



The collapsed house of Mr Duong Van Nam, 40 years old and Ms. Chau Thi Hoa, 30 years, during the flood. The couple have three children, the oldest daughter is 7 years old and the 2nd and 3rd children were born with visual impairments. Viet Nam

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MODULE 6

Disability-inclusive SBC in humanitarian settings

Addressing stigma and discrimination toward children and youth with disabilities through social and behaviour change (SBC).

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FOREWORD

Fifteen per cent of the world's population – at least one billion people – have some form of disability, whether present at birth or acquired later in life. Nearly 240 million of them are children. One in every 10 children globally has a disability.

Inclusion starts with the understanding that disability is the result of interactions between inaccessible environments and a person who has long-term impairments. Inclusion can be achieved when people work to break down physical barriers, when services are accessible to everyone, when policies equally benefit all individuals, when communications reach every person, regardless of if they are blind, deaf or have low literacy. But acting to move the world further in this direction requires an inclusive mindset as foundation.

Unfortunately, many people in most societies across the world still have negative, pitying, patronizing attitudes toward people with disabilities. As a result, over one billion people continue to experience stigma and discrimination. This sometimes manifests in violence, institutionalization or exclusion from society, and sometimes in silence or overprotection. Breaking the stigma will require multilevel strategies co-developed with children and adults with disabilities. Governments and partners need to invest in integrated, evidence-based social and behaviour change (SBC) interventions to address the negative attitudes, beliefs and norms that fuel stigma and discrimination against children with disabilities, and to make services more accessible and inclusive. Service providers and communities need to be empowered to support the inclusion of children and adults with disabilities and to enable their access to services. Policies that address stigma and discrimination against children with disabilities and their families need to be put in place, with enough resources allocated to implement them. Drawing on various disciplines – sociology, psychology, communication and behavioural economics – SBC encompasses a broad set of strategies and interventions that influence drivers of change and support local action towards better societies. In every sector, UNICEF's SBC programmes bring together local knowledge with scientific insights to support the most vulnerable. Based on the reports, In 2023, over 100 UNICEF country offices are already implementing SBC interventions to promote disability inclusion. This toolkit will support them, and contribute to rallying additional country offices to further advance inclusive SBC interventions so that all children have equal opportunities.

This toolkit was developed through extensive consultation with UNICEF employees, organizations of persons with disabilities, SBC experts, government partners, academics, and youth with disabilities. It provides insights, tools and resources to help users understand barriers to the inclusion of children with disabilities. It offers practical support to help design and implement SBC programmes that engage and empower children with disabilities and their families to be agents of change in their communities, and to enjoy the same opportunities as their peers.

We hope you will enjoy diving into this toolkit as much as we enjoyed developing it with many of you.



Vincent Petit
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Global Lead, Children with Disabilities
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Addressing stigma and discrimination toward children and youth with disabilities through social and behaviour change (SBC).

The elections of the Junior Parliament were held in the Children's Parliament of Congo.

MODULE 0
Foundation Module

Daniela Machado and Aislinn Zullo, Administrators of Inclusion, write and share. During the design, piloting and preparation of activities of the Administration of Inclusion program, Venezuela, 2021.

MODULE 1
Inclusive Evidence Generation for SBC

Children at an inclusive education activity promote children's rights of the benefit of severely disabled and protection against, water, hygiene, and sanitation, Venezuela, 2022.

MODULE 2
Empowering Children and Families

Children with autism from Jharkhand are engaged in the event of the Blue Connect program, organized by UNICEF Bangladesh to mark the World Children's Day.

MODULE 3
Understanding and engaging communities

Mangalmani, Bihar, Rajendra is a person with disability, community health worker and president of the Independence community group. He assists individuals during polio vaccination campaigns.

MODULE 4
Disability-inclusive services

The elections of the Junior Parliament were held in the Children's Parliament of Congo.

MODULE 5
Strengthening partnerships for advocacy

The damaged house of Mr. Dzung Nien Ngien, 40 years old and his wife, Mrs. Thi Thi, collapsed during the flood. The couple have three children: the eldest daughter is 7 years old and the 2nd and 3rd children were born with visual impairment, Viet Nam.

MODULE 6
Disability-inclusive SBC in humanitarian settings

Buddhis, 7 years old has received an education from UNICEF during his lesson at school with his teacher Rajanya.

MODULE 7
Monitoring, evaluating and measuring

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Sarah's story, part 6

Now that I have become a disability advocate and engage in local and regional events, I meet many young people with disabilities who share their stories. Some of them are tough to hear, others have hope.

Recently I met a young boy with osteogenesis imperfecta, a disease that make your bones very fragile. He was internally displaced due to a flood in his neighborhood. He said that when emergency workers were giving away lifejackets, they did not give him one, saying, "He is not worth it." When the evacuation started, his mom had to shout to ensure a safe place for him in the van. Another girl, who was deaf, was almost swallowed by a tsunami, because the warning system only included a siren. How many more children with disabilities are at risk when emergencies hit?



INTRODUCTION



About this toolkit

This toolkit was developed to help achieve a world where “all children, including those with disabilities, live in barrier free and inclusive communities, where persons with disabilities are embraced and supported, across the life cycle, to realise and defend their rights, and to achieve full and effective participation” (UNICEF Disability Inclusion Policy and Strategy, 2022-2030).

SBC programming has a critically important and urgent role to play in identifying and implementing solutions that empower children with disabilities and their families and support their social inclusion. We are therefore pleased to share this practical guide to understanding and tackling the social norms and behaviours that limit the inclusion of children with disabilities in their communities.

This toolkit aims to provide insights, tools and resources to help you understand the barriers to the inclusion of children with disabilities, with a focus on stigma and discrimination, and to offer practical support for designing, implementing, monitoring and evaluating social and behaviour change (SBC) interventions that include children with disabilities and their families and empower them to be included in their communities and enjoy the same opportunities as their peers.

A range of users can benefit from this toolkit – including SBC specialists, organizations of people with disabilities (OPDs), education specialists. Whatever your specialization, you are encouraged to approach this toolkit with your specific priority interventions in mind.

This toolkit is built to be both comprehensive and flexible, to accommodate a range of needs and circumstances. Its primary approach is to promote multi-layered interventions that comprehensively target disability stigma. Because resource constraints may not allow such multi-layered interventions in some cases, this toolkit offers a spectrum of options for you to choose from. Whether you are guiding practitioners through complete programme cycles or assisting in the thoughtful design of a specific, targeted intervention, you will find guidance here.

This toolkit comprises an introduction, a foundational module, seven thematic modules, a user guide and a PowerPoint presentation. The modules are as follows:

- Module 0: Foundation
- Module 1: Inclusive evidence generation
- Module 2: Empowering children and youth with disabilities and their families
- Module 3: Understanding and engaging communities
- Module 4: Building disability-inclusive services
- Module 5: Strengthening partnerships for advocacy
- Module 6: SBC for disability inclusion in humanitarian action
- Module 7: Monitoring, Evaluating and Measuring

Taken together, the modules describe the key elements of achieving sustainable social and behaviour change.

Sustainable social and behaviour change starts with a clear understanding of the stigma and barriers to inclusion experienced by children with disabilities and their families in a particular context (Module 0). Participatory research informs all interventions, so that they support an in-depth understanding of the communities they serve (Module 1).

The keys to effecting behaviour change are programmes that sustainably empower children with disabilities and their families (Module 2), create space for thoughtful community engagement (Module 3), design and implement inclusive services that are available to everyone in the community (Module 4), forge strong partnerships for advocacy (Module 5), respond to the needs of children with disabilities in humanitarian contexts (Module 6) and measure progress in clear and objective ways (Module 7).



“It’s not our differences that divide us. It is our inability to recognize, Accept and celebrate those differences”

Audre Lorde

Each module begins by explaining how its particular focus area contributes to the broader goals of improving SBC practice for children with disabilities. We have organized each module according to a simple framework that reflects the project cycle: **Ready?, Steady..., Set., Go!**. The intention is to provide you, the user, with the opportunity to engage with the content, wherever you are in your project or programming journey.

Whether you are an expert in disability inclusion or SBC, or if you're new to both fields, start with Module 0, which covers fundamental concepts related to disability and SBC. It's essential that you start with a solid grasp of the basics of these concepts. If you feel the need to delve deeper, you can explore additional resources in the 'Tools' section.

This toolkit is aligned with [UNICEF's SBC Programme Guidance](#) and [UNICEF's minimum quality standards and indicators for community engagement](#). It is intended as a tool for the implementation of the [UNICEF Disability Inclusion Policy and Strategy, 2022-2030 \(DIPAS\)](#).

● Children with disabilities and key barriers to inclusion

Fifteen per cent of the world's population – at least 1 billion people – have some form of disability, whether present at birth or acquired later in life. Nearly 240 million of them are children. Each has the right to be nurtured and supported through responsive care and education, to receive adequate nutrition and social protection, and to enjoy play and leisure time.

Too often, however, these rights are denied. The reasons vary: stigma, lack of accessible services, lack of access to assistive devices, physical barriers. When children with disabilities are excluded from society, their chances to survive and thrive are diminished, as are their prospects for a bright future. But this can and must change.

The Convention on the Rights of Persons with Disabilities defines disability as a long-term physical, mental, intellectual or sensory impairment that – in interaction with the environment – hinders one's participation in society on an equal basis with others. This means that as societies remove barriers, people experience fewer functional limitations.

impairment + barrier = disability
impairment + accessible environment = inclusion



On their own, impairments are not disabilities. Understanding the difference is the key to addressing barriers to inclusion.

Children and adolescents with disabilities are a highly diverse group with wide-ranging life experiences. They live in every community, and are born with or acquire distinct impairments that, in relation to their surroundings, lead to difficulties in functions like seeing, walking, communicating, caring for themselves or making friends. But the extent to which children with disabilities are able to function, participate and lead fulfilling lives depends on the extent to which society is inclusive.

Example: If a young girl from a village has low vision, but no access to glasses – an assistive device that is often taken for granted – we would say that her environment does not allow her to exercise the same rights as other children: to receive education, to learn and go to school. Unable to view learning materials in the classroom and to fully participate, she may not be able to keep up with other students, and may eventually drop out of school.

Children with disabilities face a range of barriers that limit their ability to function in daily life, access social services like education and health care, and engage in their communities. These include:

- **Physical barriers**, for example, buildings, transportation, toilets and playgrounds that cannot be accessed by wheelchair users.
- **Communication and information barriers**, such as textbooks unavailable in Braille, or public health announcements delivered without sign language interpretation.

- **Attitudinal and behavioural barriers** like stereotyping, low expectations, pity, condescension, harassment and bullying.
- **Policy barriers**, such as policies and laws that discriminate against people with disabilities, or the lack of legal frameworks for the fulfilment of equal rights.

Each of these barriers is rooted in stigma and discrimination that reflect negative perceptions associated with **ableism** – a system of beliefs, norms and practices that devalues people with disabilities. Because of ableism and the barriers that stem from it, children with disabilities are among the most marginalized people in every society.



UNDERSTANDING STIGMA

Stigma is one of biggest barrier to inclusion. There are two types of stigma: public stigma and self-stigma.

- **Public stigma** is a social process that contains three interdependent components: stereotypes, prejudice and discrimination.¹
- **Stereotypes** are collectively held beliefs that allow people to quickly generate impressions and expectations of individuals who belong to a particular social group – often at the price of distorting reality. One common stereotype is that people with disabilities are incompetent, unable to live and work successfully.²
- **Prejudices** are negative attitudes towards a group of people,³ resulting from endorsement of stereotypes that generate negative emotional reactions. An example of a negative attitude is that people with disabilities can't and shouldn't be included in society and services. When measuring attitudes, it is very important to measure implicit (unconscious) biases as well as explicit (conscious) ones, as they can significantly differ. See module 4 for more information on implicit biases.
- **Discrimination** is a behavioural response based on prejudice towards a group, which may result in harm towards members of that group.⁴ Examples of discriminatory behaviours include avoidance and segregation.
- **Self-stigma** – also referred to as internalized, experienced or anticipated stigma – occurs when people apply stereotypes to themselves, develop prejudices that are harmful to themselves and engage in self-discrimination.⁵ For

example, someone may hold the self-stereotyping belief, “I am incapable,” which evokes a negative attitude – “I can't and shouldn't be included in society” – leading them to self-isolate.

example, someone may hold the self-stereotyping belief, “I am incapable,” which evokes a negative attitude – “I can't and shouldn't be included in society” – leading them to self-isolate.⁶

Children who acquire disabilities early in life often contend with stigma throughout childhood. It is embedded in caregivers' paternalistic attitudes, overprotective parenting, low expectations, ableism in schools and the widespread neglect of the voices, needs and capacities of children with disabilities. Stigma is the root of such as school segregation, institutionalization and forced sterilization of children with disabilities.⁷ Due to ableist assumptions, children with disabilities are frequently seen as in need of ‘fixing’ and help, less able to contribute and participate, less worthy of attention and having less inherent value than others.

Addressing stigma and discrimination against children, adolescents and adults with disabilities require systematic, multi-level approaches. It entails addressing negative attitudes, harmful beliefs and norms, misconceptions and ableism in society – and empowering children and adults with disabilities, their families and OPDs to demand their rights and participate in processes aiming to make policies, services and communities more inclusive.

1 Corrigan, 2000. For full references, see the reference list in module 0.
 2 Pescosolido et al., 1999; Cohen and Struening, 1962; Kermode et al., 2009; Kobau et al., 2010; Pescosolido et al., 1996; Van 't Veer et al., 2006.
 3 Corrigan, 2000.

4 Crocker et al., 1998
 5 Corrigan et al., 2006.
 6 Corrigan et al., 2006.
 7 UNICEF, n.d.

PROPOSED THEORY OF CHANGE

Understanding and addressing social issues requires a thorough diagnosis, and effective Social and Behavior Change (SBC) strategies are grounded in a proper understanding of the problem. To design impactful programs, it is crucial to answer the fundamental question: "Why are people doing what they are doing?". In this case, the question is "why are people excluding people with disabilities?". Unraveling the 'why' is essential to inform the 'how'.

A theory of change (ToC) is the cornerstone of any evidence-based programme which answers this "why", serving as the blueprint for understanding and addressing the issue. Hence, this global toolkit features a thorough ToC that was carefully crafted through extensive research and insights from practice. It serves as a universal reference point for practitioners, offering a solid foundation to adapt and personalize their own strategies. Packed with comprehensive insights, it is an invaluable resource that includes everything practitioners need to contextualize their approaches effectively. It consists of two integral parts: a problem analysis and a solution analysis. The problem analysis identifies the drivers of stigma, while the solution analysis specifies the outputs and outcomes required to achieve the goal of reducing stigma.

The journey begins by defining stigma, particularly ableism, directed at people with disabilities. Stigma is dual-natured, divided into public stigma—a social process involving stereotypes, prejudice, and discrimination—and self-stigma, an internalized or anticipated form that varies among individuals within a stigmatized group.


When exploring the reasons behind disability stigma, the TOC points to three main drivers: psychological, sociological, and environmental. Within the psychological drivers, three crucial elements stand out—attitudes, self-efficacy, and interest. Sociological drivers cover social learning, social norms, and the impact of social movements. Environmental drivers include inclusive spaces, the communication environment, and moral development in schools. To provide development in schools. To provide practitioners with a thorough understanding, each of these drivers is further unpacked to reveal second and third-layer drivers. This detailed breakdown aims to offer practitioners a comprehensive insight into the root causes of each of the driver.


This ToC is both research-based and practice-oriented, functioning as a comprehensive global reference that blends practicality with evidence. It serves as a versatile guide for practitioners, designed to be adaptable to specific contexts. Practitioners from any country can refer to and customize it based on their contexts. Please see the [PowerPoint Presentation of proposed detailed TOC](#). The short version is available in Module 0.


THE PERSON-FIRST APPROACH


The toolkit introduces the person-first approach, which is not the same thing as person-first language. A person-first approach starts with the recognition that everyone is a person first. Everyone has multiple dimensions to their identity, and their impairment is only one component. A person-first approach hinges on a change in mindset, confronting the unconscious biases and legacies of ableist thinking that may influence individual decision-making and, ultimately, social and behaviour change.

The responsibility to take a person-first approach lies with each of us. To take a person-first approach means to internalize these changes and champion person-first ways of working. The shift in mindset facilitates a shift in the way programmes and services are delivered to children and youth with disabilities and their families, towards a focus on person-led or human-centred approaches. Programmes and services that take a person-first approach are:

 **Intersectional** – recognizing the compounding impact of multiple marginalizing barriers. People may experience marginalization on account of disability, gender, race, sexual identity, ethnicity, culture, rurality and other factors relating to identity – and multiple forms of marginalization intersect to multiply the challenges they experience. For instance, the experiences of a girl from a rural community are profoundly different from those of an adult man from a city, even if they have the same impairments.

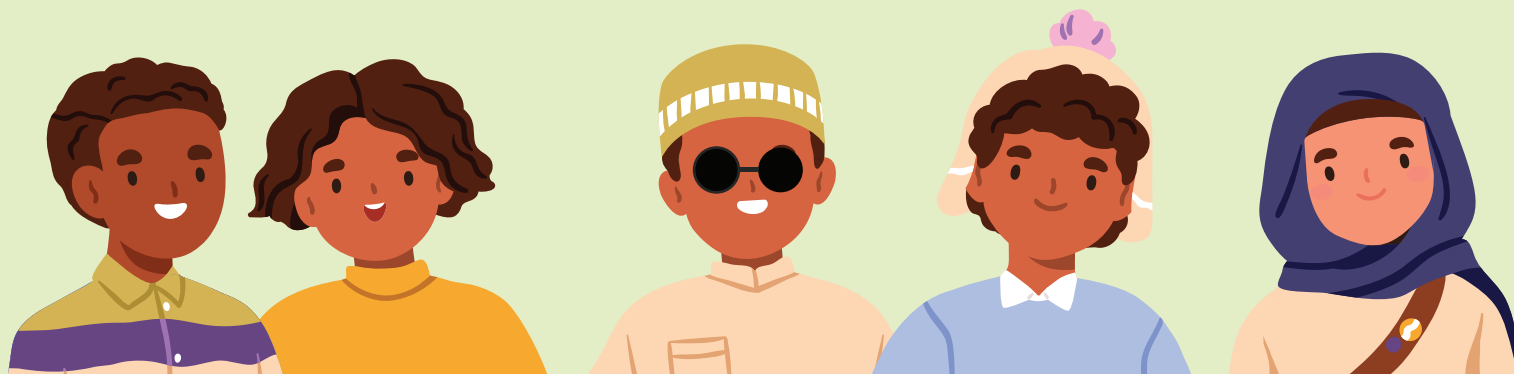
 **Empathy-led** – understanding stakeholders' pain points, emotions and motivations enables us to build empathy. We avoid blaming or finger-pointing, and invite all stakeholders to embrace a new way of working that's premised on empathy and person-first thinking. This, in turn, is key to sustainability.

 **Trans-sectoral** (multidisciplinary) – every sector is responsible for ensuring inclusive services, instead of shifting the responsibility to disability services or experts. For instance, policymakers from the education, health and social sectors need to work together to enable children with disabilities to be able to access education.

 Based on a **twin-track approach** – recognizing that general interventions may need to be complemented with specific interventions to address current inequalities. For example, the success of an SBC strategy to decrease stigma experienced by youth with disabilities seeking sexual and reproductive health services may require programmes to empower youth as advocates for inclusion.

Participatory and representative – ensuring that initiatives engage children and youth with disabilities and their families, and are planned with representation in mind – especially representation of the people who are the focus of the initiatives. For instance, a programme seeking to tackle stigma and discrimination against children with disabilities is not participatory if it engages only parents of children with disabilities, or only people of one gender or with one type of impairment.

OVERVIEW



After reading this module, you'll understand the general situation of children with disabilities in humanitarian settings and how vulnerability factors affect their existence. This module follows the core minimum actions on community engagement and social behavioral change (CE/SBC) in the [Community Engagement in Humanitarian Action \(CHAT\) Toolkit](#) developed by UNICEF and partners as well as UNICEF's [Core Commitments for Children in Humanitarian Action](#) (CCCs). It draws upon good practice from UNICEF's [Disability-Inclusive Humanitarian Action Toolkit](#).

Please note the direct link between disability and CE/SBC. [Disability](#) is a cross-sectoral commitment in the [CCCs](#), with CE/SBC as a key programmatic approach (see Figure 1).

Figure 1: Disability-related commitments and benchmarks in the CCCs are linked to SBC

3: Participation

Children with disabilities participate in the design of programmes and in the decisions that affect their lives

- Community-based mechanisms/platforms exist for the systematic engagement of children with disabilities
- 📖 See 2.2.7 Community engagement for behaviour and social change

This module will help equip you to meet the [CCC commitments on SBC](#). You will gain confidence in:

- Providing life-saving information to children with disabilities – for instance, through activities for [inclusive disaster risk reduction \(DRR\)](#).
- Advocating for and with children with disabilities to obtain information on their rights and access services and support, such as [essential assistive technologies](#).
- Supporting children with disabilities and their families to adopt healthy and protective behaviours, including psychosocial self-care practices – for instance, through [disability-inclusive Risk Communication and Community Engagement \(RCCE\)](#) related to the [COVID-19 response](#), [protection from gender-based violence \(GBV\)](#) and [child protection](#).
- Advocating for rapid assessments and SBC research to include children with disabilities, and for response activities to be informed by inclusive research.
- Creating or scaling up [community engagement platforms](#) and interventions that are inclusive of children with disabilities.
- Building the capacities of frontline workers and first responders to support children with disabilities.
- Supporting the participation of children with disabilities and their families in feedback mechanisms and [disability-inclusive Accountability to Affected Populations \(AAP\)](#) platforms.

- Promoting peacebuilding and social cohesion activities, for instance between children with disabilities in displaced communities and those in host communities.
- Contributing to the coordination of stakeholders in implementing disability-inclusive CE/SBC interventions, for instance, by engaging with [organizations of people with disabilities \(OPDs\)](#).

“ Most of the time, persons with disabilities are seen as merely recipients. When persons with disabilities say we would like to be part of the emergency response, it is not taken seriously, since the thinking is that we cannot provide any support. This is just a belief and not the truth. Persons with disabilities can be strong contributors.

Person with disability from India, Disability in humanitarian contexts: Views from affected people and field organisations, 2015, Humanity and Inclusion





IMPACT OF EMERGENCIES ON CHILDREN AND ADOLESCENTS WITH DISABILITIES

This section answers the question, **'Why do we do it?'**

Children with disabilities are disproportionately affected by disasters, conflicts and other emergencies. They may be separated from support networks and targeted for violence, and they are significantly affected by the breakdown of services and systems and the creation of new barriers.

As explained in UNICEF's [Guidance: Including children with disabilities in humanitarian action](#), disasters and armed conflict increase the number of children and adolescents with disabilities. Children with disabilities are more likely to be left behind, abandoned or neglected during disasters and conflicts, leaving them vulnerable to violence, exploitation and abuse. There are examples of children with disabilities being deprioritized during life vest distribution, reflecting the fact that their lives are often seen as less valuable.¹

¹ UNICEF Nepal, personal report by beneficiary.

² UNICEF (2022). [Fact sheet: Children with disabilities](#).

Children with disabilities may lose access to essential medications and assistive devices, which impairs their functioning and makes them more dependent on caregivers. Girls with disabilities are particularly vulnerable. They are at heightened risk of sexual and gender-based violence and exploitation, and their risk of undernutrition is higher compared to that of boys with disabilities.

► EXCLUSION FROM HUMANITARIAN ASSISTANCE

As crises exacerbate physical, communication and attitudinal barriers, children with disabilities face obstacles in accessing humanitarian assistance.² Mainstream humanitarian interventions providing food and water, essential supplies, health care, psychosocial support or education often fail to take children with disabilities into account, and they are often offered through facilities, like schools, from which children with disabilities are excluded, or from locations that are physically inaccessible to them. Supplies

like accessible WASH facilities, adapted utensils and assistive devices may not be planned, pre-positioned, supplied or distributed. Stigma may lead families to hide children with disabilities, further decreasing their access to humanitarian assistance and support.

Lack of knowledge about children with disabilities and lack of programme capacity to address their needs means that inclusive services are often unavailable, and it is often assumed that separate, specialized programmes or interventions are required. Children and adolescents with disabilities are rarely included in assessments or other data collection exercises that inform and document humanitarian action. Reasons include lack of awareness and guidance on disability data collection, lack of data disaggregated by disability³ and assessments carried out in facilities that are inaccessible or from which children with disabilities are otherwise excluded. There is an urgent need to [keep children with disabilities visible](#) through data collection methods.

► VULNERABILITY STEMS FROM BARRIERS AND DISCRIMINATION

Children with disabilities are often described as especially ‘vulnerable’ during crises. This vulnerability is not an inherent quality of children with disabilities, but results from discrimination and barriers to accessing humanitarian assistance. You need to work to understand the discrimination that people with disabilities experience and the barriers they face, in order to develop solutions to minimize them.

While the same hazards affect all members of a community, people with disabilities may experience them differently because of barriers related to disability as well as intersecting structural inequalities. Not all people with disabilities have the same level of vulnerability – it varies based on intersectional identities, related to such factors as age, gender or ethnic background. Vulnerability is not only a result of these factors making the person weaker, but also of barriers created by the social, institutional and physical environment – such as messaging that is illegible to a person with low vision, or higher levels of harassment experienced by women compared to men.

You need to take all of these factors into account when deciding who needs more intensive support. A vulnerability analysis can help you understand the needs of people with disabilities, the risks they face and how these hazards affect them differently, often more intensely. In figure 2, pay particular attention to the four categories of barriers – attitudinal, physical, institutional, communication – that need to be removed to prevent risks such as GBV, abuse, family separation and poor health outcomes. Intersectional identities – a person’s age, poverty level, gender, and ethnicity or religion – can heighten those risks.

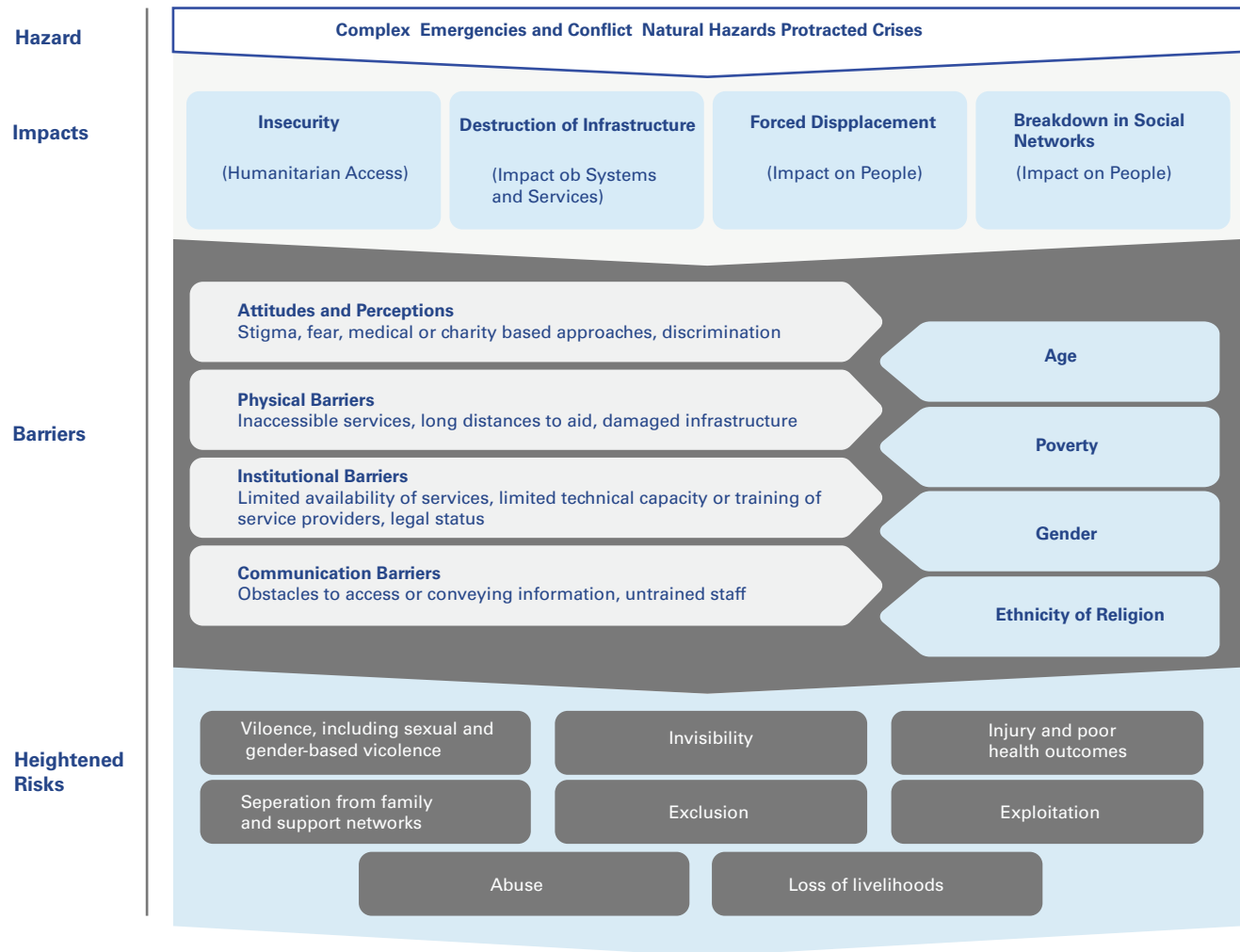
Another tool you can use is the [vulnerability assessment framework](#) developed in Jordan.

Data collection and attention to intersectional identities are critical for understanding how children with disabilities become especially vulnerable during crises. For more information on inclusive evidence generation, see [module 1](#).

3 See Lebanon blast response

Figure 2. Analytical model for vulnerability analysis

Source: UK Aid. [Guidance on Strengthening Disability Inclusion in Humanitarian Response Plans.](#)



**KEY TAKEAWAYS:
READY**

- Children with disabilities are disproportionately affected by disasters, conflicts and other emergencies. They may be deprioritized by humanitarian interventions, left behind, separated from support networks and targeted for violence, and they are significantly affected by the breakdown of services and systems and the creation of new barriers, which may exclude them from life-saving humanitarian assistance and support.
- Data are critical for making children with disabilities visible in humanitarian settings. When children with disabilities are included in humanitarian data collection processes, the knowledge gained about their needs, ideas and solutions can inform inclusive humanitarian interventions.



STEADY

CHAT

This section answers the question, ‘How do we do it?’

The [CHAT toolkit](#) (section 1.2.4) outlines the parallels between the CHAT framework and the humanitarian programme cycle (HPC), as shown in Figure 3.⁴ Since SBC and programme specialists are the primary audience of this toolkit, this section follows the CHAT framework. It presents the **minimum CE/SBC actions⁵ for disability inclusion.**

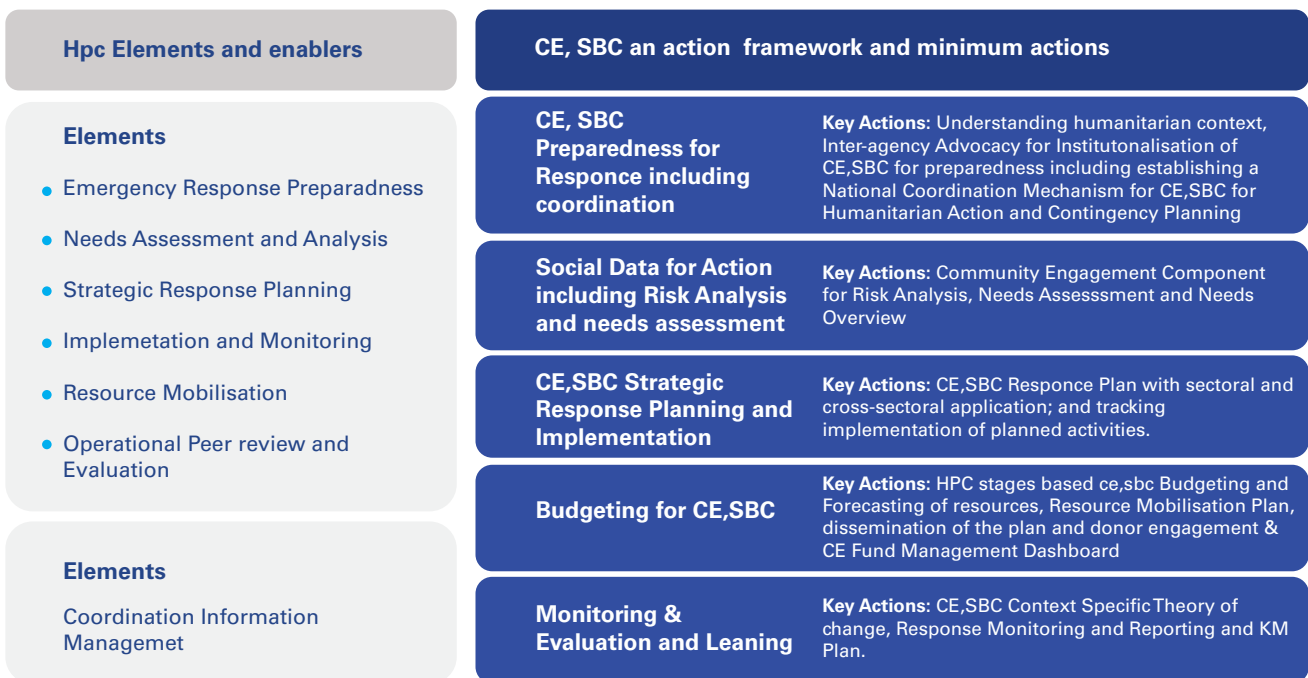


Figure 3: Humanitarian programme cycle and minimum actions for CE/SBC

Source: CHAT Toolkit, p. 31.

⁴ CHAT toolkit, p. 28.

⁵ CHAT toolkit, p. 32.

Accessibility is a key consideration in all SBC actions, whether mainstream or targeted – as per the twin track approach.

For all mainstream SBC channels:

- Ensure universal design (see, for example, the mobile parenting app BEBBO).
- Use large print for people who have low vision. When not possible, provide information orally (e.g., through loudspeakers).
- Create easy-to-read versions of informational materials, using simple text with pictures and diagrams.
- Use written formats or provide text captioning and/or sign language interpretation for videos.
- Ensure that digital platforms have [accessible web content](#) for those using assistive technologies such as [screen readers](#).
- Include images of people with disabilities in mainstream CE/SBC communications.
- For [targeted SBC channels](#):
- Use channels already used by disability sub-groups.
- Provide Braille upon request (partner with OPDs representing blind people ahead of time).
- Provide sign language interpretation at large events where deaf people may be present.
- Ensure adequate outreach and partnerships with youth with disabilities ahead of time, in order to reach them, as many are missed in SBC activities.

MINIMUM CE/SBC ACTIONS FOR DISABILITY INCLUSION

▶ 1. CE/SBC PREPAREDNESS FOR RESPONSE

Preparedness includes minimum foundational actions required by inter-agency humanitarian practitioners to plan and prepare for community engagement (CE) interventions ahead of the crisis. Preparedness measures consist of delving deeper into the humanitarian context, developing an understanding of behaviours and risks, and mapping partners (including affected communities) and their capacities.

“In Myanmar, there are a lot of floods and when the emergency response group was giving away the life jackets they did not give me one...as I'm not worth it. This has to change. Children with disabilities are children and deserves to be treated equally”

Kaung H. Young disability advocate, Myanmar



ACTIONS FOR DISABILITY INCLUSION

Making children with disabilities visible in disaster risk reduction

- National and regional coordination mechanisms on disaster risk reduction (DRR) should ensure that children with disabilities and the challenges they face are made visible.
- **Humanitarian actors need to take deliberate actions** to address the challenges that people with disabilities face in a crisis and through DRR. During a humanitarian emergency, people with disabilities have a reduced capacity (compared to others) to escape safely and have their needs met. **Contingency plans are especially important.**
- Inclusive DRR activities – working with national Red Cross or Red Crescent societies, pre-schools and school systems, families and rehabilitation centres – can help develop contingency plans to provide adequate support from nearby communities to help ensure that children with disabilities are safely evacuated and supported in an emergency if they are not at home with their families (see the example from UNICEF Turkmenistan in the Set section, below).
- During DRR activities, **ensure that children are not only reached through schools, temporary learning spaces and child-friendly spaces, from which children and adolescents with disabilities are excluded.** Ensure that health centres and other community spaces and mass communication methods are used to reach the families of children with disabilities.
- Advocate with various leaders (e.g., camp managers, local authorities, cluster coordinators) to **make all essential humanitarian services accessible.** Otherwise, children with disabilities – at least 10% of the world's children, and among the most marginalized – and their families will be excluded.
- Ensure that the moral and ethical argument for inclusiveness – that the lives of people with disabilities have value – is clearly made with DRR actors.⁶ Make it clear that anyone can be disabled or injured during an emergency – so inclusive planning benefits all of us.
- Advocate for frontline workers to practice simulating common emergency situations with local communities, schools and families of children with disabilities – including simulations of 'shelter in place' plans, to see the level of preparedness and supplies for a three-day emergency.
- For disaster-prone areas or countries, ensure ahead of time that multiple forms of communication and alert systems for people with visual and hearing impairments are available for quick dissemination or can be minimally adapted for messaging (e.g., agreements with radio stations to disseminate lifesaving messages, sign language interpreters to record videos in accessible formats).

6 European and Mediterranean Major Hazards Agreement: Including People with Disabilities in Disaster Preparedness and Response, 17 January 2014, p. 14.

Ensure that visual and auditory systems for announcing emergencies are in place. In low-technology or low-resource communities, ensure the emergency focal points have a system in place to announce emergencies (e.g., three whistle blows done consecutively over five minutes) or have flashing red lights to wave while walking around or to place outside the windows of key buildings. Ensure that early warning systems are designed with universal design principles (see Section 1.3 of [All Under One Roof: Disability-inclusive shelter and settlements in emergencies](#)).

Partnerships with OPDs

- Identify key organizations of people with disabilities (OPDs) in your area.⁷ During all stages of DRR, consult and partner with disability focal points, people with disabilities and OPDs that represent the diversity of people with disabilities.⁸
- Partnerships between humanitarian actors and OPDs on DRR and preparedness are crucial to building OPDs' capacity to act as first responders. Long-term approaches are required to build trust and collaborative working relationships among OPDs, humanitarian organizations and local governments.
- Agree with the OPDs on the type of engagement they can and want to be included in.
- **There are OPDs at the [international, regional, national and local levels](#).** Contact the Reference Group on Inclusion of Persons with Disabilities in Humanitarian Action, a platform for cooperation between UN agencies, international agencies, NGOs and OPDs in promoting disability-inclusive humanitarian response (rg.disabilityinclusion@gmail.com).

[The thematic subgroup for inclusive DRR and climate action](#) may have good information on local OPDs.

- Don't wait for a crisis to strike before engaging in partnerships! **Pre-existing partnerships between humanitarian actors and OPDs make the response more efficient** when crisis strikes.

Be aware of and plan to overcome common challenges related to partnerships with OPDs:⁹

- OPDs of people with intellectual disabilities often feel not listened to by humanitarian actors. Trust-building is needed with such groups.
- People with psychosocial disabilities are often underrepresented in OPD rights movements and excluded from advising on the provision of psychosocial care.
- NGOs, UN agencies and governments have poor information on OPDs and often hold stereotypes about them. Hold meetings with sign language interpretation, accommodations and an open mind to overcome barriers to engaging with OPDs.
- Budget needs to be allocated to cover transportation costs and accommodations in order for OPDs to participate. They should receive financial reimbursement for their expertise and time in consulting on CE/SBC.
- In the spirit of the [humanitarian-development nexus](#), OPD partnerships should always be part of UNICEF SBC work – prior to, during and after an emergency – to provide an inclusive response.

⁷ UNICEF. [Engaging with organizations of persons with disabilities in humanitarian action](#).

⁸ Inter-agency Standing Committee (2019). [Guidelines: Inclusion of persons with disabilities in humanitarian action](#).

⁹ CBM, International Disability Alliance and Handicap International (2019). [Inclusion of persons with disabilities in humanitarian action: Case studies collection 2019](#).

“Shift in thinking to recognising persons with disabilities, not only as beneficiaries of humanitarian assistance, but also as key actors in the response... On a more practical level, there is a need for capacity-building of OPDs, both building knowledge of the humanitarian system and enabling access to the financial resources required to engage meaningfully as an actor in the response”

Kirstin Lange, Inclusive Humanitarian actions specialist, UNICEF, Humanitarian Exchange, Issue 78 October 2020

Child-, household- and community-level DRR and preparedness

- Have caregivers or teachers review emergency plans with children with disabilities, to make sure children have support for evacuation, know where to meet, have a buddy system in place and build their confidence.¹⁰
- To help reduce the risk of abuse towards children during emergencies, work with parents to make sure they know the people looking after their children when they are not home, and that those caregivers are trustworthy. Ensure that parents know what to watch for in their children’s behaviour around other caregivers, to recognize warning signs such as sudden changes in behaviour, eating habits, facial expressions or vocalizations (especially if the child is non-verbal). For example, a child experiencing abuse may change their facial expressions, vocalize in a more distressed way than usual, be more agitated, aggressive or hyperactive – or else quieter and more distant, showing no interest in playing, or engaging in more rocking or head-banging than usual.¹¹
- CE/SBC plans should include behavioural results relating to children with disabilities, to ensure that they are informed through accessible formats, and that their active participation in barrier analysis is sought out – not the participation of their caregivers, but the direct participation of children themselves, using accommodations as needed. In some contexts, UNICEF has formed advisory groups of youth with disabilities to work on response planning (as in Jordan, for example), or has worked to ensure that existing youth advisory groups have two or three members with different disabilities.



¹⁰ CDC. [Helping children with disabilities cope with disaster and traumatic events.](#)

¹¹ [raisingchildren.net.au. Sexual abuse in autistic children and teenagers: Recognising the signs.](#)

▶ 2. CE/SBC DATA FOR ACTION

Data for action addresses the social and behavioural data needs for preparedness and response and includes the community engagement needs component under Risk Analysis and Monitoring, Needs Assessment and Humanitarian Needs Overview.

In addition to community engagement, it emphasizes feedback from at-risk and affected populations. Their views on immediate needs, priorities and long-term needs should be reflected adequately in both Risk Analysis and Needs Assessment, with the participation of different vulnerable and excluded groups.

Key actions: CE/SBC component for Risk Analysis and Multisectoral Needs Assessment, Needs Overview Analysis

ACTIONS FOR DISABILITY INCLUSION

Collect disaggregated data to keep children with disabilities visible

- To design a response that reflects the needs and priorities of people with disabilities, you need to know how they are affected by the crisis and what their priorities are, and what key services and infrastructure they cannot access and may need alternatives for (for example, if child-friendly spaces or schools are distant or inaccessible, instead have decentralized friendship groups near children with disabilities).
- In the absence of data or until data is produced, you should advocate based on the assumption that 15% of the total population in need have disabilities. This 15% estimate 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). Remember that in many humanitarian situations, disability prevalence can be expected to be even higher as a result of the crisis.

- For a step-by-step guide to making Humanitarian Needs Overviews (HNOs) and Humanitarian Response Plans (HRPs) disability-inclusive, see the [UNICEF guidance on strengthening disability inclusion in HRPs](#).
- **Advocate for the collection of both individual and household data, and population-level data, as discussed below.**¹²

Individual and household disability data

Identify individuals at heightened risk to target for specific interventions. Understand how people with disabilities are experiencing the crisis (see Figure 2 in the [Ready](#) section), in order to design an inclusive response that reflects who is at risk, from what or whom, and why. For example, girls with intellectual and sensory disabilities are at heightened risk for GBV, while women with disabilities from ethnic minority groups are at heightened risk of not reaching a centralized health centre.

¹² UK Aid. [Guidance on strengthening disability inclusion in humanitarian response plans](#), p. 7.

Population-level disability data

- Determine the total number of people needing support, and use that as a basis for fundraising and budget preparation for actions to improve accessibility and accommodations for people with disabilities.
- Use baseline population data to monitor access to services and participation by people with disabilities.

Inclusive Accountability to Affected Populations (AAP)

- Work on inter-agency [AAP](#) to be as accessible as possible, and to ensure that resources are allocated for working with OPDs to design AAP mechanisms, with testing by people with disabilities.
- Offer feedback mechanisms in [several different formats to reach people with different types of disabilities](#), and work to remove physical, communication and attitudinal barriers. For instance, you might use WhatsApp for those with mobility issues, email for those with communication issues, or in-person field outreach to get feedback from others.
- Train AAP staff to value gaining feedback from people with disabilities, and find creative ways to target people with disabilities as a key group that needs to be included in AAP activities.
- Collaborate with AAP focal points to engage people with disabilities in emergency preparedness and response. Include disability in a Rapid Communication and Information Assessment to understand the communication needs of people with disabilities and the best channels to use.

▶ 3. CE/SBC STRATEGIC RESPONSE PLANNING AND IMPLEMENTATION

Strategic response planning and implementation includes validation of CE/SBC preparedness actions for response plans at the onset of a crisis. This can be done through an integrated CE/SBC plan or through CE/SBC components across sectoral commitments in a Humanitarian Response Plan (HRP).

If required, revisit and adjust your plan according to prioritized risks, analysis of social and behavioural drivers, previous learnings, strategic objectives and the needs of people to be reached. Your plan must outline clear roles and responsibilities in consultation with CE partners.

It is imperative that participatory approaches are used to engage affected and at-risk communities throughout the planning, implementation and monitoring phases, and that vulnerabilities related to age, gender, ethnicity, socio-economic status and disability are addressed.

ACTIONS FOR DISABILITY INCLUSION

- Avoid perpetuating assumptions that people with disabilities need separate, specialized programmes or interventions. Try to make all programmes inclusive, and only use targeted interventions when needed (twin-track approach).
- Use [participatory SBC approaches to engaging youth with disabilities](#), just as for those without disabilities. People with disabilities and OPDs are the most effective and strongest advocates to call for the elimination of barriers to access.

Community-level considerations

- Advocate for [local and regional reception centres to be inclusive and accessible](#) if community members are displaced.
- Advocate for DRR plans to keep stock of [life-saving assistive technology](#) (AT) for replacement and distribution in the event of broken or lost devices. Ensure that these devices are not only stocked in urban areas that will be unreachable in an emergency, but decentralized to community or health centres and health posts in communities.¹³
- SBC specialists should work with OPDs to **increase demand and supply of AT** during emergency planning and response.

Social and behaviour change when designing responses to reach people with disabilities¹⁴

- Plan to mitigate stigma, myths or jealousy that may result from targeted interventions, such as cash grants or distribution of assistive devices, through SBC interventions. For example, hold meetings for open discussion with local communities and host populations to explain humanitarian activities and disability-targeted interventions, such as transport allowances and distribution of assistive devices.
- Lack of knowledge about children with disabilities and lack of programme capacity to address their needs may decrease opportunities for inclusion or perpetuate assumptions that separate, specialized programmes or interventions are required.¹⁵

- Through social science data, including knowledge, attitudes and practices (KAP) studies, monitor stigma against people with disabilities (such as beliefs that people with disabilities are responsible for spreading disease during a public health emergency).

▶ 4. IMPLEMENTATION

Implementation includes providing life-saving information, promoting or reinforcing positive behaviours and reestablishing positive social and cultural values. Guided by CHS and Community Engagement Minimum Standards, the rollout of interventions can be undertaken in a way that ensures community participation, feedback, inclusion and ownership of CE activities, and that strengthens the capacities of local actors.

ACTIONS FOR DISABILITY INCLUSION

Reaching and supporting families of children with disabilities

- Families may hide children from the community due to stigma, decreasing the child's access to humanitarian aid and support. Advocate for respite support for caregivers to build trust with them.
- **Talk about the rights of children with disabilities frequently and to all community members** (not just when you encounter someone with a disability), because anyone may know someone with a disability. Giving people lots of time and repeated messaging can encourage them come forward to seek help.

¹³ G. Wood & G. Whittaker (2022). [Overview of research project: Assistive technology in humanitarian settings](#)

¹⁴ UNICEF (2017). [Guidance: Including children with disabilities in humanitarian action – Child protection](#).

¹⁵ Women's Refugee Commission (2016). [Working to Improve Our Own Futures: Inclusion of women and girls with disabilities in humanitarian action](#).

- **Ensure community care for caregivers of children with disabilities.** Many caregivers experience high levels of stress and burnout during and after emergencies.¹⁶ Even before a crisis hits, many experience health problems as a result of their duties, which may include lifting and transferring their children, or continuous caregiving throughout the day. This may result in conditions such as back pain, ulcers, headaches, depression, worry about their child's future, anger, guilt and social isolation. They may also have issues with learning new medical terms and needing to make difficult medical decisions. Crises intensify these challenges. See [Module 2 of UNICEF's Lebanon guide](#) on caring for caregivers of children with disabilities.

- **Considerations for caregivers of children with disabilities** during a disease outbreak:

- Make sure those in your household, including friends and family members, know all the important information they would need in case you get sick or have to quarantine – including information about health insurance, any medicines you take, and the needs of those in your care (other children, elderly parents or pets).
- Broaden the number of the people you can call if you get sick or need to quarantine.
- Identify the relevant organizations in the community that you can call if needed.
- If you already have a support person, talk to them in advance about everything that needs to be done.

Life-saving information for children with disabilities

- Encourage parents to provide an identification bracelet or laminated paper, to be kept with child at all times, explaining key medications, movement needs and communication tips. Also keep extra batteries or a power bank for hearing aids or other essential assistive devices that require charging.¹⁷
- Make sure communities have a plan for children with disabilities who become separated from caregivers to be reunited with them (e.g., have contact information for caregivers or trusted family members attached to the child's assistive device, or carried with them).
- Teach children with disabilities who they can go to for help in an emergency situation, if they are in key spaces they use outside the home. Ensure that they have a whistle nearby if communication is an issue and they get stranded in an emergency.
- For some children with disabilities – such as those with autism – establishing a small daily routine in the aftermath of an emergency can help manage stress and keep a sense of normality and control.¹⁸
- **Provide life-saving information in a variety of formats:** When information is provided in only one format, it may not benefit people with visual, hearing or intellectual impairments.

¹⁶ Republic of Ghana, Department of Social Welfare, Ministry of Gender, Children and Social Protection (2020). [Training manual for caregivers of children with disabilities](#), chapter 11.

¹⁷ CDC. [Keeping children with disabilities safe in emergencies](#)

¹⁸ CDC. [Helping children with disabilities cope with disaster and traumatic events](#).

“ As a girl who lost her hearing as a result of the conflict, I devoted my life to be a lawyer, to fight for the rights of girls and women with disabilities, the most excluded group. We need to be educated, we need to be protected, we need to have the voice in any decision that effects our life

Atim O. South Sudan

▶ 5. BUDGETING FOR CE/SBC IN HUMANITARIAN ACTION

It takes sustained resources to mainstream CE across the HPC for a timely and relevant response. CE/SBC cannot be an ad hoc or one-time effort. Budgeting for CE/SBC requires a core set of practices and tools to promote systematic investments in mechanisms that integrate government and non-government service delivery platforms and resource all components of community engagement work.

ACTIONS FOR DISABILITY INCLUSION

- Inclusive services require planning and budgeting – nothing happens without **deliberate actions**.¹⁹
- You need to know how many people with disabilities are in need of humanitarian assistance, in order to set a baseline for monitoring access to assistance, to **budget for inclusion** and to advocate with donors and others.
- Consider if there are any upcoming opportunities to include disability in agenda-setting for the CO during the revision of humanitarian response levels (scaling up or down between L1, L2, L3) and fundraising strategies.
- Building an inclusive response from the outset is much more cost-effective than adapting or redesigning for inclusion at a later stage.
- To estimate the cost of the response, include a budget for inclusion in the total requirements for the response, covering issues including accessibility, training and reasonable accommodation. General recommendations are as follows:
 - Budget an additional 0.5-1% for physical accessibility (e.g., in the construction of buildings and WASH facilities).
 - Budget an additional 3-7% for specialized nonfood items (NFIs) and mobility equipment.²⁰
 - Budget funds needed for targeted interventions to directly address the disability-related needs of children (accommodations, outreach activities, decentralization of services).
- All partnership agreements, including those with OPDs, should include the required additional resources for adequate consideration of the rights and needs of children and people with disabilities.

¹⁹ UNICEF. [Budgeting and mobilizing resources for disability inclusion in humanitarian action.](#)

²⁰ UNICEF. [Budgeting and mobilizing resources for disability inclusion in humanitarian action.](#)

- Ensure that disability inclusion is appropriately reflected in the results statements of the relevant programme or response plan, based on the HNO. This requires a twin-track approach, combining explicit references to people with disabilities in mainstream outcomes and outputs (with disability-disaggregated targets), along with outcomes and outputs that are targeted to people with disabilities or to disability inclusion (see Figure 4).

MAINSTREAMING	TARGETED
<p>Nutrition information campaigns use multiple formats to improve accessibility for caregivers and children with different impairments:</p> <p>Construction (or retrofitting) of nutrition-related infrastructure are in accordance with universal design principles to ensure accessibility.</p>	<p>Provision of assistive technology (via a rehabilitation specialist) which enables children with disabilities to meet their nutritional needs at home (e.g.,mobility aid)²</p> <p>Campaign to disseminate specific information about the nutritional needs and requirements of children with disabilities</p>

- OPDs representing the diversity of people with disabilities should be consulted on project selection criteria or should participate in the review committees of selected projects to ensure that proposals adequately and appropriately include and address the needs of people with disabilities.
- Resources for humanitarian action require competencies and structures that often excludes OPDs. When partnering with OPDs, humanitarian actors should take on the responsibility to build their capacities in meeting financial and administrative standards imposed by humanitarian donors. Consider adjusted approaches, such as fiscal sponsorship or adjusted partnership criteria, to avoid exclusion of OPDs as partners. Provide support, with the sustainability and independence of OPDs as a key objective.
- Dedicated disability inclusion resources and funding requirements must be incorporated in flash appeals, the Humanitarian Action for Children (HAC) appeal and donor proposals. These can include funding mobilized from the private and public sectors and internal funding mechanisms (e.g., Emergency Programme Fund and Thematic Funding) that could be used to respond rapidly and scale up inclusive programmes.

▶ **6. MONITORING, EVALUATION, ACCOUNTABILITY AND LEARNING (MEAL)**

CE/SBC monitoring complements the overall Humanitarian Response Monitoring TOC (if available). Through this guidance, humanitarian actors will track progress in reaching CE/SBC strategic and sectoral and cross-sectoral programme activities and results.



ACTIONS FOR DISABILITY INCLUSION

CCC indicators for disability and CE/SBC

Figure 5 contains the CCC indicators for disability with the three benchmarks around CE/SBC. Figure 6 contains the CCC indicators for CE/SBC, most of which require disaggregation by disability. In this way you can see the intersection of these two areas and how indicators can be framed for your MEAL work.

Figure 5: CCC indicators for disability

EMOPS Indicator Guidance - Disability

CCC COMMITMENTS		HAC/ SitRep	Indicators	Notes
Commitment (2.4.2)	Benchmark			
			primary healthcare facilities that provide disability inclusive services based on global minimum standards	Indicator measures the commitment not the benchmark
D3: Participation Children with disabilities participate in the design of programmes and the decisions that affect their lives	Community-based mechanisms / platforms exist for the systematic engagement of children with disabilities		Design, planning and monitoring systems are disability inclusive in terms of participation of persons with disabilities	Please select YES or NO according to the extent to which the design, planning and monitoring systems do this: No: Community engagement mechanisms are not inclusive of children with disabilities/ children with disabilities do not participate in community engagement mechanisms Yes: Community engagement mechanisms are inclusive of children with disabilities and their representative organizations, including through ensuring physical and communication accessibility. Response plans reflect the views and priorities of children with disabilities and their representative organizations
			Feedback and redress mechanisms are accessible to persons with disabilities	Please select YES or NO according to the extent to which the feedback and complaints mechanisms have: No: No action has been taken to ensure accessibility of feedback and complaints mechanisms Yes: Persons with different types of disabilities have been considered in the design of feedback and complaints systems with specific measures put in place to ensure their accessibility

Figure 6: CCC indicators for CE/SBC

EMPOS Indicator Guidance - Community Engagement, Social Behavior change

Note: Sector specific indicators are replicated from row 34 downward from individual sector sheets

CCC COMMITMENTS		Indicators	Disaggregation	Disability
Commitment (2.3.4)	Benchmark			
SBC 1: Implement community engagement for behaviour and social change in collaboration with national and local actors (2.2.7)	All COs, with the support of ROs/HQ, design and implement humanitarian programmes with a planned and resourced component on community engagement for behaviour and social change	people reached through messaging on prevention and access to services	Sex Age (< 18, 18 years & above) Disability Migration status	Y
		people who participate in engagement actions	Sex Age (< 18, 18 years & above) Disability Migration status	Y
AAP1: Ensure that affected children and families participate in the decisions that affect their lives, are properly informed and consulted, and have their views acted upon (2.1.6) All COs, with the support of ROs/HQ, establish processes to ensure that affected and at-risk populations, including children and women	Participate in humanitarian planning processes and in decisions that affect their lives	adolescents and young people who participate in or lead civic engagement initiatives through UNICEF-supported programmes	Sex Age (< 18, 18 years & above) Disability Migration status	Y
		% people from the affected population/targeted populations that have been consulted and/or participated in all phases of the programme cycle, including: a- Identifying priority needs, b- program design c- program implementation d- program Monitoring & evaluation	Sex Age (< 18, 18 years & above) Disability Migration status	Y

Qualitative indicators on SBC towards children with disabilities

Work on [indicators of behaviour change towards children with disabilities](#) is available from UNICEF Europe and Central Asia (ECA)'s work with Drexel University,²¹ which uses three scales to assess changes in attitudes towards children with disabilities in the education system on the part of peers without disabilities or their parents:

- [CATCH scale](#) (Chedoke-McMaster Attitudes Towards Children with Disabilities Scale)²²
- [ORI scale](#) (Opinions Relate to Integration of students with disabilities)
- [ATDP scale](#) (Attitudes Towards People with disabilities)

This partnership between UNICEF and Drexel yielded additional [MEAL tools](#).²³ Figure 7 includes an example of their theory of change.

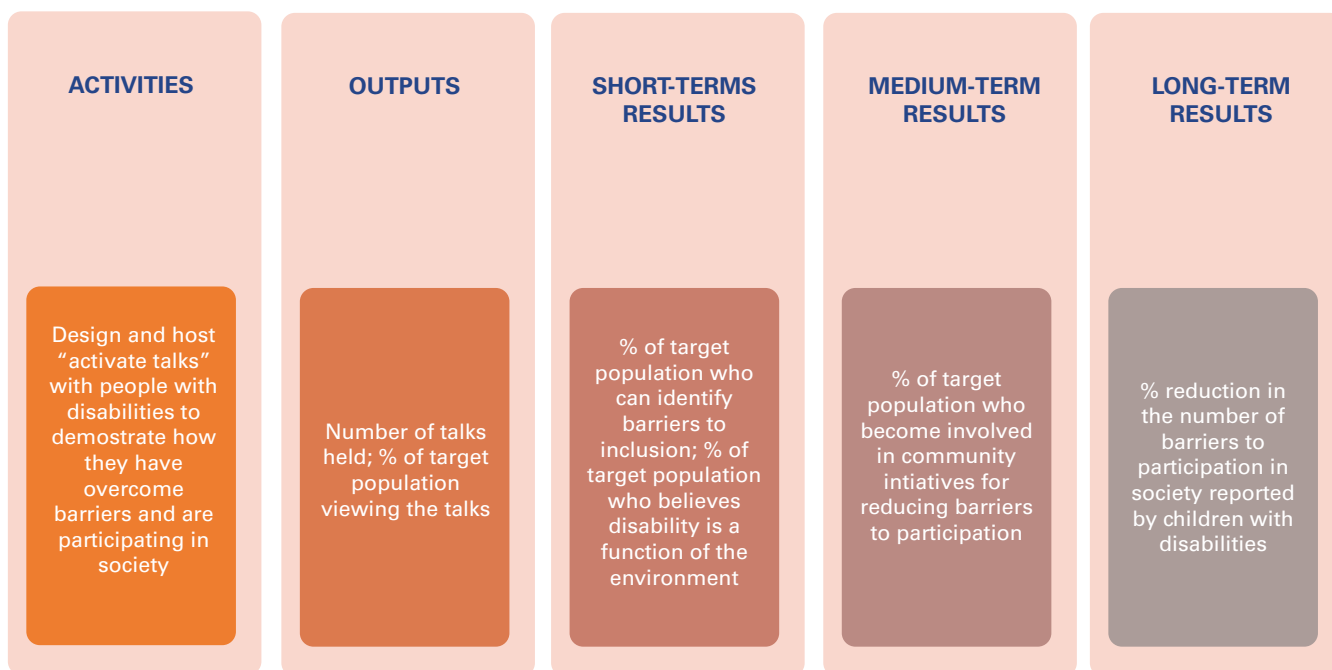
21 UNICEF & Drexel University (2018). [Desk review for developing measures of discriminatory attitudes and social norms towards children with disabilities in Europe and Central Asia region](#).

22 NOTE: some scales use outdated terminology which is not aligned with CRPD, therefore questions have to be reviewed and adopted

23 UNICEF & Drexel University (2019). [Monitoring and evaluation framework to track and assess the results of interventions aimed at changing attitudes and social norms toward children with disabilities in Europe and Central Asia](#).

Figure 7: Theory of change for attitudes towards children with disabilities

Source: UNICEF and Drexel University (2019). [Monitoring and evaluation framework to track and assess the results of interventions aimed at changing attitudes and social norms toward children with disabilities in Europe and Central Asia.](#)



7. NATIONAL CE/SBC AND RCCE COORDINATION MECHANISMS

Bring all stakeholders together and ensure that diverse and relevant partners from different sectors, including UN agencies, NGOs, in-country donor organizations and humanitarian organizations establish a coordination mechanism supporting CE interventions, including community engagement and accountability (CEA); CE/SBC; RCCE; communication, community engagement and accountability (CCEA); and national/local coordination mechanisms, depending on the location of the crisis.

ACTIONS FOR DISABILITY INCLUSION

For scalable impact, disability needs to be mainstreamed in the work of humanitarian coordination systems. This has been done through dedicated disability task forces that include OPDs and disability NGOs.

Evidence-based advocacy targeting Humanitarian Coordination Teams (HCTs) and cluster leads can be effective to ensure that strong references to disability and the priorities of people with disabilities are included in framework documents, such as HRPs. To gather evidence, consult with OPDs from both host and displaced communities. Understand what they do and their interests in engaging in response or preparedness actions.

Cluster coordination

- Appoint a disability inclusion focal point for each of the [clusters](#) and/or establish an inter-cluster disability inclusion working group or task force. This working group/task force should comprise focal points from each cluster/agency together with key national actors (including OPDs) and should be led by staff with relevant expertise in disability inclusion and humanitarian coordination.²⁴
- Hold cluster and inter-cluster meetings in accessible locations and provide support for transport, accessible communication and other reasonable accommodations when needed.
- DWGs should ideally be located within the structure of broader humanitarian coordination mechanisms. Where the cluster system is activated, they could, for example, be structured as part of the inter-cluster coordination group (ICCG). Where a DWG is established as part of a specific cluster or sector, mechanisms should be put in place to ensure that it is able to function effectively across all clusters/sectors (e.g., through a standing agenda item in ICCG meetings). The DWG should seek to establish strong links with other intersectoral groups, such as those coordinating on gender equality or AAP. Collaboration can help streamline engagement with humanitarian leadership with respect to shared strategic objectives on people-centred programming.

Inter-agency coordination

- Disability Working Groups (DWGs) facilitate intersectoral and [inter-agency coordination](#) on disability inclusion to avoid duplication of efforts, organize joint action and inform strategic decision-making to ensure that assistance reaches those who need it most.
- For RCCE work under cluster groups, ensure disability representation within various sub-groups, such as those for [GBV risk prevention](#), [COVID-19 RCCE](#) or mine action work.
- Provide a forum to support people with disabilities and their representative organizations to be actively involved in the Humanitarian Programme Cycle (HPC), including in multisector needs assessments (MSNAs) and the development of Humanitarian Needs Overviews (HNOs) and Humanitarian Response Plans (HRPs).

²⁴ UNICEF. Cluster coordination essential actions on disability inclusion.

STEADY KEY TAKEAWAY

- All SBC actions must be accessible using the twin-track approach: (1) **Mainstream actions** include children with disabilities by ensuring accessibility and representation – for instance, by using large print, accessible websites, images and first-person stories of people with disabilities in all mainstream materials. (2) These are complemented by **targeted actions** to address disability-specific needs and barriers, for instance by providing assistive devices or Braille and sign language on demand.
- It's especially critical to target children with disabilities during preparedness activities, as their risk of poor outcomes – including becoming trapped and being unable to evacuate, being separated from their families, or dying – is extremely high compared to other groups.
- Preparedness and close work with OPDs before a crisis helps to ensure that children with disabilities can be reunited with their families. Strategies include working with schools, and making sure children have identification cards with them at all times.
- Partnerships with OPDs and caregivers of children with disabilities support communication with and engagement of children.





EXAMPLES OF DISABILITY-INCLUSIVE SBC RESPONSES IN HUMANITARIAN SETTINGS

● Pushing for inclusive disaster risk reduction (DRR)

The example of [UNICEF Turkmenistan](#) shows that inclusive DRR is possible. Turkmenistan is prone to natural disasters. UNICEF and the Government ensured that DRR plans paid attention to children with disabilities, to increase their resilience and knowledge of how to cope in an emergency. School visits done together with a local NGO informed discussions about how to strengthen inclusive DRR in the preschool system. This was followed by a five-day child-sensitive and disability-inclusive DRR training for stakeholders including national actors in education and rehabilitation, the National Red Crescent society and education training resources centres. The trainees then trained other key actors.

The IASC committee shared examples of [inclusion of people with disabilities in humanitarian action](#) and inclusive DRR (see p. 9).

- In the Philippines, an OPD representing deaf people worked with Red Cross staff to prepare DRR and first aid training.
- In flood-prone Bangladesh, a local disability NGO, the Centre for Disability in Development, partnered with local communities to conduct inclusive DRR activities to identify and target households who could benefit from livelihood opportunities to help their preparedness.
- In New Zealand, disaster preparedness workshops were tailored to people with intellectual disabilities.

Disability Alliance BC has examples of [community emergency plans that are disability-inclusive](#)

● **Advocating for assistive technology (AT) in humanitarian action**

Here are three examples of [assessments of assistive technology provision in humanitarian settings](#) in [Afghanistan](#), [South Sudan](#) and the [State of Palestine](#), showing how teams identify needs to increase the demand and supply of AT.

Examples of inclusive digital platforms promoted by UNICEF in Eastern Europe and Central Asia: [BEBBO](#) and [KINDWEB](#).

● **Inclusive Risk Communication and Community Engagement (RCCE)**

Here are examples provided by [UNICEF Ukraine](#).

● **Advocating for first responders to be trained on disability**

UNICEF is finalizing a frontline worker training (2024) that can be adapted for DRR. It will be available at www.unicef.org/disabilities.

The Arc's National Center on Criminal Justice and Disability (United States) has [disability inclusion training for emergency personnel](#) and [law enforcement personnel](#), as well as [community cohesion and trust-building between law enforcement and people with intellectual and developmental disabilities](#) that covers how to avoid abuse of people with invisible disabilities, who may experience agitation in an emergency.

The Canadian Government provides [resources for communities](#), which can be adapted and formulated into trainings.

● **Inclusive Rapid Needs Assessment**

[An example from UNICEF Iraq is available](#) with key findings for advocacy and per sector.

● **Disaggregated data in humanitarian action**

When the needs of people with disabilities were not captured in a mainstream assessment during a category 5 cyclone in Vanuatu, a multi-stakeholder group did a comprehensive survey on people with disabilities over the course of 12 months, using household surveys and working closely with a local OPD.²⁵

In South Sudan, over 100,000 internally displaced people (IDPs) were assessed to gauge the situation of people with disabilities living within that population, using multi-sector assessment tools and the Washington Group questions.²⁶

● **OPD participation as humanitarian responders**

LASA, an OPD from a host community in Lebanon focused on people with intellectual disabilities, built a peer network for refugees with intellectual disabilities, creating social cohesion across host and refugee communities and addressing a sub-group within the disability community that needs particular support.²⁷

KOSHISH, an OPD in Nepal focusing on people with psychosocial disabilities, provided emergency psychosocial support and participated in cluster and coordination meetings related to health and protection, spaces that people with disabilities were normally excluded from, thanks to the support of CBM.²⁸

²⁵ CBM, International Disability Alliance and Handicap International (2019). [Inclusion of persons with disabilities in humanitarian action: Case studies collection 2019](#), p. 9.

²⁶ CBM, International Disability Alliance and Handicap International (2019). [Inclusion of persons with disabilities in humanitarian action: Case studies collection 2019](#), p. 9.

²⁷ CBM, International Disability Alliance and Handicap International (2019). [Inclusion of persons with disabilities in humanitarian action: Case studies collection 2019](#), p. 9.

²⁸ CBM, International Disability Alliance and Handicap International (2019). [Inclusion of persons with disabilities in humanitarian action: Case studies collection 2019](#), p. 9.

● Removing barriers to humanitarian assistance

In Haiti after the 2010 earthquake, inclusive camps for people with disabilities were designed with IDE, an OPD for deaf people. A new camp for deaf people was established, also including people with other types of disabilities and those living in extreme poverty. Sign language interpretation was provided to everyone.²⁹

In Niger, roving sign language interpreters were provided to support access and participation in camps, with the help of FNPH, a local OPD.³⁰

● Influencing coordination mechanisms to promote inclusion

In Myanmar, over the course of a few years, Humanity & Inclusion (HI) and other agencies have been advocating for disability to be reflected as a cross cutting issue in HRPs, leading to increased awareness by humanitarian stakeholders and donors of the need to mobilize resources for disability and to improve data collection on barriers³¹.

In the Democratic Republic of the Congo, HI collaborated with OCHA to help a pooled funding mechanism become more inclusive and have indicators to monitor disability inclusion, training OCHA staff and potential applicants to the fund³².

²⁹ CBM, International Disability Alliance and Handicap International (2019). [Inclusion of persons with disabilities in humanitarian action: Case studies collection 2019](#), p. 9.

³⁰ CBM, International Disability Alliance and Handicap International (2019). [Inclusion of persons with disabilities in humanitarian action: Case studies collection 2019](#), p. 9.

³¹ CBM, International Disability Alliance and Handicap International (2019). [Inclusion of persons with disabilities in humanitarian action: Case studies collection 2019](#), p. 9.

³² CBM, International Disability Alliance and Handicap International (2019). [Inclusion of persons with disabilities in humanitarian action: Case studies collection 2019](#), p. 9.

● Terms of reference (ToR) to coordinate groups for disability inclusion

Creating a ToR should be one of the first activities of the coordination mechanism, to ensure that the nature, scope and objectives of coordination activities are known and understood by all.

- [Mozambique: ToR Disability Working Group](#)
- [Syria: Inclusion Technical Working Group ToRs April 2020](#)
- [Afghanistan: Disability Inclusion Working Group](#)

DISABILITY-INCLUSIVE RCCE AND SBC DURING CRISES

▶ 1- STRATEGIES FOR DISEASE OUTBREAKS, EPIDEMICS AND PANDEMICS

The COVID-19 pandemic has highlighted how emergencies exacerbate the exclusion of children with disabilities – but also provide **opportunities to build back better for all children**.

- [Lessons learned during the COVID-19 pandemic](#) can inform communications during future outbreaks, to keep children with disabilities visible and served. Children with disabilities, particularly those with underlying health conditions, are at higher risk of complications and death as a result of COVID-19 infection.
- Children with disabilities and their families are among the poorest people globally, owing to increased costs of living, including health care costs, alongside diminished education and employment opportunities and inadequate social protection. They are less likely to have access to medical care for COVID-19 infections, as health services are not sensitive to the needs of children with disabilities.

- Children and youth with disabilities may miss out on crucial messages about the pandemic and how to protect themselves, as information is not always accessible.
- Children with disabilities may have difficulties complying with measures introduced by governments (e.g., physical distancing, quarantining in accessible locations). Lockdowns and other restrictions have a disproportionate impact on children who rely on essential treatments, services and at-home support (such as personal assistance). Customization and work-arounds are needed in these situations.
- Even before the pandemic, physical distancing was a reality for many children with disabilities, who spend much of their time at home and rarely socialize in person. Because many already relied on digital engagement, in some ways, they were more resilient during the pandemic. [This video narrated by a young person with a disability](#) explains the situation.
- Ensure that all health information during disease outbreaks is created using accessible templates that can be adapted to formats including Braille, large print, easy-to-read, audio, sign-language video and accessible web content using technologies such as screen readers.
- UNICEF Rwanda trained 128 people with disabilities to do risk communication for COVID-19. This example, and many communication techniques, are available in the UNICEF publication [Children with disabilities: Ensuring their inclusion in COVID-19 response strategies and evidence generation.](#)

Research done by [HI in Somalia/Somaliland](#) examines the behavioural and social drivers related to vaccination among people with disabilities – notably, an astonishing lack of information on COVID-19 and vaccinations, as well as barriers to access, primarily related to cost.

CBM presents ideas [from Bangladesh, Indonesia and Nepal](#) for engaging OPDs on communication and response planning for the COVID-19 pandemic and other disease outbreaks, including:

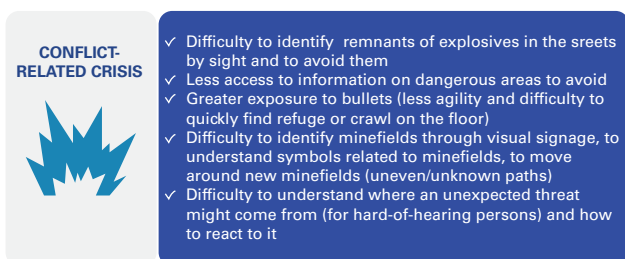
- Distributing cash, food and non-food items to vulnerable families, using age and disability focal points who are able to clearly explain targeting criteria to communities.
- Providing inclusive health and mental health services.
- Advocating for other actors to be inclusive.
- Engaging in equal and respectful partnerships with other humanitarian actors, with an awareness of the added value of each partner.



► 2- STRATEGIES FOR CONFLICTS

Disseminate SBC materials such as this [short video on children with disabilities in conflict](#).

Figure 8: Key barriers faced by people with disabilities during conflict-related crises Source: UNICEF (2022). Toolkit on accessibility, p. 26.



[Children with disabilities in situations of armed conflict](#) are at higher risk of grave violations of their rights (killing/maiming, recruitment into conflict, sexual violence, abduction, attacks on schools and denial of humanitarian access). They often acquire secondary conditions, such as pressure sores, urinary tract infections, malnutrition, depression, anxiety and infectious diseases such as polio, due to reduced access to vaccinations and other health services. The impact of armed conflict on children can be mitigated by having agreements not to attack health centres, and by government prioritizing services for those most disadvantaged.

► 3- STRATEGIES FOR DISASTER AND CLIMATE ACTION

Today's children with disabilities are part of the generation most affected by climate change. Their risk of being displaced due to climate change is higher than for previous generations. In spite of this, and despite being a force for change, they remain largely excluded from climate action.³³

In all communications, use positive images of children, adolescents and women with disabilities to help transform attitudes towards people with disabilities and avoid provoking pity.³⁴

Use or adapt SBC materials such as this [short video on children with disabilities and climate change](#), highlighting that:

- Disasters hit children with disabilities harder.
- Not all children can hear a warning siren.
- Not all children can run away.
- Children with disabilities need to know what to do and where to go when disasters strike.
- Create safe pathways and accessible shelters, and ensure that food reaches children with disabilities, too.
- Children with disabilities often need different solutions, and you need to work together with them to find these solutions – so start before disaster strikes.

In the aftermath of [Cyclone Idai in Zimbabwe](#), a barrier analysis examining physical, attitudinal and institutional barriers faced by people with disabilities highlighted issues that could use CE/SBC support. For example:

- To address extortion and robbery of items distributed to people with disabilities by UN agencies or NGOs, vouchers to obtain food or assets were connected to a person's ID.
- SBC interventions (e.g., open-discussion meetings) helped to mitigate jealousy about targeted interventions.
- People with disabilities had to navigate dangerous, debris-filled roads (inaccessible for crutch users) to access health services. This was addressed through advocacy for the clearing of key pathways, along with targeted interventions by health providers, for instance by offering weekly mobile clinics to the homes of people with mobility issues.

³³ UNICEF (2022). [Fact sheet: Children with disabilities](#).

³⁴ UNICEF (2017). [Guidance: Including children with disabilities in humanitarian action – General](#), p.61.




EMERGENCY	EXAMPLES OF ACCESSIBILITY-RELATED RISKS FOR PERSONS WITH DISABILITIES
<p>Earthquake, flood, tsunami</p> 	<ul style="list-style-type: none"> ✓ Roads full of debris: difficulty circulating in the streets to seek food, help, etc ✓ Difficulty and stressfulness in finding alternative itineraries to avoid debris ✓ Regarding displacement by boat: inaccessibility for persons with certain disabilities or using wheelchairs ✓ Impossibility/difficulty to reach or access temporary community shelters
<p>Cold wave, storm, cyclone</p> 	<ul style="list-style-type: none"> ✓ Difficulty to adopt safety measures without help (due to blocked doors and windows, barriers to upper floors) ✓ Difficulty to perform winterization/summerization adaptations (external protections to shelters, etc) ✓ Difficulty to prepare stocks of food and other items
<p>Heat wave, draught</p> 	<ul style="list-style-type: none"> ✓ Increased distances to sources of water and increased difficulty to reach them by persons with mobility or visual impairments ✓ Fewer water sources and longer lines: increased difficulty for some persons with disabilities to wait long periods of time without sitting

Figure 9: Key accessibility barriers faced by people with disabilities during disasters

▶ 4- STRATEGIES FOR RESILIENCE

● **Nutrition :**

In the Lao People’s Democratic Republic, messages on disability in the Lao language were included in World Food Programme nutrition awareness campaigns. In addition to messages on the importance of nutrition for mothers and babies to prevent disabilities, the following messages were included:

- A mother with a disability can breastfeed and has enough milk for her baby.
- Village health volunteers should ensure that all mothers with disabilities and mothers of children with disabilities receive assistance.

● **Child protection³⁵ :**

- Provide easy-to-understand information on existing protection services, such as access to registration, legal support and protection benefits for families with children or adolescents with disabilities. Ensure that information is available in at least two formats.
- A 2014 campaign in the Za’atari refugee camp in Jordan shared the message that “Our sense of safety is everyone’s responsibility.” It focused on how to better protect children and

adults from harm and violence, including one message directed to children with disabilities: “Our abilities are different, but our rights are always the same.” The campaign promoted the rights of children with disabilities, encouraging other children to play with them and to speak to adults about any violence they saw.

● **Health³⁶ :**

- Disseminate messages on the right to health services, including sexual and reproductive health services for all girls and boys with disabilities, targeting health workers.
- Provide easy-to-understand information about the use and maintenance of assistive devices.
- Share information on existing health services for children with disabilities in health facilities through parenting groups and during health campaigns.
- Provide health information in at least two different formats, such as posters, banners or signs for services, text message campaigns and audio announcements on radio or community loudspeakers.



- These examples of disability-inclusive SBC – for scenarios including disease outbreaks, conflicts, disasters, climate change and resilience-building – can be adapted and elaborated, and can inspire your work. You don’t need to reinvent the wheel.
- A disability coordination group in a humanitarian setting can be an invaluable source of cooperation, crowd-sourcing solutions and support for communities.

³⁵ UNICEF (2017). *Guidance: Including children with disabilities in humanitarian action – Child protection.*

³⁶ UNICEF (2017). *Guidance: Including children with disabilities in humanitarian action – Health and HIV/AIDS.*



TOOLS FOR DISABILITY-INCLUSIVE CE/SBC IN HUMANITARIAN ACTIONS

One of the most solicited tools is an **inclusive rapid community assessment**. When this is in place from the outset, **children with disabilities stay visible**, enabling an inclusive response.

► HOW TO MAKE SURE YOUR ASSESSMENT IS INCLUSIVE

Agree on a minimum level of questions that need to be part of all UNICEF tools. For example, include the [Washington Group set of questions \(WGOs\)](#) (e.g., in [Multi-Sector Needs Assessments](#)) in the demographic section of your data collection to identify and disaggregate data by disability. This will allow you to gather comparative data.

[Use this excellent decision tree](#) with your monitoring teams to see how to adapt the data to be disability-inclusive. It may lead you to add questions that cover the following topics:

▶ INDIVIDUAL AND HOUSEHOLD LEVEL

- Identify children at heightened risk ([using WG/UNICEF CFM questions](#)).
- Understand how people with disabilities are experiencing the crisis, the risks they face and the factors contributing to their vulnerability.
- Understand the concerns and priorities of people with disabilities.

▶ INFRASTRUCTURE AND PROGRAMME-LEVEL

- Identify various types of barriers and enablers that people with disabilities may face (e.g., fast track lineups, volunteers to help mobilize, preferred communication channels, experiences of discrimination).
- Determine the number and location of accessible and inaccessible facilities.
- Understand the knowledge, attitudes and perceptions of humanitarian actors and local communities regarding people with disabilities
- For these extra questions, adapt the questions developed for post-disaster needs assessment in the [Post-Disaster Needs Assessment](#).
- For general information on inclusive data collection, see Chapter 4 of [IASC Disability-Inclusive Guidelines](#).

▶ MORE RESOURCES ON INCLUSIVE HUMANITARIAN ACTION

- [The Humanitarian Emergency Settings Perceived Needs Scale \(HESPER/WHO\)](#)
- [Vulnerability Assessment Framework \(VAF/UNHCR Jordan\)](#)
- Checklists from Disability-Inclusive Humanitarian Toolkit to sensitize sectoral colleagues:
 - [General checklist](#), [Education](#), [Health](#), [Nutrition](#), [Protection](#), [WASH](#).
- [CCC Indicator Guidance 2022](#) (Disability, CE & SBC)
- [Introductory training on disability inclusion in Humanitarian Coordination](#) (UNICEF)
- [Inclusive feedback response mechanisms \(AAP\)](#) – Excellent work by IRC, with ideas on how to test feedback-and-response mechanisms (FRMs) with people with disabilities, plus various accessible tools to collect feedback from various people with disabilities.
- UNICEF's [accessibility toolkit](#) includes a section on **accessibility in emergencies**, which highlights:
 - Early warning systems and community evacuation shelter identification and preparation
 - Post-disaster needs assessments
 - Community building accessibility
 - Emergency shelter and temporary shelter considerations
 - Distribution sites considerations
 - Out-of-camp contexts

 **GO**
KEY TAKEAWAY

A disability-inclusive community assessment is the key tool to ensure the collection of data on children with disabilities, their demographics, the barriers they face and the solutions they and their caregivers suggest.

Plan to train frontline workers on disability, to increase their confidence and ownership over their work. Offer training on specific areas that may be of interest to them (e.g., accessibility, barrier analysis, barrier removal).

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