk management:

- are accessible to people with disabilities;
- meet the specific needs associated with their disability
- prevent avoidable health conditions.

This guidance on integrating disability-related issues in to mainstream health services for emergency risk management should be used in conjunction with overall guides and standards for the health sector, e.g. *The Sphere Project* (29). Many of the actions listed for emergency risk management, including response, are adapted from routine good practice in ongoing and development health work, including for people with disabilities.

Annex 5 provides an overview of some of the emergency risk management actions that can be taken to ensure that services in other sectors/clusters are inclusive of people with disabilities.

2.7 Community capacities

Many actions described in this guidance are implemented at the community level where people with disabilities at risk of emergencies reside and, hence, where building the capacities for managing risk should be focused. Within the health sector, emergency risk management should focus on mobilizing communities to ensure that health services are available and accessible to people with disabilities at all phases of an emergency. Community mobilization requires multidisciplinary efforts, whereby actors communicate and collaborate with one another to strengthen community capacity and resilience. The health sector should carry out or contribute to risk assessments at the community level and ensure that these assessments consider the general principles outlined in Section 2.4; risk assessments carried out at the community level provide a good opportunity to collect more specific information on individuals or groups of people with disabilities and their personal circumstances. These assessments can inform the design and implementation of local programmes to ensure that the needs of people with disabilities in the community are addressed before, during and after emergencies. The health sector should encourage and assist individuals with disabilities and their support networks to take responsibility for their health before, during and after emergencies through, for example, individual and household measures such as personal action plans for early warning, evacuation and emergency situations. The health sector should also ensure that risk awareness programmes are inclusive of people with disabilities, that adequate support services such as self-help groups are in place within communities, and that the role of DPOs is encouraged and strengthened.



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Conclusion

The United Nations *Convention on the Rights of Persons with Disabilities* (CRPD) provides an agenda for change for all persons with disabilities, and specifically notes the requirement for States Parties to ensure the protection and safety of persons with disabilities in situations of risk, including armed conflict, humanitarian emergencies and natural disasters (3). The purpose of this guidance note is to highlight the needs of people with disabilities during emergency situations and to point out the health-related actions that are required across the emergency risk management continuum to ensure that both mainstream and specific forms of support are available and accessible to people with disabilities. This guidance note draws attention to the need for concerted and inclusive actions before, during and after emergencies in order to manage the health risks for people with disabilities. While the guidance note focuses on the health sector, it also recognizes the need for action across all sectors and the commitment and involvement of a range of stakeholders at the local, national and international levels, working together to ensure optimal outcomes for people with disabilities and their families. A summary checklist of essential considerations based on the content of this document is included in Annex 6 as an *aide-memoire* for users.



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Annex 1

Multisectoral functions and emergency risk management actions for people with disabilities

Common functions across all sectors	Key emergency risk management actions for people with disabilities
Policies, legislation and strategies	<ul style="list-style-type: none"> • Include disability in emergency risk management policies, legislation, strategies and programmes. • Include emergency risk management in disability policies, legislation, strategies and programmes. • Engage people with disabilities and disabled people’s organizations (DPOs) in the development, implementation and monitoring/evaluation of policies, legislation, strategies and programmes. • Apply a human rights framework in policies and practices to support people with disabilities and to prevent all forms of discrimination.
Resource management: financial resources	<ul style="list-style-type: none"> • Include dedicated funding for services, programmes and capacity development to address the needs of people with disabilities in all aspects of emergency risk management.
Resource management: human resources	<ul style="list-style-type: none"> • Where feasible, identify and recruit staff and volunteers who have knowledge about disability and local culture. • Consider people with disabilities for roles in emergency risk management. • Organize orientation and training of relevant staff and volunteers in disability-related issues, including the delivery of information in accessible formats. • Enforce staff codes of conduct and ethics, including those specifically addressing the rights of people with disabilities.
Planning and coordination	<ul style="list-style-type: none"> • Facilitate disability sector participation, input and ownership in planning and coordination for multisectoral emergency risk management.

Common functions across all sectors	Key emergency risk management actions for people with disabilities
	<ul style="list-style-type: none"> • Establish multisectoral coordination mechanisms for disability involving people with disabilities and representatives from the disability sector for all aspects of emergency risk management. • Facilitate inclusion of emergency risk management actors from all relevant sectors in disability sector coordination mechanisms. • Involve people with disabilities in decision-making in all aspects of emergency risk management. • Address disability considerations in planning across all aspects of emergency risk management.
<p>Information and knowledge management (including assessments and communication)</p>	<ul style="list-style-type: none"> • Include disability issues in all information management systems to ensure that data used to inform policy and practice are relevant to people with disabilities. • Establish community-level disability registers to identify people with disabilities and their particular needs before, during and after emergencies. • Gather information about local disability support services, programmes and networks. • Integrate disability in assessments for all aspects of emergency risk management, including gathering of disability-disaggregated data. • Include people with disabilities and representatives from DPOs in participatory assessments and analyses, and in monitoring, evaluation and reporting of programme impact. • Provide information, using accessible formats (e.g. sign language, Braille, pictures, large print), to people with disabilities on risks, emergency impacts, response and recovery efforts (including support available) and their rights. • Adapt early warning communication systems and media to ensure that they reach and are understood by people with disabilities. • Identify local or community members who can assist with communication (e.g. interpreter for people who are deaf). • Link with local DPOs to disseminate accessible information to people with disabilities about such things as hazards, risks, emergency preparedness and the availability of services.

Common functions across all sectors	Key emergency risk management actions for people with disabilities
Infrastructure and logistics	<ul style="list-style-type: none"> • Apply accessibility considerations in site planning, design and the development of facilities (such as hospitals and shelters) to ensure safety, service provision, dignity and ease of use for people with disabilities. • Stock supplies and equipment, including assistive devices, for people with disabilities in inventories, emergency kits and logistics systems.
Service delivery	<ul style="list-style-type: none"> • Ensure that people with disabilities have access to mainstream services across all sectors that are available for the general population. This will require that infrastructure and information are accessible with reasonable accommodations made where necessary. • Ensure that people with disabilities have access to specialized services across all sectors that meet their specific requirements/needs.
Community capacities	<ul style="list-style-type: none"> • Establish links between people with disabilities and local disability groups and ensure their inclusion in all aspects of emergency risk management. • Raise awareness among people with disabilities, their support networks and relevant disability organizations about the need to take responsibility at an individual and community level to reduce risks. • Support people with disabilities to develop personal emergency action plans that include, for example, means of evacuation and action required when medication, assistive devices or support networks are lost. • Encourage the development of support mechanisms in the community for people with disabilities, e.g. support/self-help groups, the role of DPOs in emergency risk management. • Facilitate the reunification of people with disabilities and their carers as soon as possible following an emergency, and provide appropriate community support when support systems breakdown or are limited, e.g. volunteer assistance. • Design community-based recovery with the participation of people with disabilities, building on their experience, resources and needs.

Annex 2

Summary of information for disability-inclusive risk and needs assessments^f

Type of information	Examples	Sources of Information
Relevant demographic and contextual information	<ul style="list-style-type: none"> • Prevalence of disability and main health conditions associated with disability • National policies and human rights frameworks • Social, political, religious and economic structures and dynamics pertaining to disability • Basic ethnographic information on cultural resources, norms, roles and attitudes to different types of disability • Areas at high risk for emergencies from all causes, including natural and technological hazards and conflicts 	<ul style="list-style-type: none"> • National registries • Health information systems • International databases • Governmental websites
People with disabilities' perception and experience of emergencies	<ul style="list-style-type: none"> • Perceptions that people with disabilities have of risks, vulnerabilities, capacities and resilience • Expected consequences of emergencies • Experiences of past emergencies, including ways people with disabilities have dealt with adversity 	<ul style="list-style-type: none"> • Governmental, nongovernmental and non-profit agencies specializing in disability and/or emergency

^f Source: adapted from *Mental health and psychosocial support in humanitarian emergencies: what should humanitarian health actors know?* (1)

Type of information	Examples	Sources of Information
Existing sources of care and support for people with disabilities	<ul style="list-style-type: none"> • Types of assistance available in the community (e.g. health care, social support) • Level of access to services and support for basic physical needs (e.g. health care, food, shelter, water and sanitation) and education • Ways in which people with disabilities are able to help themselves and are assisted by other people 	<ul style="list-style-type: none"> • Governmental, nongovernmental and non-profit agencies specializing in disability (including disabled people's organizations) and/or emergency • Local agencies who provide care to people with mental health and psychosocial problems
Organizational capacities and activities before, during and after emergencies	<ul style="list-style-type: none"> • Structure, locations, staffing and resources for disability: <ul style="list-style-type: none"> – in the health sector (including discharge and rehabilitation) – education and social services – emergency-related disability services • Mapping of potential partners, capacities, disability training and skills, e.g. for rehabilitation • Impact of the emergency on the availability, accessibility and quality of services 	<ul style="list-style-type: none"> • Local and national governmental agencies • Health information systems • Risk assessments and needs assessments • School registries • WHO emergency risk management and humanitarian response webpages¹ • WHO disability and rehabilitation webpages²
Programming needs opportunities, and evaluation	<ul style="list-style-type: none"> • Needs and gaps identified • Recommendations by stakeholders to fill gaps • Extent to which key actions outlined in this guideline are implemented • Functionality of referral systems between and within health and other social, education, community and religious sectors 	<ul style="list-style-type: none"> • Key policy documents, assessments, emergency plans and financing systems • Evaluations, tracking and monitoring systems

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Annex 3

Emergency assessment tools and how they can be used to assess disability^g

The following information should be considered for inclusion in assessments to identify the unmet needs of people with disabilities for different sectors/clusters, as they relate to health.

Population description

- Include people with disabilities as a vulnerable group who are under-served.

Shelter and essential non-food items

- Is available shelter accessible to people with disabilities?
- Is support available to assist people with disabilities who may not be able to build their own shelters?
- Do people with disabilities have enough clothing, bedding, blankets and cooking utensils to meet their needs?
- Do people with disabilities have enough fuel for heating, particularly those people who have difficulty regulating their body temperature?

Water supply, sanitation and hygiene

- Are water supplies accessible to people with disabilities?
- Are functioning toilets accessible to people with disabilities?
- Are people with disabilities receiving items such as soap, mosquito nets and water cans?

Food security and nutrition

- Consider the food/livelihood situation of people with disabilities and ensure that they are identified as a vulnerable group.

^g Adapted from Inter-Agency Standing Committee's Initial rapid assessment form (1). Also refer to the Multi-Cluster/Sector initial rapid assessment (MIRA): provisional version March 2012 (https://docs.unocha.org/sites/dms/CAP/mira_final_version2012.pdf; accessed 28 September 2013).

Health risks and health status

- Are violence prevention and response programmes accessible to and inclusive of people with disabilities?
- Visit institutions for people with disabilities and older people, including hospitals, old age homes and child care institutions, to identify whether people with disabilities have been forgotten or abandoned; are without access to clean water, food or health care; and/or are vulnerable to violence, abuse and exploitation.
- Are children with disabilities routinely included in vaccination programmes?

Health facility/outreach site assessments for health services

- Are health services and facilities physically accessible to people with disabilities, including children with disabilities?
- Are accessible forms of transport available to take people with disabilities to referral centres?
- Review the checklist of services available at the facility or site and verify that there are specific disability checklist items under community care, and secondary and tertiary care levels.
- Are injury care and acute rehabilitation services provided at primary care level? This is particularly important for preventing long-term disability.
- Assess the availability of medications for chronic health conditions, equipment such as catheters and basic hygiene kits for people who are incontinent, and appropriate assistive devices such as wheelchairs and crutches.

Reference: Annex 3

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Annex 4

Health services to support people with disabilities

Core health services	Actions to support people with disabilities
Health care (general)	<ul style="list-style-type: none"> • Map the location and accessibility of health services/facilities for people with disabilities, and use as a basis for emergency-related planning and to improve existing services/facilities. • Facilitate access to health services such as primary health care for people with disabilities. For example, ensure that health facilities are physically accessible, information is available in accessible formats, accessible transportation is available, and systems are in place to prevent the need to queue for long periods. • Facilitate access to specialized health services and assistance for people with disabilities when required, e.g. emergency surgical services, medication and assistive devices. • Where people with catastrophic injuries such as spinal cord injury (SCI), traumatic brain injury (TBI) and severe burns cannot be admitted to the local hospital, arrangements must be made for their referral to alternative and appropriate health services/facilities. • Arrange specialized clinics or regular visits by specialists for people who have specific health conditions or impairments. • Consider alternative models of care, such as outreach care, when it is difficult for people with disabilities to directly access health services/facilities. • Implement measures to prevent secondary conditions for people with disabilities such as pressure sores and comorbidities. • Establish referral systems to ensure people with disabilities who need ongoing treatment or follow-up care (e.g. wound care) are referred to existing health services in community or camp settings. • Provide information on services in accessible formats, and ensure that this information is delivered where possible through outreach to families and disabled people’s organizations (DPOs). • Facilitate community-based early intervention and longer-term rehabilitation programmes, including the reintegration of people with existing or newly acquired disabilities into the community^h.

^h Community-based rehabilitation is an approach to ensure that people with disabilities and their family members are able to access the benefits of the health, education, livelihood and social sectors (1).

Core health services	Actions to support people with disabilities
Child health	<ul style="list-style-type: none"> • Design health education messages to help community health workers and parents understand the benefits of early intervention for children with disabilities in both existing and emergency situations. • Facilitate access to early intervention, including early childhood development and addressing the child’s cognitive, social, emotional and physical development. • Ensure that essential medicines for the treatment of childhood health conditions such as epilepsy and juvenile diabetes are available in the appropriate dosages and formulations. • Make sure that children with disabilities have access to prevention and treatment programmes such as the Expanded Programme on Immunization (2) and the Integrated Management of Childhood Illnesses (3). • Screen the nutritional status of all children with disabilities taking into consideration normal variation in children with development delays. Refer to nutritional services as needed conditional on the person’s physical requirements and not necessarily on their age.
Communicable diseases	<ul style="list-style-type: none"> • Include disability considerations and ensure equal access for people with disabilities to existing preventive health services for communicable diseases, i.e. promotion and awareness campaigns, diagnostics, immunization and treatment. • Identify and establish physically accessible sites to ensure that all people who require isolation and treatment of infectious diseases, for example cholera, can be accommodated. • Address any disability-specific considerations while providing care for communicable diseases, e.g. management of pressure sores for individuals who are unable to move and confined to a bed due to an infectious disease.
Injury prevention and trauma care	<ul style="list-style-type: none"> • Raise awareness about injury prevention, including specific hazards associated with unexploded ordnance in conflict contexts. • Assess the availability and quality of trauma and surgical services and rehabilitation expertise and resources. For example, use the WHO situation analysis method to assess emergency and essential surgical care (4).

Core health services	Actions to support people with disabilities
Injury prevention and trauma care (contd.)	<ul style="list-style-type: none"> • Use the assessment information to increase existing capacity where possible and to inform emergency response plans (e.g. establish systems and protocols for the referral of injured patients for advanced care, including surgery, post-operative care and rehabilitation at different levels of the health system, i.e. primary/ community, secondary and tertiary levels). • Ensure that definitive trauma and surgical services and rehabilitation are only provided by agencies with appropriate expertise and resources, or refer patients to relevant specialists. • Train health workers in mass casualty management and ensure that they are able to recognize injuries arising from emergencies such as SCI and TBI, mobilize and transport people safely (particularly those with SCI), and refer appropriately to advanced care. • Identify people likely to experience short- and long-term impairments associated with disability as a result of injury. • Train health care staff in post-operative care and rehabilitation and use of appropriate positioning and bedding equipment. • Include rehabilitation professionals in emergency response teams to provide post-operative rehabilitation or develop relevant partnerships to ensure service provision. • Include assistive devices (e.g. wheelchairs, crutches) in contingency stocks, make them available as soon as practical for people with newly acquired impairments and ensure that people are trained in their proper use and care. • Ensure that injury care for people with disabilities accounts for disability-specific needs (e.g. plain language for wound management). • Before discharge, provide appropriate education and equipment for self-care to prevent secondary complications such as bedsores and urinary tract infections, and facilitate linkages with any available community-based rehabilitation (CBR) programmes and local DPOs for peer support. • Create partnerships with all relevant sectors and between relevant government ministries to ensure support for CBR programmes.

Core health services	Actions to support people with disabilities
Mental health and psychosocial support	<ul style="list-style-type: none"> • Raise awareness among health staff about mental health conditions associated with emergencies such as alcohol and substance abuse, depression and post-traumatic stress disorder. • Identify and ensure that existing mental health and psychological services, including at the community level, are inclusive of and accessible to people with disabilities and their family members/ caregivers. • Ensure that people with existing mental health conditions have continued access to care. • As the risk of severe neglect or abuse of people in institutions is extremely high, visit mental hospitals and residential homes for people with severe mental health conditions regularly, especially in the acute phase of an emergency. Provide safety, basic physical needs (water, food, shelter, sanitation and medical care), human rights surveillance and basic psychiatric and psychosocial care throughout the emergency. • Ensure that family members and caregivers of people with disabilities are able to access mental health care if needed. • Prevent isolation of people with disabilities by facilitating their participation in communal, cultural and spiritual healing processes. • Encourage the development of peer support groups through partnerships with DPOs and make sure that traditional and pre-existing social support services/groups are accessible to support both people with pre-existing disabilities and people experiencing disability for the first time.
Non-communicable diseases (NCDs)	<ul style="list-style-type: none"> • Ensure that essential diagnostic equipment, core laboratory tests and medication for the routine and ongoing management of noncommunicable diseases (NCDs) (e.g. diabetes, cardiovascular disease) are available through primary health care. For example, include essential equipment and medication for NCDs in the essential medicines list, contingency plans and stocks. • Facilitate preparedness measures for individuals receiving treatment for NCDs before an emergency, including people with disabilities, to ensure continued treatment in the event of disrupted supplies. • Provide accessible information for people with disabilities on how to use medications correctly.

Core health services	Actions to support people with disabilities
Sexual and reproductive health	<ul style="list-style-type: none"> • Consult with people with disabilities, caregivers and DPOs on the barriers and facilitators to accessing comprehensive reproductive health services and work with them to facilitate access to these services. • Provide information on services in accessible formats and ensure that this information is delivered where possible through outreach to families and DPOs. • Enable access for people with disabilities, including adolescents, to reproductive health services outlined in the <i>Minimum Initial Service Package</i>.⁴ • Ensure that common contraceptive methods are available to men and women with disabilities. • Raise awareness and provide training for health care staff on the increased risk of sexual violence faced by people with disabilities, the safe and confidential identification and care of people with disabilities who have experienced sexual violence, and the processes for obtaining and documenting informed consent for services. • Ensure that people with disabilities who have experienced sexual violence can access clinical care, mental health and psychosocial support, legal assistance, and HIV prevention screening (including information) and treatment. • Raise awareness among health care staff about health conditions that can pose complications during pregnancy and additional requirements in childbirth for some women with disabilities.

References: Annex 4

1. *Community-based rehabilitation guidelines*. Geneva, World Health Organization, 2010.
2. *Immunization Service Delivery: Expanded program on immunization* [website]. Geneva, World Health Organization, 2012 (http://www.who.int/immunization_delivery/en/, accessed 1 February 2013).
3. *Maternal, newborn, child and adolescent health: Integrated Management of Childhood Illnesses* [website]. Geneva, World Health Organization, 2013 (http://www.who.int/maternal_child_adolescent/topics/child/imci/en/, accessed 1 February 2013).

4. *Integrated Management for Essential and Emergency Surgical Care (IMEESC) tool kit* [website]. Geneva, World Health Organization, 2013 (<http://hinfo.humaninfo.ro/websites/imeesc/index.html>, accessed 15 May 2013).
5. *Minimum initial service package (MISP) for reproductive health in crisis situations* [website]. Geneva, Reproductive Health Response in Crisis Consortium, 2012 (<http://misp.rhrc.org/>, accessed 1 February 2013).

Annex 5

How to make services in health-related sectors inclusive of people with disabilities

Sector	Key actions
Nutrition and food security	<ul style="list-style-type: none"> • Identify people with disabilities who may be more vulnerable to undernutrition in emergency contexts and ensure that they are targeted in emergency preparedness, including response planning. • Ensure that appropriate food is available for people with disabilities. Modifications may be required for people with feeding or swallowing difficulties. For example, a person with swallowing difficulties may need puréed food and/or a straw for drinking. • Ensure that rations are accessible to people with disabilities. For example, create separate queues for people with disabilities. • Manage malnutrition in people with mobility and feeding difficulties, for example, access to supplementary feeding sites. • Make sure that the particular needs of people with disabilities are addressed to ensure that access to food and an adequate nutritional status are assessed and addressed in ongoing programmes.
Water, sanitation and hygiene (WASH)	<ul style="list-style-type: none"> • Integrate disability into water, sanitation and hygiene (WASH) policy development and services at national and local levels. • Assess the level of access people with disabilities have to WASH facilities and use results to inform vulnerability reduction, emergency response planning and the design of ongoing WASH services. • Design and develop new WASH facilities that can be accessed independently or with the aid of a personal assistant by all people with disabilities. • Develop and implement strategies to increase access to existing WASH facilities. For example, adapt hand pumps and water-carrying containers where necessary and identify people in the community who can provide support.

Sector	Key actions
	<ul style="list-style-type: none"> • Involve people with disabilities in the design of new and rehabilitated water and sanitation facilities to ensure that they can access and use them.
Housing and shelter	<ul style="list-style-type: none"> • Integrate disability considerations into housing, building and urban development policies, building codes and safety standards to reduce risks and vulnerability to emergencies. • Include specifications for people with disabilities in site planning, design and development of housing, emergency shelters and temporary accommodation to ensure safety, security and accessibility. For example, consider rails, ramps, washing facilities, lifts and other measures to promote independent access. • Build houses/shelters for people with disabilities with appropriate modifications to accommodate their specific needs, or provide assistance to people with disabilities and their families who are building their own houses/shelters.
Education	<ul style="list-style-type: none"> • Strengthen access to safe and supportive environments and education for children and adults with disabilities. • Ensure that child-friendly spaces are physically accessible to children with disabilities and have supplies to facilitate participation of children with disabilities on an equal basis with others.
Protection	<ul style="list-style-type: none"> • Ensure that people with disabilities are included in assessments and registers, with data disaggregated by disability, age and gender. • Identify, monitor, prevent and respond to protection risks and incidents experienced by people with disabilities. • Raise awareness and provide training for staff about the protection issues facing people with disabilities and the support needed for people with disabilities who have experienced some form of violence. • Provide protection and care for people with disabilities, particularly people with significant difficulties in functioning and those people living in institutions such as mental health institutions and aged care homes. • Raise awareness among children and adults with disabilities and implement evidence-based measures to prevent violence, e.g. to recognize and avoid potentially sexually abusive situations.

Annex 6

Disability and emergency risk management: checklist of minimum actions required by the health sector

Function/domain	Checklist of minimum actions	Yes	No
Policies, legislation and strategies	<ul style="list-style-type: none"> • Is disability included in emergency risk management for the health sector? • Is emergency risk management included in the disability sector? • Do people with disabilities and disabled people's organizations (DPOs) have input in policies, legislation and strategies related to health? • Is a human rights framework used as a basis for legislation, policies and strategies related to health? 	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Resource management: financial resources	<ul style="list-style-type: none"> • Does the health sector have dedicated funding to address disability in emergency risk management? 	<input type="checkbox"/>	<input type="checkbox"/>
Resource management: human resources	<ul style="list-style-type: none"> • Does the health workforce have knowledge about disability? • Is orientation and training on disability available for the health workforce? • Are codes of conduct and ethical guidelines in place for the health workforce? 	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Planning and coordination	<ul style="list-style-type: none"> • Has a coordination mechanism for disability been established within the health sector for emergency risk management? • Is the disability sector involved in planning and coordination processes of emergency risk management for health? • Are people with disabilities involved in decision-making for all aspects of emergency risk management for health? 	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>

<p>Information and knowledge management, including assessments and communication</p>	<ul style="list-style-type: none"> • Is disability included in relevant health information systems? <input type="checkbox"/> • Do registers that identify people with disabilities and their health needs exist at the community level? <input type="checkbox"/> • Has relevant information been collected regarding existing disability programmes, services, support groups, etc? <input type="checkbox"/> • Is disability included in health emergency risk assessments and in needs assessments during and after emergencies? <input type="checkbox"/> • Are people with disabilities, families, DPOs, etc., included in assessment and information management processes? <input type="checkbox"/> • Is health information available in accessible formats for people with disabilities? <input type="checkbox"/> • Have local community members been identified who can communicate relevant health information to people with disabilities? <input type="checkbox"/> • Have links been established with DPOs to ensure dissemination of relevant health information? <input type="checkbox"/> 	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<p>Infrastructure and logistics</p>	<ul style="list-style-type: none"> • Has access for people with disabilities been considered in the planning, design and development of health facilities? <input type="checkbox"/> • Have relevant health equipment and supplies been included in inventories, emergency kits, and logistics systems? <input type="checkbox"/> 	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
<p>Service delivery</p>	<ul style="list-style-type: none"> • Do people with disabilities have access to mainstream health services? <input type="checkbox"/> • Do people with disabilities have access to specialized health services? <input type="checkbox"/> • Are reasonable accommodations in place to ensure access? <input type="checkbox"/> 	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

Community capacities	<ul style="list-style-type: none"> • Have local health services established links with people with disabilities, their families and local disability groups to ensure their inclusion in emergency risk management? 	<input type="checkbox"/>	<input type="checkbox"/>
	<ul style="list-style-type: none"> • Has the health sector raised the awareness of people with disabilities, their families and local disability groups about their responsibility to reduce risks to their health before, during and after an emergency? 	<input type="checkbox"/>	<input type="checkbox"/>
	<ul style="list-style-type: none"> • Do individuals with disabilities have emergency action plans in place that detail, among other things, the actions required to maintain their health during and after an emergency? 	<input type="checkbox"/>	<input type="checkbox"/>

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