Disability Inclusive Approaches to Humanitarian Programming: Summary of available evidence on barriers and what works

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Query: What is the evidence on barriers to humanitarian programme access/participation for people with disabilities? What is the evidence on what works for people with disabilities in humanitarian response, both in terms of access/participation and outcomes?

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Contents

1. Overview

Under Article 11 of the UN Convention for the Rights of Persons with Disabilities (CRPD), States' and other relevant humanitarian actors are obliged to ensure the protection and safety of persons with disabilities in all situations of risk, including armed conflict, humanitarian emergencies and natural disasters.[1] However, **people with disabilities continue to be disproportionately affected by humanitarian crises**. Research has shown that in the event of an emergency, be this is a sudden onset natural disaster, or a protracted conflict situation, people with disabilities can be extremely vulnerable, and yet often struggle to access humanitarian assistance (Rohwerder, 2017a). A 2015 global consultation highlights how **people with disabilities are 'falling through the cracks' of humanitarian response**, with over three quarters of people with disabilities interviewed reporting to not have adequate access to basic assistance such as water, shelter, food or health, and half of respondents reporting to not be able to access specialised services such as rehabilitation, assistive devices, access to social workers or interpreters. (Handicap International, 2015)

DFID is committed to ensuring humanitarian response efforts become more inclusive. Humanitarian Action has been identified as one of four strategic pillars within DFID's Strategy for Disability Inclusive Development 2018-2023. The new strategy aims to promote a fully inclusive humanitarian response within DFID and across the broader system, which is evidence-based, equitable, inclusive in design, and founded on the principles of dignity, safety, empowerment and protection. (DFID, 2018)

[1] https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities/article-11-situations-of-risk-and-humanitarian-emergencies.html

This report provides a rapid review of the evidence on approaches to ensuring people with disabilities are reached through humanitarian programmes, including evidence on barriers to access as well as evidence of impact on participation and outcomes. The purpose of this review is to support DFID advisers and partners designing and implementing humanitarian programmes with the best available evidence to ensure they are more inclusive of people with disabilities.

After outlining the methodology in Section 2, Section 3 provides a summary of factors affecting access for people with disabilities including individual, environmental, attitudinal and institutional barriers. Section 4 provides an overview of available evidence on what works to ensure inclusion of people with disabilities within humanitarian programming, as well as an assessment of the strength of the evidence, and highlighting key evidence gaps.

This rapid review identifies **multiple factors that that limit or exclude people with impairments from accessing humanitarian services and programming** – including individual, attitudinal, environmental and institutional barriers (summarised in the table below).

Factors affecting access to humanitarian programming for people with disabilities			
Individual	**Environmental**	**Attitudinal**	**Institutional**
Evidence suggests that older people, women, adolescent girls and children with disabilities are especially vulnerable to marginalisation, discrimination, violence, and exploitation in humanitarian settings. People with psychosocial disabilities and mental health conditions are particularly excluded. Lack of specialized services and equipment presents 'double setbacks'	Inaccessible information on services Physical inaccessibility of food and service distribution points and essential services and lengthy wait times Long distances and lack of accessible transport Inaccessible housing and WASH facilities Lack of specialist services and equipment Forced encampment GBV and safety issues	Negative attitudes among family members and communities Social and cultural attitudes which devalue lives of people with disabilities Attitudes and knowledge of field staff and service providers Stigma and discrimination	Lack of financial and human resources Lack of disability mainstreaming Exclusion of specialised services for people with disabilities Lack of disability disaggregated data and comprehensive needs assessments Lack of disability inclusion expertise Lack of accountability mechanisms and official guidance Gaps in policy development and implementation Exclusion from official planning processes Lack of indicators and targeting

Overall, the evidence base on what works to include and deliver outcomes for people with disabilities in humanitarian response – both in terms of specialised services as well as mainstream programming - is extremely limited. Whilst some recent studies have highlighted a lack of access to humanitarian programming for people with disabilities, there is little evidence on what works to ensure inclusion of people with disabilities within the humanitarian response, However, there are a few examples of promising approaches largely from qualitative grey literature including project reports, further highlighted in section 4.

Particular gaps in the evidence and therefore priorities for future research include: limited evidence on disability inclusion in specific sectors of the humanitarian response (for example, in relation to health: nutrition, sexual and reproductive health (SRH), gender-based violence (GBV), and accountability to affected populations[2]); limited evidence on disability and intersectionality in resilience-based programmes; and a lack of gender, age and disability disaggregated data.

2. Methodology

This rapid research query has been conducted as systematically as possible within 4.5 combined days of researcher and expert time. The methodology is described below.

Search strategy: Studies were identified through a variety of search strategies; focusing on low and middle-income countries:

- **The review prioritised existing syntheses, evidence reviews, and systematic reviews** where possible in order to draw on the fullest range of evidence possible. However, no systematic reviews related to disability and humanitarian settings were identified at the time of the review, and whilst there are a number of international guidance documents and a few peer-reviewed articles, but the majority of literature on this topic is from non-peer-reviewed articles and grey literature including guidelines, policies and organisational reports.
- **The DFID Disability Inclusive Development Programme consortium partners[3] and relevant experts were contacted** for evidence recommendations including both published and unpublished literature (see page 15 for experts provided contributions).
- **Google and relevant electronic databases** (PubMed, Science Direct, and Google Scholar) for priority sources using a selection of key search terms[4] used in other systematic reviews to identify more recent materials including academic and grey literature.
- **Review of key disability portals and resource centres**, including the Leonard Cheshire Disability and Inclusive Development Centre, Disability Data Portal, Source, International Centre for Evidence in Disability, the Impact Initiative, and Sightsavers Research Centre.
- **Disability-focused journals**, such as Disability & Society, and the Asia-Pacific Disability Rehabilitation Journal.

Criteria for inclusion: To be eligible for inclusion in this rapid review of the literature, studies had to fulfil the following criteria:

[2] Please note that as it was not feasible to conduct a review into individual sectors in humanitarian response, further research is needed to identify exactly where the significant gaps are. The sectors highlighted come from a review on health interventions in humanitarian crises and so does not cover all sectors.

[3] The Disability Inclusion Helpdesk is funded under the DID programme. The DID consortium partners are ADD International, BBC Media Action, BRAC, Institute of Development Studies (IDS), International Disability Alliance (IDA), Humanity & Inclusion, Leonard Cheshire Disability, Light for the World, Sense, Sightsavers and Social Development Direct.

[4] Key search terms included: humanitarian, relief, conflict, emergency response AND disabled / disability / disabilities, impairment, deaf, blind, wheelchair AND interventions, programmes, evaluations, reviews, research, study.

- **Focus**: Either targeted humanitarian programming aimed at people with disabilities, or mainstream humanitarian programming where access and outcomes for people with disabilities are tracked.[5]
- **Time period**: 2008[6] – 2019.
- **Language**: English.
- **Publication status**: publicly available – in almost all cases published online.
- **Geographical focus**: LMICs.

3. Barriers for people with disabilities to access humanitarian programmes

People with disabilities face significant barriers accessing both mainstream and specialised services within humanitarian settings. A 2015 global consultation including a survey with 484 respondents with disabilities in humanitarian contexts, found that three quarters of respondents did not have adequate access to basic services such as water, shelter, food or health services; and only half reported to be in receipt of specialist services such as rehabilitation, assistive devices and interpreters. (Handicap International, 2015)

The following section summarises the evidence on factors affecting access to humanitarian programming, based on a framework used by the Disability Inclusion Helpdesk that combines a recognition of **individual factors** that can marginalise people with disabilities (e.g. multiple intersecting factors such as age, gender, impairments) and the **environmental, attitudinal and institutional barriers** that limit or exclude people with impairments.[7]

4.1 Individual factors

DFID's Strategy for Disability Inclusive Development 2018-23 recognises that people with disabilities face intersecting and compounding forms of discrimination. Disability intersects with other sources of discrimination or social disadvantage which might limit access to humanitarian programming such as age, gender, sexuality, ethnicity, or poverty. (Wapling, 2018; DFID, 2018)

Evidence suggests that older people, women, adolescent girls and children with disabilities are especially vulnerable to marginalisation, discrimination, violence, and exploitation in humanitarian settings (Pearce, 2015a):

- **Older people with disabilities:** A recent mixed-method study[8] found that older people with disabilities are more at risk escaping from conflict or natural disasters, and face particular barriers including to accessing social protection, work, health, rehabilitation services, adequate food and other essential services. The study also highlighted that older people with disabilities are particularly at risk of social isolation, loneliness and poor mental health. (Sheppard and Polack, 2018)
- **Women and girls with disabilities:** Women and girls with disabilities experience 'double discrimination' in crises as a result of their gender and disability status (Cornelsen, 2012: 109-110). Women and girls with disabilities (especially those with intellectual and psychosocial disabilities) are especially vulnerable to acts of sexual and gender-based violence (GBV) in

[5] Please note a review of disability inclusion under individual sectors in humanitarian response was not feasible under this rapid review.
[6] Note: The Disability Inclusion Helpdesk reviews evidence from 2008 onwards as this is the year that the Convention on the Rights of Persons with Disabilities and its Optional Protocol came into force.
[7] Disability Inclusion Helpdesk training by Lorraine Wapling (December 2018)
[8] The study undertaken by HelpAge International, the International Centre for Evidence on Disability (ICED), and the London School of Hygiene and Tropical Medicine (LSHTM) involved quantitative analysis of six population based surveys, as well as primary qualitative research with older people with disabilities in refugee camps in Western Tanzania and Eastern Ukraine, as well as interviews with experts from humanitarian agencies.

emergencies (WRC, 2008: Pearce and Sherwood, 2016), and they face particular barriers accessing sexual and reproductive health (SRH) and GBV prevention and response services.

- **Adolescent girls:** Adolescent girls with disabilities face '*multiple intersecting and often mutually reinforcing forms of discrimination and oppression, which are exacerbated in situations of crisis'* (Pearce et al, 2016, p.118). In humanitarian settings, adolescent girls with disabilities are particularly vulnerable to exploitation and abuse, particularly those with intellectual disabilities (Pearce et al, 2016).
- **Children with disabilities:** Children with disabilities are more likely to be left behind, abandoned or neglected during natural disasters and conflict situations (UNICEF, 2013), and more vulnerable to violence, exploitation and abuse as a result of being separated from their caregivers and family (UNICEF, undated)

People with psychosocial disabilities and mental health conditions are more likely to be excluded from access to information and services than those with physical and sensory disabilities. A 2008 study undertaken by the Women's Refugee Commission in five refugee settings[9] found that people with intellectual and psychosocial disabilities are more stigmatised and tend to be especially 'invisible' in refugee and internally displaced persons (IDP) assistance programmes: "*Refugees with mental disabilities were less likely to be identified in registration and data collection exercises; they tended to be more excluded from both mainstream and targeted assistance programs, and they were less likely to be included in decision-making processes or in leadership and program management structures"* (WRC, 2008, p.12)

Barriers will differ depending on the type and severity of impairment, and access to specialised services is often limited in humanitarian settings. For example, a qualitative, ethnographic study in refugee camp in southern Africa found that unmet need for mobility aids such as wheelchairs, constituted a double setback for people with disabilities by further hindering their access to other essential services including food and healthcare (Mirza, 2015) A recent study including field research with refugee survivors of SGBV with communication disabilities in Rwanda, found that people with communication disabilities are at increased risk of SGBV, and face particular barriers accessing SGBV prevention and response interventions (Marshall and Barrett, 2018)

4.2 Environmental Barriers

Humanitarian programming is less accessible to people with disabilities. Examples of environmental barriers cited in the literature include:

- **Lack of accessible information:** The lack of accessible information was perceived as one of the main barriers faced by people with disabilities in accessing services according to a 2015 study. Almost a third of the 484 people with disabilities surveyed (30% and 32%) did not know where to find available services or what types of services existed. (Handicap International, 2015) A rapid qualitative study of the humanitarian response to the Nepal earthquake found that while a variety of communication methods were used to communicate (such as hotlines and notice boards), these did not necessarily overcome the specific barriers experienced by people with disabilities. (Searle et al, 2016)
- **Physical inaccessibility:** For example, inaccessible food distribution points and lengthy wait times (WRC, 2008); use of schemes such as food-for-work which (unintentionally) discriminate against those who are unable to work; difficulties to carry home food rations (IDDC, 2009); and inaccessible school buildings and water, sanitation and hygiene (WASH) facilities (WRC, 2008)
- **Design, layout and location of refugee and IDP camps:** Research undertaken by the Women's Refugee Commission found that **"***even in refugee situations where there were high*

[9] The study involved field research in Nepal, Thailand, Yemen, Jordan and Ecuador.

levels of awareness of disability rights and well-established disability programs and services, the design and layout of the camps and the physical inaccessibility of many services were major impediments" (WRC, 2008, p.17) The geographic location of camps such as Dadaab in Kenya, located in a river delta with very sandy ground presents mobility challenges for refugee with physical disabilities, including those reliant on wheelchairs to move within the camps. (WRC, 2008)

- **Inaccessible housing:** For refugees with disabilities living in urban areas, housing may often be inaccessible (e.g., on high floors without elevators), cramped and wheelchair inaccessible. (WRC, 2008)
- **Long distances and lack of accessible transport:** Long distances and lack of accessible transportation/high transportation costs present particular barriers especially for people with physical impairments. (Handicap International, 2015) The geographical dislocation that people with disabilities often face in humanitarian settings presents practical barriers in distance from the humanitarian response area, and where most disabled peoples organisations (DPOs), civil society organisations (CSOs) and community-based organisations (CBOs) are based. (Pearce and Sherwood, 2016)
- **Lack of trained field staff:** This includes both lack of knowledge, skills and expertise among field staff on disability inclusion (Handicap International, 2015), as well as a lack of locally trained specialists and rehabilitation professionals. (Mirza, 2015)
- **Lack of specialist services and equipment:** including lack of special food rations or prioritisation in food distribution systems (IDDC, 2009; WRC, 2008); unmet need for assistive devices such as wheelchairs and specialised medical care including treatment for chronic physical and mental health conditions; and rehabilitation services such as physical and occupational therapy (Mirza, 2015; Shivji, 2010). Such services tend to be viewed as 'complex, long-term and non-life threatening' within a sector focused on provision of short-term emergency aid and basic primary care. (Mirza, 2015, p. 484)
- **Forced encampment:** Lack of specialised care within refugee camp settings can be compounded by forced encampment policies which hinder people with disabilities being able to access care outside of camp premises. (Mirza, 2015)
- **GBV and other safety issues:** Research undertaken by Humanity and Inclusion in Yemen found that over half of all respondents reported to feel unsafe when accessing services and GBV specifically was identified as a barrier to accessing humanitarian support. (Humanity and Inclusion, 2018a) Research undertaken by Human Rights Watch in Northern Uganda found that over a third of the 64 women and girls with disabilities interviewed had experienced some form of sexual and GBV. (HRW, 2010)

4.3 Attitudinal barriers

Negative attitudes, stigma and discrimination towards people with disabilities can contribute to exclusion, in the following ways:

- **Negative attitudes among service providers and staff:** A WRC-led participatory study on the SRH needs of refugees with disabilities in Kenya, Nepal and Uganda found that negative attitudes of service providers were the most significant barrier preventing access to services. (Tanabe et al, 2015) A 2016 WRC-led global mapping of women with disabilities in humanitarian response found that *"while training on disability is conducted in many settings, it may have only limited impact on the attitudes of field staff, and disability actors report that humanitarian actors continue to perceive women with disabilities as the objects of charity and protection, rather than as active participants in humanitarian action or change agents in their community".* (Pearce and Sherwood, 2016, p.14-15)

- **Lack of awareness of disability issues and misconceptions among humanitarian actors:** A rapid qualitative study of the Nepal earthquake response found that awareness of discrimination based on disability status was generally much lower than awareness of discrimination based on gender or social hierarchy. (Searle et al, 2016) Furthermore, there are common misconceptions that people with disabilities require specialist care (rather than access to the same basic services as everyone else), and that specialist care and adaptations are prohibitively expensive. (Kett and Trani, 2012)
- **Negative attitudes among family members:** Negative attitudes around disability were ranked by humanitarian actors as one of the most significant challenges to including women with disabilities in humanitarian activities in a recent study by the WRC. (Pearce and Sherwood, 2016) In particular, families may not disclose, or may hide, relatives with a disability, making it difficult for humanitarian actors to identify them and respond to their needs. In a recent qualitative study in Turkana, Kenya, disability-related stigma was found to isolate mothers of children with disabilities, increasing their burden of care and further limiting their access to services and humanitarian programmes. (Zuurmond et al, 2016)
- **Social and cultural attitudes and norms around disability:** Social and cultural norms which devalue the lives of people with disabilities may lead to a de-prioritisation of people with disabilities in humanitarian settings and harmful and neglectful practices regarding feeding and health seeking practices. "*crisis-affected communities perceive that there is "no hope" for women and girls with disabilities, and as such community leaders simply do not view them as a "priority" or represent their needs in community decisions".* (Pearce and Sherwood, 2016, p,14) Consequently, awareness raising activities around the rights of women and girls with disabilities, "*are often met with resistance and can foster a sense of distrust between them* [women and girls with disabilities] *and the community."* (Ibid., p.14).
- **Stigma and discrimination.** In particular, stigma and discrimination towards people with psychosocial disabilities and mental health conditions can be particularly acute and may lead to them being "*hidden away, physically restrained and frequently neglected"* (WRC, 2008, p.11)

4.4 Institutional barriers

The importance of integrating the needs of people with disabilities is increasingly being recognized in international policies, standards and guidelines, including (see annex 1 for relevant links):

- Sphere Humanitarian Charter and Minimum Standards in Humanitarian Response
- The Core Humanitarian Standards (CHS) for Quality and Accountability
- Humanitarian Inclusion Standards for Older People and People with Disabilities
- DG ECHO Operational Guidance on The Inclusion of Persons with Disabilities in EU-funded Humanitarian Aid Operations DG.

However, significant gaps remain in terms of the operationalisation of these policies, standards and guidelines at the field level (Rohwerder, 2017).

Institutional barriers include:

- **Lack of disability mainstreaming across sectors:** Humanitarian agencies tend to refer the people with disabilities to service providers for health, rehabilitation and provision of assistive devices, sometimes failing to recognise their needs in social dimensions – such as lack of inclusion in schools, shelter, livelihoods and protection programming. (Rohwerder, 2017: Pearce, 2015) The needs of people with psychosocial disabilities and mental health conditions were less likely to be integrated within mainstream programmes such as education and livelihood activities (WRC, 2008)

- **Exclusion of specialised health services from 'basic bundle' of care:** Research in southern Africa found that 'a consistent trend across camps was exclusion of disability-specific health services from the 'basic bundle' of healthcare'. (Mirza, 2015, p.485)
- **Lack of disability disaggregated data:** People with disabilities are not often not identified or counted in refugee registration and data collection exercises, rendering them programmatically "invisible". (WRC, 2008) A 2016 rapid qualitative study (Searle et al, 2016) on inclusive humanitarian response to the Nepal earthquake by the Humanitarian Partnership Agreement (HPA) Agency found that agencies rely on self-identification of persons with disabilities within the household - a practice which is well known to significantly underestimate numbers of people with disabilities. Similarly, a rapid assessment of disability and age inclusion in the Rohingya refugee response in Cox's Bazar region of Bangladesh found few actors were collecting gender, age and disability disaggregated data, and there was limited awareness and practice of identifying people with disabilities in the response. (Arbeiter-Samariter-Bund, 2017)
- **Lack of assessment of needs:** Whilst vulnerability and capacity assessments (VCA) offers a good opportunity to incorporate disabled people's needs and resources in counter-disaster programming, a 2014 review of 28 VCAs found that disability is largely disregarded within the process, with over half failing to mention disability at all, and only two raising issues of disability-related exclusion (Twig, 2014). Further, in none of the five research settings explored in a 2008 study by the WRC, did refugees with disabilities receive individual, comprehensive assessments in order to ascertain their specific (physical, medical, psychological, educational, training or livelihood) assistance and protection needs. (WRC, 2008, p.15)
- **Lack of disability inclusion expertise:** A 2016 global mapping including an online survey with humanitarian actors (including representatives from INGOs and UN Agencies) found that staff themselves perceive that they do not have the capacity and know how to ensure inclusion of women and girls with disabilities. (Pearce and Sherwood, 2016)
- **Lack of accountability mechanisms and official guidance:** There is no globally endorsed operational guidance to systematically support disability inclusive approaches to humanitarian programmingby ensuring appropriate human and financial resourcing, strengthening staff knowledge, attitudes, and practices; and monitoring access and inclusion of women and girls with disabilities. (Pearce and Sherwood, 2016, p.1) In particular, VCA manuals and guidelines, '*while promoting the general idea of inclusiveness, are insufficiently aware of the difficulties in achieving this in practice, and do not give enough guidance on how to reach and include disabled people'* (Twig, 2014, p.475).
- **Gaps in policy development and implementation:** In particular, policies and commitments (including those focused on gender equality and women's protection) often lack specific reference to women and girls with disabilities. (Pearce and Sherwood, 2016) The needs of persons with disabilities are also notably absent from the standard guidance for SRH in emergencies. (Tanabe et al, 2015) Research undertaken by the World University Service in Canada (WUSC) on education provision in Kakuma and Dadaab refugee camps found gaps in providing education to girls with disabilities both in host and in the refugee settings, with education partners failing to integrate issues around disability and gender. (Handicap International, 2016)
- **Exclusion from official planning processes**: A recent study by the UN Office for Disaster Risk Reduction (UNISDR) found that only 15% of people with disabilities had participated in ongoing disaster management and risk reduction processes in their communities (UNISDR, 2014). The 2016 qualitative study on inclusive humanitarian response to the Nepal earthquake found that none of the 12 agencies included in the study were intentionally and systematically undertaking meaningful consultation with and feedback from people with disabilities. (Searle et al, 2016) Similarly, the 2017 rapid assessment of the Rohingya response in Bangladesh found

no evidence of participation of people with disabilities in camp activities, service provision and planning. (Arbeiter-Samariter-Bund, 2017) Women and girls with disabilities are often under-represented in gender, protection, and disability forums in a humanitarian crisis, (Pearce, 2015a) and consequently they often 'fall through the cracks' with no enforced accountability mechanism to ensure their inclusion in the humanitarian sector. (Pearce and Sherwood, 2016)

- **Lack of indicators and targeting:** A lack of specific targets or indicators for the participation people (including women and girls) disabilities in humanitarian activities presents significant challenges to monitoring of access and inclusion in implementation (Sherwood and Pearce, 2016)

4. Evidence on what works for people with disabilities in humanitarian response

This section summarises the evidence base on approaches to reaching people with disabilities in humanitarian programming.

Overall, the evidence base on what works to include and deliver outcomes for people with disabilities in humanitarian response is extremely limited. The evidence includes a 2017 systematic review of mental health and psychosocial support (MHPSS) interventions in humanitarian settings, however there is a lack of robust evidence on what works in terms of access and outcomes for people with disabilities within other specialist services as well as mainstream services in humanitarian settings. A series of evidence reviews published in 2018 on disability inclusion found a dearth of evaluations in humanitarian settings, for example: a rapid evidence assessment of social inclusion and empowerment for people with disabilities found just one example (out of 16) of evidence in a humanitarian setting (White et al., 2018); and a rapid evidence assessment of education programmes for children with disabilities included no studies (amongst 24 primary studies and five systematic reviews) (Kuper et al., 2018). Although some rights-based standards, good practice guidance and toolkits on disability inclusion in humanitarian action exist, there is limited evidence on 'what works' to operationalise them in practice. For example, a 2015 review undertaken by the WRC finds found very little evidence on the implementation of UN agency and donor government policies on women and girls with disabilities, and no evidence of the impact these policies may have on the lives of women and girls with disabilities in humanitarian settings. (Pearce, 2015b)

There remain considerable **gaps in the evidence base** on inclusive approaches to humanitarian programming. In particular,

- **Lack of research on disability inclusion in specific sectors of the humanitarian response:** A 2015 evidence review (Blanchet et al., 2015) on health interventions in humanitarian crises found a lack of research on disability inclusion in humanitarian health programming across several areas including nutrition, sexual and reproductive health (SRH), gender-based violence (GBV), and accountability to affected populations. The review highlighted that "little is done" to target people with disabilities and design and adapt appropriate interventions (ibid;). There is also a lack of evidence on the how disability is being addressed (or not) in recent advances in the humanitarian sector more broadly (i.e. technology). It is important to mention that a review of evidence pertaining to individual sectors within humanitarian response was not feasible under this rapid query. More research is needed to understand where the most significant gaps are.
- **Limited evidence on intersectionality** in relation to humanitarian response, in particular through age and gender-disaggregated data, for example in resilience-based programmes (WRC, 2017), and a lack of evidence on the needs of people who develop impairments as a result of conflict and natural disasters versus those with pre-existing impairments.

- **A lack of monitoring data on disability inclusion in humanitarian settings,** including standardised use of the Washington Group Questions.

The following provides a summary of the available evidence, including examples of promising practices from grey literature due to a lack of robust evidence in this area:

- **Mental health and psychosocial support:** A 2017 systematic review of mental health and psychosocial support (MHPSS) interventions in humanitarian response included 26 randomised controlled trials (RCTs) and found strong evidence pointing to effectiveness in "reducing functional impairment but have little or no impact on anxiety," and moderate evidence in reducing symptoms of post-traumatic stress disorder, distress and conduct problems (iv). However, there was also moderate evidence that MHPSS interventions have no impact on depression and prosocial behaviours and moderate evidence suggesting psychosocial interventions may increase levels of depression. The review also conducted thematic synthesis of process and outcome evaluations to identify a series of success factors. These factors are grouped thematically and include ensuring community mobilisation and sensitisation, recruiting and retaining appropriate numbers of providers, increasing meaningful enjoyment of culturally appropriate activities, providing a group-based safe space and building positive and supportive relationships (Bangpan et al., 2017).
- **Capacity building of GBV practitioners:** A recent project led by IRC and the Women's Refugee Commission aimed to build the capacity of GBV practitioners to integrate disability inclusion in humanitarian settings in four countries.[10] The project identified barriers to programme access and piloted and evaluated approaches to improving disability inclusion. A 2015 qualitative study (Women's Refugee Commission, 2015) involving focus groups with people with disabilities and their caregivers, a consultation with humanitarian actors and monitoring data review found the following:
  - The project achieved positive shifts in attitudes towards people with disabilities in response to experiential and reflective learning activities.
  - Supporting practitioners to better tailor their services to people with disabilities, for example through home visits and activities and adapted communications approaches works well.
  - Girls and women appreciate the strengthening of peer networks achieved through social and economic empowerment activities. These also led to improved self-esteem and increased skills.
  - Women with disabilities invited to join Village Savings and Loans Associations (VSLAs) found these groups offered an opportunity for positive community recognition and increased economic independence.
- **Prioritisation in food distribution systems:** A 2008 study in Kenya found that where UNHCR had reached an agreement with the World Food Programme, people with disabilities were prioritised in food distributions. Furthermore, community members had been mobilised to help transport food rations back to their homes. The report notes, however, that people with disabilities did not receive any additional food rations. (WRC, 2008) A recent situational analysis on IDP camps in Kachin state, Myanmar, identified setting up an alternative distribution system to deliver items directly to the shelters of the most vulnerable was an example of good practice. (Humanity and Inclusion, 2018b)
- **Initiatives to promote inclusion and leadership of women and girls in humanitarian action:** In 2016, the Women's Refugee Commission and UN Women conducted a pilot project supporting networks of women with disabilities from South Asia and Africa to advocate on the issues of women and girls with disabilities affected by crisis and conflict in development,

[10] Burundi, Ethiopia, Jordan and the Northern Caucasus in the Russian Federation.

humanitarian and human rights forums, at national, regional and global levels. This pilot project demonstrated the skills and capacities that grass-roots organisations of women with disabilities bring in reaching and advocating for the most marginalised women and girls in their communities, particularly those displaced by crisis and conflict.[11]

- **Engagement with DPOs:** A significant feature of the CBM approach is active engagement with DPOs and disabled people to identify, address and overcome risks causes by disaster. An annual report on CBM's response to the Nepal earthquake in 2015 highlighted that ensuring the inclusion of DPOs in coordination fora, creating an advocacy alliance with likeminded partners, appointing disability focal points in affected districts and partnering with DPOs to ensure accessible media information worked well to ensure the inclusion of people with disabilities. (CBM, 2015)
- **Vulnerability and resilience-based approaches:** A literature review of vulnerability and resilience-based approaches in the Syrian crisis noted that vulnerability assessments do not tend to consider age and gender, see people with disabilities as a homogeneous group, and there is a significant lack of research on youth with disabilities. The review found promising practice in strengths and assets-based interventions which have been piloted with youth in Lebanon and Iraq, for example adolescent girls reported improved social networks and mentors reported changes in knowledge, attitudes and practices with relation to engaging with people with disabilities (WRC, 2017).
- **Participatory action research:** The Women's Refugee Commission applied a participatory model to examine the intersections of sexual and reproductive health and disability in Kenya, Nepal, and Uganda in 2013-2014. The rights-based, inclusive and empowerment approach involved DPOs and people with disabilities at all stages in the research process. The inclusive methodology included the provision of personal assistants, vehicles for movement, sign language interpretation, Braille documents, and tactile ink-based diagrams; use of a "talking pen;" and creation of a "supporter" role in the facilitation process. (Tanabe et al, 2017)
- **Improving data on disability through the Washington Group Questions:** The DFID funded Disability Data in Humanitarian Action project aims to enhance the quality of data on persons with disabilities for better programming and monitoring. The project is the first of its kind, and started in 2017 and is being led by Humanity and Inclusion[12]. It focused on addressing the challenge of identifying and monitoring the situation of persons with disabilities in humanitarian action through testing the usability of the Washington Group (WG) Set of Questions in humanitarian contexts. The WG sets were initially developed to improve the quality and robustness of population statistics through national level surveys and census. The HIEP project collaborated with the Washington Group and IDA. It targeted humanitarian actors, including local and international NGOs, Organisations representing persons with disabilities (ORPDs), UN agencies and ICRC/IFRC. It undertook capacity development and technical support, while testing the WG questionnaires and documented changes and challenges experienced in applied research. Good practices were also documented for learning. Products of the project, such as sensitisation and learning materials for better data collection are available online. Findings from the research include, but are not limited to:
    - The identification of persons with disabilities was improved among humanitarian actors by using the Washington Group questions,
    - Enhanced quality of data on persons with disabilities,
    - Improved targeting of vulnerable households through improved vulnerability assessments, and

[11] 61st Session of the Commission on the Status of Women. Side Event Concept Note.
[12] https://humanity-inclusion.org.uk/en/disability-data-in-humanitarian-action

- Better monitoring the situation of persons with disabilities in relation to key humanitarian outcomes, such as food security. [13]

It should be noted there are several new projects which aim to contribute to the evidence base in the coming months and years, in particular a number of projects led by the International Rescue Committee, summarised in annex 2.

[13] Source: Humanity and Inclusion written inputs for this query.

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Annex 1: International guidance documents

- **Sphere Humanitarian Charter and Minimum Standards in Humanitarian Response** Available at: https://spherestandards.org/wp-content/uploads/Sphere-Handbook-2018-EN.pdf
- **The Core Humanitarian Standards (CHS) for Quality and Accountability** Available at: https://corehumanitarianstandard.org/files/files/Core%20Humanitarian%20Standard%20-%20English.pdf
- **Humanitarian Inclusion Standards for Older People and People with Disabilities** Available at: https://reliefweb.int/sites/reliefweb.int/files/resources/Humanitarian_inclusion_standards_for_older_people_and_people_with_disabi....pdf
- **DG ECHO Operational Guidance on The Inclusion of Persons with Disabilities in EU-funded Humanitarian Aid Operations DG.** Available at: https://ec.europa.eu/echo/sites/echo-site/files/2019-01_disability_inclusion_guidance_note.pdf
- **All Under One Roof: Disability-inclusive Shelter and Settlements in Emergencies.** Available at: https://www.ifrc.org/Global/Documents/Secretariat/Shelter/All-under-one-roof_EN.pdf

Annex 2: Case studies of current IRC disability inclusive programming

- **Early Marriage in Crisis:** The project aims to build the capacity of humanitarian actors to support, protect and empower adolescent girls in crisis from early marriage and other forms of gender-based violence. Funded by BPRM. Sept 2018- Sept 2021
- **USAID-funded Safe at Home project**, aiming to build the evidence base on violence against people with disabilities in the home. The project works with caregivers on parenting and positive discipline, including piloting a module on parenting children with disabilities. Research will be conducted in humanitarian settings in the Democratic Republic of Congo (DRC) and Myanmar.
- **Build Local Think Global,** a three-year project funded by BPRM. The project supports NGOs at the local and national level to become technical resources for GBV emergency preparedness and response. IRC is developing a training curriculum and guidance note that accompanies the IRC GBV Emergency Preparedness and Response model and training package, providing additional content to help GBV actors examine their own attitudes, skills and knowledge, and take concrete actions to reach and support diverse women and girls throughout GBV emergency preparedness and response programming.
- **Leave No Girl Behind**, Girls' Education Challenge programme, Sierra Leone which will integrate the Washington Group Questions in its evaluations. The Leave No Girl Behind (LNGB) consortium made up of 4 agencies (International Rescue Committee - Lead Partner, Restless Development, Concern Worldwide, BBC Media Action) has embarked on a 48 month project called EAGER (Every Adolescent Girl Empowered and Resilient). This project will be implemented in 10 districts (Bo, Western Area Urban, Kailahun, Kambia, Kenema, Koinadugu, Kono, Port Loko, Pujehun and Tonkolili districts) in Sierra Leone, EAGER will target 32,500 out-of-school adolescent girls (13-17 years) who have never been in school or who have been out of school for 2+ years and do not have basic literacy and numeracy skills. The project will target the most educationally marginalized in Sierra Leone. This will include girls who are pregnant or young mothers, girls with disabilities, girls who are married, those who have been

affected by Ebola, those affected by violence, and those who are engaged in income-generating activities and/or cannot afford the cost of schooling.

- **Sesame Seeds project**, delivering inclusive education through television, mobile phones, and direct services in Iraq, Jordan, Lebanon, and Syria by Sesame Workshop and IRC. IRC are due to develop an M&E plan which will assess the barriers children with disabilities face, their participation in the project and evidence on what works, including disaggregated data collection plans.

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About Helpdesk reports: The Disability Inclusion Helpdesk is funded by the UK Department for International Development, contracted through the Disability Inclusion Team (DIT) under the Disability Inclusive Development Programme. Helpdesk reports are based on between 3 and 4.5 days of desk-based research per query and are designed to provide a brief overview of the key issues and expert thinking on issues around disability inclusion. Where referring to documented evidence, Helpdesk teams will seek to understand the methodologies used to generate evidence and will summarise this in Helpdesk outputs, noting any concerns with the robustness of the evidence being presented. For some Helpdesk services, in particular the practical know-how queries, the emphasis will be focused far less on academic validity of evidence and more on the validity of first-hand experience among disabled people and practitioners delivering and monitoring programmes on the ground. All sources will be clearly referenced.

Helpdesk services are provided by a consortium of leading organisations and individual experts on disability, including Social Development Direct, Sightsavers, Leonard Cheshire Disability, ADD International, Light for the World, BRAC, BBC Media Action, Sense and the Institute of Development Studies (IDS). Expert advice may be sought from this Group, as well as from the wider academic and practitioner community, and those able to provide input within the short time-frame are acknowledged. Any views or opinions expressed do not necessarily reflect those of DFID, the Disability Inclusion Helpdesk or any of the contributing organisations/experts.

For any further request or enquiry, contact enquiries@disabilityinclusion.org.uk

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