



Guidance on strengthening disability inclusion in Humanitarian Response Plans

This guidance includes the Humanitarian Needs Overview development process in recognition of the importance of the HNO as the basis for the Humanitarian Response Plan



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1 Objectives of the Guidance

This guidance provides support to seven UN entities¹ on how to strengthen inclusion of disability in Humanitarian Response Plans (HRPs) as part of the UK Department for International Development (DFID) Humanitarian Investment Program.² The aim of this work is to make humanitarian programming more responsive to the needs of people with disabilities affected by crisis.

Humanitarian Response Plans are the product of a strategic planning process that is informed by humanitarian needs assessment activities. Therefore, this guidance focuses primarily on the steps in the humanitarian program cycle (HPC) leading to the HRP, including the process of developing the Humanitarian Needs Overview (HNO). This guidance has been aligned to the 2019 revision of this process.

It is recognized that more substantive work on the inclusion of persons with disabilities will need to continue concurrently to this initiative, including in relation to how disability-inclusive projects are designed, how they can be monitored, and what disability-inclusive humanitarian evaluation would involve, recognizing that all this requires a wider capacity building effort focused on disability inclusion throughout the HPC.



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¹ UNICEF, WFP, UNHCR, OCHA, IOM, WHO and CERF
² See Annex 1



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2 Rationale for disability-inclusive humanitarian action

Reaching the people who are most in need of assistance is central to the humanitarian mandate and is reflected in the humanitarian principles of humanity and impartiality. Quality programming aligns with this mandate by ensuring both access to protection and assistance in safety and dignity. In a humanitarian emergency, people with disabilities are often among those most in need of assistance as they are at heightened risk of violence, exploitation or abuse. Persons with disabilities also face discrimination due to significant barriers in accessing needed humanitarian assistance.

Increased vulnerability of persons with disabilities is created by a range of factors, including environmental barriers, stigma and discrimination, as well as the design and delivery of the humanitarian response itself. If persons with disabilities are not adequately considered at all phases of the HPC, there is a risk that humanitarian action may fail to address the specific factors that place them at risk, including barriers to equitable access to protection and assistance.

In order for persons with disabilities to be adequately considered, humanitarian actors need to have sufficient information about the number of persons with disabilities in a given context or crisis, their situation, needs and the barriers and risks they face, as well as their capacities, views and priorities.

Inclusion of persons with disabilities in humanitarian action is also central to meeting broader commitments, such as:

Accountability to Affected Populations (AAP):³

Individuals accessing humanitarian assistance are the primary stakeholders of any humanitarian action. This means that they must be able to receive communications in a form they can understand, provide feedback on the delivery of humanitarian assistance and to be included in decisions that affect their lives. For humanitarian actors to take account of, give account to, and be held to account by affected populations, mechanisms for AAP need to be inclusive of persons with disabilities.

³ See the IASC Task Team on Accountability to Affected Populations and Prevention of Sexual Exploitation and Abuse: <https://interagencystandingcommittee.org/accountability-affected-populations-including-protection-sexual-exploitation-and-abuse>

Protection mainstreaming⁴: meaningful access, safety and dignity in humanitarian action will not be achieved without considering risks and barriers to access faced by persons with disabilities.

Collecting data on persons with disabilities is also an obligation for States who have ratified the Convention on the Rights of Persons with Disabilities (CRPD). Article 31 on Statistics and Data Collection requires states parties to “undertake to collect appropriate information, including statistical and research data” and sets out that data “shall be disaggregated, as appropriate, and used to help assess the implementation of States Parties’ obligations under the present Convention and to identify and address the barriers faced by persons with disabilities in exercising their rights”. UN Agencies have an important role in supporting states to meet this obligation.

2.1 Role of Data

High quality humanitarian programming needs to be built on an understanding of the needs and priorities of persons with disabilities in the crisis context. This foundation consists of (1) identifying what risks the affected population faces and who faces specific or heightened risk, (2) identifying the factors contributing to risk (noting that these factors may include barriers to accessing humanitarian assistance or information needed to make informed decisions), and (3) understanding the capacities of the affected population to keep themselves and their communities safe.

Table 1, below, sets out the type of data needed to build this understanding.

Further, in humanitarian settings characterized by urgency and often constrained capacity for primary data collection, it is important that data on persons with disabilities be mainstreamed into existing tools with a focus on utility; collecting only what is needed to promote quality and accountability in programming. Information should only be collected if it will be acted upon.

Understanding the concept of disability

The Convention on the Rights of Persons with Disabilities states that persons with disabilities “include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others”. Understood in this way, disability is not synonymous with “impairment”. Disability is the result of an interaction between a person with an impairment and barriers in their environment that hinder his or her full and effective inclusion and participation in society. For example, a person with a mobility impairment experiences disability if he or she encounters a building entrance with stairs they are unable to climb.

This understanding of the concept of disability has a number of implications for data collection and analysis. For example, medical approaches to identify persons with disabilities (e.g. approaches that rely on medical reports or a list of impairments) are not sufficient for fully capturing disability because they do not include the impact of barriers. Further, disability is not a simple binary indicator; it is a matter of degree. Therefore binary categorization fails to fully capture disability. However, it is often difficult to reliably measure disability and all its complexity directly, so in humanitarian settings there must be a focus on collecting and analyzing only data that is needed to promote quality and accountability in programming.

4 See the Global Protection Cluster (GPC): <http://www.globalprotectioncluster.org/themes/protection-mainstreaming/>

Table 1 Types of data (quantitative and qualitative)**Type of data (quantitative and qualitative)****Contribution to quality programming**

Individual/
household level

Identify individuals at heightened risk to inform targeted interventions.

Understand how persons with disabilities are experiencing the crisis, risks faced and factors contributing to vulnerability, in order to design an inclusive response that reflects who is at risk, from what or whom, as well as why.

Understanding the impact of the crisis on persons with disabilities in terms of mortality, health conditions, protection status or other.

As part of AAP mechanisms, understand concerns and priorities of persons with disabilities, to ensure that the response is inclusive and appropriate.

As part of response monitoring, understand how persons with disabilities are accessing assistance, and any facilitators and barriers.

Infrastructure/
program-level

Identifying various types of barriers persons with disabilities may face, including attitudes and perceptions, physical, institutional and communication barriers, enables the design of better programs that take into account diverse needs, and addressing the gaps that may exist.

This can also provide a basis for fundraising by informing the budget preparation process for actions that improve accessibility.

Population level

Data on the number (proportion) of persons with disabilities increases visibility of disability inclusion at the decision-making level.

Baseline population data informs monitoring of access to services and participation by persons with disabilities.

Data on the size and demographics of the affected population supports prioritization and targeting, and the development of appropriate programming.

This can also provide a basis for fundraising by informing budgeting for an inclusive response.



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3 The Humanitarian Needs Overview Process

This step-by-step guidance follows the process and logic of the IASC Practical Guide for Humanitarian Needs Overviews, Humanitarian Response Plans and Updates revised for the 2020 HPC, and is meant to be considered in an integrated way, not as a separate strand of work.

STEP 1 Agree on the scope and focus of the analysis

1.1 Integrate questions related to disability into the joint analysis plan to inform planning decisions

Begin with a reflection and analysis about what information about persons with disabilities needs to be

known in this context to promote their inclusion in the humanitarian response, including:

[What are the needs and the heightened risks faced by persons with disabilities?](#)

[What barriers do persons with disabilities face in accessing assistance?](#)

Consider how effective the response has been in reducing vulnerability and enhancing resilience of persons with disabilities; how the humanitarian situation may have changed and how this may have impacted on persons with disabilities, such as what needs continue or what new ones have emerged, etc.

Understand how the views and perceptions of persons with disabilities may differ from other population groups/sub-groups.

1.2 Identify the data, indicators and other information required to answer these questions

Identify the types of data needed to answer the key questions posed in order to inform planning decisions.

1.3 Identify the sources of data, information and indicators

Identify where the needed data can be found, from both humanitarian and development actors. Needs assessment plans should strive for data minimization, i.e. the collection of the minimal amount of viable data necessary to effectively complete the assessment.

Table 2 outlines sources of existing quantitative and qualitative data on persons with disabilities, along with considerations when using these sources.

1.4 Define and agree on agencies' and clusters/sectors' roles and responsibilities

Determine who will do what. It is highly recommended that a disabilities focal point be identified to help align approaches and provide technical support (or identify where this support can come from).

STEP 2 Review and analyse data and information and identify gaps

2.1 Review existing data, indicators and other information to answer the key analysis questions

Prepare a data analysis plan. Define what information is sought, and how it will be used. Always start with the data that already exists.

While secondary data to support needs analysis for persons with disabilities may exist in some contexts, it is important to consider that these figures may significantly under-estimate the numbers of persons with disabilities or may not adequately reflect their needs, views and priorities. However, the absence of robust data about the number of persons with disabilities and their particular situation should not block the assessment of needs. In these cases, it is recommended to assume that 15% of the population has a disability.⁵ The 15% estimate will often be more useful for planning purposes than the low-quality secondary quantitative data that is available; analyzing low-quality secondary data would waste resources, and the 15% estimate will help ensure that programs adequately account for disability in their plans. The proportion of persons with disabilities also varies among age cohorts, with older people experiencing significantly more disability, while for children, UNICEF recommends that a 10% estimate be used.⁶ Also remember that in many humanitarian situations it is expected that more people will have disabilities, including as a result of disruption in services or new injuries.⁷ For example, research involving persons affected by the Syria crisis in Jordan suggest that 22.9% of Syrian refugees aged 2 years and above had disabilities.⁸

Table 2 provides possible secondary sources of data on persons with disabilities as well as considerations when using these data sources.

5 WHO, "World Report on Disability" (2011). Chapter 2, "A Global Picture," p.44.

6 UNICEF, "Promoting the Rights of Children with Disabilities," Innocenti Digest Number 13, 2007, p.4.

7 Humanity and Inclusion, "Disability in Humanitarian Contexts" (2015) <http://www.un.org/disabilities/documents/WHS/Disability-in-humanitarian-contexts-HI.pdf>

8 Disability in this study being defined as "the level of difficulties a person is facing when performing basic activities that could put him/her at risk of not participating in society" see p.1, Humanity and Inclusion, "Removing Barriers, The Path towards Inclusive Access: Disability Assessment among Syrian Refugees in Jordan and Lebanon" (Jordan Report) July 2018. <https://reliefweb.int/sites/reliefweb.int/files/resources/65892.pdf>

Table 2 Secondary Data Sources

Information Needed	Quantitative Data Sources	Considerations
How many people with disabilities are there?	<p>Government statistical departments</p> <p>Government databases:</p> <ul style="list-style-type: none"> • Education • Health • School enrollment data triangulated with attendance data or vaccination records (to capture exclusion) 	<p>National disability statistics should be treated with caution as they vary widely depending on the methodology used.</p> <p>Administrative data systems rely on individuals registering with government, and many people with disabilities may be excluded due to lack of knowledge or access. Data on exclusion can be particularly impactful (e.g. on out of school children), but can be difficult to ascertain from these databases.</p> <p>Health data will often focus more narrowly on impairments, but may allow for certain assumptions to be drawn (e.g. regarding functioning).</p>
	Registration or profiling for refugees, IDPs and migrants	Registration or profiling data may under-identify persons with disabilities due to methodology used (e.g. if based on visual cues or medical approaches).
	UN Statistics Division ⁹	Database of data compilations that reference disability at the national level.
	<p>Household surveys</p> <p>Multiple Indicator Cluster Surveys (MICS) or Demographic and Health Surveys (DHS)</p> <p>Site assessment surveys</p>	<p>Situational assessments, thematic reviews, project baselines and other studies may have systematically surveyed households or individuals in the location of the crisis but still need to be treated with caution. Section 3.1 refers to several factors that may impact on the quality of the data.</p> <p>Recent Multiple Indicator Cluster Surveys (MICS round 6, since 2017)¹⁰ and Demographic and Health Surveys (DHS, since 2016) have used the Washington Group short set questions¹¹ for adults, and the MICS has used the UNICEF/WG child functioning module for children to assess disability prevalence. While currently the number of countries that have been covered by these samples is limited, over time an increasing number of countries will have this data available to support humanitarian needs assessments.</p>
	Data kept by disabled people's organizations (DPOs) or specialized NGOs	
Mine Action Data	Designed to track incidents related to landmines and explosive remnants of war but does not capture disabilities unrelated to landmine and ERW incidents.	

⁹ Besides curating national census and survey estimates of disability prevalence for many countries, the UN Statistics Division database includes metadata describing types of disability included in national surveys, and in many cases an example of the survey instrument itself.

¹⁰ Caution should be applied to interpreting MICS data in terms of disability prevalence given its methodology. Among adults, only those of reproductive age (15-49 years) are surveyed, which excludes older persons who have a much higher disability prevalence. For adults MICS is targeted at individual respondents who are excused from participating if they are "incapacitated" which could be interpreted by enumerators to include many persons with disabilities. DHS surveys overcome these limitations to some degree by interviewing at the household level, where the head of the household can respond on behalf of others. As well, DHS includes a broader age group so captures older persons with disabilities more completely.

¹¹ [The Washington Group](#) question sets were developed for use in censuses and surveys. The questions reflect advances in the conceptualization of disability and use the World Health Organization's International Classification of Functioning, Disability, and Health (ICF) as a conceptual model. The questions ask whether people have difficulty performing basic universal activities (walking, seeing, hearing, cognition, self-care and communication) and were originally designed for use with the general population. However, the focus on functioning and the brevity of the tool mean that it can be rapidly and easily deployed in a variety of settings, including humanitarian needs assessments.

Table 2 Secondary Data Sources

Information Needed	Quantitative Data Sources	Considerations
<p>What are barriers to accessing assistance?</p>	<p>Accessibility audits</p>	<p>Check-list based approach¹² to evaluate the level of accessibility and safety of facilities, premises and service delivery, which may have been conducted by local DPOs (Organization of Persons with Disabilities) or NGOs.</p>
	<p>Post-Distribution Monitoring systems</p>	<p>If disaggregated by disability, may allow for analysis of barriers faced by persons with disabilities and any instances of exploitation or other protection risks created through delivery of assistance.</p>
	<p>Feedback and complaints mechanisms</p>	<p>Can give an important insight into barriers faced by persons with disabilities as well as satisfaction with assistance. However, feedback mechanisms are often inaccessible to persons with disabilities. Further, feedback mechanisms are also often anonymous or confidential, especially if they relate to sensitive issues, and therefore may not disaggregate by disability.</p>
<p>What are the needs and heightened risks faced by persons with disabilities?</p>	<p>Gender Based Violence IMS Child Protection IMS Protection Case Management</p>	<p>While not equated with incidence data, this type of data can highlight gaps in access. Persons with disabilities may be less likely to access case management services given the existence of physical and communication barriers, common perceptions and beliefs, and stigma.</p>
	<p>Needs assessments Participatory assessments</p>	<p>Persons with disabilities may have not been systematically included in participatory/ needs assessments resulting in limited reliable data. For example, persons with disabilities may be more hidden, assessment processes may have been inaccessible, or assessments may not seek information about their specific risk factors (such as barriers to accessing assistance).</p>

¹² An example of guidelines for conducting accessibility audits can be found at <http://bit.ly/2ad0V9y>.

Remember, where personally identifiable data from secondary sources is available, informed consent and purpose-driven data sharing according to best practices and policies on sharing personally identifiable information is required. These principles are not changed when persons with disabilities, including those with intellectual or psychosocial disabilities, are involved.

Use of secondary data should be complemented with active outreach to persons with disabilities who are not accessing services that are being used as sources of data on needs. Analysis of secondary data should also be informed by and validated with community and local experts, including persons with disabilities themselves.

2.2 Identify critical gaps of data, indicators and other information

After reviewing the available secondary data on persons with disabilities (see **Table 2**) and planning assumptions (see **Section 2.1**), consider what information gaps exist regarding how many persons with disabilities are affected, their needs, risk factors (including barriers faced) and their views and perceptions.

2.3 Fill in critical data and information gaps

Existing needs assessment tools, frameworks and processes can be adapted to contribute to a strengthened understanding of disability inclusion in humanitarian contexts. **Annex 4** presents a selection of existing needs assessment tools, with examples of how they can be used or adapted to improve understanding of the situation, needs and priorities of persons with disabilities. As part of this process it is important to ensure that persons with disabilities are involved in any key informant interviews and focus group discussion. **Annex 2** provides tips and advice on how to collect this type of information.

Two of the most common and tested tools used to generate comparable data about persons with disabilities are the Washington Group Question sets (WGQs) and the World Health Organization's Disability Assessment Schedule (WHODAS). Both relate to

the global standard International Classification of Functioning, Disability and Health and are aligned to the UN Convention on Persons with Disabilities. The WGQs have been most widely used and tested in humanitarian contexts.¹³

There is a growing consensus¹⁴ around the utility of the Washington Group short question set as a tool that can be quickly and inexpensively added to censuses and surveys to generate disaggregated, internationally comparable data. It has also been the most widely used and tested in humanitarian contexts. **Annex 3** provides a short overview of these principal instruments used to collect data on persons with disabilities including some commentary on their use in humanitarian contexts. It is important to understand that these tools are useful for the purpose of disaggregation of data, not to identify particular health conditions or diagnostic categories¹⁵ and should therefore not be used for individual assessment or for targeting without complementary data relating to needs and risk factors, including barriers.

In principle, where data on age and sex is collected, data related to disability should be collected as well.

2.4 Conduct an inter-sectoral analysis of existing data, indicators and other information

While the same hazards impact on all members of the community, persons with disabilities may experience them differently due to barriers they face and intersecting structural inequalities.¹⁶

Figure 1 explores the specific disability-related dimensions of vulnerability and other intersecting/structural inequalities that contribute to a more nuanced understanding of risks facing persons with disabilities.

In analyzing needs and risks, consider how the impacts of the hazard affect persons with disabilities differently.

13 A fuller discussion of the Washington Group Questions versus the Model Disability Survey referenced in **Annex 2** can be found at Nora Groce, et. al., "[Which one to use? The Washington Group Questions of Model Disability Survey](#)," (2018) Working Paper Series 31, University College London.

14 Daniel Mont and Nora Groce, "[Counting disability: emerging consensus on the Washington Group questionnaire](#)," *The Lancet*, July 2017.

15 Daniel Mont, "[How does the WG-SS Differ from Disability Eligibility Determination?](#)," Washington Group on Disability Statistics, 5 May 2017.

16 The [Humanitarian Inclusion Standards for Older People and People with Disabilities](#) provides systematic guidance to identify barriers in relation to different sectors.

For example:

- Are there physical barriers to accessing humanitarian assistance and/or fleeing conflict or natural hazards?
- Do information barriers exist? Is information regarding risk reduction and availability of assistance accessible to persons with disabilities?
- Do prevailing perceptions of persons with disabilities promote violence, abuse, exploitation or exclusion?
- Are there service disruptions or stock-outs that specifically affect persons with disabilities?
- Are standards for inclusive humanitarian programming being adhered to?¹⁷
- Are there specific coping strategies employed by persons with disabilities? If so, what are they, and how can they be supported or strengthened?

Further, consider how these disability-related dimensions can interact with other structural inequalities to increase risk.

For example:

- Disability may impact on gender norms, increasing the risks of gender-based violence and abuse
- Community expectations relating to age may interact with disability to exacerbate exclusion
- Perceptions and beliefs associated with disability can vary and lead to heightened risk of exclusion or abuse in some contexts

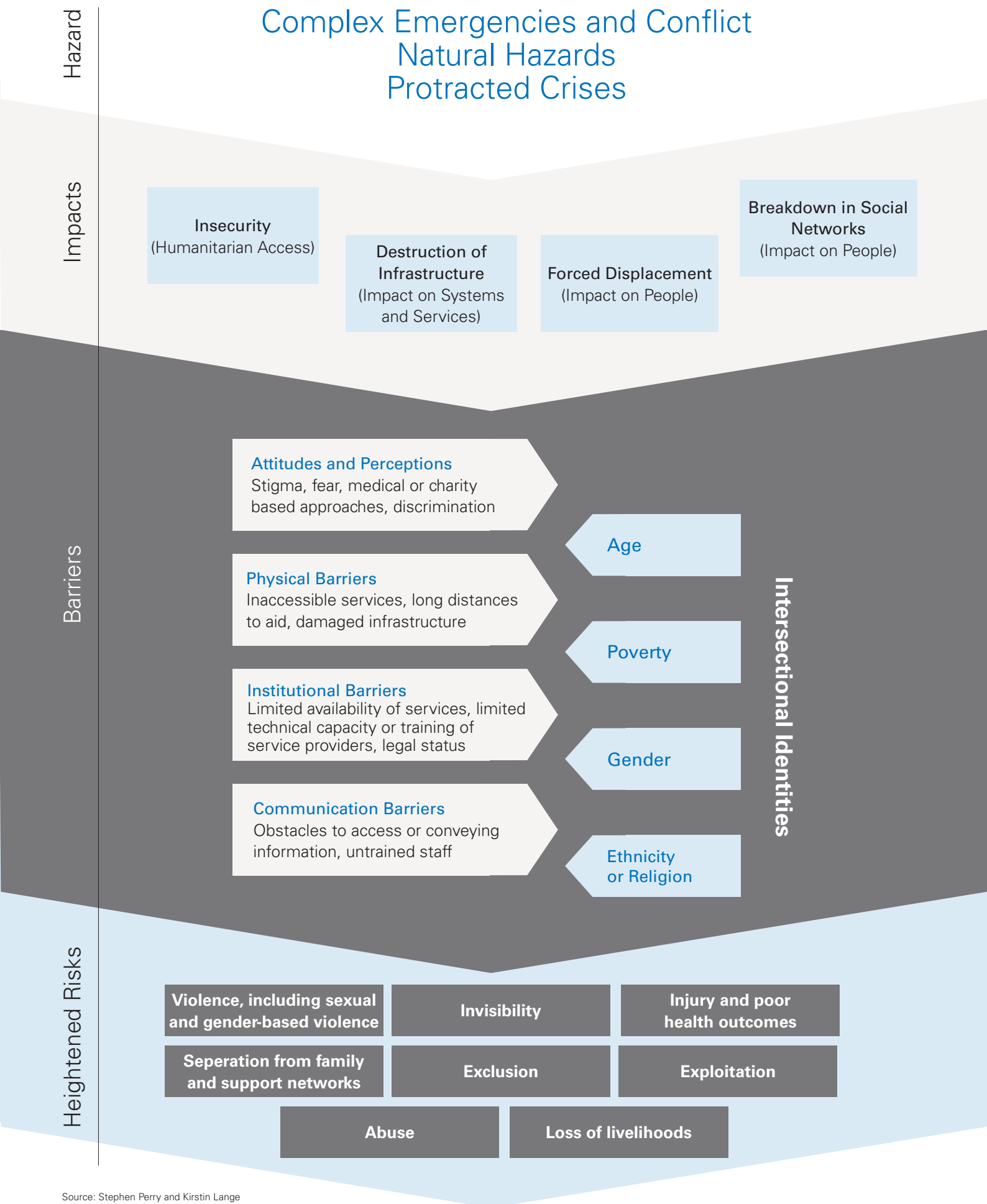
The objective of an intervention that reduces vulnerability and enhances resilience of persons with disabilities is to respond to these disability-related dimensions (including barriers) and intersecting structural inequalities. A strong needs assessment and analysis process will therefore aim to identify and describe the factors contributing to heightened risk, rather than merely identifying the groups at risk or the risks themselves.



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¹⁷ Age and Disability Consortium, "[Humanitarian inclusion standards for older people and people with disabilities](#)," 2018.

Figure 1 Analytical model for vulnerability analysis



STEP 3

Review and obtain approval of analysis results an monitoring information

3.1 Present and obtain endorsement by decision-makers on the analysis results

Clarify gaps and uncertainties regarding planning assumptions, especially where the global disability prevalence estimates of 15% was used in lieu of existing secondary quantitative data. Available data may differ from accepted global estimates for a variety of reasons. The following issues are included here to give needs assessment teams lessons learned they can use in advocating for the use of the 15% estimate:

- Understanding of the concept of disability varies**
 Approaches to data collection differ in their conceptualization of disability, with some focused solely on impairment whereas others are more broadly concerned with issues of participation, access and support needs. Which disability domains (mobility, seeing, hearing, intellectual, psychosocial etc.) the data collection tool explicitly considers will also impact who is identified as having a disability. Understanding of the concept of disability varies across cultural contexts, which further impacts who is identified as having a disability, including through self-identification. For example, age-related impairments or impairments acquired through conflict may not be commonly identified as disabilities in many contexts.
 - Stigma**
 In many contexts disabilities are hidden or misunderstood, “having a disability” carries the risk of being stigmatized, resulting in people being reluctant to identify themselves or family/household members as having a disability. This can impact the quality of data collection processes as these perceptions may be harbored by humanitarian actors as well as enumerators.
- Direct questions such as “do you have a disability?,” with binary answer options often under-report disability prevalence due to stigma and differing understandings of the concept of disability (as described above).
- What level of functioning is necessary to “count” as being a disability**
 Disability exists along a spectrum, rather than being a binary concept. However, approaches to data collection may set different thresholds for who is and who is not considered as experiencing

disability. Some thresholds may be stricter than others, leading to the consideration of only a narrow group of “people with disabilities” and differing understandings of the concept of disability (as described above).

Further, in some contexts, there may be sensitivity around disability data for political reasons.

- Purpose of the data collection**
 The purpose for which data is collected may impact on who is identified as having a disability. For example, a health survey may have a different approach to identification of persons with disabilities than a general population census, or a household survey looking at livelihood issues.
- Limitations of common sampling and reach of data collection**
 Some persons with disabilities (such as those who are isolated in the home or living in institutions) may not be included in data collection processes. This is a particular issue concerning children with disabilities.
- How current the data is**
 Pre-conflict data may not reflect the current situation due to large scale population outflows and inflows as well as the impact of conflict leading to others acquiring new disabilities.

Assuming 15% of the total Persons in Need have disabilities is preferable to either making no estimate, or using data where the risk of under-identification is high. Note that this globally accepted 15% prevalence estimate includes a diverse range of individuals, including men, women, boys and girls of all ages and types of disabilities (physical, hearing, visual, cognitive and psychosocial). Also remember that in many humanitarian situations it is expected that the disability prevalence could be even higher as a result of the context and the consequences of the crisis.

3.2 Present and seek endorsement of decision-makers on the situation and needs data, indicators and other monitoring requirements

Table 3 follows the IASC Humanitarian Needs Overview template and illustrates where disability inclusion can be reflected in the HNO.

Table 3 Disability Inclusion in the Humanitarian Needs Overview - an overview

HNO Sections	Guidance on integrating disability
Key findings	At a minimum, disaggregate total number of PiN by disability. Where reliable data is not available, use the global estimate that persons with disabilities make up 15% of the population. See the points in Section 3.1 for considerations in situations where secondary data suggests a disability prevalence rate that differs significantly from the global estimate.
Humanitarian consequences	Describe the specific or heightened risks faced by sub-groups of the population due to disability, considering that persons with disabilities are disproportionately impacted by humanitarian crises and often face barriers to accessing assistance. Use Figure 1 as a framework or guide.

Part I: Impact of the crisis

Context of the crisis	Describe (1) key problems, (2) how the crisis impacts differently on persons with disabilities (including existing capacities/coping mechanisms), (3) the factors contributing to heightened risk, and (4) their priorities and needs from their own perspective. Again, use Figure 1 as guide for analysis.
Humanitarian consequences and causal factors associated with needs	<p>Persons with disabilities should be identified as a sub-group. Reflect intersectionality by describing how disability-related factors (including barriers) intersect with other structural inequalities (such as on the basis of age, socio-economic status, gender, ethnicity or religion) and contextual factors to create heightened risk for persons with disabilities within the prioritized population groups (e.g. IDPs with disabilities, women with disabilities).</p> <p style="text-align: center;">Examples of contextual factors:</p> <p>Markets: persons with disabilities may face barriers to physically accessing markets and items needed specifically by persons with disabilities (e.g. to meet dietary needs) may not be available at local markets</p> <p>Health services: persons with disabilities may face particular barriers to accessing health services due to physical access obstacles or inaccessible information. Often, health services needed specifically by persons with disabilities (such as rehabilitation and assistive technology) may not be available in a humanitarian emergency</p> <p>Schools: schools may not be inclusive of children with different types of disabilities due to inaccessible or unsafe transport, inaccessible buildings, lack of adapted curriculum or trained teachers</p> <p>Assistance: may not be designed or delivered in an accessible way</p> <p>Rights and other related protection considerations: persons with disabilities may experience particular forms of discrimination, targeted violence or exploitation</p>

Table 3 Disability Inclusion in the Humanitarian Needs Overview - an overview

HNO Sections	Guidance on integrating disability
	<p>Financial flows: persons with disabilities are disproportionately impacted by poverty due to barriers to accessing income-generating opportunities and additional expenses at the household level</p> <p>Communication means: inaccessible early warning systems, information about assistance, feedback and compliant mechanisms can heighten risk for persons with different types of disabilities</p> <p>Social and community dynamics: harmful beliefs and practices related to disability can increase risk of persons with disabilities, including through isolation from protective community networks.</p> <p>Where relevant, describe how the perceptions of affected people with disabilities are differ from those of other sub-groups.</p>
Severity of humanitarian needs	Analysis should include, at a minimum, the impact of disability-related factors on humanitarian consequences and needs.
Number of persons in need	Where robust secondary data is unavailable use the global estimate of persons with disabilities making up 15% of the population noting that a higher proportion of persons with disabilities is expected in humanitarian contexts. Highlight the number of PiN with disabilities with a visual representation.
Part II: Risk Analysis	
Risk analysis	Use available results from recent analysis in the crisis context to describe the broad risk context that persons with disabilities face using analysis produced by UN Country Team members, bilateral donor analyses, or recent studies. Seek out perspectives from organizations of persons with disabilities (DPOs) and local/international NGOs working with persons with disabilities.
Part III: Monitoring of Situation and Needs	
	Identify how humanitarian consequences and needs may evolve for persons with disabilities, with consideration for access to assistance and other factors that heighten risk.

Table 3 Disability Inclusion in the Humanitarian Needs Overview - an overview

HNO Sections	Guidance on integrating disability	
Part IV: Sectoral Analyses		
For each sector	Describe how the crisis impacts differently on persons with disabilities and factors contributing to heightened risk, with regard to each sector. See Section 5 as guide, and examples below:	
	Examples of how risk is often described	Suggested reformulation
	“Drought exacerbates vulnerability of persons with disabilities”	Persons with disabilities are at heightened risk of drought-induced food insecurity due to their more limited access to employment as a coping mechanism
	“Persons with disabilities are more exposed in situations of insecurity”	In situations of insecurity, persons with disabilities are at heightened risk of experiencing violence due to their difficulties in fleeing to safe areas
	“Persons with disabilities experience disproportionate impacts of food shortages”	Limited access to land due to disability-related discrimination increases the risk of food insecurity and malnutrition for persons with disabilities
“Persons with disabilities have specific health-related needs which remain unmet”	Persons with disabilities are experiencing poor health outcomes due to difficulties reaching health posts and limited availability of rehabilitation service providers in conflict-affected areas	

Annex: Analysis Methods, Information Gaps and Gap-filling Plans

Information gaps

Reflect on what additional information is needed for programming and how it will be used. If reliable data on persons with disabilities is not already available, describe how this will be integrated into planned needs assessment and other data collection processes. If disability cannot be integrated into planned needs assessment processes, consider conducting a dedicated primary data collection exercise. Specific references to local disability actors may be appropriate.



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4 The Humanitarian Response Plan Process: Designing the Response

The following guidance concerning persons with disabilities in the Humanitarian Response Plan process is meant to be considered in an integrated fashion with the broader questions and issues raised, and not as a separate strand of work.

STEP 4 Select priority humanitarian outcomes to address

4.1 Review the analysis results from the HNO or update

The analytical process described at [Section 2.4](#) and [Figure 1](#) will guide identification of the risks faced by persons with disabilities and the factors contributing to their heightened vulnerability to these risks.

4.2 Decide which population sub-groups and geographic areas should be prioritized

Persons with disabilities should be considered a population sub-group of whatever priority population group is identified.¹⁸ That is, if IDPs are a priority population sub-group, consider persons with disabilities as a sub-group.

A key outcome should be to strengthen inclusiveness of the humanitarian response, with a focus on most at-risk groups.

18 The [Humanitarian Profile Framework](#) defines a typology of targeted humanitarian population groups, at the broadest level "affected" and "casualties". Comprising 15% of the total population and facing particular and heightened risk, persons with disabilities are necessarily a major sub-group of whatever groups are targeted.

STEP 5

Analyze response options and formulate strategic objectives

5.1 Analyze response options

A key consideration for persons with disabilities is their adequate access to humanitarian assistance, and whether specific barriers exist in the way that the response is designed and delivered that limits this. It is important that this analysis is informed by the views and feedback of persons with disabilities themselves. The needs analysis in the HNO will have identified the sources of heightened risk for persons with disabilities. At the strategic planning phase, it is important to design a response that will address these factors in order to reduce vulnerability and heighten resilience of persons with disabilities. Focusing the design of the response on these factors, rather than on the individual's impairment alone, recognizes the impact of environmental factors in creating vulnerability.

5.2 Formulate strategic objectives

At the Strategic Objective level, it is not relevant to make specific reference to persons with disabilities, as strategic objectives set out higher level change that the humanitarian community aims to achieve to cover all people. However, in the description of strategic objectives it is relevant to reference the need to ensure that persons with disabilities benefit equally, and that specific actions are required to do so. This provides a good basis for inclusion to be reflected in cluster-level objectives, indicators and targets.

5.3 Identify indicators to monitor the achievement of the strategic objectives

As stated above, it is not relevant to make specific reference to persons with disabilities in strategic objective indicators and targets as these define changes at the broader population group level, of which persons with disabilities are a sub-group. However, broader concepts of inclusion can be reflected, including through reference to accountability to affected populations or the centrality of protection.

Cluster-level objectives may refer to inclusion more broadly, such as by referring to equal access to assistance or protection by all affected populations, or by prioritizing those most at-risk.

Outcomes related to equal access and inclusion may be best reflected through the use of disaggregated data at the monitoring stage. For example, rather than including a specific indicator such as “number of children with disabilities accessing education”, it may be more appropriate to include the broader count of “number of children accessing education” but ensure that this is disaggregated by disability, in order to enable comparison and monitoring of equal access for children with and without disabilities.

Generally, it will be most meaningful to reflect specific disability-related considerations at the cluster-level output indicators (and activities, where included in the strategic framework). These indicators can reflect actions to improve accessibility of assistance, to promote participation or to provide targeted support to persons with disabilities.

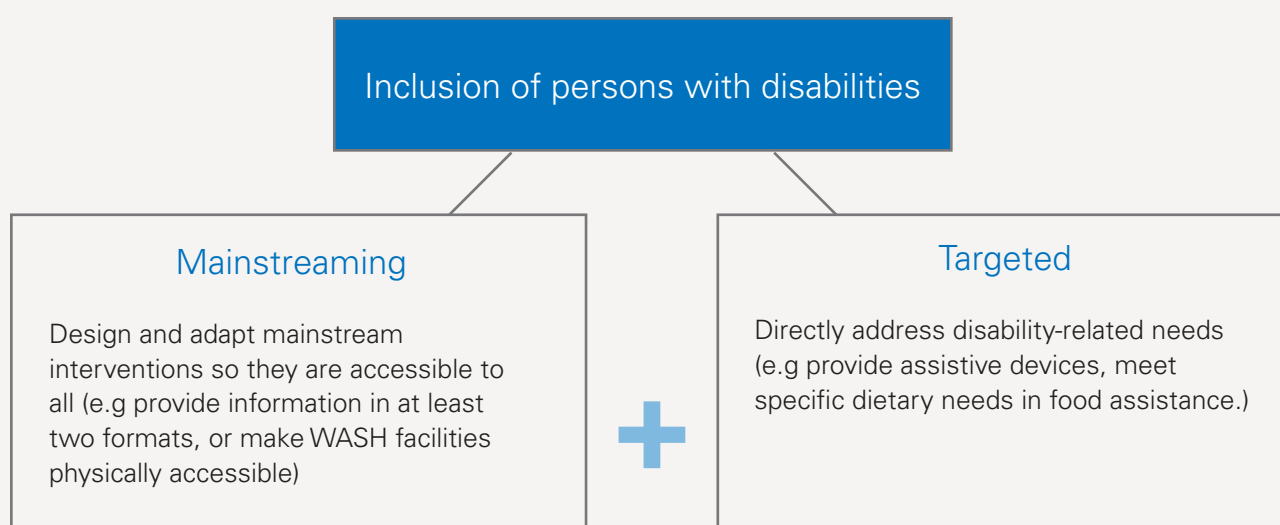
Annex 6 (output level indicators by theme area) provides examples of possible output-level indicators by thematic area. **Annex 6** is not intended as a comprehensive or exhaustive list, but as an example of how output indicators can be formulated to reflect inclusion. They are anchored by the Commitments Areas in the Charter on Inclusion of Persons with Disabilities in Humanitarian Action (Participation, Inclusive Policy, Inclusive Response and Services and Cooperation and Coordination) to facilitate reporting.

While the HRP is a high-level document, it should provide a basis for development of inclusive projects. At the project design stage, therefore, it will be important to set targets for inclusion of persons with disabilities and to require reporting on inclusion using disaggregated monitoring data.

5.4 Define response approach and modalities

It is essential that inclusion of persons with disabilities be considered as cross-cutting, to be considered by all sectors, rather than being reflected as the responsibility of one sector (e.g. protection).

A disability inclusive response should be designed in accordance with a “twin track approach”, as outlined in **Figure 2**, below. The response should include both actions to improve accessibility of assistance, as well as actions targeted to persons with disabilities themselves, to enable access on an equal basis with others.

Figure 1 The Twin Track Approach

The design of an inclusive response will benefit from strong participation from persons with disabilities. For example, adapting consultation methods to include people with disabilities and improving representation of persons with disabilities in local committees and associations. For more detailed guidance on designing a disability-inclusive response, see **Annex 5** Links to Key Disability Inclusion Resources.

STEP 6 Review and approve the strategic objectives and monitoring requirements

Participation by DPOs can be valuable to provide feedback on the appropriateness of the proposed response for persons with disabilities.

STEP 7 Formulate the activities and estimate the cost of the response plan

7.1 Elaborate the activities/ projects required to achieve the strategic objectives

Actions responding to the needs identified at the HNO stage should be elaborated at this point. For example, if persons with disabilities are found to be at heightened

risk of gender-based violence due to isolation of women and girls with disabilities and communication-related barriers to reporting, the response should be designed to reduce isolation and to strengthen accessibility of reporting mechanisms (rather than simply prioritizing persons with disabilities).

7.2 Estimate the cost of the response

It is important that a budget for inclusion is included in the total requirements for the response. Issues to take into consideration include budgeting for accessibility, training and reasonable accommodation. Building an inclusive response from the outset is much more cost-effective than adapting or redesigning for inclusion at a later stage. Generally, it is recommended that for physical accessibility (e.g. in the construction of buildings and WASH facilities), an additional 0.5- 1% should be budgeted. To also include specialized non-food items (NFIs) and mobility equipment, an additional 3-7% is recommended.¹⁹

7.3 Finalize and write up the response plan

Refer to **Table 4** which annotates the outline of the HRP template with specific guidance as to where disability inclusion can be strengthened in the document.

¹⁹ See Light for the World, "Resource Book on Disability Inclusion" (2017), p.36 [Link](#)

Table 4 Disability Inclusion in the Humanitarian Response Plan - an overview

HRP Sections

Guidance on integrating disability

Forward by the Humanitarian Coordinator

Make a reference to the need to ensure the response is fully inclusive, including for persons with disabilities, as an important statement of leadership and commitment to inclusion.

Summary

The Humanitarian Response Plan at a Glance

Include total estimated number of persons with disabilities in need. Where reliable primary or secondary data is not available, use the global estimate of 15% of the population.

Part I: Strategic Humanitarian Priorities

Priority Humanitarian Outcomes, population groups and geographic locations

A key outcome should be to strengthen inclusiveness of the humanitarian response for all prioritized sub-groups, which should, at a minimum, include persons with disabilities.

Describe how the crisis impacts persons with disabilities capturing their priorities and needs from their perspective, and considering disability-related dimensions of vulnerability and other structural inequalities, including a summary of the identified barriers to inclusion.

Consider including a text box or similar to highlight the specific outcome, with rationale, for prioritized sub-groups, including persons with disabilities (e.g. "age, gender and disability", or "reaching the furthest left behind"). This will allow space for focused attention on these groups.

Strategic Priorities

Ensure that the needs analysis including persons with disabilities undertaken during the HNO process is reflected in the strategic priorities of the HRP, including:

- Impacts of social exclusion or marginalization due to disability-related discrimination
- Obstacles to accessing humanitarian assistance (including due to lack of physical access or inaccessible information)
- Unmet health needs (including rehabilitation-related needs)
- Heightened risk of violence or abuse, including targeted violence against persons with disabilities

Table 4 Disability Inclusion in the Humanitarian Response Plan - an overview

HRP Sections

Guidance on integrating disability

Part II: Strategic Objectives Response Approach

Strategic Objectives

In the description of each strategic objective, make reference to persons with disabilities in the explanation of how this result or change will impact all affected populations, or how it will specifically benefit groups who are most at-risk.

Consider having a specific SO on quality under which people with disabilities can be better highlighted.

Example: SO 4 in Yemen HRP 2018

“Deliver a principled, integrated, coordinated and inclusive humanitarian response that is accountable to and advocates effectively for the most vulnerable people in Yemen with enhanced engagement of national partners”

Response approach and costing

Rather than simply listing persons with disabilities as a group to be targeted or prioritized, describe how the response will address the factors contributing to vulnerability and the barriers to inclusion of persons with disabilities.

Review on-going or planned responses, including by the government or development partners. Determine if persons with disabilities have adequate access to the response, if there are specific barriers faced, and what adjustments are needed in order to improve access.

Review the feasibility of different response modalities, including on-going responses, with particular attention to the acceptability of the response modalities to persons with disabilities, recognizing that priorities may differ according to age, gender and other intersectional identities.

Part III: Monitoring and Accountability

Response monitoring

Indicate if there is need to strengthen collection and use of data on persons with disabilities to monitor access to assistance in safety and dignity and the impact of assistance on vulnerability and resilience of persons with disabilities.

Describe how affected groups, including people with disabilities, will participate in monitoring the response.

Table 4 Disability Inclusion in the Humanitarian Response Plan - an overview

HRP Sections

Guidance on integrating disability

Part IV: Refugee Response Plan

Part V: Sectoral Objectives and Responses

Sector description

Consider adding a specific sub-heading for each sector describing the prioritized sub-groups, with attention to age, gender and disability at a minimum.

Consider how disability can be reflected, particularly at output indicator level. As plans shift in level from strategic to operational and down to project level, the inclusion of disability becomes more relevant and impacts more directly the people in need of assistance.

Annexes

Response Options Analysis

Indicate if there is need to strengthen collection and use of data on persons with disabilities to monitor access to assistance in safety and dignity and the impact of assistance on vulnerability and resilience of persons with disabilities.

Describe how affected groups, including people with disabilities, will participate in monitoring the response.

Costing Methodology

Ensure that the requirements include budgeting for inclusion and quality. Issues to take into consideration include budgeting for accessibility, training and reasonable accommodation. It is recommended to budget an additional 0.5-1% for physical accessibility and 3-7% for specialized non-food items, such as assistive devices and mobility equipment.

Planning figures: People in Need and targeted

Consider adding a single disaggregated estimate of the number of persons with disabilities, using the 15% global estimate if needed when available data is not considered sufficiently robust.

What if we fail to respond?

Where relevant, note how a failure to respond will impact persons with disabilities, referencing the heightened risks identified in the HNO. Emphasize that without resourcing for inclusion, the most at-risk populations (including persons with disabilities) will not be reached and will be placed at heightened risk.

Annex 1 | DFID Humanitarian Investment Programme

This guidance has been developed under the framework of the Humanitarian Reform of the United Nations through Core Funding (2017-2020), a multi-year, multi-agency initiative built around a single results framework supported by the Department for International Development (DFID). The Programme contributes to the implementation of reform commitments made by UN agencies under the Grand Bargain and the World Humanitarian Summit that promote a greater focus by the UN humanitarian system on protecting vulnerable persons, including persons with disabilities.

Joint performance indicators for the Programme include a target on disability in Humanitarian Response Plans (HRPs), specifically: “By the end of 2020, 70% of HRPs use a common recognised methodology and routinely disaggregate data on disability (with clear justification when this is not possible) in order to make programming more responsive to the needs of people with disabilities.”

This target for the promotion of inclusive programming is understood to have three components:

- 1 HRPs to include total estimated number of persons in need with disabilities;
- 2 HRPs to provide a narrative description of how the response will address factors contributing heightened risk/ vulnerability of persons with disabilities; and
- 3 integration of disability into the HRP strategic framework, with the precise nature of this component to be defined in consultation with pilot countries.

An HRP will be considered to have met the target if it provides a narrative description of how the response will address factors of heightened risk/vulnerability of persons with disabilities, plus at least one of the other two aspects – persons with disabilities disaggregated in the persons in need estimates and/or the integration of disability into the HRP strategic framework.

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Annex 2 | Tips on Conducting Inclusive Key Informant Interviews

Where to begin

- Identify local Organizations of persons with disabilities (otherwise known as disabled persons organizations, DPOs)²⁰ through national civil society registries and the relevant national or local level authorities. The [International Disability Alliance](#) is a useful starting point to identify regional and local federations or networks.
- Consult with DPOs and people with disabilities about locally preferred communication preferences. Use a minimum of two communication methods to consult and engage persons with disabilities (e.g. visual and spoken) considering all local languages.
- Training for interviewers on accessible communication methods is important. It is also important to budget for accessible communication, such as sign language interpreters.
- Find interview venues that are accessible and safe for people with disabilities. For people with more limited mobility, provide outreach to conduct an interview in the home Interview sample or group composition.

Interview sample or group composition

- Persons with disabilities who are able to represent the views and priorities of this group should be included among key informants, in order to ensure that the situation, views and priorities of persons with disabilities are represented. A diverse sample of persons with disabilities is recommended that includes men and women, boys and girls, of all ages and impairment types, so that a diverse insight into the risks and barriers can be understood.

Data protection and informed consent

- Individuals have a right to make their own decisions, requiring their informed consent to participate. In order to enable some individuals to provide informed consent, information regarding participation may need to be provided in a different format or more time given to understand the information and make a decision. Some individuals may wish to choose a trusted person to support them in making an informed decision.

Learn how persons with disabilities are differently affected

- Gain an understanding of how the concerns of the general population might be experienced differently by men, women, boys and girls with different disabilities; in addition to any specific concerns that persons with disabilities may have.
- Understand both needs and capacities, aspirations and priorities of persons with disabilities.
- Determine the experiences persons with disabilities had in past emergencies, such as the barriers they faced and coping mechanisms used.
- Understand the roles that persons with disabilities have in the community, including their contributions or how they are assisted by other people.

Communication needs and preferences

- When interviewing persons with hearing disabilities determine how best to communicate (accessible communication formats include written text, sign language, pictures, speaking slowly).²¹
- For individuals with visual disabilities clearly describe the surroundings and the persons present in the interview.
- Provide options for different ways of communicating (symbols for yes/no, emotions happy/sad) or use drawings, illustrations, modelling materials. For example, rather than direct questions, the interviewer might invite participants to share stories or accompany them on a walk through the community.
- Communicate directly with individuals with disabilities, not their interpreters or care givers/ assistants.
- In some circumstances people with disabilities may feel more comfortable participating in an interview with a support person. The person with a disability themselves should always choose whether or not they would like to have a support person present in the interview.

²⁰ DPOs are usually self-organized organizations where the majority of control at the board level and at membership level is with people with disabilities. The role of a DPO is to provide a voice of their own, on all matters related to the lives of people with disabilities. (CBM 2017)

²¹ Some useful tools to facilitate meetings and better communication have been developed by CBM. (<https://hhot.cbm.org/task-card/meeting> and <https://hhot.cbm.org/task-card/communication>)
Note that vernacular languages can have their own sign languages, and that refugee populations might not know the host community sign language.

Annex 3 | Disability Data Survey Instruments and Applicability in Humanitarian Settings²²

	Use	Applicability in humanitarian settings
Washington Group short set of disability questions (WG-SS) ²³	Designed expressly as an add-on to existing censuses and surveys to generate internationally comparable data on persons with disabilities. That is, to identify people at greater risk than the general population for participation restrictions.	<p>Set of 6 questions adds an additional two minutes per survey. Can be reduced to 4 questions in situations where the 6-question set is still too lengthy.</p> <p>The tool is increasingly being used by humanitarian organizations and has recently been tested in a variety of humanitarian contexts.²⁴</p> <p>However, it does not directly address mental health functioning or identify barriers persons with disabilities face.</p>
Washington Group extended set of questions on functioning	Additional questions (total of 37) on anxiety and depression, pain, fatigue, use of assistive devices, age onset of disability and environmental factors. The Enhanced Short Set adds 6 questions to the Short Set, on upper body and psychosocial functioning domains.	Questions on anxiety and depression have been added to WGSS questionnaires in some humanitarian settings.
Washington Group/ UNICEF Module on Child Functioning (CFM)	Tool for use with children and youth aged 2-4 and 5-17 years, as the Washington Group short set is not recommended for these age groups. Both modules are designed with the primary caregiver as the respondent.	Longer than the short set of questions, but has been used in resource-poor settings (e.g. has been embedded in the MICS 6 survey that covers many high-risk humanitarian settings).

²² Important to note that these are tools to support the disaggregation of data, not for diagnosis, assessment or targeting.

²³ Additional versions of the Washington Group short set of questions have been developed. Leonard Cheshire and Humanity and Inclusion have produced a tool called the [Washington Group short set enhanced](#) consisting of 12 questions: the 6 included in the short set, plus additional questions covering anxiety, depression and upper body mobility.

²⁴ Leonard Cheshire and Humanity and Inclusion. ["Disability Data Collection: A summary review of the use of the Washington Group Questions by development and humanitarian actors"](#) (October 2018)

Annex 3 | Disability Data Survey Instruments and Applicability in Humanitarian Settings

	Use	Applicability in humanitarian settings
WHO Model Disability Survey	General population survey that provides information about how people with and without disabilities conduct their lives and the difficulties they encounter. Intended to identify environmental barriers that prevent full participation by persons with disabilities.	Capacity module with 13 questions (3-5 minutes); assistive technology model with 9 questions (additional 3-5 minutes). So far has not been tested in humanitarian contexts.
WHO Disability Assessment Schedule Version 2.0	Provides a standardized summary measure of functioning in six life domains: cognition, mobility, self-care, getting along, life activities and participation. Different versions of the tool have been designed for various administration modes, ranging from 12 to 36 items, each with multiple questions.	12 questions requiring 3-5 minutes per interview. Tested in one humanitarian context (Pakistan), as well as over 100 other settings.

Annex 4 | Examples of existing needs assessment tools

Needs assessment tool	Quantitative data approach	Qualitative data approach	Recommended modifications to improve disability inclusion
<p>Multi-cluster Rapid Needs Assessment²⁵ (MIRA/IASC)</p>	<p>Persons with disabilities are included as one possible category of vulnerable people among others with unmet needs.</p> <p>May provide insight on information gaps. However, the primary data collection element is very limited and only meant to inform overarching strategic priorities.</p> <p>Use of quantitative data focuses largely on pre-crisis and limited in-crisis secondary data, which may under-report disability.</p>	<p>The methodological framework includes direct observation, key informant interviews and community group discussions as primary data collection approaches.</p> <p>However, disability is considered only as a specialized issue in the analysis of unmet needs and key humanitarian priorities (i.e. with the question, ‘is there specialized response capacity in place?’), and not mainstreamed throughout.</p>	<p>The MIRA process does not specify tools, leaving their design up to the assessment team. The following general points may improve disability inclusion in the process:</p> <ul style="list-style-type: none"> • When initiating a MIRA specifically designate responsibility for disability inclusion. • In conducting a secondary data review ensure that disability data is among the agreed categories for analysis. • If primary data is sought ensure that interview guidance and direct observation checklists are inclusive of disability-related issues. The DTM/IOM interview checklists is a good example of a disability-inclusive tool that can be adapted for this purpose. • In order to account for the differing impact of the crisis on persons with disabilities, interview participants should represent a cross-section of persons with disabilities (i.e. men, women, from a range of age groups and types of disabilities) in a 3/20 ratio (15%).
<p>Needs Assessments for Refugee Emergencies checklist (NARE/UNHCR)</p>	<p>Based primarily on secondary pre-crisis data. The tool offers a useful checklist of the kinds of secondary data to seek out, and the kinds of issues the data should speak to. Potential service providers, census information or analysis of marginalized or excluded groups may have relevance to persons with disabilities, depending on the availability of reliable data on persons with disabilities in the particular context.</p>	<p>The methodological framework includes community observations, community and household key informants, focus groups and infrastructure site visits. However, the framework does not specify how persons with disabilities can be included in these approaches.</p> <p>The checklist does not make specific reference to disability but does include analysis of Age, Gender and Diversity (AGD) factors, which will include disability. The checklist also makes indirect reference to persons with disabilities under questions related to ‘specific needs’, although this will not capture the full spectrum of disability, including barriers to participation and access.</p>	<p>NARE’s checklist approach could be adapted for use in other needs assessment processes. One way to strengthen disability inclusion in the checklist is to make more specific reference to barriers to accessing assistance, including attitudinal, environmental and institutional barriers.</p> <p>There may also be value in including in the checklist a brief overview of how to ensure that primary data collection processes can mainstream Age, Gender and Diversity (AGD) considerations, including by identifying persons with disabilities as key informants. This approach would help to ensure that issues of accessibility and inclusion are raised, even if questions asked are not modified.</p>

²⁵ The Joint Intersectoral Analysis Framework (currently under development) aims to be the next generation of the MIRA analysis framework, and will offer another opportunity to reflect upon those with disabilities within the wider context and crisis analysis. The JIAF will produce current and forecasted priority needs/concerns according to age, gender “and diversity groups” making it necessary to advocate strongly that persons with disability are considered a sub-group.

Annex 4 | Examples of existing needs assessment tools

Needs assessment tool	Quantitative data approach	Qualitative data approach	Recommended modifications to improve disability inclusion
Vulnerability Assessment Framework (VAF/UNHCR)	<p>Developed originally for work with Syrian refugees in Jordan, as a measurement tool for vulnerability. Used to establish the eligibility of individuals to receive benefits based on a common set of vulnerability criteria, thereby targeting assistance more effectively toward persons most in need. The tool is based on home visits with standardized universal as well as sector-specific vulnerability criteria. The Washington Group short set questions have been added to the VAF as a universal criteria, allowing for disaggregation of data by disability.</p>	<p>Reporting of VAF data can include qualitative analysis of vulnerability. However, the tool does not add to the understanding of the barriers faced by persons with disabilities.</p>	<p>VAF data can and should be used in conjunction with other types of analysis. Follow-up interviews by sector level service providers (e.g. shelter, WASH) directly with individuals with disabilities identified through VAF home visits could be useful to identify factors contributing to vulnerability, including barriers to accessing assistance.</p>
The Humanitarian Emergency Settings Perceived Needs Scale (HESPER/WHO)	<p>This tool is a rapid survey to assess perceived needs in order to provide a quantitative assessment of unmet needs. While all the areas addressed in the survey are relevant to persons with disabilities, the tool currently does not include disaggregation by disability, only by sex and age.</p>	<p>Each of the 26 issue areas are coded 0/1 (“not a problem/a problem”) and respondents are also asked to rank order the problems, which can provide an indication of priority concerns. However, the tool is not able to provide an explanation of the factors contributing to these concerns.</p>	<p>Including disaggregation by disability, alongside age and sex, would enable the collection of data on the perception of persons with disabilities, including what they view as priority concerns and barriers to accessing assistance, and analysis on how these may differ from others in the affected population. Examples of possible tools are listed in Annex 3.</p> <p>For example, if the responses to the question “Do you have a serious problem because you do not have easy and safe access to a clean toilet?” was disaggregated by disability, this would enable identification of disability- related barriers, which may differ from barriers related to gender, and require a different response.</p>

Annex 4 | Examples of existing needs assessment tools

Needs assessment tool	Quantitative data approach	Qualitative data approach	Recommended modifications to improve disability inclusion
<p>Displacement Tracking Matrix (DTM/IOM)</p>	<p>Globally, only limited disability specific information is collected, but the framework is in place -</p> <p>Mobility Tracking: estimate of a population type in a given area (e.g. the number of IDPs in a camp). The Multi-Sectoral Location Assessment tool includes estimates on the number of persons with disabilities.</p> <p>Flow Monitoring: movement past a defined location (e.g. border point, transport junction) can, in certain contexts, track persons with disabilities.</p> <p>Registration: census-like data on individuals within a population, including information on individuals with specific vulnerabilities.</p> <p>Surveys: qualitative or quantitative surveys through individual or household interviews. The Bentiu site assessment report from South Sudan used the Washington Group short set of questions to collect data on persons with disabilities.</p>	<p>Multi-Sectoral location assessments are undertaken routinely, particularly in cases where the population is relatively static, for example in South Sudan IDP camps. These assessments analyze the risks faced by affected populations in accessing services, using key informant and focus group methods. Some tools used in assessments have integrated disability.</p> <p>Key informant interview checklists integrating disability into the Bentiu site assessment are a good example of how disability can be integrated. “Women in Displacement”²⁶ group discussion guides address both disability and gender-related issues and are a good example of how intersectionality can be captured in site assessments.</p>	<p>Where more detailed data is collected, moving from the broad initial estimates towards detailed registration data, DTM tools could be modified to incorporate a standard primary data collection tool (see Annex 3).</p> <p>DTM mobility tracking tools like the Global Core Site Assessment that feed into global statistics use “best estimates” provided by key informants about vulnerability characteristics of the population, such as disability status. Using the global estimate of 15% disability prevalence rate is recommended where reliable primary or secondary data may not be available.</p>
<p>JIPS Essential Toolkit (Joint IDP Profiling Service)</p>	<p>Internally displaced person profiling is a collaborative data collection process to establish a shared understanding of a displacement situation. Household surveys are used to establish a demographic profile of the displacement-affected population that can be disaggregated by displacement status, location, sex, age and diversity characteristics, as well as a wide range of other information on their humanitarian and development needs, living conditions and coping mechanisms.</p>	<p>Qualitative methods are often used in displacement profiling exercises to inform, complement or validate findings produced by household surveys. Key informant interviews and focus group interviews are commonly used methodologies.</p> <p>These methods can be used to understand the barriers faced by persons with disabilities.</p>	<p>Disability could be included among other diversity characteristics in surveys that are undertaken. Where disability data is collected in household surveys, a standard primary data collection tool (see Annex 3) should be used.</p> <p>Persons with disabilities should be included among key informants, and questions should be asked about how the crisis impacts differently on persons with disabilities.</p>

26 Requires site registration to access.

Annex 4 | Examples of existing needs assessment tools

Needs assessment tool	Quantitative data approach	Qualitative data approach	Recommended modifications to improve disability inclusion
<p>Kenya Inter-Agency Rapid Assessment (KIRA)</p>	<p>Countrywide Kenyan-owned mechanism with capacity to conduct multi-agency and multi-sector assessment of humanitarian needs to support strategic decision-making. Quantitative data drawn primarily from pre-crisis secondary reviews prepared as a preparedness measure where prevalence estimates of persons with disabilities are not included.</p> <p>County Integrated Development Plans are a good source of secondary quantitative data in Kenya, and these include detailed disability prevalence data based on the Analytical Report on Disability (2012).</p>	<p>New primary qualitative data is collected using key informant interviews, community group discussions as well as direct observation. Structured interview guides have been developed to capture data facilitating rapid aggregation of findings. Questions are limited to needs and assistance provided. Purposeful sampling approaches are recommended to include a cross-section of livelihood zones, geography, communities impacted by the crisis and living arrangements (camps, pastoral communities etc.)</p> <p>Using these approaches the views of persons with disabilities can be captured, provided that they are included among KIs and community focus groups.</p>	<p>The KIRA approach is based on approximations given existing secondary data from the 2009 national census. The methodology in that survey used screening questions, and this approach tends to produce under-counts of persons with disabilities. It is recommended that the more general accepted global estimate of 15% of the population be applied to the county-level population estimates used in the KIRA secondary data reviews.</p> <p>Persons with disabilities, their care-givers and organizations of persons with disabilities should be systematically involved in the qualitative interviews.</p> <p>Interview guides for use with KIIs, CGDs and direct observation focus on largely on service provision and the availability of assistance, not barriers to accessing these services. Questionnaires should be redesigned to capture information related to physical, communication or institutional barriers as well as attitudes and perceptions related to persons with disabilities.</p>

Annex 5

Key Resources for Inclusion of Persons with Disabilities

Resource	Description
<p>United Nations, Convention on the Rights of Persons with Disabilities (UN-CRPD). A/RES/61/106, December 2006 Link</p>	<p>Articles of particular relevance are Article 9 (Accessibility), Article 11 (Situations of risk and humanitarian emergency) and Article 31 (Data collection). Articles on rights to inclusion, access to information, education, health, work and employment, and social protection.</p>
<p>Humanity and Inclusion, Learning toolkit on the use of the WGOs in humanitarian action, 2018. Link</p>	<p>Two-hour course has been designed to support humanitarian program staff understand, plan for and use the Washington Group Questions to identify persons with disabilities in humanitarian action. With case studies, practical examples and a wealth of supporting resources, the e-learning is an essential entry point for all program staff interested in understanding more about how to use the WGOs.</p>
<p>Age and Disability Consortium. Humanitarian inclusion standards for older people and people with disabilities, 2017 Link</p>	<p>Designed to help address the gap in understanding the needs, capacities and rights of older people and people with disabilities, and promote their inclusion in humanitarian action. Each chapter presents a set of standards with key actions to meet the standard, guidance notes to support delivery of the actions, tools and resources, and case studies illustrating how older people and people with disabilities access and participate in humanitarian response.</p>
<p>CBM, Disability-Inclusive Development Toolkit, 2017 Link</p>	<p>Designed as a resource to support staff orientation to disability-related issues, team meetings, training workshops and self-study. It is aimed at program management and activity implementation, to provide material for inclusive training and facilitation. The tools are oriented towards disability inclusive development. Materials related to disability awareness, participation, accessibility and universal design, the “Twin Track Approach,” empowerment and gender equality are relevant to humanitarian action.</p>

Annex 5 | Key Resources for Inclusion of Persons with Disabilities**Resource****Description**

United Nations Children’s Fund (UNICEF),
Including children with disabilities in
humanitarian action, 2017

[Link](#)

Guidance to provide insight to humanitarian actors to engage in response to the situation of children with disabilities in humanitarian contexts, especially how they are excluded from humanitarian action. Topics include nutrition, health and HIV/AIDS, water, sanitation and hygiene, child protection, education as well as general guidance. Each offers practical actions and tips to better include children and adolescents with disabilities in all stages of the humanitarian program cycle. The materials are useful across a broad range of humanitarian actors, United Nations as well as implementing partners.

CBM, Humanitarian Hands-on Tool, 2017.

[Link](#)

Web application with simple one-page guidelines on all issues relevant to the design and implementation of inclusive humanitarian action.

IFRC. All Under One Roof,
Disability-inclusive shelter and
settlements in emergencies, 2015

[Link](#)

Guidance to improve inclusion across the different phases of disaster management, with general advice as well as specific references to shelter and settlement support. Technical guidance. Recommendations on promoting participation and equal opportunities in assisted self-settlement as well as inclusive cash programming.

United Nations High Commissioner for
Refugees, Need to Know Guidance:
Working with persons with disabilities
in forced displacement, 2011.

[Link](#)

Focused on refugee and forced displacement situations. Provides a range of key considerations sector-wise, including specific protection issues. Key practical actions are summarized.

World Health Organization. World Report
on Disability, 2011

[Link](#)

Key reference point for the global disability prevalence estimate used in this guideline, and more widely. Chapter two (the global picture) provides additional context to why data on disabilities is so hard to obtain, and why such wide variations exist between surveys and censuses in different countries.

Annex 6

Examples of output-level Indicators by thematic area

Thematic Area	Examples of Activity/ output-level Indicators	Commitment Area ²⁷ Aspect of vulnerability addressed	Means of Verification Tools and methods
Health	# of health facilities constructed or adapted in accordance with universal design standards	Inclusive Response and Services Physical barriers to safe and dignified access	Accessibility audits to identify facilities that do not meet standards. Accessibility Design Guide
Health	# of persons with disabilities accessing health-related rehabilitation services, including assistive technology	Cooperation and Coordination Interruption of essential health service due to disruption caused by the crisis	Health post/clinic records. HeRAMS checklist of services may require adaption.
Education	# of classrooms retrofitted or constructed in accordance with universal design standards	Inclusive Response and Services Physical barriers to safe and dignified access	Checklists to facilitate systematic monitoring. Standards (e.g. width of doors, height of tables, accessibility ramps)
WASH	# of toilet facilities retrofitted or constructed in accordance with universal design standards	Inclusive Response and Services Physical barriers to safe and dignified access	Checklists to facilitate systematic monitoring. Standards (e.g. toilet fixtures, drinking water, hand-washing, signage)
WASH	# of hygiene messages provided in a minimum of two formats (written and oral)	Inclusive Response and Services Communication barriers prevent access to important information	Checklists to facilitate systematic monitoring. Tips and guidance by CBM on accessible communication
Food Security and Nutrition	# of distribution points/markets retrofitted or constructed in accordance with universal design standards	Inclusive Response and Services Physical barriers to safe and dignified access	Common Operational Dataset or Foundational Operational Datasets issued to identify appropriate and accessible distribution points. SPHERE food security – Food assistance standard 6.3: Targeting, distribution and delivery
Protection	# of staff, partners and communities trained in working with people with disabilities	Cooperation and Coordination Limited capacity of protection actors to include persons with disabilities in core activities	Follow-up assessment of efficacy will require a baseline of knowledge attitude and practice. Tips and guidance by UNICEF

Annex 6 | Examples of output-level Indicators by thematic area

Thematic Area	Examples of Activity/ output-level Indicators	Commitment Area ²⁸ Aspect of vulnerability addressed	Means of Verification Tools and methods
Gender-based violence prevention and response	% or # of GBV staff trained in disability inclusion	<p>Non-discrimination</p> <p>GBV prevention and response activities not accessible to persons with disabilities</p>	<p>Training records and staff lists.</p> <p>Training materials on preventing GBV against children and youth with disabilities produced by the Women's Refugee Commission and ChildFund</p>
Gender-based violence prevention and response	# of women with disabilities recruited to participate in community leadership structures	<p>Participation</p> <p>Lack of access to information and inclusion in decision-making processes</p>	<p>Narrative reports.</p> <p>See tool kit on Strengthening the Role of Women with Disabilities in Humanitarian Action</p>
Child protection	# of children and youth with disabilities participating in child rights committees and other community-based structures for child protection	<p>Non-discrimination</p> <p>Children and youth with disabilities not participating in identification of risk and design of appropriate response</p>	<p>Narrative reports.</p> <p>Tips and guidance by UNICEF, guidance on child protection, including children with disabilities in humanitarian action</p>
Child protection	# of CP staff trained on how to adapt MHPSS and recreational activities for all children, with attention to the participation of children with disabilities	<p>Inclusive Response and Services</p> <p>Activities are not adapted to the diverse needs and interests of children with disabilities</p>	<p>Training records and staff lists.</p> <p>UNICEF tool kit including children with disabilities in humanitarian action – child protection.</p>
Housing, land and property	# of DPOs trained to engage in housing, land and property issues affecting persons with disabilities	<p>Non-discrimination</p> <p>Children and youth with disabilities not participating in identification of risk and design of appropriate response</p>	<p>Civil society directories and databases.</p> <p>All Under One Roof, chapter on recovery has guidance on policy influence</p>
Housing, land and property	# of persons with disabilities provided support to enable independent living	<p>Inclusive Response and Services</p> <p>Dependence on family members, caregivers and other community members</p>	<p>Narrative reports compared to needs assessment that defines caseload.</p> <p>Shelter, Settlements and Household Items in the Humanitarian Inclusion Standards for older people and people with disabilities</p>
Mine action	# of DPOs and individuals with disabilities trained in risk reduction and education activities	<p>Participation</p> <p>Information and communication barriers</p>	<p>Training records.</p> <p>Risk Education chapter in the "Guide to Mine Action"</p>

Annex 6 | Examples of output-level Indicators by thematic area

Thematic Area	Examples of Activity/ output-level Indicators	Commitment Area ²⁸ Aspect of vulnerability addressed	Means of Verification Tools and methods
Mine action	# of persons with disabilities trained to take part in community liaison activities to identify and assess risk	Cooperation and Coordination Disability-related factors impacting on mine risk are not understood or addressed	Training records. Risk Education chapter in the "Guide to Mine Action"
Shelter	# of housing/shelters optimized through individual adaptation based on specific needs	Inclusive Response and Services Inaccessible shelters contributing to isolation	Accessibility audits to identify facilities that do not meet standards. All Under One Roof , chapter on Standards for Shelter
Camp Coordination and Management	# of persons with disabilities represented on community leadership structures	Participation Lack of participation in decision-making	Community group self-assessments. Resource Kit for Field Workers on Improving Services for Displaced Persons with Disabilities
Camp Coordination and Management	# of participatory assessments conducted that include persons with disabilities	Inclusive Response and Services Inappropriate services or designs that create barriers	Narrative reports. Resource Kit for Field Workers on Improving Services for Displaced Persons with Disabilities

Annex 7 | Terminology

Accessibility

Accessibility means ensuring that people with disabilities are able to have access to the physical environment around them, to transportation, to information such as reading material, to communication technology and systems on an equal basis with others. Accessibility requires forward thinking by those responsible for delivery of private and public services to ensure that people with disabilities can access services without barriers. ([CBM 2017](#))

Barriers

Factors that prevent a person from having full and equal access and participation in society. These can be environmental, including physical barriers (such as the presence of stairs and the absence of a ramp or an elevator) and communication barriers (such as only one format being used to provide information), attitudinal barriers (such as negative perceptions of older people or people with disabilities) and institutional barriers (such as policies that can lead to discrimination against certain groups). Some barriers exist prior to the conflict or natural disaster; others may be created by the humanitarian response. ([ADCAP 2018](#))

Disability

“In the International Classification of Functioning, Disability and Health (ICF),²⁸ disability is defined as a limitation in a functional domain that arises from the interaction between a person’s intrinsic capacity, and environmental and personal factors. From this perspective, functioning occurs at three levels: body function and structures, activities and participation. For example, if an individual cannot move their legs, he/she experiences a limitation in functioning at the body function level. If an individual has difficulty walking, he/she experiences a limitation at the basic activity level, in other words difficulty combining body functions to perform a particular task. If an individual cannot work, because of environmental barriers (e.g. an inaccessible work place), then he/she is restricted at the participation level. Similarly, the CRPD recognizes “that disability is an evolving concept and that disability 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.”²⁹

The overall experience of disability is diverse as it is the combination of limitations in functioning across multiple domains (e.g. walking, seeing), each on a spectrum, from little or no disabilities to severe disabilities, either within a particular domain or across multiple domains. For each domain, the level of functioning a person experiences depends both on the intrinsic capacity of the individual’s body and the features of his or her environment that can either lower or raise, the person’s ability to participate in society. Since domains of functioning are on a continuum, in order to determine prevalence of disability some threshold level of functioning needs to be established to distinguish between “persons with disabilities” and “persons without disabilities”.

Countries, in their data collection activities, do not define persons with disabilities uniformly and have adapted practical definitions and thresholds for their own data collections on the basis of their policy needs. National definitions differ in both meaning and scope and severity of disability.”³⁰

Intersectionality

This means the interaction of multiple factors, such as disability, age and gender, which can create multiple layers of discrimination, and, depending on the context, entail greater legal, social or cultural barriers. These can further hinder a person’s access to and participation in humanitarian action, and more generally, in society. ([ADCAP 2018](#))

Reasonable accommodation

Necessary and appropriate modification and adjustments not imposing a disproportionate or undue burden, where needed in a particular case, to ensure to persons with disabilities the enjoyment or exercise on an equal basis with others of all human rights and fundamental freedoms. ([Handicap International, 2015](#))

Universal design

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

28 WHO (2001). International Classification of Functioning, Disability and Health. Available at: <http://www.who.int/classifications/icf/en/>

29 Preamble, paragraph (e).

30 This definition of disability is taken from, United Nations Department of Economic and Social Affairs (DESA), “Realization of the Sustainable Development Goals by, for and with persons with disabilities: UN Flagship Report on Disability and Development 2018”, p.44 ([link](#))