ADCAP
Age & Disability Capacity

INCLUSION OF AGE & DISABILITY IN HUMANITARIAN ACTION

A TWO-DAY TRAINING COURSE

Learner's Workbook

redr uk
people and skills for disaster relief

International Federation of Red Cross and Red Crescent Societies

OXFORD BROOKES UNIVERSITY

UKaid
from the British people

HelpAge International

HANDICAP INTERNATIONAL

cbm
together we can do more

disasterready.org
a Cornerstone OnDemand Foundation initiative

USAID
FROM THE AMERICAN PEOPLE

START NETWORK

AGE AND DISABILITY INCLUSION TRAINING COURSE

Training Workbook

This edition of the Age and Disability Inclusion training course was jointly developed by the Age and Disability Capacity programme (ADCAP) consortium, a group of seven agencies working to promote age and disability inclusive humanitarian assistance: CBM, DisasterReady.org, Handicap International, HelpAge International, IFRC, Oxford Brookes University and RedR UK.

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Front cover photo: shelter kit distribution Leyte, Philippines by Joselito Dela Cruz/Help Age (2013)

Age and Disability Training Course – Training Workbook

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AGE AND DISABILITY INCLUSION TRAINING COURSE

Training Workbook

This two-day training course has been developed alongside a set of Minimum Standards for Age and Disability Inclusion in Humanitarian Action and open access e-learning modules. To deliver this training, please also use the ADCAP Trainer Handbook and resources that will guide you through the sessions. The content of the sessions should be adapted to suit the needs of the audience and be contextualised to the community.

AGE AND DISABILITY INCLUSION TRAINING COURSE

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INTRODUCTION

Welcome to the Age and Disability Training Course

Blending theory with practice, the Age and Disability Training Course of ADCAP will help you to understand the social, cultural and environmental barriers that people with disabilities and older people may experience in a humanitarian context. It will also present examples and tips on how humanitarian response and programmes can overcome these challenges and be more inclusive, in order to make sure people with disabilities and older people are actively participating in, and benefiting from, humanitarian assistance, in line with the 'Minimum Standards for Age and Disability Inclusion in Humanitarian Action' (Minimum Standards)

The information you are given in this workbook will provide you with a background to many of the concepts being discussed, summaries of the sessions presented and information on further reading. This workbook also contains course diaries and note-taking spaces for you. The workbook can then act as a reference point and toolkit.

We hope you find the course enjoyable and informative.

Course aim and objectives

Aim

For participants to develop critical insights and understanding into age and disability inclusion issues in humanitarian action to improve programming, response and monitoring.

Objectives

By the end of the course, participants will be able to:

- Recognise cultural, attitudinal and environmental barriers that people with disabilities and older people experience during humanitarian crises and how a humanitarian crisis exacerbates them;
- Explain how discrimination based on disability and age causes exclusion and how to change these attitudes to move towards inclusion;
- Recognise intersectionality of age and disability with gender, but also of age with disability and disability with age;.
- Navigate the 'Minimum Standards' and explain how to prioritise meeting the standards and practical applications of the standards in future work;
- Identify programme changes to move towards inclusion throughout the project cycle:
    - Using inclusive data collection (SADDD – Sex, Age, Disability-Disaggregated Data collection) with a focus on influencing needs assessments to be more inclusive
    - Using advocacy methods on age and disability
    - Using the humanitarian architecture: coordination, clusters, referral mechanisms etc.

Gender sensitive age and disability inclusion

Please note that gender is mainstreamed throughout the training and all associated materials. All topics in this course are gender sensitive and you should consider gender in all areas of learning, examples, case studies, etc. This is to recognise the different ways in which subgroups are considered and included, or not, by humanitarian actions – for example, older men compared to older women, women with disabilities compared to men with disabilities.

In this training handbook, inclusive practices focus thoroughly on age and disability factors. If discrimination based on other factors – religion, ethnicity, language – are also prevalent in your context, please be aware of this discrimination and at the very minimum have some discussion on it, even if immediate solutions are not available.

How to use this workbook

The purpose of this workbook is for use in humanitarian staff training and capacity building. It should be used alongside the accompanying training resources and materials, and not read as an academic or 'how to' guide or a set of standards.

The Minimum Standards for Age and Disability Inclusion in Humanitarian Action' ("Minimum Standards") are to be consulted as a reference on how to mainstream age and disability into humanitarian programming, and give specific guidance on inclusive-humanitarian action and response.

Suggested agenda

Day one

Welcome and introduction

Session 1

Data and evidence on age and disability in humanitarian contexts

Break

Session 2

Key concepts on age and disability

Lunch

Session 3

Minimum standards for age and disability inclusion in humanitarian action

Break

Session 4

Identifying barriers that aggravates exclusion

Daily feedback

Day two

Learning review

Session 5

Removing barriers and improving access and participation

Break

Session 6

Age- and disability-inclusive project cycle management

Lunch

Session 7

Advocating for age and disability inclusion in humanitarian action

Break

Continuing session 7

Advocating for age and disability inclusion in humanitarian action

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Recap, Review lessons learned

Your objectives

Record your personal objectives for this course here:

Objective

What do I want to learn by the end of the course?

How will I know that I have learned it?

How will I use what I have learned here back at work?

Learning Logs

Learning logs are a way to enhance learning. They do this by helping you think about what you have learned and how you can apply it back at work. They are also a record of what you have done that you can refer back to later.

Learning logs also serve other purposes. One is to help you identify gaps in your learning and areas for further improvement. Another is to help you organise your learning, making it easier to revisit at a later date. Learning logs help you to reflect on the very process of learning, which in turn will help you discover how you best learn.

On the next page is a learning log for this course. It is designed to feed into an action plan at the end of the course and it includes space to note what you thought and what you learnt from each session. This can be used to reflect on your learning and also as a basis for feedback to the trainers.

Learning logs are usually completed first thing in the morning or at the end of the day. However, you can fill it in at any time.

Other examples of learning logs

http://www.bbc.co.uk/keyskills/extra/module5/3.shtml

http://www.campaign-for-learning.org.uk/cfl/assets/documents/Activitiesandworksheets/diary_law.pdf

All In Diary
www.allindiary.org

A resource for humanitarian workers working in disaster situations and a tool to aid organisational learning and programme continuity.

AGE AND DISABILITY INCLUSION TRAINING COURSE

Learning Logs

Session/ Topic	What did I think of this session?	What did I learn from this session? What insights/ideas did I get?	How can I apply learning in my work?

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AGE AND DISABILITY INCLUSION TRAINING COURSE

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1. Key data and information on age and disability in humanitarian contexts

1. Key data and information on age and disability in humanitarian contexts

The following table contains some basic facts and insights on age and disabilities.

Global data	Implications of this data
AGEING: The world population is experiencing significant ageing – a process which leads to smaller proportions of children and larger proportionate shares of older people in the population. • Today, almost 1 in 10 people are over 60 years old[1]. • By 2050, the number of older people in the world will exceed the number of young for the first time in history, accounting for 22 per cent of the world's population. • By 2050, more than 80% of the world's older people – compared with 60% today – will live in developing countries, where disasters are more likely to occur and their effects are felt more severely. • The age group that is fastest growing is people above 80, expanding at a rate of 3.8% a year, compared to the expansion rate of 2% per year for the 60–79 group.[2] Such a significant ageing process will obviously lead to smaller proportions of children and young people and larger proportionate shares of older people in the population. This will strongly impact socio-economic development.	Use these figures for advocacy in humanitarian contexts, as the data on older people is usually highly underestimated in many countries, due to a lack of adequate tools and knowledge to identify them. The data can equally be used in a rapid needs assessment in the absence of data on disability and age, giving a projection of the affected population number.

[1] http://www.helpage.org/resources/ageing-data/global-ageing-statistics

[2] United Nations, Department of Economic and Social Affairs, Population Division (2013). World Population Ageing 2013, New York. http://www.un.org/en/development/desa/population/publications/pdf/ageing/WorldPopulationAgeing2013.pdf

Global data

- Worldwide, more than 46% of people aged 60 and over have disabilities, many of them associated with sight or hearing loss.[3] Older people with disabilities are also disproportionately poor.[4]
- Older people are among those at higher risk in emergencies. 56% of those who died in the Great East Japan Earthquake in 2011 were people aged 65 and over. 75% of those killed by the 2005 Katrina hurricane in New Orleans were aged 65 and over.[5]
- 26 million older people are affected by natural disasters every year.[6]

This situation will create unprecedented challenges in humanitarian emergencies – challenges that the humanitarian community has been slow to realise and, to a large extent, has so far failed to address.

Implications of this data

DISABILITY

Studies and data on the impact of disasters on people with disabilities are scarce. Some studies though show that disasters disproportionately place people with disabilities and their families in more at-risk situations.

People with disabilities experience increased problems due to separation from family, loss of assistive and mobility devices, and difficulties with accessing information. For example, research indicates that the mortality rate among people with disabilities was twice that of the rest of the population during the 2011 Japan earthquake and tsunami.

This data can be used for advocacy in humanitarian contexts, as data on people with disabilities is usually difficult to obtain in many countries because of lack of adequate tools and knowledge on identifying them.

[3] WHO and the World Bank (2011). World Report on Disability, WHO, Geneva.

[4] Masset, E. and White, H. (2004). Are chronically poor people being left out of progress towards the Millennium Development Goals? A quantitative analysis of older people, disabled people and orphans. Journal of Human Development, 5(2), 279-297.

[5] National Police Agency Tokyo, 2012; Wilson, N. (2016). Hurricane Katrina: Unequal opportunity Disaster, Public Policy and Ageing Report Vol 16(2).

[6] Cambridge Scholars; Rebuilding Sustainable Communities with Vulnerable Populations after the Cameras Have Gone; page XXI. www.cambridgescholars.com/download/sample/60157

[7] United Nations. (2013). Panel Discussion on Disaster Resilience and Disability: ensuring equality and inclusion.

Global data

An estimated one billion people or 15% of the world's population have a disability.

- It is estimated there will be at least 200 million people displaced by climatic events by 2050, of which at least 30 million are likely to be people with disabilities.
- Women, men, girls and boys with disabilities can be often left behind in times of emergency. For example, observations from the Philippines claim that only 10% of people with disabilities found shelter in the evacuation centres, and those who got there were often pushed aside by the crowd.[10]
- People with disabilities are not prepared for disasters: 70% of people with disabilities said that they had no personal preparedness plan and only 17% knew about any disaster management plan in their community.[11]

Implications of this data

The data can equally be used in rapid needs assessment in absence of data on disability and age, making a projection on the affected population number.

GENDER

The following are some statistics with regards to gender:

- Today more than 75 per cent of people affected by humanitarian crises are women and children. And adolescents aged 10-19 years constitute a significant proportion of the population in many conflict and post-conflict settings.[12]
- The World Health Survey highlights the lower rates of primary schoolcompletion for females with disabilities (41.7 per cent), compared to men with disabilities (50.6 per cent) and females without disabilities (52.9 per cent). [13]

Gender sensitive programming:

- considers gender norms, roles and relations, for women and men and boys and girls, and how they affect access to/ control over resources;
- considers women's and men's and boys' and girls' specific needs;
- intentionally targets and benefits a specific group of women or men, or boys or girls, to achieve certain policy or programme goals or meet certain needs;

[7] United Nations Headquarters, October 10, 2013

[8] WHO and the World Bank. World Report on Disability (2011). WHO, Geneva.

[9] UNOCHA at http://www.unocha.org/top-stories/all-stories/humanitarian-issues-safeguarding-people-disabilities-during-emergencies. CBM (2013) Thematic brief on Sustainable Development.

[10] Ibid.

[11] Ibid.

[12] UNFPA. Humanitarian Action. 2016 overview. May 2016, New York.

Global data

Despite recent increases in women's educational attainment, women continue to earn less than men in the labour market even when they have the same education and years of work experience as men.[14]

- Men and boys make up 88% of casualties of Explosive Remnants of War.[15]
- When disaster strikes, men and women have different abilities and ways of responding, and are ultimately impacted differently. It has been widely documented that women are more at risk than their male counterparts of the same social class, race, ethnic and age group during all phases of a disaster.[16]
- Men are harmed by gender-based social expectations, especially after disasters have occurred. In many communities, socially and culturally, they are expected to deal with their losses and grieve alone and psychosocial support often bypasses men, since stereotypes expect them to be strong and face the crisis in a 'manly' manner.
- Men and women often feel they have their 'normal' gender roles undermined during humanitarian crisis. For men, this may mean that they can no longer provide for or protect the family as they had done previously. This can result in a rise in violence towards women and children, as there is an attempt to reassert authority in power.[17]

Implications of this data

- makes it easier for women and men to fulfil duties that are ascribed to them based on their gender roles.

[13] WHO and the World Bank (2011), World Report on Disability, chapter 7, p. 206

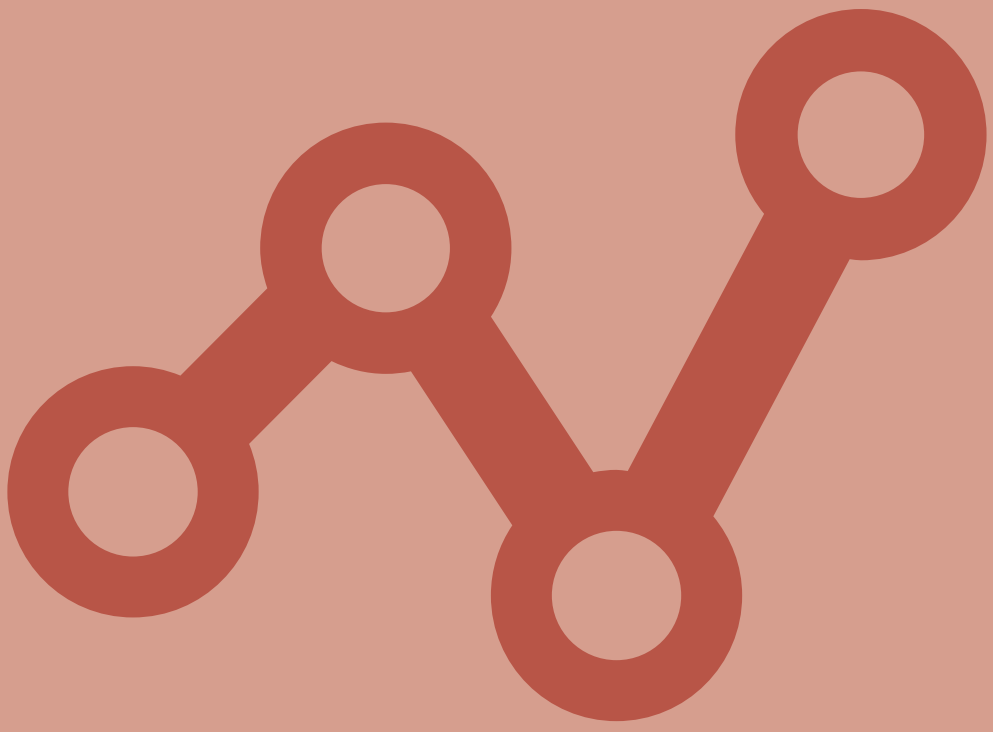
[14] World Bank (2001). Engendering Development: Through Gender Equality in Rights, Resources and Voice. Washington. http://www.un.org/womenwatch/daw/beijing/beijingat10/A.%20Women%20and%20poverty.pdf

[15] ICBL Factsheet (November 2010) Landmine and cluster munition monitor factsheet: Impact of mine/ERW on women and children.

[16] UNISDR (2009). The Disaster Risk Reduction Process: A Gender Perspective. A Contribution to the 2009 ISDR Global Assessment Report on Disaster Risk Reduction, Inputs from the Gender and Disasters Network, Geneva.

[17] Charles, L. and Denman, K. (2013). Syrian and Palestinian Syrian Refugees in Lebanon: the Plight of Women and Children, Journal of International Women's Studies,14(5), 96-111.

2. Key concepts on age and disability



2. Key concepts on age and disability

The exclusion of older people and people with disabilities from emergency response and humanitarian aid increases casualty rates, psychosocial impact, and health issues. The humanitarian principle of impartiality, meaning to provide assistance on the basis of need and without discrimination, requires donors and aid agencies to reduce barriers so that older people and people with disabilities can access relief on an equal basis with others.

2.1 Understanding disability

Everybody is likely to experience disability directly, or to have a family member who experiences difficulties in functioning, at some point in their life, particularly when they grow older. People with disabilities are disproportionally affected by emergencies and experience higher rates of mortality and morbidity.[18]

Article 1 of the UN Convention on the Rights of People with Disabilities (CRPD) refers to disability being an evolving concept that "…results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others".[19]

In this manual, 'people with disabilities' refers to women, men, girls and boys with long-term physical, mental, intellectual or sensory impairments, who, in interaction with the environment and social and attitudinal barriers, are hindered from participating on equal basis with others in the society.[20]

There are different ways of describing or defining disability, and each country will have its own definition depending on social, cultural and political situations. There are some attempts to measure and define disability globally, for example, the International Classification of Functioning, Disability and Health (ICF), which describes disability as the interaction between health conditions and environmental and personal factors. Disability is then described as occurring at three levels:

- Impairment in a body function, such as for example a cataract that prevents the passage of light and the sense of shapes and forms,
- Activity limitations, such as difficulties to read or understand instructions or to move around,
- Participation restrictions, such as exclusion from school or being prevented to take part in community meetings.

The ICF is useful for a lot of purposes, such as research; surveillance and reporting on measuring health and disability; defining eligibility criteria for disability benefits; or developing health and disability surveys.

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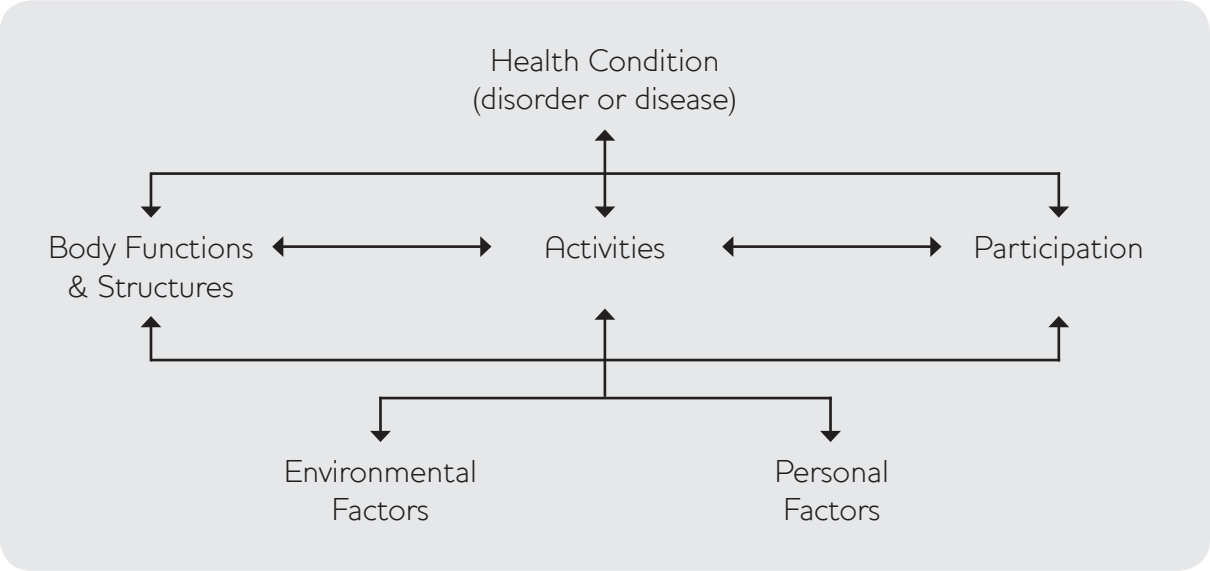
[17] Charles, L. and Denman, K. (2013). Syrian and Palestinian Syrian Refugees in Lebanon: the Plight of Women and Children, Journal of International Women's Studies,14(5), 96-111.

[18] WHO (2013) Guidance note on disability and emergency risk management for health, WHO Press, Geneva.

[19] Convention on the Rights of Persons with Disabilities. http://www.un.org/disabilities/documents/convention/convoptprot-e.pdf

[20] ADCAP (2015). Minimum Standards for Age and Disability Inclusion in Humanitarian Action. Age and Disability Consortium, HelpAge International, UK.

This is a visual representation of the ICF:



To learn more, visit:

http://www.who.int/classifications/icf/icfbeginnersguide.pdf?ua=1

This shows that people's experiences of disabilities are extremely varied. People have different kinds of impairments, which affect them in different ways, and there are people with impairments who do not consider themselves to be disabled. A child born with a congenital condition such as cerebral palsy, a woman who has lost her sight due to diabetes, or a young girl losing her leg in a landmine accident, will all be described as people with disabilities but will of course encounter different barriers in society – and they require different services to support them fulfil their lives.

The CRPD describes people with disabilities as "...those who have long-term physical, mental, intellectual or sensory impairments..."

Impairment – is only one component of disability and refers to the body function, such as a cataract that prevents the passage of light in the eye, or the loss of one limb, or a mental function that is affected. The other components of disability are activity limitation and participation restrictions, as mentioned earlier.

Simply put, disability is a factor of the environment:

Impairment + barriers = disability

"Disease, trauma and other disruptions to a person's integrity and development may cause impairments and lead to temporary or permanent disabilities, which could be static, progressive, or regressive. It is nevertheless the different obstacles or facilitators met in the environment that, in correlation with their own disabilities, which hinders the accomplishment of life habits, compromise everyday life activities and social roles, as well as put them into a full social participation or disability and exclusion".[21]

[21] Fougeyrollas, P., Cloutier, R., Bergeron, H., Cotè, J., and St Michel, G. Quebec Classification: Disability Creation Process. International Network on the Disability Creation Process. 1999. http://www.ripph.pc.ca/

As an example to illustrate the model, we can look at a woman that becomes blind due to a disease. She used to be a bus driver but due to the impairment, she will have to re-orient her work completely in line with her new situation. On the other hand, a woman who becomes blind due to a similar reason, but used to work in the reception of a hotel, could continue her work with adequate adaptations and assistive technology. Using the DCP to understand disability shows us that:

- Disability is not a permanent state but an evolving process that varies with time and life situations.
- Disability is relative and varies depending on the context and the environment, as well as the health condition.
- It is a situation that can be modified through rehabilitation and provision of assistive devices, as well as through developing capacities and adapting the environment, including the political and social dimensions.

Shift of paradigm

Recent years have seen an important evolution on how disability and age is considered in many societies. People with disabilities and older people, as with several other marginalised groups, were for a long-time considered to be objects of charity, or strictly from a medical viewpoint, as persons needing medical treatment, rehabilitation and care. This is what sometimes is described as the **charity and medical models.** They are perspectives based on disability and older age being an individual problem that has to be managed, cared for, or fixed. The so-called **social model** developed as a reaction against the individualistic approaches of the charitable and medical models. It focuses on society and considers that the problem lies with society, that due to barriers, be they social, institutional, economic or political, people with disabilities and older people are excluded.

More recently, many people with disabilities and older people want to talk about a rights-based approach to participation and inclusion. This approach focuses on equity and rights and looks to include all people equally within society: women and men, girls and boys, regardless of background, age, disability or any type of characteristic. It is founded on the principle that human rights for all human beings are indisputable, and that all rights are applicable and indivisible. This approach sees people with disabilities and older people as the central actors in their own lives as decision-makers, citizens and rights-holders.

When it comes to disability, a rights-based approach takes the CRPD as its main reference point and prioritises ensuring that duty bearers at all levels meet their responsibilities. The shift that has been promoted with the adoption of the CRPD in 2006 is to promote the inclusion of people with disabilities by removing barriers and obstacles, rather than addressing individual impairments through specialised interventions. This includes accessibility adaptations of the built environment, accessible information and communication, and ensuring access to basic services, provision of technical and assistive devices, changing attitudes and reducing stigma, as well as empowerment of people with disabilities and their families.

While disability correlates with disadvantages, not all people with disabilities and older people are equally disadvantaged.

- People with visual, hearing and intellectual impairments or severe mental health conditions are often more socially excluded and therefore might be less prepared to cope with events that lead to emergencies.
- People with disabilities and older people will also face additional challenges to evacuate and may lose essential assistive devices, such as spectacles, hearing aids or wheelchairs.
- People with disabilities might also face difficulties to meet their basic needs, including food, water, shelter, latrines and healthcare services on an equal basis with others.

Children and older people with disabilities are also more at risk during emergencies, due to separation from families and carers, and when traditional community and family mechanisms of support break down. This increases the risk of violence, exploitation and sexual abuse.

2.2 Understanding ageing and the life-course

Populations around the world are rapidly ageing, with some of the fastest change occurring in low- and middle-income countries.

As human beings grow older, they go through different phases or stages of life. It is helpful to understand ageing in the context of these phases, as ageing is not simply a physiological process. A life course is the period from birth to death, including a sequence of predictable life events, such as physical maturation and the succession of age-related roles: child, adolescent, adult, parent, senior, and so on.

The fact that age-related roles and identities vary according to social determinations, means that the process of ageing is much more significantly a social phenomenon than a biological phenomenon.

Old age does not always have to be equal to chronological age (number of years you have). Often, it is connected to shift in social roles and positions, which vary greatly among different cultures and societies. The changes that constitute and influence ageing are complex, and involve a gradual decrease in physiological reserves due to among other cellular damage, leading to increased risk of many diseases. But such changes are not linear and are loosely associated with age in years. Somebody that is 70 years of age might perfectly well still be working and playing an active role in society, while others might be frail and require significant support to meet their needs.

A few things that may affect physiological aspects of ageing are:

1. Exposure to health problems (e.g. bad work conditions, pollution, lack of health services, infectious diseases).
2. Hard physical labour.
3. Multiple pregnancies in the case of women (i.e. related to poverty and lack of demographic transition or contraception).
4. Living through a prolonged crisis with uncertainty, high levels of stress and poor living conditions (e.g. displacements and separation from family; war and conflict contexts).

In this training manual, the age definitions by the UN will be used:

- Old person > 60 years of age
- Oldest person > 80 years of age

However, older people should not be defined only by chronological age but also by taking into account the contextual and cultural aspects of defining old age in each society. For example, this might be based on being grandfather or grandmother, or being considered having wisdom and leadership attributes, change of work patterns, and so on. It might also involve changes in capabilities, such as dementia, functional limitations, or changes in physical functions.

Some impairments that older people may have are:

- dementia or other mental health conditions;
- visual impairments, such as blindness or low vision;
- hearing impairment;
- chronic non-communicable diseases, such as diabetes, heart conditions, or reduced lung capacity, which affects their mobility and autonomy;
- physical impairments, such as decreased balance, weakness of muscles, or amputation of a leg because of diabetes, among many others.

2.3 Carers and/or personal assistants

Desscription: Ahmad practices using his wheelchair with Lotfi. Seven year old Ahmad Basal had both legs amputated after a bomb landed behind him in Syria. His mother and two sisters and two brothers fled to Adwa, Lebanon, near Tripoli. Handicap International has given him a toilet chair, axillary crutches, and a wheelchair. He does rehabilitation exercises once per week with Handicap International Physiotherapist Lotfi Lakiss.

© Molly Feltner / Handicap International.

Carers and/or personal assistants are women, men, girls and boys who care for and support a family member, relative, or friend requiring support to be more independent and manage daily life activities.

In a humanitarian crisis, the life of any person is challenged, and for people with disabilities and their carers or assistants, this challenge is often greater.

The situation for a carer or assistant is also affected during a crisis, where displacement, insecurity or violence puts additional pressure and stress on managing daily life. This can result in an unsustainable situation for the carer, who might have to care for his or her own needs primarily, and be forced to abandon the person they care for. Increased stress and insecurity, and lack of fulfilment of basic needs, can also increase the risk of abuse and neglect of the older person or person with a disability.

The contribution of carers and assistants goes largely unrecognised, especially in a humanitarian crisis, because it is often assumed without questioning.

Take into account the family, carers and personal assistants as part of the response to people with disabilities and older people:

1. Family members, carers and personal assistants should also be consulted in the design of services, especially in the case where they are spokespersons for people who have difficulties in communicating.
2. Family members, carers and personal assistants might need support, for example from volunteers, peer-to-peer exchange, or psychosocial support for managing stress and increased challenges.
3. Family members, carers and personal assistants should be taken into account in the distribution process, especially in situations where the person they are supporting is not able to reach distribution points. To avoid misuse and abuse of the older person or person with disability's access to supplies and relief items in this case, a system of delegation or authorisation should be ensured.
4. Access to information has to be made accessible for people with disabilities and older people who might not easily leave their homes. In some cases, the information will be provided to them via carers or family members, so information channels have to reach household levels.
5. Carers who are children require special attention and support, to provide them with protection, access to school, child-friendly spaces and other activities and services.
6. People with disabilities and older people are often not considered for cash-for-work activities (an example of exclusion, which is important to remedy), and may thus face higher levels of economic hardship. If they have care responsibilities, this will also impact on those under their care.

7. It is important to note as well that:

   a. Not all older persons and persons with disabilities need a carer or personal assistant

   b. Personal assistance can be also a professional role

   c. Persons with disabilities and older people can –and are –often also caring of others.

2.4 Intersectionality of age, disability and gender

The discrimination and exclusion of people with disabilities and older people may occur not only because of negative and prejudicial attitudes as a result of disability and/or age, it can also occur because they are an older women or a young girl or from a minority group or other ethnicity. This is recognised as multiple discrimination, and women and girls of all ages and with disabilities, due to the intersection of their gender and older age or disability, experience this across all countries of the world to varying degrees.

Some global data is available to highlight this intersectional discrimination, which will be equally valid in a crisis or emergency situation. The World Report on Disability highlights that while men with disabilities experience lower rates of participation compared to men without disabilities, women with disabilities fare less well than men with disabilities and women without disabilities, in both education and employment.[22]

For example, with respect to education, statistics highlight that 50.6% of males with disabilities have completed primary school, compared with 61.3% of males without disabilities. For females with disabilities the report notes that 41.7% completed primary school compared to 52.9% of females without disabilities. With respect to employment rates, the difference between women and men with disabilities is even starker with 52.8% of men with disabilities in employment and 19.6% for women with disabilities in employment.

To illustrate this further, looking at key areas of life during a humanitarian situation, a woman with a disability is often at higher risk of violence and abuse than a woman without a disability. Because of their age and gender, an older woman might also be excluded from cash-for-work opportunities because she is considered to be too frail and not fit for the activity required.

For example, in some societies, an older woman with a disability can be discriminated against or face particular barriers to participation in society because she is a woman, because she is older, and because she has a disability. A man with a disability from a minority ethnic group can be more discriminated in accessing work than a man with a disability from the majority ethnic group. The graphic below illustrates the differences among older people and among people with disabilities, which shows that their capacities, abilities and support needs will vary depending on the context and situation.

Description: "Aysha is 93 years old. She arrived in Za'atari one year ago. She now lives alone in a tent, waiting to see her 10 children again. Aysha suffers from mobility limitation due to her age, as well as from heart and hearing problems. Handicap International gave Aysha a wheelchair and a commode chair. The association is also supporting her thanks to physiotherapy sessions in order to strengthen her mobility."

Copyright © Sarah Pierre/Handicap International

[22]WHO and the World Bank (2011). World report on disability, WHO Press, Geneva.

It is important to keep intersectionality in mind during needs assessment and response, as well as when doing capacity analysis in planning a response. The scheme below illustrates an example of how older people have different roles in society depending on their personal characteristics and, as such, the response might have to be differently targeted.

For example, the response needs to consider:

1. Relations between men, women boys and girls of all ages
2. Relations between people without disabilities and people with disabilities of all ages and genders.

2.5 Understanding the rights-based approach to age and disability inclusion

Human rights

Women, men, girls and boys with disabilities and people of all ages, while not explicitly referenced in international humanitarian law, should be given protection during disasters and conflict. Human rights treaties such as the CRPD (Article 11) further clarify these rights to ensure that State Parties take "all necessary measures to ensure the protection and safety of people with disabilities in situations of risk, including situations of armed conflict, humanitarian emergencies and occurrence of natural disaster".

Applying a human rights-based approach implies to respect human rights principles of inherent dignity, equality and non-discrimination in all planning, implementation and monitoring and evaluation of humanitarian action.

Sendai framework for Disaster Risk Reduction 2015-2030

Progress has been made with the inclusion of people with disabilities and older people in international frameworks. The Sendai Framework for Disaster Risk Reduction (DRR) has set a precedent in this aspect, as it mentions both groups as key actors to participate in DRR processes and programmes.

Madrid International Plan of Action on Ageing, endorsed by the General Assembly in 2002

Three priorities for action were identified in their recommendations: "older persons and development; advancing health and well-being into old age; and ensuring that older people benefit from enabling and supportive environments".

They include: promoting health and well-being throughout life; ensuring universal and equal access to health-care services; providing appropriate services for older persons with HIV or AIDS; training care providers and health professionals; meeting the mental health needs of older persons; providing appropriate services for older persons with disability; providing care and support for carers and preventing neglect and abuse of, and violence against, older people.[23]

[23]WHO (2015). World Report on Ageing and Health, WHO Press, Geneva.

Charter on Inclusion of Persons with Disabilities in Humanitarian Action

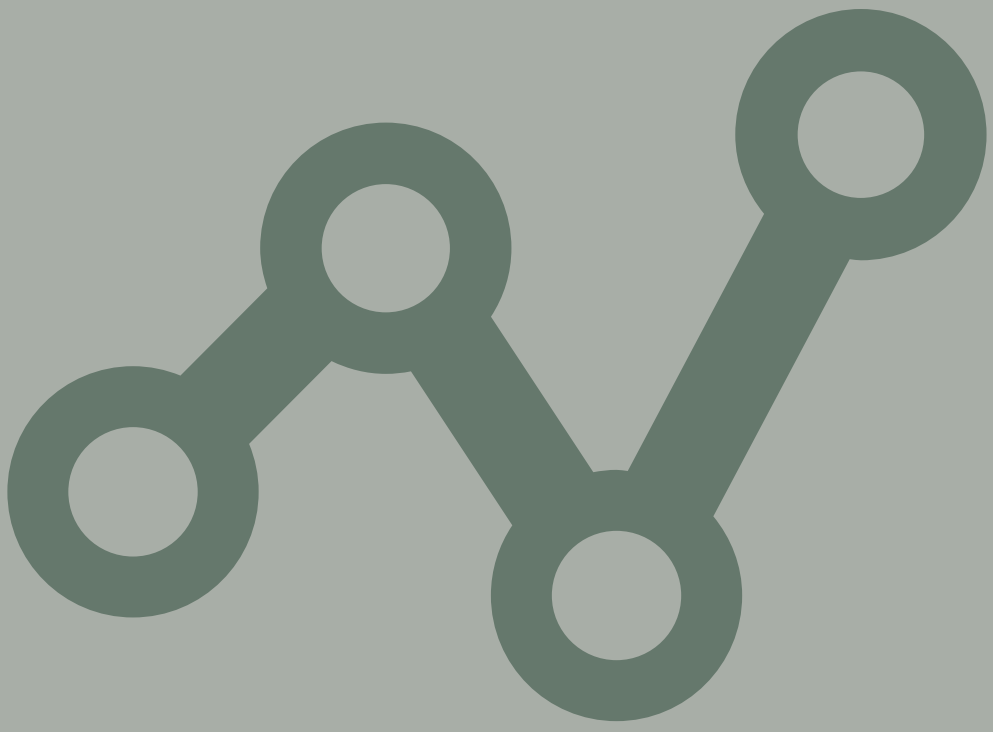
The Charter on Inclusion of Persons with Disabilities in Humanitarian Action was developed in advance of the World Humanitarian Summit in Istanbul in May 2016, by over 70 stakeholders from Member States, UN agencies, the international civil society community and global, regional and national organisations of persons with disabilities. Today the charter has been endorsed by over 160 stakeholders.

The Charter asks for commitment to render humanitarian action inclusive of persons with disabilities, by lifting barriers persons with disabilities are facing in accessing relief, protection and recovery support, and ensuring their participation in the development, planning and implementation humanitarian programmes.

Protection Mainstreaming

Protection mainstreaming is the process of incorporating protection principles and promoting meaningful access, participation, accountability, safety and dignity in humanitarian aid. Age and disability mainstreaming are important cross-cutting issues that are supported by the promotion of protection principles.

3. Minimum Standards for Age and Disability Inclusion in Humanitarian Action



3. Minimum Standards for Age and Disability Inclusion in Humanitarian Action

The Age and Disability Consortium, as part of the ADCAP programme, to promote the inclusion of people with disabilities and older people at all stages of emergency response, has developed a pilot Minimum Standards for Age and Disability Inclusion in Humanitarian Action ("Minimum Standards").

The purpose of these Minimum Standards is:

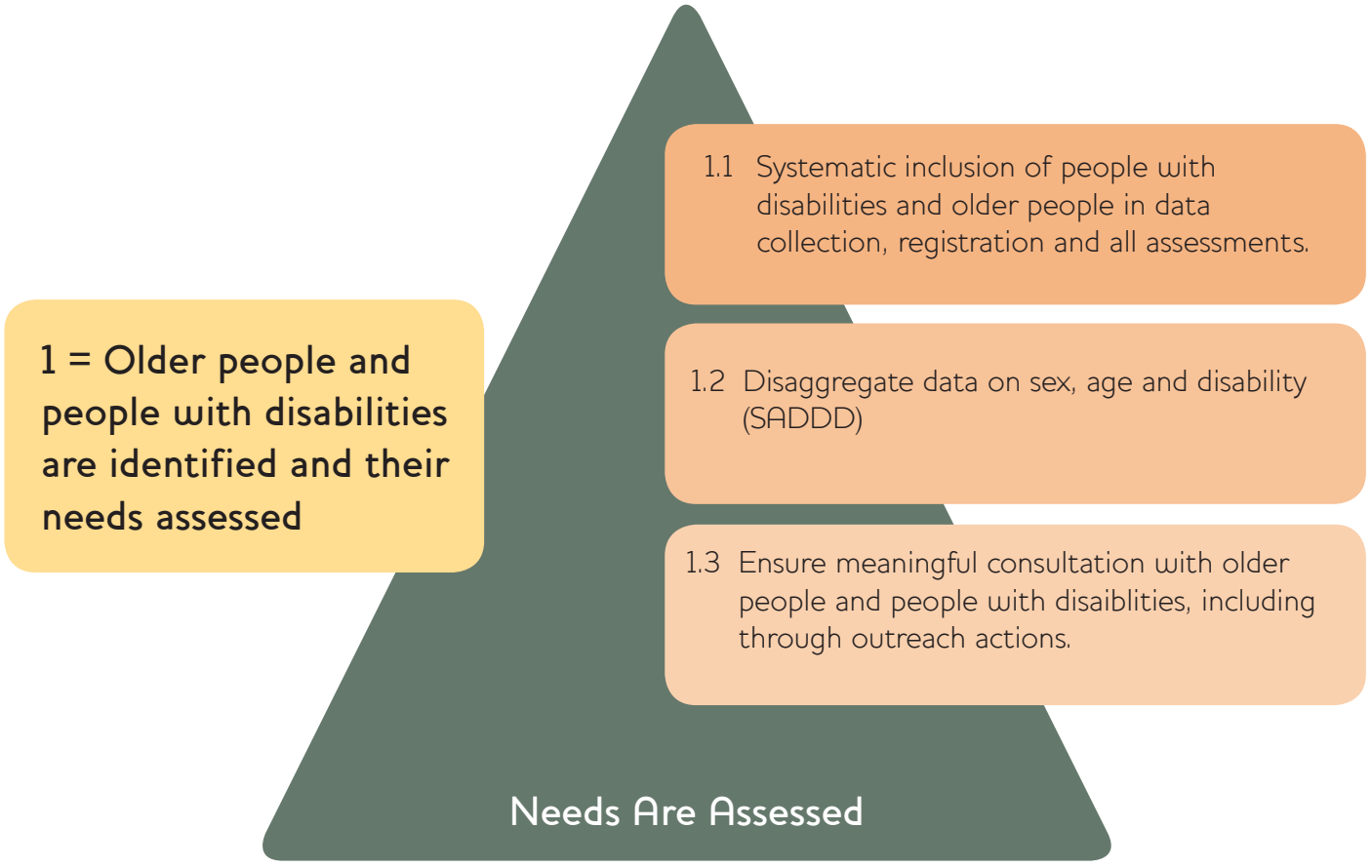
1. To promote and ensure that older people and people with disabilities are included at all stages of all stages and in all sectors of humanitarian response.
2. To inform the design, implementation, monitoring and evaluation of humanitarian programmes and to support advocacy, capacity building and preparedness on age and disability across the humanitarian system.

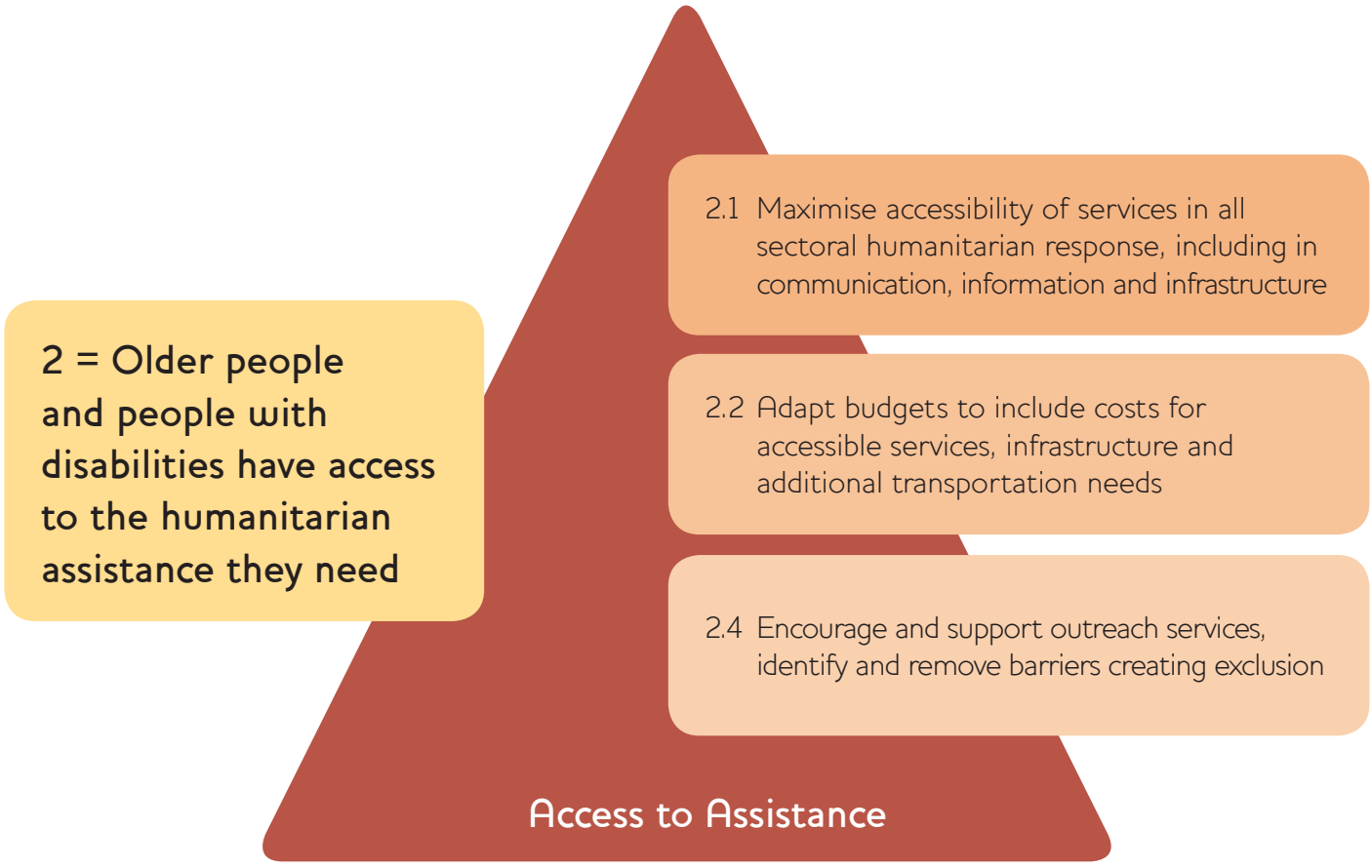
The Minimum Standards for Age and Disability inclusion consist of eight key inclusion standards and an accompanying set of sector-specific standards. In the schemes below you can find a description of these eight standards.[24]

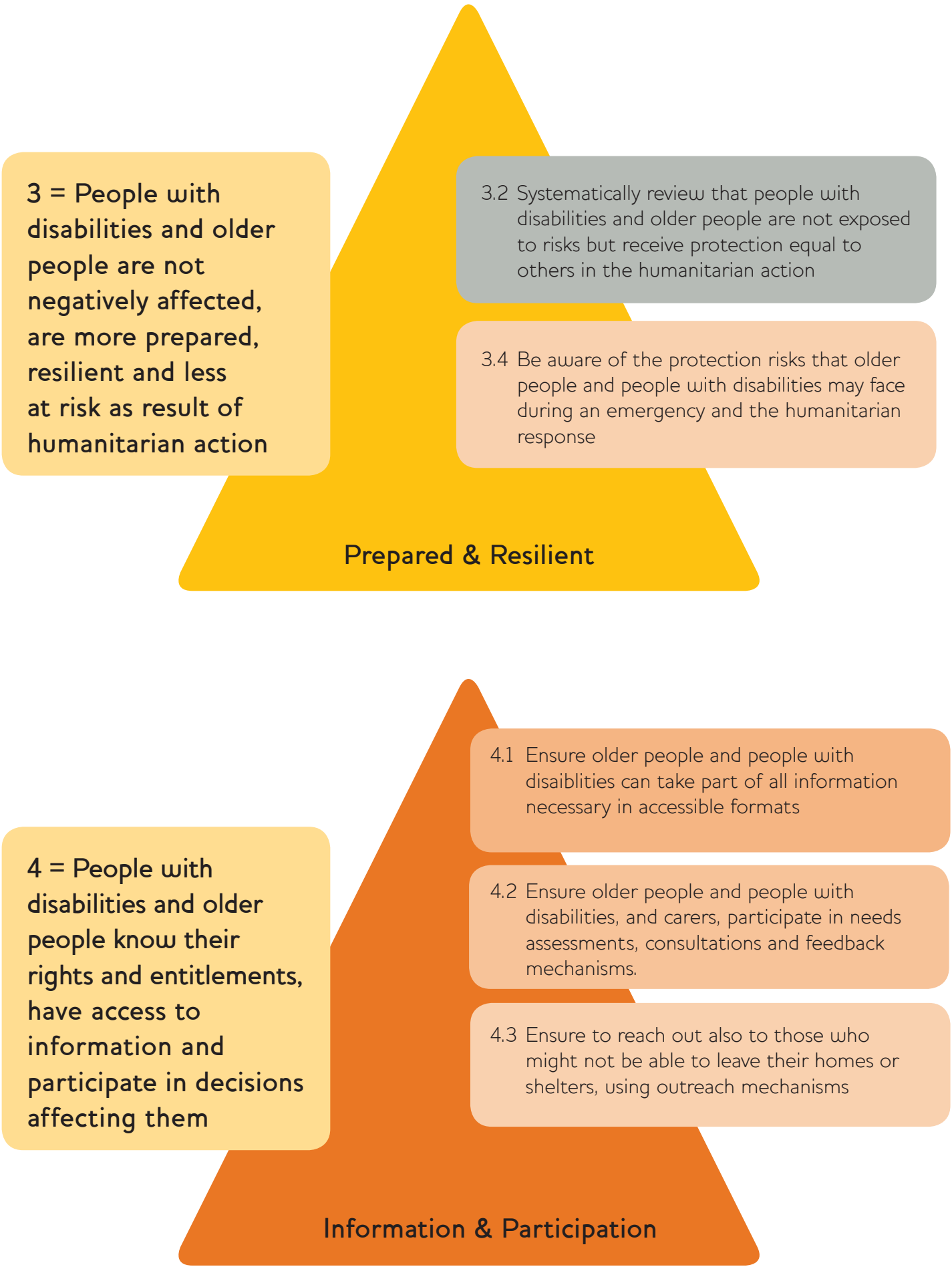
Look out for a revised edition of the Minimum Standards due for publication late by 2018. Keep up to date here: http://www.helpage.org/what-we-do/emergencies/adcap-age-and-disability-capacity-building-programme/

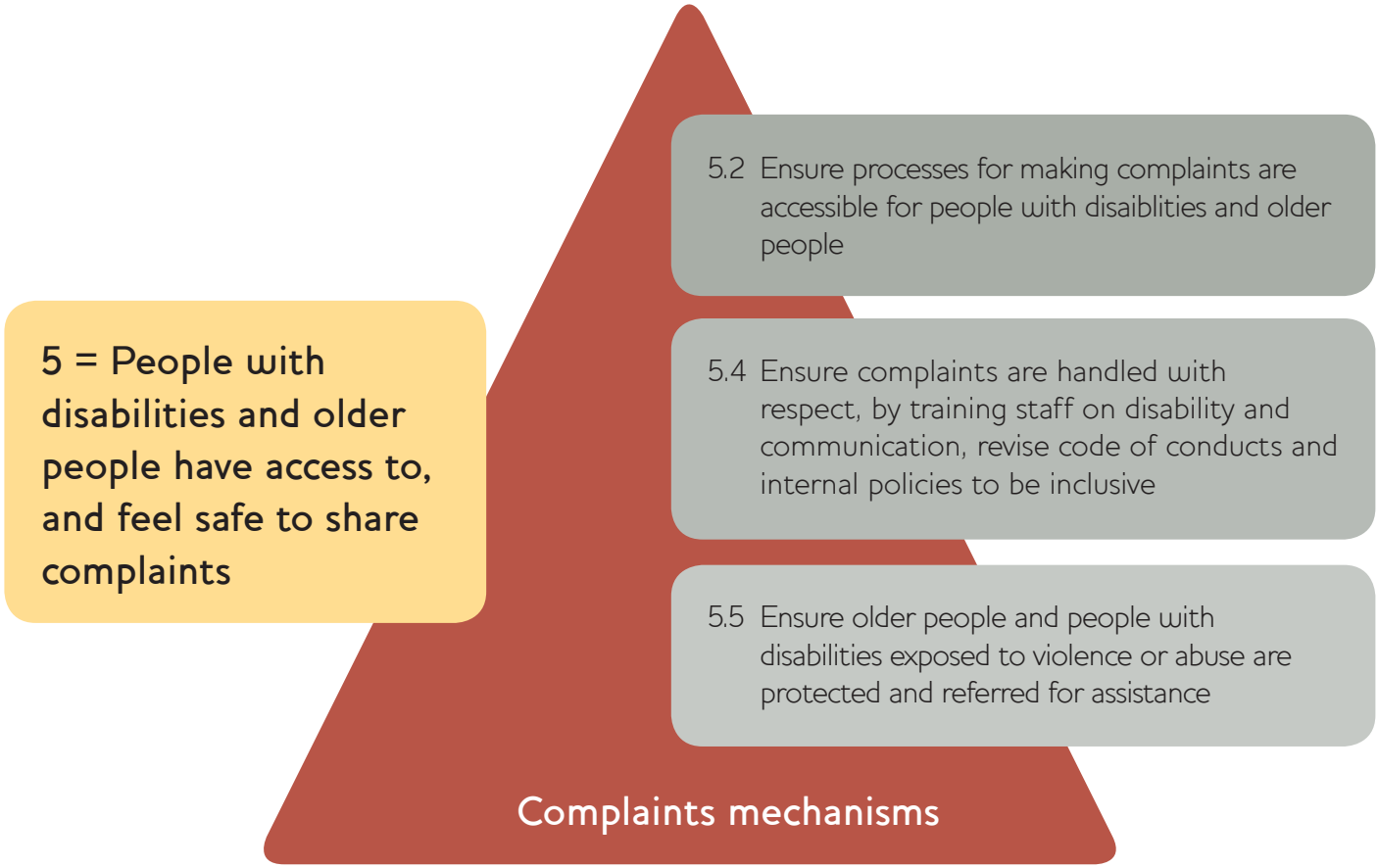
[24]Diagrams from HelpAge Powerpoint, 2015 courtesy of Diana Hiscock

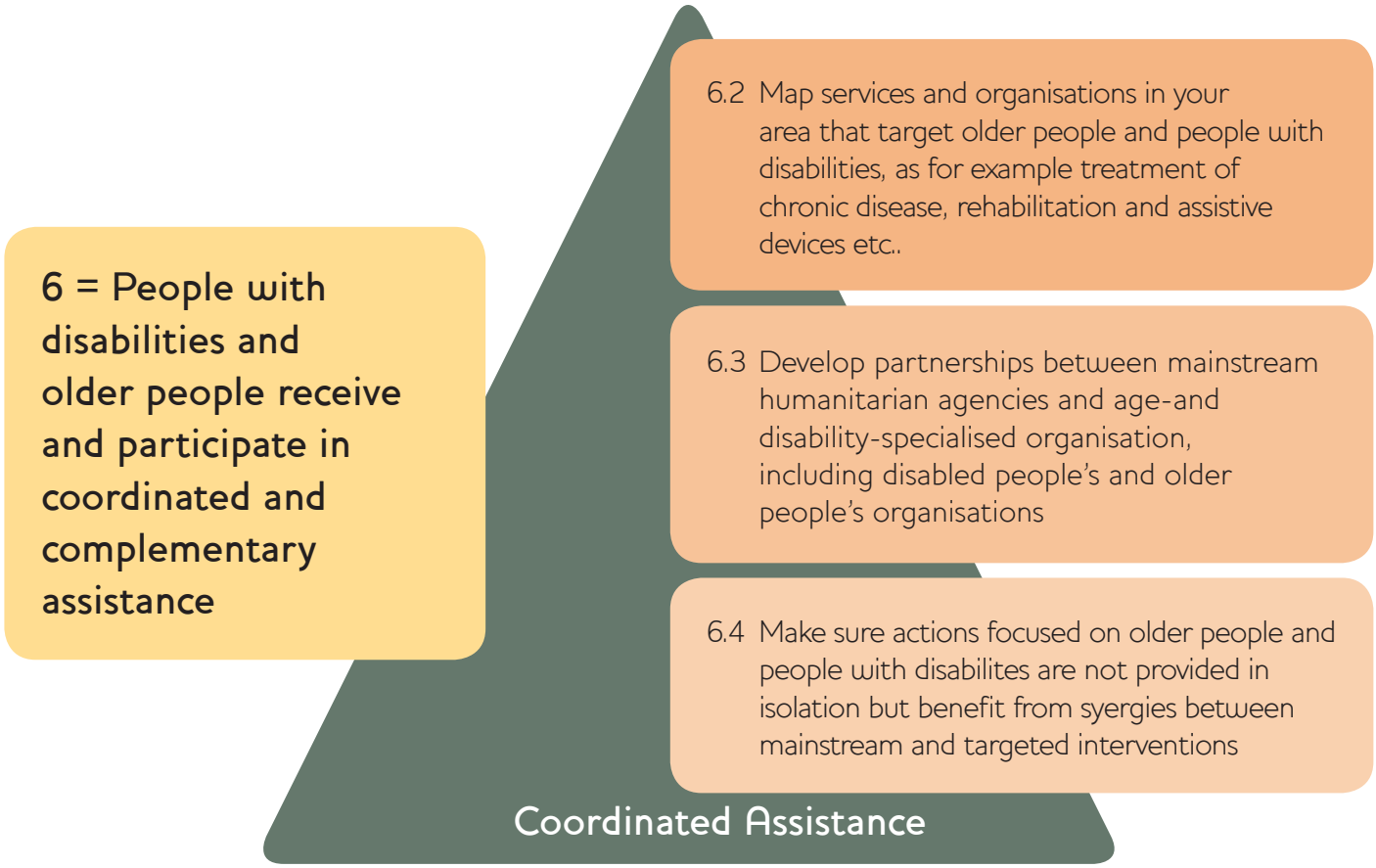
3.1 Key Inclusion Standards

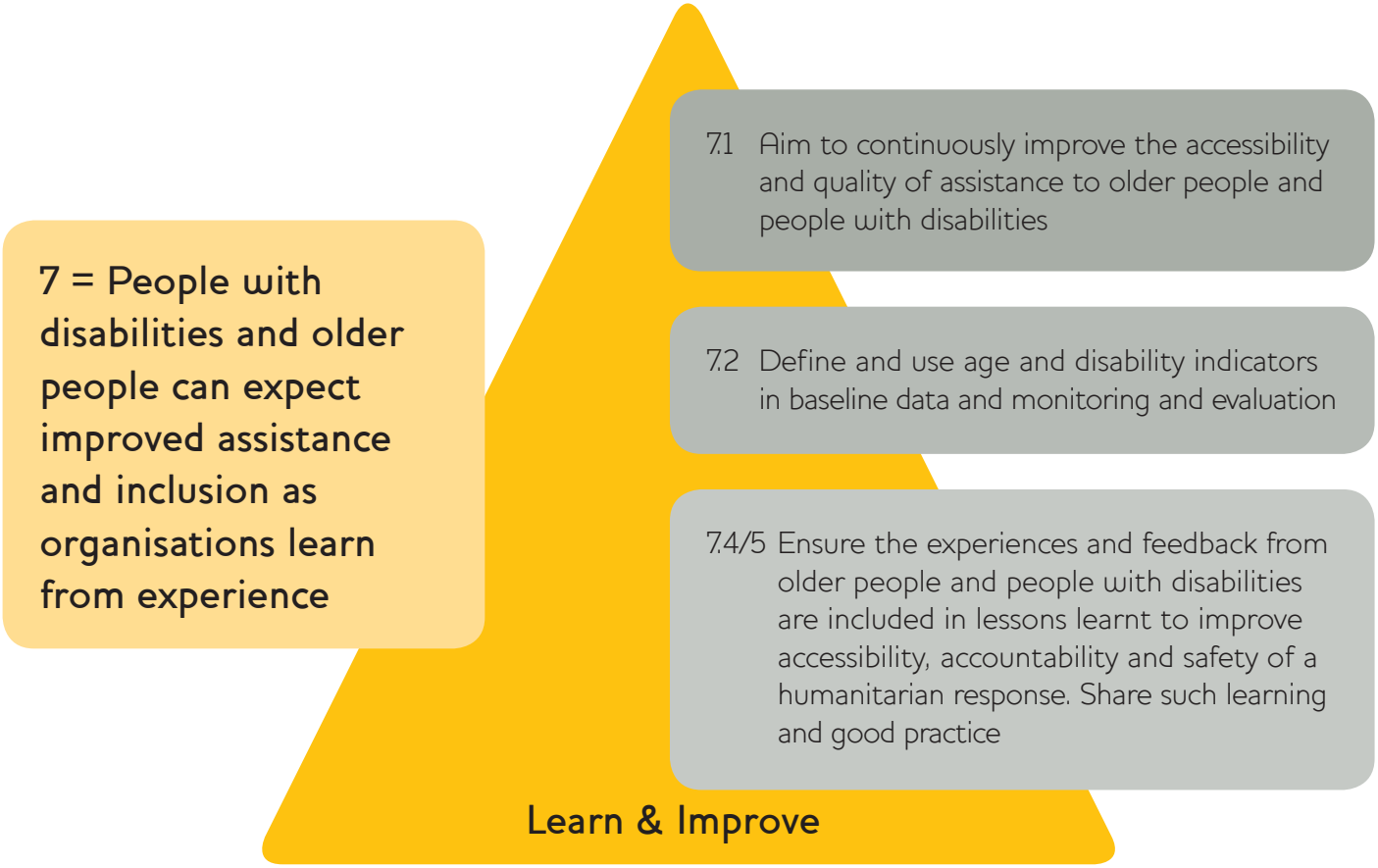


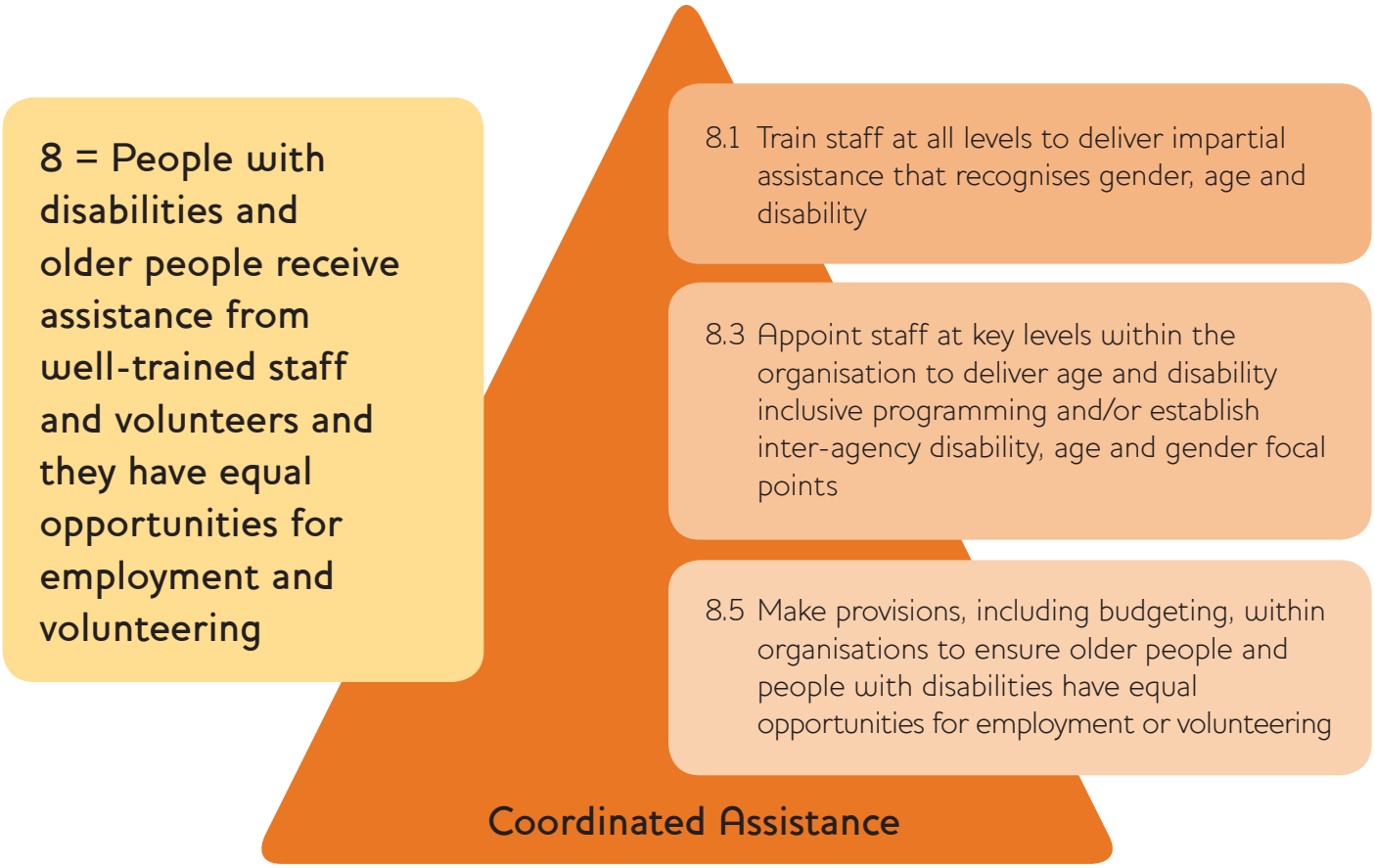



3 = People with disabilities and older people are not negatively affected, are more prepared, resilient and less at risk as result of humanitarian action
3.2 Systematically review that people with disabilities and older people are not exposed to risks but receive protection equal to others in the humanitarian action
3.4 Be aware of the protection risks that older people and people with disabilities may face during an emergency and the humanitarian response
Prepared & Resilient
4 = People with disabilities and older people know their rights and entitlements, have access to information and participate in decisions affecting them
4.1 Ensure older people and people with disaiblities can take part of all information necessary in accessible formats
4.2 Ensure older people and people with disabilities, and carers, participate in needs assessments, consultations and feedback mechanisms.
4.3 Ensure to reach out also to those who might not be able to leave their homes or shelters, using outreach mechanisms
Information & Participation


5 = People with disabilities and older people have access to, and feel safe to share complaints
5.2 Ensure processes for making complaints are accessible for people with disaiblities and older people
5.4 Ensure complaints are handled with respect, by training staff on disability and communication, revise code of conducts and internal policies to be inclusive
5.5 Ensure older people and people with disabilities exposed to violence or abuse are protected and referred for assistance
Complaints mechanisms


6 = People with disabilities and older people receive and participate in coordinated and complementary assistance
6.2 Map services and organisations in your area that target older people and people with disabilities, as for example treatment of chronic disease, rehabilitation and assistive devices etc..
6.3 Develop partnerships between mainstream humanitarian agencies and age-and disability-specialised organisation, including disabled people's and older people's organisations
6.4 Make sure actions focused on older people and people with disabilites are not provided in isolation but benefit from syergies between mainstream and targeted interventions
Coordinated Assistance


7 = People with disabilities and older people can expect improved assistance and inclusion as organisations learn from experience
7.1 Aim to continuously improve the accessibility and quality of assistance to older people and people with disabilities
7.2 Define and use age and disability indicators in baseline data and monitoring and evaluation
7.4/5 Ensure the experiences and feedback from older people and people with disabilities are included in lessons learnt to improve accessibility, accountability and safety of a humanitarian response. Share such learning and good practice
Learn & Improve


8 = People with disabilities and older people receive assistance from well-trained staff and volunteers and they have equal opportunities for employment and volunteering
8.1 Train staff at all levels to deliver impartial assistance that recognises gender, age and disability
8.3 Appoint staff at key levels within the organisation to deliver age and disability inclusive programming and/or establish inter-agency disability, age and gender focal points
8.5 Make provisions, including budgeting, within organisations to ensure older people and people with disabilities have equal opportunities for employment or volunteering
Coordinated Assistance

Now, thinking of your own context and organisation, what do you think could be the first few inclusion standards you would try to address?

For example, you could try to prioritise some standards to get started, such as those here highlighted in yellow (1,2 & 8).

Be aware, priorities will not be the same in every context.

1 = People with disabilities and older people are identified and their needs assessed

2 = People with disabilities and older people have access to the humanitarian assistance they need

3 = People with disabilities and older people are not negatively affected, are more prepared, resilient and less at risk as result of humanitarian action

4 = People with disabilities and older people know their rights and entitlements, have access to information and participate in decisions affecting them

5 = People with disabilities and older people have access to, and feel safe to share complaints

6 = People with disabilities and older people receive and participate in coordinated and complementary assistance

7 = People with disabilities and older people can expect improved assistance and inclusion as organisations learn from experience

8 = People with disabilities and older people receive assistance from well trained staff and volunteers and they have equal opportunities for employment and volunteering

3.2 Sector-specific minimum standards

Besides the key inclusion standards there are also seven sets of sector-specific standards:

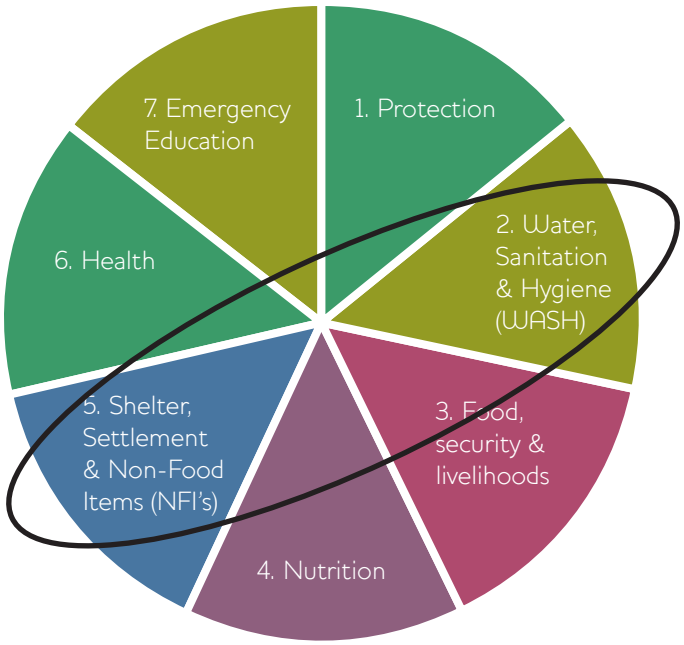
- Protection
- WASH
- Food Security and Livelihoods
- Nutrition
- Shelter, Settlement and Non-Food Items
- Health
- Emergency Education

Would you be able to prioritise 2 or 3 of these sectors to address first for a context you know well?

See the diagram below for an example.

Can you prioritise 2-3 of the seven sectors to address first

1. In Pakistan, emergencies from yearly floods are common in several regions; which sectors could be most urgent to address? Discuss.



4 and 5: Identifying and removing barriers for age and disability inclusion in humanitarian action

4. Identifying barriers for age and disability inclusion in humanitarian action

© CBM/Shelley Sebastien, 10, uses his crutches to navigate a drainage ditch in the tent camp where he lives in the Carrefour neighborhood of Port-au-Prince on Saturday, October 30, 2010. His mother was killed and his leg crushed in the January 12 earthquake. He now lives with his aunt, uncle and a lot of cousins. (Photo by Allison Shelley for CBM)

4.1 Identifying attitudinal barriers

Physical

Physical barriers can be natural or man-made, and the list is infinitely long. Common man-made barriers include narrow doors and passageways, staircases, thresholds, level changes, steep slopes, inaccessible public toilets, waste and debris, etc.

Information

Information barriers occur when information is not made accessible for everyone. This type of barrier can be invisible, but it is no less present and excluding for a very large number of people, particularly those with sensory disabilities.

Attitudes

Attitudes are still, unfortunately, one of the major barriers to full and equal participation. Negative attitudes exist in all parts of society, from community members to policy-makers to programme managers in non-governmental organisations.

Institution

Institutional barriers are procedures and policies that discriminate against persons with disabilities. This can refer to organisational practices (for example recruitment policies) that are not flexible or adapted to persons with disabilities, thus leading to exclusion.

© IFRC, Geneva, 2015.

It is important to keep in mind that pre-existing inequalities and socio-economic disadvantages determine people's resilience and response to crisis and emergency. People with disabilities and older people and their families often face more challenges to break out from poverty, as poverty is both a cause and consequence of disability. This also means that pre-existing biases or assumptions might be aggravated during emergencies and create additional barriers for people with disabilities and older people to access humanitarian assistance.

The following table shows examples of biases and assumptions towards age and disability and what to consider with regards to these biases:

Bias	Assumption	Reality
1. Age bias	"We don't like to say it, but older people 'have had their day.' Their time has passed. When food and water are limited, we have to make difficult decisions and cannot waste resources. They are weak; they cannot work and may soon die due to these difficult conditions. I am sorry but we need to focus the food and water distribution on our youth, pregnant women and our men."	Everyone should be considered equal and no lives have higher value than others. Many older people are resilient and live long, even in difficult conditions, and make crucial contributions to family and community life. Many older people take care of their grandchildren because their children have died in a conflict, or have had to leave to find work in other areas. They also contribute to agriculture or other income-generating means of supporting their families in their own ways, and their health and sustenance should be ensured.
2. Disability bias	"I don't think we have people with disabilities in our camp, I have not seen any. If there are, their families take care of them, that is part of our culture."	Humanitarian agencies and staff might not be aware that people with disabilities and older people cannot move around the camp easily and are often obliged to stay inside the shelters or homes. This could be due to separation from their families or support system (social network) that makes them less independent. In some cases, families might also hide and isolate family members that have a disability, due to beliefs or shamefulness.
3. Gender bias	"Women are overly-emotional and cannot think calmly and come up with solutions during a humanitarian crisis. It is better to talk to their husbands or sons to help decide things for the family."	This is a bias due to gender norms. Everyone reacts differently in a crisis and might need support to deal with the situation. Women and girls are still considered a key figure in ensuring the family well-being, and therefore men and women, girls and boys have to be consulted and included in discussions and needs assessments.

Bias	Assumption	Reality
4. Gender, age & disability biases	"Older men and women and people with disabilities should not apply for 'cash-for-work' programmes in the camps. The work we have is too physically demanding and typically for the men, I don't know why others bother to apply."	This is a bias where many staff and agencies take for granted that older people and people with disabilities will automatically be cared for by their families. They are not considered to be productive and contributing members of the community. Particularly women with physical impairments or psychosocial disabilities are often denied these opportunities. Good practice shows several ways to include older people and people with disabilities in cash-for-work activities, by diversifying type of work, delegating to family members, or providing less physical tasks to people (monitoring or reporting).

Attitudes and assumptions often contribute to both physical and social barriers. Reflect on the following statements with your colleagues and discuss. Consider your own attitudes towards older age and disability, and how those may shape your actions.

Statements	Reality
It is always obvious when someone has a disability	Not always. Some people have disabilities that are not visible upon first encounter. For example, some mental health conditions, neurological disease such as epilepsy, or neuropsychiatric conditions such as autism. Chronic diseases, such as diabetes or heart diseases, can also lead to disabilities and decreased level of functioning. Moreover, people with physical or sensorial impairments may be perfectly able to function independently but still face difficulties in some activities or in some environments.
Most people with disabilities and older people cannot work	Not true, people with disabilities and older people can take up any job providing they have the proper support and technology, as well as education, to perform it. In many countries, older people continue to work and are responsible for their own or family income.

Older people need to stay at home and rest	Older people have the same desires as everyone for socialising and being part of a community. Like the rest of us, some like to stay at home and some like to go out. This is based on their personality, health condition and life habits, not their age.
Older people have the main decision-making power in a family	This is based on the culture and social structures, and can be true in some communities but not in others.
Older people and people with disabilities need help all the time	Not true. The majority of people with disabilities can lead an independent life, if provided with adequate support, assistive devices, access to services such as education, health and employment, and – where required – personal assistance. When the environment is inclusive and accessible, and services are available, older people and people with disabilities require little additional help compared to others.
People with disabilities need financial support from NGOs or charity organisations to help them survive.	People with disabilities and older people who are poor are rights-holders and need equal access to services and social protection programmes. This is a government responsibility, often provided for by the constitution, and, if the country ratified the CRPD, this strengthens the legal obligations. During emergency situations, people with disabilities and older people should be equally considered in cash transfers, cash-for-work programmes or direct food and non-food item distribution.
People with disabilities need livelihood access like other people	True, people with disabilities have equal rights and should have access to equal opportunities to contribute to their families.
The main thing that older people and people with disabilities need in a crisis is good health services.	Older people or people with disabilities have same survival needs as anyone else, such as access to shelter, food, WASH, information, etc. They also need access to health services like everyone else, with some having health conditions that requires continuous medication, rehabilitation or more specialised health service.
Women with disabilities are not at risk of sexual violence like other women.	Not true, they are often at higher risk of violence and sexual abuse. Women with disabilities may be dependent on their families or husbands and have less access to information; limited possibilities to seek redress, and some might not be able to communicate the abuse to family members, police or health workers.

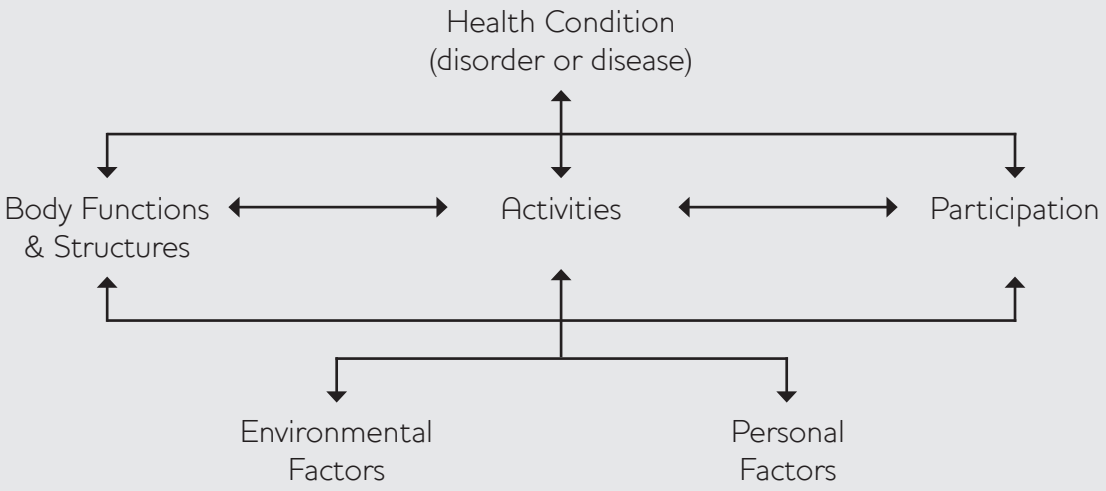
[27] The Guardian, December 15, 2011. Accessed on October 6, 2015. Available at: http://www.theguardian.com/global-development/2011/dec/15/talk-point-disability-stigma

What can be done to change or challenge these such barriers and biases in your own work and context?

1. Firstly, we need to see if we are biased ourselves and why. Ask yourself how you would manage the recruitment of a person with disability or an older person in your team. What are your own biases? Often our biases are very deeply rooted and build on misconceptions and ignorance, which might make it hard to think in another way. Understanding this and starting to interact with older people and people with disabilities will make it easier to be a more inclusive organisation.
2. Secondly, if you do want to challenge your biases (and we hope you do!) discuss why you think these biases are true and what would convince you that they are not true. Not everyone will have all these biases, but most of us have at least a few biases, perhaps towards other groups in society.
3. Lastly, if you agree these biases are NOT TRUE, try to find ways forward to change practices and policies in your work and in your organisations. You may use actions from the Minimum Standards for reference.

4.2 Identifying barriers that aggravate exclusion

Use the ICF, introduced in chapter 2, as a way of identifying environmental barriers for people with disabilities and older people, which will help to classify physical, communication, attitudinal and institutional barriers and intersectional discrimination. This will help to look at how the design and implementation of humanitarian action can become more inclusive of people with disabilities and older people.



Example: a woman who is a wheelchair user and a teacher as a profession, was forced to leave her home due to violence in the neighbouring town. She used to teach in a primary school and lived quite independently with her family in small town. She now lives in a temporary camp, together with some of her previous neighbours, in a two-room shelter. She had to leave everything behind and also lost her wheelchair during the chaos. Due to insecurity and a chaotic environment she has become almost totally dependent on her neighbours, and she has had difficulties in finding a new wheelchair, which prevents her from going out of the shelter.

If using the ICF to analyse the personal and environmental factors she has to face in this new situation, we find that while her impairment has not worsened, her surroundings have become an obstacle. She is limited in her mobility because of not having her wheelchair (barriers = no access to rehabilitation services and assistive device) and because of an unknown environment (barrier = lack of assistance and an inaccessible camp infrastructure). As she was separated from her family, she feels less safe (barrier = no assistance support and insecurity) even if she lives close to neighbours, as they are overprotective towards her. She has tried to apply for teaching in a school via a local aid organisation but she was turned down because of her disability (barrier = stigma and discrimination).

In this example, both physical and attitude barriers have been identified, which lead to exclusion:

Physical barriers, such as inaccessible camp infrastructure, non-adapted shelters and a lack of assistance support, prevented the woman from fully participating in camp life. Other barriers often found in emergency situations could be: stairs in schools and health clinics; distributions points located far from people's shelters; or food parcels or water cans too heavy for older people or people with disabilities to carry.

Tips for addressing physical barriers: Think of the acronym **RECU**[25], which reminds us to examine barriers to: **reach** (road condition, transport), **enter** (doorways, stairs), **circulate within** (hallways/ room space) and **use** (table height, toilet, sink, computers).

Attitudinal (sometime also called social) barriers, such as negative attitudes and discrimination because of disability, or overprotection, were reasons why the woman in the example couldn't ensure her livelihood in a dignified way. Other social barriers that people with disabilities and older people often encounter in emergency situations are neglect, due to not being considered productive or capable of contributing, or harassment, which makes older people and people with disabilities avoid public places.

The table below, which is taken from IFRC's guidelines on disability-inclusive shelters and settlements in emergencies,[26] summarises different barriers people with disabilities, as well as many older people, encounter.

[25] http://handicapinternational.ph/blog/2014/11/14/hot-off-the-press-brochure-on-universal-accessibility

[26] IFRC (2015). All under one roof. Disability-inclusive shelters and settlements in emergencies, IFRC, Handicap International and CBM, Geneva.

5.1 Suggestions on how to eliminating or reduce physical and attitudinal barriers

After identifying different barriers and obstacles that people with disabilities and older people face in emergency situations, a reflection on how to overcome and remove such obstacles has to be done, in terms of organisational policies, programme and project design, and monitoring and evaluation systems.

The following are some suggestions on how to eliminate or reduce physical and attitudinal (social) barriers and obstacles, to promote better access for people with disabilities and older people to emergency response.

1. People with intellectual impairments or learning difficulties

Adults, older people and children with intellectual impairments or learning difficulties can have difficulties in coping with unfamiliar environments, such as emergency shelters, or will be more at risk in a chaotic situation. Emergency shelters or camps are often cluttered and noisy, with unclear or non-existent signage, which may increase a sense of intimidation and exclusion. Ensuring a barrier-free emergency shelter for people with intellectual impairments or learning difficulties might include:

- Taking steps to reduce overall noise levels or creating some quiet spaces that are uncluttered and calm.
- Providing clear and frequent signage to direct people around the environment, to decrease the need for assistance.
- Give an orientation tour around shelter area and point out landmarks that people can try to remember, or put red flags on them to make it easier for people to follow.
- Raise awareness among sector leading organisations about the difficulties people with disabilities may face, so that measures are not put in place that increase obstacles and barriers.

Tips on communication:

- Interact with people directly, do not ignore them by only talking to family members or carers.
- Break information down into smaller and concrete facts and easier to understand sections of information.
- If necessary, involve a family member to better understand the needs and requirements of the person.
- Sometimes it might be easier to use pictures or signs to explain certain situations.

2. Persons with mental health conditions or chronic health conditions associated with age

People who have mental health conditions or chronic health conditions, including persons with psychosocial disabilities, or older people who have Alzheimer or other types of dementia, may be confused, have concentration or memory difficulties, or problems with logical reasoning. They often face stigma and exclusion, which can sometimes result in a different behaviour, such as anger or fear. In an emergency situation, chaos, quick changes in the environment, evacuation or displacement can be particularly challenging:

- Taking steps to reduce overall noise levels or creating some quiet spaces that are uncluttered and calm.
- Providing clear and frequent signage to direct people around the environment to decrease the need for assistance.
- Give an orientation tour around shelter area and point out landmarks that people can try to remember, or put red flags on them to make it easier for people to follow.
- Raise awareness among sector leading organisations about the difficulties people with disabilities may face, so that measures are not put in place that increase obstacles and barriers.
- Issue of fear for their safety and/or are uncomfortable around new people: have the person with mental health issues meet you with a family member or a friend
- Space issues (claustrophobia): explain to them nearest exit or meet them outside, making sure not to stand/sit too close to them if this makes them uncomfortable.
- Angry/upset feelings: find productive ways to accommodate these feelings that are comfortable to you.
- Fear of getting lost: meet them in a location they know how to get to and accompany them to new places from there.

3. People with visual impairment

People with visual impairments, including older people with visual loss as a result of ageing, or who are blind, might be at higher risk during disasters and emergencies. Evacuation may be more difficult, as they often require personal support in a chaotic and stressful situation. New environments are not easy to move around in and therefore they risk being isolated and not access needed relief services. Ensuring that people who are blind can access humanitarian assistance will be beneficial to many other people who may have moderately impaired vision; such as older people who may have deteriorating vision or people who wear glasses:

- Marking the front edge of steps with a contrasting strip so that they can be easily identified.
- Ensuring that all areas are well lit.
- Ensuring that all signage is clear, in large letters and at eye level. Some information can be provided with raised letters, such as a map of a shelter or settlement for example, that can be felt.
- Ensuring all pathways and commonly used areas are clear of any objects or debris.
- Inform them of location of services, take them for a walk around the camp/tent area, and provide orientation and explanation of surroundings (number of people, physical structures, hazards, water points, toilets, etc.).
- Create a safe shelter space with reduced hazards and landmarks (brightly coloured object contrasting with surroundings, to help people to mobilise safely).
- When communicating with people with visual impairments, speak directly to the person and not to the family member of carer, and introduce yourself in a customary way.
- When meeting a person with a visual impairment, speak for some time, so that they learn the sound of your voice.
- In a meeting or group consultation, ask people to introduce themselves when speaking.
- Read out any written information and consult with people in which way they prefer to receive information and assistance.

Image source: https://www.dinogrip.co.uk/media/wysiwyg/megamenu/stair-treads-3.jpg

Description: Steps using yellow contrast strips so they can be easily identified

4. People with hearing impairment and/or communication difficulties

People who are deaf or have a hearing impairment, including older people with hearing loss as a result of ageing, may find it difficult to access humanitarian assistance during and after an emergency. In the first instance, evacuation or rescue can be a challenge when people are not able to hear oral warning messages or evacuation signals. During the post-emergency, in chaotic environments or in temporary shelters, information is often provided through mass communication or by word-of-mouth, and people who are deaf or hard of hearing might miss out on such information. Therefore, life-saving relief and assistance, such as food distribution, health services, or WASH services, will be difficult for them to access. Furthermore, people with a speech impairment might also have difficulty in communicating their needs during assessment and consultation, and asking for other relevant information.

Ensuring a barrier-free emergency shelter for people with hearing and/or communication difficulties might include:

- Clear and visible signs identifying the location of facilities.
- Provision of written information, outreach visits, and information complemented by pictures, to help people to understand the delivery of humanitarian assistance. For example, signs to a health centre/pharmacy are below and general pictograms.
- Good glare-free lighting to assist lip-reading as well as the visibility of signs and written communication.
- When communicating with people who are deaf, use a sign language interpreter where available and where this is a common practice. Always remember that you are communicating with the person, not the sign language interpreter. If this is not available, use your body language and facial expressions to try to understand and communicate your information.
- Use pen and paper if you speak the same language.
- Some people who are deaf of hard of hearing might use lip reading. Remember to speak in normal voice but with clear pronunciation and articulation, face the person you talk to at all times, and use gestures if relevant to the context and culture.

Please consider that persons with intellectual, psychosocial and physical disabilities may also have difficulties communicating.

5. People with physical impairments and/or reduced mobility

Not all people with physical impairments, including older people with age-related mobility limitations, use a wheelchair. Some use a walking stick, have a prosthesis or orthotic, or use crutches. Some move without assistive devices but at a slower pace or shorter distances. If a temporary shelter or settlement has included accessibility measures, for example, it will also assist people with other mobility difficulties. Removing or reducing physical barriers in a humanitarian context might involve the following (consult technical guidelines (see the box below) for more in-depth information on physical accessibility):

- Locating toilets and washing facilities so that they are accessible both in terms of location and design.
- Making sure ramps and verandas are wide enough to allow a wheelchair or hand-propelled tricycle to move around.
- Placing things such as wash basins, tables, benches, and other facilities so that they can be reached from a sitting position and have sufficient space under them so a chair can be wheeled right up to them.
- Making seats/benches available close to distribution sites, health clinics, water points and common spaces, so that people can rest whenever needed.
- Securely fixing handrails to assist with walking up and down slopes and steps/stairs.
- In general, services should be built in an accessible place (not at the end of the camp or a lengthy distance for people to travel), and the route of access must be as level as possible, in order to avoid obstacles (trunks, branches, holes etc.).
- Clearing public pathways of obstructions.
- Using non-slip materials for inside surfaces (shower and sanitation facilities for example).
- Using levers rather than knobs for door handles and taps.
- Extending the length of the pump-handle on water-pumps to make the pump action easier.
- Having trolleys available for easier carrying of food packages/water (see the picture on the right).

General reminders:

For shelter allocation within a refugee camp (example camp below)

- People with disabilities and older people should always be asked where they want to be located and this can be built into the planning. An example is shown here, where they can be located in the line/area closest to the cluster of services, if that is their preference (see picture below – the red arrows are the recommended placement of people with disability and older people, especially those with functional limitations).

- During the construction of new camps, fill the middle section of the camp first (yellow arrows) before allocating spaces closest to services, to avoid 'first come first serve'. Reserve the red area for people with functional limitations or other disabilities (visual or intellectual, who may get lost).
- DO NOT place vulnerable people in area of blue arrows, farthest from services
- It is importance to ensure that they are with their community and feel safe with an existing social network around. Ensure a "do no harm" approach: inform the community about "positive discrimination" measures, such as consulting with people with disabilities and older people on where they want to be, and reserving spaces close to services for them, while not doing so with other families.
- Creating settlements of older people and persons with disability and their families, separated from the rest of the community, will not create an inclusive environment.

5.2 Using the Minimum Standards to remove barriers

The seven sector specific standards in the Minimum Standards provide guidance on how to make each sector more inclusive. Reflect on the specific guidance on the sector specific standards while reading through the scenarios in the table below.

	Non-inclusive action	Examples of inclusive action
1. Protection	The camp authorities have put in place a reporting and surveillance system of protection against sexual violence and abuse within the camp. The system though has not been disseminated in an accessible way and many older women, and women and girls with disabilities, have been left out. Furthermore, most security personnel are men and not sensitised to disability, which makes it difficult for them to address their complaints.	At-risk groups among the population, including women and girls with disabilities and older people, are identified by an NGO focused on SGBV, and they are included in community and women's activities. The camp is well lit and women and girls are given whistles/flashlights and other things to help increase their sense of safety. They are also informed about how to report any concerns in a 'safe space', with trained female and male staff. Awareness campaigns about sexual and gender-based violence are held in the camp.
2. WASH	Two boxes of diapers are given to parents of children with disabilities every month by a local charity. It is not enough, families are asking for more. Adults who have bladder issues are not considered in this response.	After a series of community meetings, families raise the idea of hiring four women who are seamstresses in the camp, including women with disabilities, to make reusable diapers for children and adults. The diapers are bought by the NGO and then provided as part of the NFI kits to families who need them.
3. Food security & livelihood	Cash vouchers are given to vulnerable households (woman-headed, older person- or person with disability-headed) because they are considered as not able to join cash-for-work or other livelihood programmes. Several of these recipients, however, have skills to offer the camp population and would like to be hired to work for a salary, like others. Since they receive vouchers, they cannot apply for any livelihood work in camp.	Livelihood and cash-for-work programmes are designed so that older people and people with disabilities can participate. Through support to self-help groups, or the establishment of Age and Disability Focal Points, awareness of the capacities of these groups is raised in cluster meetings and other coordination mechanisms.

4. Nutrition

A local drinks company has donated nutritional supplements to one NGO working in a camp settlement. They are provided to older people. However, it turns out that they do not contain the sufficient nutrients, the majority of older people do not find them tasty, and they are unfamiliar with these types of supplement.

The health centre in the camp develops a list of nutritional deficiencies that are common in the camp population, both among children and older people based on health issues they are identifying. They do a community assessment to identify the population who are at risk, including people of all ages who have difficulties in chewing or eating food rations, and older people who may not be getting enough food. They also consult on people's food habits and cultural preferences. After this outreach, they work with food distribution actors to add nutritional boost to food packages, as well as providing food that is easy to digest and chew for these groups.

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5. Shelter & NFI

A wealthy local family has donated 40 heaters, which have been given to people with disabilities. Half of them already have heaters and sell their heater to other people in the camp. Some people in the community get upset that people with disabilities 'get everything and the rest of us are ignored'.

300 older people and people with disabilities and their families are surveyed to identify persons in need of heaters. NGOs doing NFI distribution revise their vulnerability criteria to target families identified by the survey who have not received assistance and who have special health needs that make them at risk in cold winter months.

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6. Health

Health centres in a camp are managed by an international NGO. Medication for chronic diseases such as diabetes, high blood pressure and some mental health conditions are being provided on a weekly basis. Unfortunately, very few older people or people with disabilities are coming to the health centre, and the staff are considering reducing the stock of such medication.

The NGO consults with older people and people with disabilities when designing and setting up the health clinic. This has ensured accessibility, and the hiring of health volunteers who can inform people about the clinic and conduct health awareness activities.

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7. Emergency education

Health centres in a camp are managed by an international NGO. Medication for chronic diseases such as diabetes, high blood pressure and some mental health conditions are being provided on a weekly basis. Unfortunately, very few older people or people with disabilities are coming to the health centre, and the staff are considering reducing the stock of such medication.

The NGO consults with older people and people with disabilities when designing and setting up the health clinic. This has ensured accessibility, and the hiring of health volunteers who can inform people about the clinic and conduct health awareness activities.

Remember! You will need to identify and remove all barriers through creating physical access, ensuring people have appropriate equipment and that communication is accessible for all and the attitudes of staff and the community are open and welcoming.

Infographic credit: Aaron Walawalkar © RedR UK

Description: Zaatari camp. Jordan. Extending the length of the pump-handle on water-pumps to make the pump action easier.

Photo: Caroline Gluck/Oxfam

Additional reading and technical guidelines on inclusive humanitarian action

- Ensuring inclusion of older people in initial emergency needs assessments (2012), HelpAge: http://www.helpage.org/what-we-do/emergencies/ensuring-inclusion-of-older-people-in-initial-emergency-needs-assessments/
- Guidelines for creating barrier free emergency shelter (2009): http://www.hiproweb.org/uploads/tx_hidrtdocs/CreatingBarrierFree2009.pdf
- All under one roof. Disability-inclusive shelter and settlements in emergencies, IFRC: http://www.ifrc.org/Global/Documents/Secretariat/Shelter/All-under-one-roof_EN.pdf
- Humanitarian Aid All Inclusive! How to include people with disabilities in humanitarian action, Light for The World, Diakonia and CBM: https://www.light-for-the-world.org/uploads/media/HA_all_inclusive_web_02.pdf
- UNICEF (2017) Including children with disabilities in humanitarian action. http://training.unicef.org/disability/emergencies/index.html

General information around inclusion

- GSDRC Disability Inclusion http://www.gsdrc.org/topic-guides/disability-inclusion/
- CBM Toolkit for information on disability inclusion – text p 21 + http://www.cbm.org/article/downloads/54741/CBM-DID-TOOLKIT-accessible.pdf
- World Vision – p 52 onwards for visual charts http://www.wvi.org/sites/default/files/Travelling_together%5B1%5D.pdf

6. Age- and disability-inclusive project cycle management in humanitarian action

6. Age- and disability-inclusive project cycle management in humanitarian action

The purpose of Initial Rapid Assessments (IRA) is to discover:

What has happened?

- Population affected?
- Affected area?
- Extent of damage?
- At risk population? Protection issues?

What is already there?

- Resources/capacities present?

What is needed?

- Outside interventions?
- Emerging threats?
- Key information gaps?

First steps when preparing an emergency response

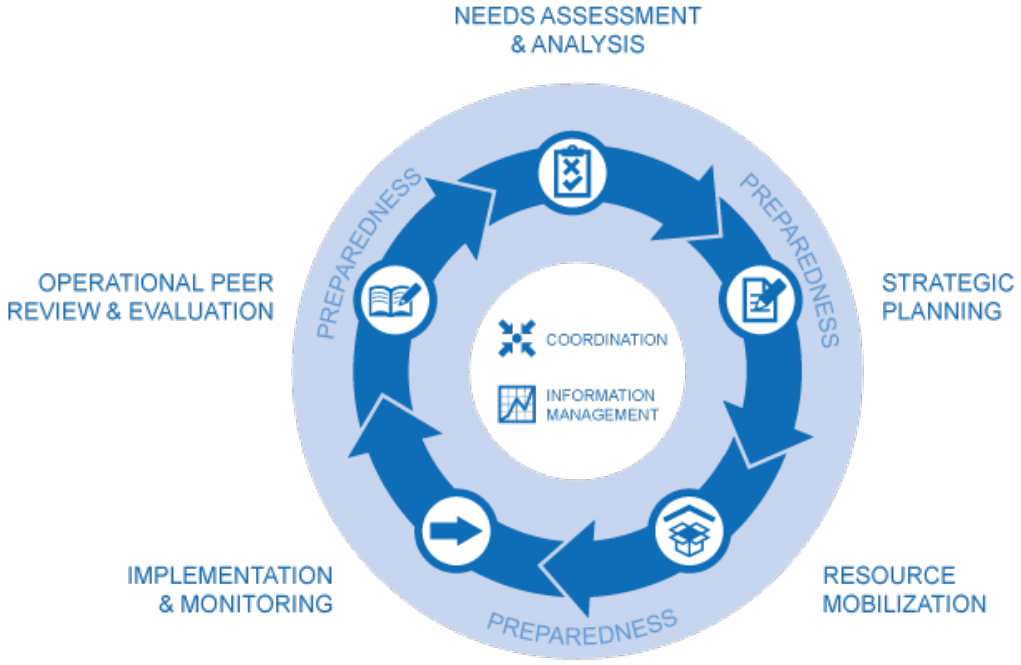
1. Collect and analyse the primary data collected during a Rapid Needs Assessment.
2. Review and analyse secondary data.
3. Identify vulnerable and at-risk groups.
4. Identify questions or checklists to collect sex, age and disability disaggregated data in a gender sensitive manner.
5. Collect sex, age and disability disaggregated data (SADDD).

© Dan Giannopoulos / Handicap International.

Description: Mousu Abd and his grandson Mohammad attend Handicap International clinic in Zataari refugee camp in Mafraq, Jordan.

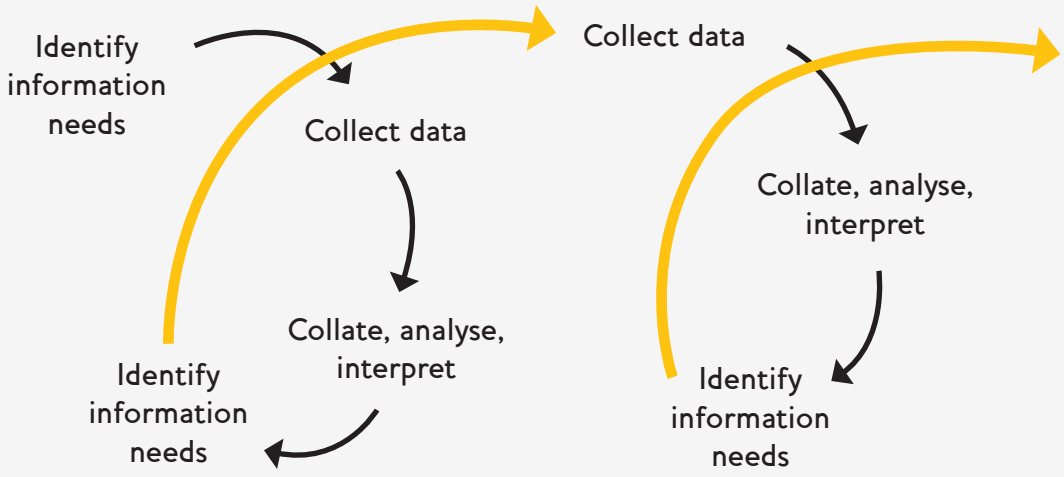
6.1 Preparedness and needs assessment

The humanitarian programme cycle (HPC) is a coordinated series of actions undertaken to help prepare for, manage and deliver humanitarian response. It consists of five elements coordinated in a seamless manner, with one step logically building on the previous and leading to the next. Successful implementation of the humanitarian programme cycle is dependent on effective emergency preparedness, effective coordination with national/local authorities and humanitarian actors, and information management. In a fast changing environment, humanitarian interventions require fast adaptation and continuous revision based on updated needs assessments and coordination with other actors.



Source: OCHA, Humanitarian Programme Cycle, https://www.humanitarianresponse.info/en/programme-cycle/space

Collection, collation and analysis needs to be an iterative process



People with disabilities and older people are often forgotten or ignored during emergencies because needs assessments do not include these groups in their data collection methods. It is therefore important to revise needs assessment tools, checklists and data collection methods so that they 1) identify and register people with disabilities and older people, and 2) identify their needs (see inclusion standard 1.2).

This requires that humanitarian agencies and organisations have appropriate tools and trained staff to identify people with disabilities and older people. It is important to keep in mind that people with disabilities and older people have the same basic needs as any other person in an emergency, but they might face some specific obstacles to accessing relief services. In addition, some will require more specialised support and services, due to health-related needs they might have.

Rapid Needs Assessment

As mentioned earlier, the rapid needs assessment is crucial in defining the immediate humanitarian intervention. Because of the time constraints, it often relies on secondary data and primary data that is collected to the best possible extent. Sometimes primary data is only collected at a later stage. Both primary and secondary data collection can take into account disability and age, bearing in mind the suggestions in chapter 1 regarding estimating the percentage of people with disabilities and older people, and the key challenges they face in humanitarian situations.

Here are a few suggestions to keep in mind when planning a rapid needs assessment and preparing data collection:

1. Sensitise field workers and volunteers on disability and age.
2. If there is a lack of data on disability, estimate that 15% of the affected population has some form of disability (mobility, sensorial, intellectual and mental health conditions) and around 11.5% might be older people (aged 60 and over).
3. Assess data from previous disasters; was disability and age mentioned and assessed?
4. Establish contacts with Disabled People's Organisations (DPOs) and Older People's Associations (OPAs), or disability and age specialist organisations, to exchange data and – where possible – coordinate with or directly involve people with disabilities and older people in data collection.
5. Build assessment teams with disability and older age experience whenever possible.
6. Conduct group interviews with persons with different types of disabilities and all ages, or, if this is not possible, with key informants from local DPOs and OPAs.
7. When people with disabilities and older people are identified, register them and their needs, but be careful with protection of personal data – always ask for consent and explain the use of the data.
8. Make observations, such as whether people with disabilities and older people are visible in the affected area, what the level of inclusion or exclusion seems to be, whether there are gender issues, what the status of people with disabilities and older people seems to be.
9. Assess damages to services used by people with disabilities and older people, such as special schools, institutions, rehabilitation centres, social services, and DPOs and OPAs.
10. Take pictures of water points, food distribution points, hospitals and other services in the area, to analyse the level of accessibility.
11. Analyse data to identify barriers, share your assessment results, and use these to influence other partners or organisations involved in the response. Keep in mind the principle of protection when sharing data, particularly in conflict contexts.
12. Has the disaster led to increased number of people with impairments and disabilities? Plan for those that might be in need for referral to more specialized health services or psychosocial support.

Below are some examples of sources of data and information for disability and age, to consider when collecting primary and secondary data during rapid needs assessments:

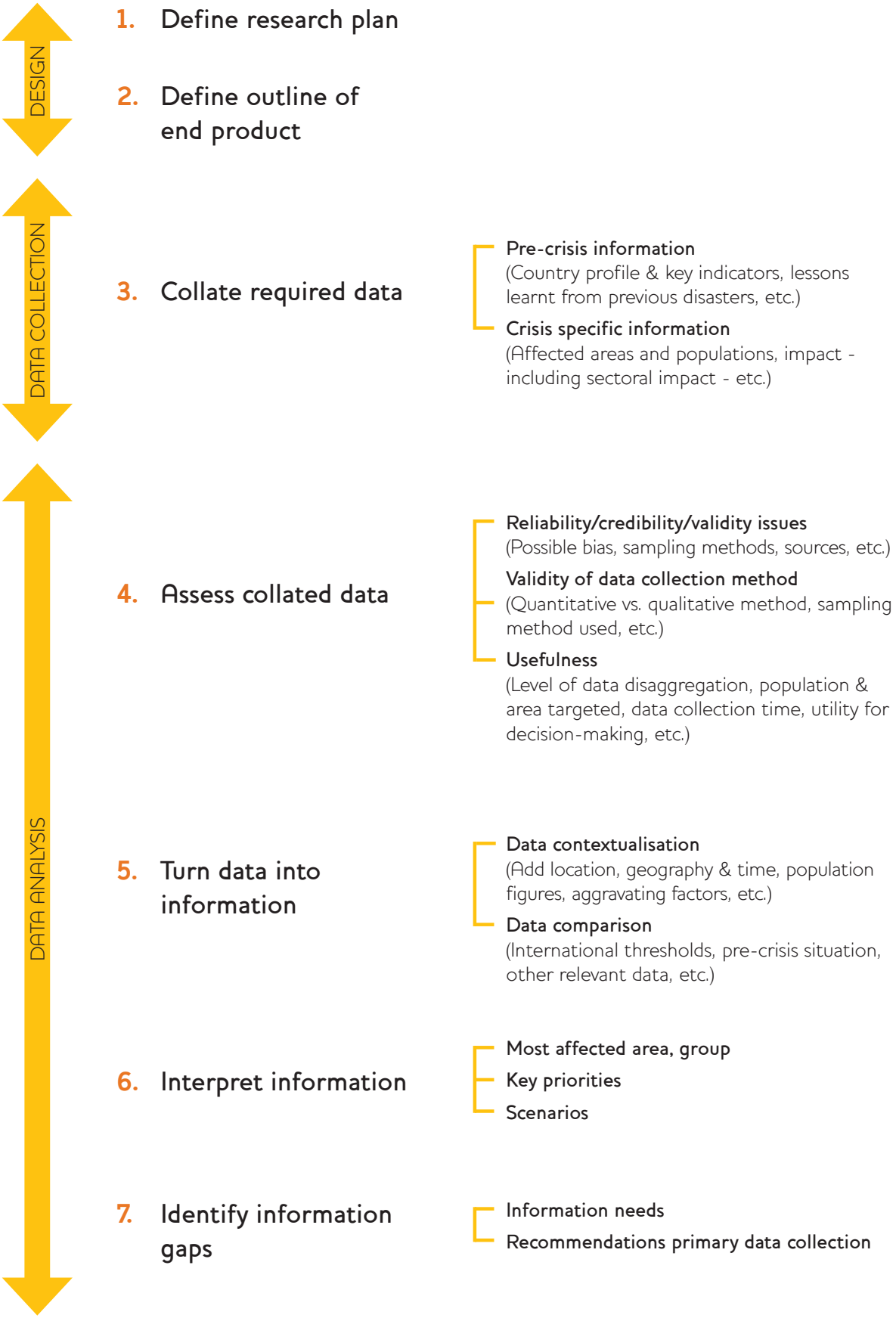
- Primary data examples:
  - Field visits/observations (are people with disabilities and older people visible? If not, ask some questions about where they might be living. Are women visible? Accessibility aspects, infrastructure, transport, services?).
  - Surveys/questionnaires.
  - Key informant interviews (include questions on women, men, and children with disabilities in interviews with headteachers; ask health staff about people with disabilities and older people, and so on).
  - Case studies.
  - Focus groups (including older men and women and women, men, girls and boys with disabilities).
- Secondary data examples:
  - Public, national-level statistics/census data, or local level registries.
  - DPO or OPAs' data/registry.
  - Preparedness/evacuation/contingency plans.
  - NGO reports with reference to disability in the area.
  - Maps and satellite imagery.

Laxmi Chaudhary, 27 years old, received physiotherapy and elbow crutches to regain mobility after an unproperly treated leg fracture, which causes her to limp. Laxmi could regain her self-confidence and now works in a sewing shop. in Dang, Nepal

© Brice Blondel / Handicap International

Step-by-step secondary data analysis

The following chart shows step by step how secondary data can be analysed



Source: https://docs.unocha.org/sites/dms/Documents/mira_final_version2012.pdf

6.2 Sex, age and disability disaggregated data

The Minimum Standards, as well as the Sustainable Development Goals (SDGs) and the Sendai Disaster Risk Reduction (DRR) framework, require organisations to apply a more detailed disaggregation of data, not only based on sex and children/adults, but to also include older age and disability: Sex, Age and Disability Disaggregated Data (SADDD). This is also explained in Key Inclusion Standard 1 of the Minimum Standards and the annex on SADDD. Neither people with disabilities nor older people are homogenous groups, and it is still important to group types of impairments or functional limitations, and ranges of ages, to manage data effectively.

Ongoing collection of SADDD includes:

- Age and sex disaggregation by the following age groups: 0-5, 6-12, 13-17, 18-29, 30-39, 40-49, 50-59, 60-69, 70-79, 80+, for both male and female.
- Consider including the **Washington Group** short set of questions in more in-depth needs assessments, when individual data is collected.[28] These are a set of six questions, seeking to identify people with functional limitations that have the potential to limit their independent participation in society. Responses are categorised on a scale of severity of the difficulty experienced (no difficulty, some difficulty, a lot of difficulty, and cannot do at all). The Washington City Group recommends that all those with at least one domain that is coded as "a lot of difficulty" or "cannot do it at all" is identified as a person with disability.

The Washingtin group questions are:

1. Do you have difficulty seeing, even if wearing glasses?
    a. No – no difficulty
    b. Yes – some difficulty
    c. Yes – a lot of difficulty
    d. Cannot do at all
2. Do you have difficulty hearing, even if using a hearing aid?
3. Do you have difficulty walking or climbing steps?
4. Do you have difficulty remembering or concentrating?
5. Do you have difficulty (with self-care such as) washing all over or dressing?
6. Using your usual (customary) language, do you have difficulty communicating, for example understanding or being understood?

To ensure comparability of data, it is important to keep the same wording of the questions, answers and the cut-off point when defining disability.[29]

[28] Washington Group Short Set of Questions on Disability http://www.washingtongroup-disability.com

[29] http://www.washingtongroup-disability.com/wp-content/uploads/2016/01/interpreting_disability.pdf Please read also the guidelines on translation of questions into other languages.

© Frederik Buyckx / Handicap International

Description: Anwar is 42 yrs old and living with his wife, his 4 kids, and his mother in law (Zaila) in a small flat. The family (Anwar, his wife, daughter, twins Ahmad and Mohamad and mother-in-law Zaila) arrived in Lebanon 4 months ago after their house was bombed. Members of their family got killed in the bombing . Anwar got injured to the head which resulted in memory loss problems for him. He is also facing lung problems and needs medical treatment that he can't afford. His mother-in-law is suffering from diabetes and also needs medical treatment. Zaila, benefited from PT sessions and donation of a walker and a wheelchair. His daughter is benefiting from psychological support. The family has been referred to another NGO in order to live in another place and to provide the mother-in-law with medication for her diabetes

In-depth needs assessment

Once the emergency context is more stable, it is important to complement the initial assessment with more precise quantitative and qualitative data. At this stage, there will be more time to assess age- or disability-related needs and analyse to what extent people with disabilities and older people are accessing the initial relief and response (see inclusion standards 1.1 and 1.2).

A few tips to keep in mind when complementing the initial needs assessment:

- Sensitise staff and volunteers on disability and age; make sure volunteers conduct home visits, knowing that some people with disabilities or older people might have difficulties to move around.
- Complete assumption data with more reliable data; conduct household surveys (or representative samples) where possible.
- Hold focus group discussions or group interviews with persons with different types of disabilities and groups of older people. Define more precisely the needs and barriers they face, but also the capacities and opportunities for the participation of people with disabilities and older people in the response.
- Complement the needs assessment with data shared by NGOs or government-updated data. Advocate with partners to include disability and age data in surveys and assessments

- Consider whether DPOs or OPAs have collected additional data and information that can be shared.
- Identify possible new barriers through group discussions; pay particular attention to the situation of women and girls with disabilities, and older women.
- Include resources in the budget to facilitate people with disabilities' and older people's participation in meetings and discussions (travel, accompaniment, etc.).
- Develop referral networks, especially for newly injured people or people with disabilities and older people requiring more advanced medical or rehabilitation services.

When designing a project proposal based on the needs assessment, the following should be taken into consideration for age and disability inclusion:

1. Are people of different abilities and ages consulted during pre-project analysis?
2. Are budgets set for adequate training on age and disability inclusion?
3. Are budgets set for all sites and other project aspects to be fully accessible?
4. Have age and disability data been collected and considered?

6.3 Project implementation

Throughout the implementation of humanitarian project and response, it is important to involve people with disabilities and older people in the action, to the widest extent possible (see inclusion standards 4.2, 4.3, 7.3 and 7.4). For example, be open to recruiting people with disabilities and older people as staff or volunteers. Don't forget that many of them can also participate in cash-for-work activities, or be involved in supervising tasks or supportive tasks in such actions. Other tips to keep in mind during project implementation to promote age and disability inclusion are:

- Sensitise staff and volunteers, as well as support staff (such as guards, maintenance workers, and receptionists) on disability and age. Ensure that the barriers identified are understood and addressed. Include and work with DPOs or OPAs in awareness sessions for project staff, to change attitudes.
- Involve people with disabilities and older people in finding solutions to problems of access, security, discrimination, and so on.
- Train staff to collect the SADD data required and produce relevant reports.
- Train staff to collect dignified human-interest stories that positively portray the situation of people with disabilities and older people, alongside other people affected by the emergency.
- Continuously coach staff and build confidence.
- Adapt your information, awareness and other communication materials into various formats, to better reach out to all people. For example, audio messages that would better reach people with visual impairments or non-literate people; using SMS systems where relevant; providing information through household visits; or signage and orientation systems with pictures and large letters.

6.4 Monitoring and evaluation

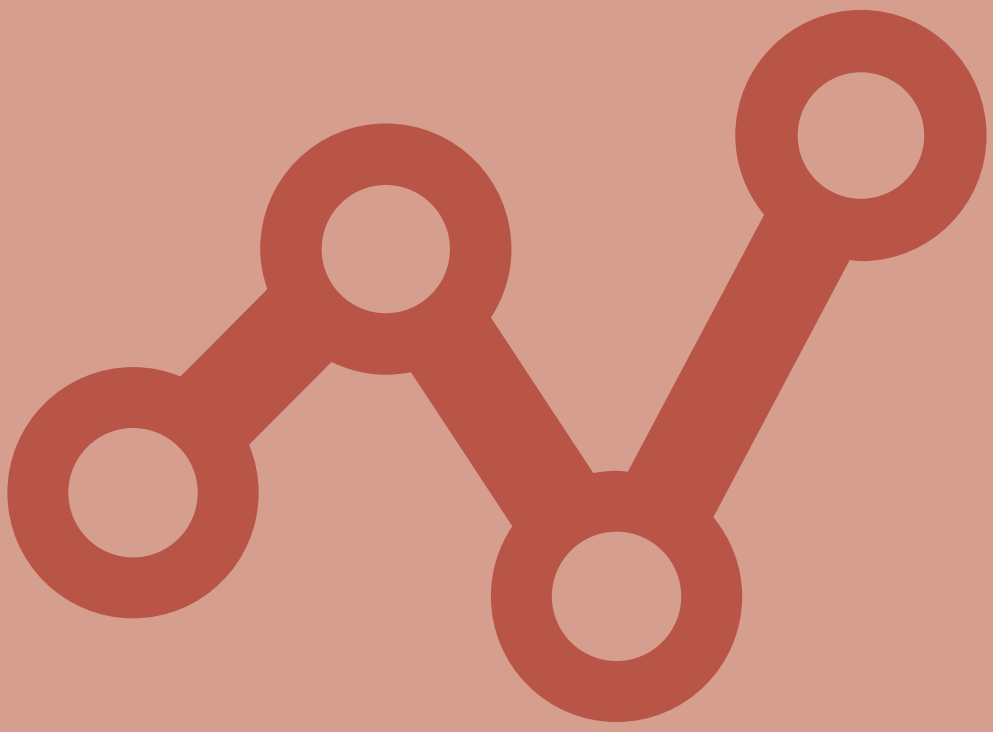
Monitoring is to measure that the intervention is going as planned, or if it requires some adaptation or revisions. Monitoring is a continuous and systematic process throughout the project implementation. It is therefore also a key mechanism to understand to what extent the relief services are inclusive to people with disabilities and older people. This requires that there are process indicators that are inclusive of disability and age (see key inclusion standard 7).

- Process indicators: for example, women, men, girls and boys with disabilities and older men and women benefitting; barriers removed (ramps constructed, information material adapted, referrals to specialised services made, and so on); and capacity building of people with disabilities and older people (Key inclusion standard 2).
- Build-in feedback (complaint) mechanisms from beneficiaries into the project, making sure they are safe and accessible to people with disabilities and older people (Key inclusion standard 5).
- Disaggregate data (sex, age, and disability) in periodic reporting.
- Budget for the monitoring system; collecting some data on disability and age might require additional budget (accompaniment for participating in meetings and discussions groups, physical and information accessibility, home visits for surveys etc.).

Evaluation and learning. Did the project achieve what was planned, what were the lessons learned? Were the objectives and targets reached, including the disability and age indicators? If not, what could have been done different?

- Have people with disabilities and older people had equal access to the aid and services provided? How to measure: records of participation and beneficiaries; focus group discussions and in-depth interviews; key informant interviews; human interest stories follow-up, etc. (Key inclusion standards 2 and 6).
- If not all objectives and targets were reached, what could we learn; how do we improve inclusion?
- Involve DPOs and OPAs in the design and implementation of the final evaluation.
- Did women, men, girls and boys with disabilities develop capacities for resilience (Key inclusion standards 3 and 7)?

7. Advocating for age and disability inclusion in humanitarian action



7. Advocating for age and disability inclusion in humanitarian action

Mainstreaming disability and age into humanitarian action and the organisations involved in providing aid and relief, is a key aspect of improving the access of people with disabilities and older people to humanitarian relief and life saving measures. It is the principle of impartiality and ensuring that no one is left behind in the situation of an emergency or disaster.

Advocacy could be described as an activity by an individual or group, which aims to influence decisions within political, economic, and social systems, institutions and organisations. Advocacy represents the series of actions taken and issues highlighted to change the 'what is' into a 'what should be'.[30]

Advocating and making the case for including age and disability in humanitarian agencies and organisations is therefore important. It requires internal awareness-raising and influencing to change policies, practices and attitudes.. External technical support is often required, and age- and disability-specific organisations might be able to provide such support.

7.1 Advocacy for age and disability inclusion during humanitarian action

One way of advocating for disability and age mainstreaming directly during emergency response is to raise the issue in the relevant cluster meetings, or other coordination mechanisms set-up in the emergency response. Facilitating data on age and disability and offering support in identifying solutions to improve access can greatly improve the overall response to the crisis and support a more inclusive response from other humanitarian organisations. Furthermore, well-planned facilitation of DPO and OPA participation, ensuring they are well prepared and briefed, could also have an important impact.

Establishing an **Age and Disability Focal Point** is another way of both improving access to response and relief, and advocating for better inclusion in overall emergency response. Such Focal Points have been set-up now in a number of emergencies and have proved to be very useful for 1) identifying and mapping relief services provided by different structures during the emergency; 2) identifying and referring people with disabilities and older people to relevant relief services, as well as to more specialised services where necessary; and 3) involving DPOs, people with disabilities and older people in the emergency response, and building their capacity to advocate for inclusive humanitarian action. These Age and Disability Focal Points can be fixed or mobile in structure, depending on the context of the emergency situation. They can have outreach components or smaller satellite focal points in more remote areas.[31]

Using advocacy is one way to advance the mainstreaming of disability and older age into humanitarian organisations, in order to influence the change of attitudes, policies and practices. It is important that people with disabilities and older people are at the forefront of advocacy and represent their group. The principles of the CRPD – together with other human rights instruments – are equally valid in a humanitarian context, and participation and representation are at its core. Therefore, building capacity of DPOs and OPAs on emergency response management, and humanitarian principles and actions, is key to advancing inclusion. Empowered DPOs and OPAs are crucial partners in designing, implementing and evaluating emergency programmes.

Key Inclusion Standards 4 and 5 provide ways to support the participation and inclusion of older people and people with disabilities.

The Minimum Standards are supported by 7 principles, which are derived from the human rights-based approach to humanitarian action.

1. **Principled humanitarian action** – services are provided on the basis of the principles of humanity and the humanitarian imperative. These fundamental principles apply to everyone affected by disaster and conflict, including people with disabilities and older people.
2. **Non-discrimination** – ensuring that all of the affected population including older women and men, and women, men, girls and boys with disabilities can access assistance and benefit from humanitarian response on an equal basis with others.
3. **Meaningful access** – ensuring that any barriers affecting the access and participation of people with disabilities and older people in humanitarian assistance and protection are addressed.
4. **Respect for the inherent dignity of people with disabilities and older people** – an inclusive humanitarian response requires staff to be aware of disability and age and of how to respect and communicate with these groups.
5. **Active and effective participation and equality of opportunities** – ensuring that people with disabilities and older people participate in all aspects of the humanitarian response on an equal basis with others.
6. **Respect for diversity, including equality between women, men, girls and boys of all ages** – ensuring that all persons with disabilities and older people receive the assistance and protection that they need during a humanitarian response.
7. **Recognition of the essential role of carers, personal assistants and families** – ensuring the contribution provided by carers / personal assistants is recognised and their needs are supported, and acknowledging the fact that many people with disabilities, children and older people are themselves carers and family members.

[30] https://en.wikipedia.org/wiki/Advocacy

[31] Handicap International (2014). The Disability and Vulnerability Focal Points (DVFP). Emergency Response Division, Lyon.

7.2 Identify advocacy targets

- Primary audience: those with the authority to make the changes desired.
- Secondary audience: people who may support the advocacy cause but cannot bring about the changes themselves.

Your targets will depend on your objectives and your understanding of the decision-making context. A stakeholder analysis is a useful tool for helping you to identify who these actors are (as well as possible opposition).

Advocacy targets for mainstreaming age and disability into humanitarian action may include government departments, donors, humanitarian clusters, and international institutions like the UN, international NGOs or local officials.

Good relationships are essential to successful advocacy. Build the necessary relationships with decision-makers or key persons/positions that can influence organisational change. It may even be the first and crucial advocacy objective, or part of the pre-emergency preparedness work. Alternatively, you may need to think about how you can influence your secondary audience, who in turn will influence your target.

Power analysis – find out the advocacy target's current position on age and disability inclusion, and what would be required to change their mind. To answer these questions, contact other international NGOs that have worked on inclusion, or DPOs that have already advocated for such change, for example. This could be a consultation process to test the assumptions about the ability of specific targets to make the required changes. Such an analysis can prevent surprises that might undermine your position or credibility.

7.3 Steps for successful advocacy

To develop and implement successful advocacy, strategies require some key steps:

1. **Context analysis** – it is important to know well the environment where the impact is intended to be felt, and whether advocacy is a viable means of achieving the required change. Identify who has the authority to make the change to be achieved. For example, consider whether the type of change you want to see, for example a change in policy or attitudes, is realistic based on the contacts, relationships and evidence you have. You may decide that, given the attitude of the organisation or the decision-makers towards advocacy, the risks associated outweigh the benefits.
2. **Problem analysis** – having a clear and well-articulated understanding of the problem to be addressed is vital to successful advocacy.
    a. Is it a new issue for those you are trying to influence, or is it already understood?
    b. Is there evidence available to support your position?
    c. Who has the authority to make the required change you at what levels will it require endorsement – local, national, regional, global or projects, programmes or policy and strategic level?
    d. To what extent can this objective be brought about by advocacy alone? Is there a need to build wider community awareness and support for your proposed change?
    e. Do you or the organisation have the legitimacy to achieve this objective? Is there a realistic chance of success?
    f. Does the issue affect men and women differently, if so, how?

3. **Aims and objectives** – setting clear aims and objectives is essential to support the development of the advocacy message, the activities, targets and partners, and in the attempts to assess the success of your advocacy activity. Try to keep objectives SMART (Specific, Measurable, Achievable, Realistic, Time-bound). This process will require the identification of who should make the change, to what extent, and within what timeframe.
4. **Clear messages** – this is the most important part of any advocacy strategy. Translate the change desired and your existing evidence into clear and coherent messages that the target audience(s) will understand. Key messages should explain:
    a. What you want to achieve.
    b. Why you want to achieve it and what the current problems are (with evidence to support your case).
    c. How you want to achieve it.
    d. What you want others to do – here you should outline specific action they can take.
5. **Appropriate activities** – once you have decided on your targets and messages, you need to decide the most appropriate ways for delivering those messages. Tailor your activities to the targets that you are seeking to influence and the resources you have available. Being strategic with the activities is very important, as it is better to have one or two well-prepared meetings with key decision-makers than to launch a long series of activities with no clear plan about how they will support the objectives. When choosing the activities, keep two questions in mind: are the activities necessary (the right ones)? Are they sufficient to achieve the objectives?
6. **Opposition** – because the change that is advocated for may not be positive for everyone, be prepared to anticipate opposition in some key messages. Those who are opposed may feel threatened, not persuaded by the argument or ambivalent, and hence weaken your overall position.
7. **Partners and allies** – once there is an agreement on working with other actors to achieve the objective, it is important to involve them in the development of the strategy, messages and advocacy activities. In any case, involving DPOs and OPAs is fundamental. It adds strength and legitimacy to the advocacy work by bringing in further evidence and experience, illustrating the wider appeal of your proposed change, or by increasing or improving your access to decision-makers.

The meaningful involvement of people with disabilities and older people is essential to provide informed advocacy messages. Building their capacity to directly advocate for inclusive humanitarian action will have a strong impact, but reinforcing the organisations with professional staff with disabilities, and of a range of ages, is another way. If there are no DPOs or OPAs available, try to involve individual people with disabilities or older people in your advocacy.

7.4 The importance of data and evidence

Data and statistics are an excellent basis for discussion and advocacy, but only if they are reliable. The aim of any data collection on age and disability or other issues, is to describe a real situation and to find ways to change this situation. If you have detailed facts about a situation, the planning becomes easier. For example, if it is definitely known that 100 children in a crisis-affected area have disabilities, it will be easier to design the response for including them in emergency education structures, and define support mechanisms for their integration.

Data also helps to compare situations. For example, if there is reliable data on the percentage of people with disabilities in a temporary shelter at the set-up of the camp, it will be easier to measure the level of integration into different relief actions at the end of the project. It is easier to develop inclusive indicators when reliable data is available.

It takes both time and financial resources to produce quality data, therefore in an emergency context, data is preliminary and will require revision as the situation develops. Some humanitarian organisations might also not consider the gathering of disability and age data to be a priority, and it this is where the advocacy for inclusion becomes even more relevant.

Ultimately, you need to think about what it is that motivates change in your target – is it evidence of needs, evidence of efficiency, political considerations, economics or value for money, or legal obligations. This will help shape your messaging.

In addition, you should make yourself aware of:

1. Key materials in the sector you are trying to advocate for change:
    - National Guidelines and protocols.
    - Cluster guidance, tools, accountability commitments or strategies.
    - Policies of relevant UN agencies, donors or international NGOs.
2. Existing common frameworks or principles to which humanitarian agencies are committed, which can help make the case for humanitarian responses that address the needs of older people and people with disabilities:
    - The Red Cross Code of Conduct
    - Sphere Standards
    - The Core Humanitarian Standards (CHS)
    - The Commitments on Accountability to Affected Populations (CAAP)

A clear message consists of the following elements, and could look something like this:

Element	Message
1. Statement	In the temporary emergency shelter, children with disabilities are not accessing education.
2. Evidence	Only 1% of the registered children with disabilities are enrolled in the temporary schools of the camp.
3. Example	"I am John, I am 10 years old and live here in the camp; I have difficulties in walking and cannot go to the school every day as I don't have a wheelchair and school is far away."
4. Invitation to action (this is optional and depends on what you want to achieve)	Raise awareness of teachers and NGOs involved in education cluster on the right to education of children with disabilities. Advocacy in the education cluster. Propose capacity building of trainers on inclusive education.

More information:

- GSDRC Disability Inclusion:
  http://www.gsdrc.org/wp-content/uploads/2015/11/DisabilityInclusion.pdf
- Handicap International: Making PRSP Inclusive:
  http://www.making-prsp-inclusive.org/en/8-advocacy-and-lobbying-influencing- policies.html
- CEDPA (1999):
  Advocacy: Building Skills for NGO Leaders. The CEDPA Training Manual Series, Volume IX, Washington.
- Oxfam:
  Influencing Poverty Reduction Strategies: A Guide. Section Three: Influencing the Content of Policy.

Examples of advocacy documents can be found on following pages.

First page of an advocacy document on shelter allocation to camp management of one refugee camp in Iraq

DANISH REFUGEE COUNCIL

HANDICAP INTERNATIONAL
Co-winner of Nobel Peace Prize

IMPORTANT CONSIDERATIONS for allocation of shelter to persons with disabilities within camps and spaces

Based on experience of HI and DRC in supporting persons with disabilities (PWDs), we ask you to consider the following to INCREASE ACCESS OF PWDS to essential services:

1. **PWD should always be located in the line/area closest to the cluster of services (see picture below –red arrows IS RECOMMENDED placement of PWD within Qstapa camp)** ☺

2. **During construction of new camps (ex: Qstapa 2), please fill middle section of camp first (yellow arrows) before allocating spaces closest to services to 'first come first serve', please reserve red spots for persons with mobility issues or other disabilities (visual, intellectual who may get lost).**
3. **Please DO NOT place PWDs in area of blue arrows (farthest form services)** ⊗
4. **If people with disabilities are placed along the same main road, such roads should be paved (1.5 width) and be made as accessible as possible.**

When building new sections of camp with permanent shelters (e.g. emirates section of Qstapa), AVOID placement persons with disabilities in these new spaces, because:

- They will be far from essential services they need (distribution points and hospital) and **as road to new areas are not paved/muddy and inaccessible,** it will make them imprisoned in their shelters unable to participate in camp activities.

If you must relocate PWDs and their families to newer sections, please:

- Position them at the very front of these spaces –closest to the main roads.
- Provide reliable and regular tuc-tuc services to take them to hospital and/or distribution points

Developed by Shirin Kiani (TA)

Age advocacy – AGE DEMANDS ACTION

"On three key dates each year, groups of older people from all over the world lobby their local and national governments on the issues most important to them, such as healthcare, human rights and pensions. Campaigners of all ages join marches, debates and petition signings."

From http://www.helpage.org/get-involved/campaigns/age-demands-action/

Excellent advocacy video on UN Convention to protect older person's rights:
https://www.youtube.com/watch?t=1&v=m6BBti0Blv0

Disability day advocacy, December 3, 2014. Kawergosk Camp, Iraq

- Invited local authorities to disability day.
- Man with disability talked about disability issues during the day's celebrations.
- Conducted awareness-raising activities.

The image below shows a man with a disability at the disability day talking to the community about disability.

Kawergosk Camp, taken by Shirin Kiani, December 2014

Global Protection Cluster: Protection mainstreaming toolbox

The website provides links to guidance and tools endorsed by the Global Protection Cluster. It also provides external resources from humanitarian organisations, to support agencies in incorporating protection principles and promoting meaningful access, safety and dignity for affected populations in all humanitarian activities.

Available at: http://www.globalprotectioncluster.org/en/areas-of-responsibility/protection-mainstreaming.html

Top 10 Critical Needs Facing Refugees and Those Displaced in Emergencies, Available at the Women's Refugee Council:

https://www.womensrefugeecommission.org/images/stories/Top_10_list_one_pager.pdf

Disability

UNICEF Including Children with Disabilities in Humanitarian Action consists of six booklets full of practical actions and tips. The guidance has been developed by UNICEF in collaboration with Handicap International; it is addressed to UNICEF's staff and partners, and it includes practical information for both humanitarian coordinators and "first line" field staff. Available at: http://training.unicef.org/disability/emergencies/index.html

IASC Guidelines on Inclusion of Persons with Disabilities in Humanitarian Action (under development):

Available at: https://interagencystandingcommittee.org/iasc-task-team-inclusion-persons-disabilities-humanitarian-action

Various resources on disability

Available at the Women's Refugee Council: https://www.womensrefugeecommission.org/resources/232-disabilities

UNHCR Need to Know: Working with People with Disabilities in Forced Displacement

This UNHCR Guidance on Disability, developed by UNHCR and Handicap International, provides field staff and partners with an essential introduction to, and action-oriented advice on, a range of protection issues relating to people with disabilities in situations of forced displacement.

Available at: http://www.unhcr.org/4ec3c81c9.pdf

Disability inclusion in programmes for refugees and displaced people

This training is designed for UNHCR staff, implementing partners and disability stakeholders at field levels. This PowerPoint is an outline of a three- day training developed by the Women's Refugee Commission to raise awareness and facilitate participation of people with disabilities in community decision-making.

Available at: http://wrc.ms/1eXGoAT

Inclusion Made Easy, CBM - designed for program staff in international development organisations.

http://www.cbm.org/Inclusion-Made-Easy-329091.php

Step-by-step practical guidance on inclusive humanitarian field work through CBM HHoT app gives you quick access to practical guidance with or without an internet connection.

https://hhot.cbm.org/

Mental health

World Health Organisation & United Nations High Commissioner for Refugees on Assessing

mental health and psychosocial needs and resources available at:

http://www.who.int/mental_health/resources/toolkit_mh_emergencies/en/

Sphere Assessment tool 4

http://www.sphereproject.org/news/new-tools-for-assessing-humanitarian-needs/

GSDRC Disability Inclusion

http://www.gsdrc.org/wp-content/uploads/2015/11/DisabilityInclusion.pdf

Age

ADTF (2011) Ageing and Disability in Humanitarian Response: A Resource Book on Inclusive Practices

http://reliefweb.int/sites/reliefweb.int/files/resources/ADTF_Report.pdf

European Commission Gender-Age Marker Toolkit

https://ec.europa.eu/echo/files/policies/sectoral/gender_age_marker_toolkit.pdf

HelpAge International (2011) Guidance on including older people in emergency shelter programmes

http://disaster-relief.org/pdf/HelpAge-IFRC-Shelter-Guidelines.pdf

HelpAge International (2012) Food security and livelihoods interventions for older people in emergencies

http://www.helpage.org/resources/practical-guidelines/emergency-guidelines/

HelpAge International (2012) Health interventions for older people in emergencies

http://www.helpage.org/resources/practical-guidelines/emergency-guidelines/

HelpAge International (2012) Older people in emergencies: identifying and reducing risks

http://www.helpage.org/resources/practical-guidelines/emergency-guidelines/

HelpAge International (2012) Protecting older people in emergencies: good practice guide

http://www.helpage.org/resources/practical-guidelines/emergency-guidelines/

HelpAge International (2013) Nutrition interventions for older people in emergencies

http://www.helpage.org/resources/practical-guidelines/emergency-guidelines/

HelpAge International (2013) Protection interventions for older people in emergencies

http://www.helpage.org/resources/practical-guidelines/emergency-guidelines/

World Health Organisation (2008) Older people in emergencies: consideration for action and policy development

http://www.who.int/ageing/publications/Hutton_report_small.pdf

UNHCR The Heightened Risk Identification Tool (version 2)

http://www.refworld.org/docid/4c46c6860.html

UNHCR Working with Older Persons in Forced Displacement

http://www.refworld.org/docid/4ee72aaf2.html

Training Resources

Keep a note of any useful websites, books and other sources

Websites

Other Resources

Training Resources

Keep a note of any useful websites, books and other sources

Notes

DisasterReady.org

Free online learning resources

disasterready.org
a Cornerstone OnDemand Foundation initiative

DisasterReady.org is a free online learning portal built to increase the preparedness and effectiveness of humanitarian and development workers around the world. Developed in collaboration with leading aid agencies and humanitarian experts, DisasterReady.org makes over 600 online learning resources available to humanitarian and development workers and volunteers. The team at DisasterReady is constantly expanding this learning library which covers core topics such as Humanitarian Essentials, Technical Sectors, Safety and Security, Program Support, Management and Leadership, Staff Care, and Soft Skills. DisasterReady.org is available in English, French, Spanish and Arabic.

DisasterReady.org:

- Unlimited access
- Take training at your own pace anytime, anywhere in the world
- View resources on desktop, tablet, and/or smartphone
- Resources available in English, French, Spanish and Arabic
- Participate in learning communities led by experts
- Connect with colleagues and mentors around the world

DisasterReady by the numbers

100,000
Active Learners

195
Countries

600
Learning Resources

4
Languages

Current Learning Resources on Age and Disability Inclusion

Online Courses:

1. Basic Principles of Disability Inclusion In Humanitarian Response
2. Understanding Older People and Their Needs in a Humanitarian Context
3. Comprehensive Accessible Humanitarian Assistance for Older People and People with Disabilities

Age and Disability Inclusion Webinar Series:

1. Making Humanitarian Response Age and Disability Inclusive: The Minimum Standards
2. Humanitarian Protection
3. Health and Nutrition
4. Collecting and Using Age and Disability Disaggregated Data in Humanitarian Settings

Sign-up today for a free account at DisasterReady.org.

Technical Support Services

Knowledge Point

Are you sometimes asked technical questions that you don't know the answer to? Whilst in the field, do you sometimes need expert advice on specific technical issues? Or would you like to know more about a subject of your interest? Or update yourself on the latest in a particular topic? Do you know that you can ask our RedR Experts for help, any time, for free? And now we've made it even easier to ask with a new forum called KnowledgePoint.

KnowledgePoint allows you to search for information and ask questions on any topic, with around 150 RedR Experts waiting to give answers. Most of our experts have direct field experience and have faced the challenges that you and your trainees face. They will try to respond to your question within 48 hours of you posting it. KnowledgePoint has been developed in partnership with WaterAid, EngineerAid, Practical Action and IRC, so not only will you have the strength of the RedR Experts behind you, but you will also get support from our partners.

Knowledge Point is:

- Free, expert advice to humanitarian aid workers.
- An information management system.
- A sustainable technical support system.
- A robust platform to share expert knowledge and experience with a rapid response.
- Made up of 150 experts in all fields.
- A rapid response, establishing good practice in an emergency setting in near real time: an initial expert answer to 80% of emergency questions within 48 hours of enquiry posting.
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- Technical IT & communications
- Telecommunications
- Transport access
- Vehicle maintenance (electrics, engine, transmission & suspension)
- Water sources, supply & treatment
- Sanitation & hygiene promotion
- Waste management

Knowledge Point

Testimonials

'Thanks for support with this query. Your help is very much appreciated from the field'.

Adam, GOAL

'Thanks to everyone who sent us that information – I felt well supported knowing that we had access to so many specialists'.

Sarah, Oxfam

www.redr.org.uk/knowledgepoint

Or email queries on KnowledgePoint@redr.org.uk

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