Humanitarian aid and disability

VADEMECUM

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AIFO dal 1961 con gli ultimi

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Preface

I am pleased to present the concrete result of the experience jointly developed by Italian Cooperation and the Italian Network for Disability and Development as part of the "Emergency" working group. The group was established in 2013 following the adoption of the "Italian Development Cooperation Disability Action Plan".

This Vademecum is intended to provide a benchmark for aid workers—whether working in the field or at a strategic level—in particular concerning the formulation and implementation of programmes of prevention or response to humanitarian crises. It is not solely a theoretical document because, in addition to guiding principles, it also provides concrete examples of how to ensure protection of the rights of people with disabilities, including in terms of humanitarian aid. This Vademecum has been drafted in adherence to the UN Convention on the Rights of Persons with Disabilities, which has been in force since 2006 and which reaffirms the importance of protecting the safety of people with disabilities in dangerous situations.

Although the inclusion of people with disabilities is possible in emergency situations, it requires a radical change in approach. In addition, we need to recognise that people with disabilities not only have the same rights as others, but may themselves be a powerful agent for change. Whereas in the past people with disabilities were considered recipients of interventions, now they play an active role in every phase of the project, including planning and management.

The debate on this issue is at a very early stage, but Italy has been a driving force in raising cultural and social awareness—at European and international level—something that has always distinguished our country with regards to the protection of human rights. In this respect, I am pleased to point out that the protection of people with disabilities in humanitarian crises was one of the priorities of the recent Italian Presidency of the EU Council.

Consequently, my personal wish is that this Vademecum will become the starting point for a renewed focus—including in humanitarian aid programmes—on people with disabilities and for a more fruitful partnership with civil society, which is a key partner in development processes.

Giampaolo Cantini

Director General for Development Cooperation

Chapter 1. Introduction: the international and national context

1.1. Introduction to disability

As **defined** in the UN Convention on the Rights of Persons with Disabilities (CRPD), the term *persons with disabilities* includes "those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others". The condition of disability "results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others"[1]. In recent years, the approach has changed from an individual and medical perspective to a social and structural one, in which disability means more than a physical individual characteristic, because it indicates the way in which society implements the rights of people with disability (the social model of disability).

According to the World Health Organization, which in 2001 developed a classification tool that analyses and describes disability (called ICF – International Classification of Functioning, Disability and Health), disability is a human experience that everyone can experience. The ICF provides a comprehensive analysis of the health of individuals by placing the correlation between health and environment. In this respect, the definition of disability sums up a specific health condition in an unfavourable environment. The definition of the ICF is based on a "biopsychosocial approach" to disability, a model built on the interaction between body functions, body structures, activities and participation, and environmental and individual factors.

The CRPD also defines the concept of **discrimination based on disability**, defined as "any distinction, exclusion or restriction on the basis of disability which has the purpose or effect of impairing or nullifying the recognition, enjoyment or exercise, on an equal basis with others, of all human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field". It includes all forms of discrimination, including denial of reasonable accommodation, meaning necessary and appropriate adjustments not imposing a disproportionate or undue burden, to ensure to people with disabilities the enjoyment and exercise of all human rights and fundamental freedoms.

[1] United Nations, *Convention on the Rights of Persons with Disabilities*, 2006. Preamble e); Article 1.

The World Health Organization (WHO) estimates that **around a billion people, about 15% of the world's population[2], have some form of disability**, including around 80 million people in the European Union, of whom over 10% (nine million) live in Italy. More than a third of people over 75 years of age suffer from a partial disability and more than 20% have a severe disability. Furthermore, there are 93 million children with disabilities between the ages of 0 and 14 years (5.1% of the world's population), mainly in developing countries where children are exposed to multiple risks (poverty, malnutrition, lack of medical structures, an often hostile environment), that can be debilitating from a cognitive, motor and socio-emotional point of view.

It is also estimated that 80% of people with disabilities live in developing countries, where there is a high probability that they will be living in poverty. In many cases the condition of disability can in itself constitute an additional poverty factor, preventing full participation in economic and social life, especially if there are no adequate services and infrastructures. These figures are expected to increase as the EU population ages[3].

According to data provided by the Internal Displacement Monitoring Centre (IDMC), the number of people displaced due to natural disasters was approximately 22 million in 2013, while the number of people displaced due to wars was around 33.3 million. In total, 55.3 million people needed humanitarian interventions. Of these, around 8.3 million (15%) were people with disabilities, the cause of which often coincided with the disaster event.

Addressing the needs of people with disabilities in emergency situations requires appropriate skills, since this population is strongly heterogeneous—due to social, environmental and individual factors—and with differences in sensory and mobility terms as well as intellectual abilities and social skills.

1.2. Principles and international conventions

On 13th December 2006 the UN adopted the ***Convention on the Rights of Persons with Disabilities*** (CRPD). Italy was one of the first 50 signatories and the Italian Parliament ratified the Convention in May 2009[4] (one of the first governments to do so within the European Union). The Convention—ratified by

[2] The World Health Organization and World Bank, *World report on disability,* 2011, Geneva.

[3] European Commission, *Communication from the Commission to the European Parliament, to the Council, to the European Economic and Social Committee and the Committee of the Regions. European Disability Strategy 2010-2020: a renewed commitment to a barrier-free Europe*, 2010, p.3.

[4] The ratification took place with Italian Law 18, 3 March 2009. "Ratification and implementation of the UN Convention on the Rights of Persons with Disabilities, with the Optional Protocol, signed in New York on 13th December 2006, and establishment of the National Observatory on the condition of persons with disabilities", published in the *Gazzetta Ufficiale,* no. 61, 14 March 2009. The text of the Convention in Italian can be downloaded from the official website of the Italian government (www.lavoro.gov.it/NR/rdonlyres/9768636A-77FE-486D-9516-8DF667967A75/0/ConvenzioneONU.pdf).

160 countries (81% of countries within the United Nations)—is an important tool for promoting human rights and recognising the right to equal opportunities for all.

The CRPD emphasises that environmental and social factors may hinder the full and effective participation in society of people with disabilities (Art. 1). Moreover, the Convention also demands that states remove all discrimination, to ensure equal opportunities for people with disabilities (Art. 5) – recognising the importance of development cooperation for the realisation of the purpose and objectives of the Convention (Art. 32). With reference to humanitarian aid, the CRPD asks states to adopt—according to international humanitarian law and international standards on human rights—"all necessary measures to ensure the protection and safety of persons with disabilities in situations of risk, including situations of armed conflict, humanitarian emergencies and natural disasters" (Art. 11).

On 13 October 2013 the United Nations, committing to embracing the principles of the CRPD, dedicated the International Day for Disaster Risk Reduction to the theme "Living with disability and disasters". For this occasion, the United Nations Office for Disaster Risk Reduction (UNISDR) launched a questionnaire for people with disabilities and their caregivers[5]. Specific references to the protection of people with disabilities in event of natural disasters can be found in the Outcome Document of the Third UN World Conference on Disaster Risk Reduction (WCDRR)[6], held in Sendai (Japan) from 14 to 18 March 2015, with a session devoted to people with disabilities. Moreover, the Outcome Document confirms that it will promote the creation of systems for collecting unbundled data, in line with the dictates of the CRPD[7].

With regard to the European commitment, the European Consensus on Humanitarian Aid, signed by the Presidents of the EU Commission, Council and Parliament on 18 December 2007, emphasised (Art. 17) the need to give special attention to people with disabilities and their specific needs in responding to humanitarian need (Art. 39). Thereafter, the European Union—which ratified the CRPD in January 2011—defined the **European Disability Strategy** (2010-2020) at the end of 2010, committing to introducing the principles of the Convention within the external actions and to "raise awareness of the UN Convention and the needs of people with disabilities, including accessibility, in the area of emergency and humanitarian aid"[8].

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[5] http://www.unisdr.org/2013/iddr/

[6] http://www.wcdrr.org/uploads/Sendai_Framework_for_Disaster_Risk_Reduction_2015-2030.pdf

[7] CRPD, Art. 31: "*1. States Parties undertake to collect appropriate information, including statistical and research data, to enable them to formulate and implement policies to give effect to the present Convention.* […] *2. The information collected in accordance with this article shall be disaggregated, as appropriate, and used to help assess the implementation of States Parties' obligations under the present Convention and to identify and address the barriers faced by persons with disabilities in exercising their rights. 3. States Parties shall assume responsibility for the dissemination of these statistics and ensure their accessibility to persons with disabilities and others.*"

[8] European Commission, *Communication from the Commission to the European Parliament, to the Council, to the European Economic and Social Committee and the Committee of the Regions. European Disability Strategy 2010-2020: A Renewed Commitment to a Barrier-Free Europe*, 2010, p.9.

In 2015, the European Council adopted the ***Council Conclusions on disability-inclusive disaster management***[9], which defined the actions that Member States and the European Commission will have to implement to ensure that emergency responses take into account the needs of people with disabilities.

Furthermore, it is important to underline the commitment of the **Council of Europe**, which in 2006 adopted the **Disability Action Plan 2006 - 2015**. The aim of this plan is to help Member States strengthen anti-discrimination measures and the protection of human rights, to ensure equal opportunities and independence for people with disabilities, allowing them to participate actively in community life. The implementation of the aforementioned Action Plan is monitored by the *European Coordination Forum for the Council of Europe Disability Action Plan* 2006-2015 (CAHPAH). In 2014 the Council of Europe defined the *Guidelines and Recommendations on Including People with Disabilities in Disaster Preparedness and Response*[10], based on consultation with all relevant institutions and civil society.

1.3. The Directorate General for Development Cooperation and disability

As a result of the statements of the UN Convention and the commitments made at international level, the DGDC has launched several initiatives for the protection and promotion of the rights of people with disabilities in various countries in the perspective of mainstreaming, including the **mapping** of development cooperation initiatives for the protection of people with disabilities (period 2000 – 2008). Data analysis carried out by a group of Italian and international experts made it possible to conduct the study "***Disability, International Cooperation and Development – The experience of Italian Cooperation 2000-2008***" in conjunction with the World Bank, in June 2010.

The reflection resulting from this work was cemented in the strategic document "**Guidelines for the introduction of the issue of disability in the policies and activities of the Italian Cooperation**", approved by the Steering Committee of the DGDC in 2010.

This document, which is characterised by an operational approach and was drafted in the form of practical recommendations, updated the previous guidelines of 2002 and provided for the drafting of an **Action Plan** for their implementation. To this end, the Working Table MAE/RIDS (Italian Network on Disability and Development, formed of the associations AIFO, DPI Italy Onlus, EducAid and FISH) was established in September 2011.

[9] *Council conclusions on disability-inclusive disaster management:* http://www.consilium.europa.eu/register/en/content/out/?&typ=ENTRY&i=ADV&DOC_ID=ST-6450-2015-INIT

[10] *Guidelines and Recommendations on Including People with Disabilities in Disaster Preparedness and Response:* http://www.coe.int/t/dg4/majorhazards/ressources/Apcat2013/APCAT2013_11_Gudelines_Disability_Alexander_Sagramola_17jan2014_en.pdf

The Working Table, which was attended by representatives of central and local institutions, civil society and the world of academia and business, culminated in the document "Plan of Action of the Italian Cooperation on Disability", adopted by the DGDC in July 2013, with a multi-disciplinary and participatory approach.

The basic aim of the Action Plan is to promote the inclusion of the issue of the rights of people with disabilities in the policies and activities of Italian Cooperation, taking into account the suggestions contained in its three-year programming guidelines. It consists of **five major areas of intervention**, including one focused on "**Humanitarian aid and emergency situations**", with actions to improve planning ability according to the most accurate knowledge of the needs of people with disabilities in situations of catastrophes and natural disasters.

The realisation of the present **Vademecum** formed part of this Action Plan, and in particularly the chapter devoted to "aid and humanitarian emergency situations". It is intended to provide a support guide for all Italian humanitarian workers, in order to make their actions in emergency situations more respectful of the rights of people with disabilities, with careful attention to their needs and inclusion.

With a new and innovative approach, Italy also included the issue of protecting people with disabilities in the humanitarian programme of the semester of **Italian Presidency of the EU Council**. Consequently, associations specialised in the field (CBM International and Carlo Besta Institute of Milan) gave two presentations on the specific needs of people with disabilities in emergency situations within COHAFA (EU Council Working Group on Humanitarian Aid and Food Aid). Italy also developed a concept paper that identifies opportunities for better protecting people with disabilities in emergency situations and creates the basis for the work of future presidencies on the same issue. Moreover, the next Latvian Presidency gave continuity to the Italian programme by including the issue of protection of people with disabilities in risk management into the agenda of COHAFA. On 12 March 2015, the Council approved the so-called Council Conclusions[11], which emphasise the need to include people with disabilities in programmes of prevention, management and response to natural disasters. These conclusions were presented at the World Conference of Sendai as a common position of EU Member States.

[11] EU Council, *Council conclusions on disability-inclusive disaster management*, 12/03/2015. http://www.consilium.europa.eu/register/en/content/out/?&typ=ENTRY&i=ADV&DOC_ID=ST-6450-2015-INIT

Chapter 2. Humanitarian aid and emergency situations: the value of protecting people with disabilities

2.1. Humanitarian aid and disability

Over the last decade, the number of people involved in humanitarian crises has almost doubled, with around 52 million people needing humanitarian aid in 2014 alone. To meet this growing need, the international community is investing more and more in humanitarian aid programmes in response to catastrophic events, be they man-made or natural, in order to "preserve life, prevent and alleviate human suffering and maintain human dignity, wherever governments and local actors are overwhelmed, unable or unwilling to act" (European Consensus on Humanitarian Aid - 2008)[12].

Humanitarian aid includes assistance, protection and rescue aimed to saving and preserving human life in humanitarian crisis and post-crisis situations, and also the implementation of all measures to promote or permit access to populations in need and the free flow of humanitarian aid. This includes both interventions for reconstruction and crisis response at local level, as well as for disaster risk reduction and human and institutional capacity development, to prevent and mitigate the impact of the humanitarian crisis and strengthen the response.

Four key principles are the foundations on which humanitarian action must be built:

1. **Humanity**, meaning the alleviation of human suffering wherever it is found, with particular attention to the most vulnerable groups within the population and respect for the dignity of all victims;

2. **Neutrality**, meaning that humanitarian aid must not favour any side in an armed conflict or other dispute;

3. **Impartiality**, because humanitarian action must be provided solely on the basis of need, without discrimination between or within affected populations;

4. **Independence**, insofar as humanitarian objectives must remain independent from political, economic, military or other objectives.

[12] European Union, *European Consensus on Humanitarian Aid*, Joint Statement by the Council and the Representatives of the Governments of the Member States meeting within the Council, the European Parliament and the European Commission, signed on 18th December 2007 and published in the Official Journal of the European Union on 30.1.2008 (2008/C 25/01).
http://eur-lex.europa.eu/legal-content/IT/ALL/;jsessionid=g7CRTLXGTZyTQJWLCxPbpNjrfQLmMVnKQwL16Qyhlr2wQY11TMTD!1424045317?uri=CELEX:42008X0130(01)

The **active participation** of beneficiary populations is one of the key principles of the **Good Humanitarian Donorship** (GHD) and the European Consensus on Humanitarian Aid, which emphasise the need for adequate involvement of beneficiaries from the identification phase to the evaluation of initiatives (Consensus Art. 44; GHD Principle 7) and to "pay special attention to women, children, the elderly, sick and disabled people, and to addressing their specific needs" (Consensus, Art. 39).

In 2011 the **European Parliament** pointed out that "the provision of aid must be based solely on identified need and the degree of vulnerability, that the quality and quantity of the aid are determined primarily by an initial evaluation and that the evaluation process needs to be further improved, particularly with regard to the application of vulnerability criteria, especially regarding women, children and disabled groups"[13].

In addition to framework texts for international humanitarian aid, the **Convention on the Rights of Persons with Disabilities** of the United Nations obligated, under Article 11, Member States to take "...in accordance with their obligations under international law, including international humanitarian law and international human rights law, all necessary measures to ensure the protection and safety of persons with disabilities in situations of risk, including situations of armed conflict, humanitarian emergencies and the occurrence of natural disasters". Since the adoption of the Convention, there has been renewed international interest in issues concerning people with disabilities, thanks to the increased involvement of Organizations of People with Disabilities (OPD) on topics such as security, risk prevention and emergency response[14]. In the past, people with disabilities have played a minor role in planning activities and in searching for solutions to reduce risk in disaster situations. However, recently this section of the population has been recognised as a priority target in the immediate response to emergency situations caused by natural and man-made disasters such as wars. This revised approach has implications at different levels, especially for the recognition of the right to protection, under legislation on security and civil protection. The involvement of associations for people with disabilities in planning measures and in their implementation phases is an essential element for promoting the best response to the needs and the rights of these people.

[13] European Parliament, *European Parliament resolution of 18 January 2011 on implementation of the European Consensus on Humanitarian Aid: the mid-term review of its action plan and the way forward* http://www.europarl.europa.eu/sides/getDoc.do?pubRef=-//EP//TEXT+TA+P7-TA-2011-0005+0+DOC+XML+V0//EN

[14] Council of Europe, *Recommendation 2013/1 of the Committee of Permanent Correspondents on the inclusion of people with disabilities in disaster preparedness and response*, adopted at the 64th meeting of the Committee of Permanent Correspondents of the European and Mediterranean Major Hazards Agreement (EUR-OPA), Paris, France, 24-25 October 2013. More information is available on the website: http://www.un.org/disabilities/default.asp?id=1614

On the **response to natural disasters**, the European Commission has funded specific projects within the powers of national civil protection agencies and of the **European Parliament**, which in the **Resolution of 4 September 2007** on natural disasters[15] underlined "the need to take special care of persons with disabilities in cases of natural disasters in all actions undertaken by the Civil Protection Mechanism" (Article 19).

In 2007, as part of a European project, the **Verona Charter on the Rescue of Disabled Persons in Case of Disaster** was defined, which identified the key issues on which to base the emergency actions that include people with disabilities. The Verona Charter highlights the need for a multidimensional approach that takes into account different types of disabilities and degrees of vulnerability, carefully considering the needs of children with disabilities and the difference between people with disabilities who already have resilience capacities, and people who became disabled as a result of the catastrophic event.

The DGDC also carries out a constant action of international advocacy, promoting and supporting the adoption of documents that include the protection of people with disability by the United Nations and other international organisations.

2.2. The vulnerability of people with disability and disabilities arising from emergency situations

Recent studies conducted by the World Bank show a strong correlation between poverty and disability, as a cause and consequence of each other. **Disability** can force people into poverty due to difficulties in gaining access to employment, education and medical care. However, it is also true that **poverty** can create or exacerbate conditions of disability, as a result of malnutrition, limited sanitation and education facilities, debilitating working conditions, and inaccessibility of transport. It therefore leads to a vicious cycle "**poverty-disability-poverty**", which is hard to break because such groups are very vulnerable.

In emergency situations, **the condition of people with disabilities is made even more fragile by the catastrophic event**, whether it be natural or man-made: this creates additional barriers that deny them access to the environment, exacerbating their psychological and physical conditions. People with disabilities, such as blind and deaf people, may be unprepared in facing the disaster, as information on the emergency is often not accessible to them, or they may not be taken into consideration in the drafting of evacuation plans. Statistical data collected after the earthquake and tsunami in Japan in 2011

[15] European Parliament, *European Parliament resolution of 4 September 2007 on this summer's natural disasters*. http://www.europarl.europa.eu/sides/getDoc.do?pubRef=-//EP//TEXT+TA+P6-TA-2007-0362+0+DOC+XML+V0//EN

illustrate the heightened vulnerability of people with disabilities, whose mortality rate is twice (2.06%) that of the general population (1.03%)[16].

In emergency situations with limited resources, people with physical, sensory, psychosocial or intellectual/relational disabilities **generally still have no access to services and the distribution of goods**. For example, a person with physical disabilities has many more difficulties to face in collecting and carrying international aid handouts, or in accessing basic services—such as latrines and sanitation in refugee camps —which are all too often inaccessible for such people. At other times, exclusion is sometimes the result of cultural barriers. The strong sense of discrimination against people with disabilities can lead them to be considered less worthy of survival.
All of this results in the exclusion of people with disabilities, who have to count on family help for even the simplest activities that, by contrary, could be carried out independently in a community that respected the needs and rights of all equally.

In emergency situations, the **ability of social or health workers to provide assistance could also be limited**: for example, facilities for the elderly or the chronically sick, which are often destroyed in the event of a disaster, or are unable to provide the necessary facilities due to lack of funds, as in the most recent case of the conflict in Ukraine. Even evacuation measures and transfer to relief camps are extremely difficult, due to a lack of suitable transport for people in wheelchairs and/or due to the inaccessibility of hospitalisation or relief sites. Moreover, in crisis situations the family and social support network for people with disabilities often breaks down. Displacement or the death of family members or caregivers sometimes leaves people with disabilities without any help and can even lead to their death. Even community activities organised in long term camps (education, socio-economic and social activities) often exclude people with disabilities.

Furthermore, humanitarian aid programmes often involve **countries where disability leads to strong cultural and social discrimination and exclusion**, as there is no legal preservation of the rights of people with disabilities. This discrimination can also result in increasing health and social care costs, because of the aggravation of diseases due to lack of care, prevention and mitigation of different disabilities.

Not all people with disabilities are discriminated against in equal measure: some are more vulnerable and marginalised than others in terms of having to face dual discrimination, such as women, children

[16] World Health Organization, *Guidance Note on Disability and Emergency Risk Management for Health*, 2013. (p. 9).

and the elderly. Take, for example, babies with disabilities who frequently do not receive necessary birth care or are not breastfed or fed properly, causing an increase in mortality, or women and infirm elderly people who are left behind by families fleeing a war. In addition, isolation and abandonment also expose people with disabilities to greater risk of **violence, including sexual violence**, which especially affects women and girls.

2.3. Disabilities caused by emergency situations

Disasters affect the conditions of ordinary life and make it impossible for many people to live independently. In fact, catastrophes often produce conditions of generalized disability[17]. A large number of people bear the consequences, such as destruction of goods and property. Above all, physical and mental trauma worsen the health conditions of many people, often due to lasting operational limitations and, as a result, loss of autonomy and substantive changes in lifestyle. **In fact, natural and man-made disasters, especially wars, increase the number of people with disabilities**. For instance, physical impairments caused by the explosion of devices—26,000 victims of unexploded ordnance each year, of which 20% are children—or by the collapse of infrastructure during a disaster, such as the 300,000 people injured as a result of the earthquake in Haiti in 2010.

The lack of health care can **aggravate pre-existing diseases**, leading to the death of the sick or causing irreversible damage. As a result of the earthquake in Haiti, Handicap International estimated that up to 4000 people suffered amputations, sometimes due to late or inadequate care. Similarly, in the ongoing Ukrainian conflict, 80% of families living in rural areas have problems finding medication necessary for the treatment of pre-existing disorders, such as diabetes; in addition, the reduction of public health services has put people with disabilities in a condition of risk[18].

Moreover, the consequences of disasters on the mental and psychic health of victims, who because of trauma can suffer from mental disorders such as Post-Traumatic Stress Disorder (PTSD), must be taken into consideration. PTSD may manifest itself through a number of symptoms—aggressive behaviour, loneliness, insomnia, lack of appetite—which need proper and specialised care, also to prevent their degeneration into chronic form. There are countless studies about the connection between war trauma and mental disorders. Several studies show that the rate of incidence of PTSD on refugees fluctuates between 10% and 40%, with peaks among children and teenagers reaching 90%[19]. According to data concerning the former Yugoslavia, it is calculated that 29.2% of refugees, 75% of displaced people and

[17] http://ec.europa.eu/agriculture/analysis/external/insurance/definitions_en.pdf; http://europa.eu/pol/hum/index_it.htm.
[18] Ukraine NGO Forum, *Ukraine Multi-Sector Needs Assessment (MSNA) Report*, 30 March 2015.
[19] http://refugeehealthta.org/physical-mental-health/mental-health/.

11% of civilians are affected by severe psychological disorders due to the experience of war[20]. According to recent research, in Ukraine psychological trauma is the main health concern of families living in areas of conflict[21].

During emergency situations, the lack of suitable nutrition for children in early childhood often increases the risk of contracting diseases such as measles, malaria and pneumonia. In addition, it decreases resistance to diarrhoea, making it potentially fatal, and may result in permanent disability.

People with a physical, mental, sensory or psychosocial impairment caused by a disaster require more complex post-traumatic treatments than people with a pre-existing disability. In fact, the latter have often already developed a resilient approach to this condition, whereas people suffering from an operational limitation as result of a disaster need to be supported in their change of lifestyle, with proper tools and treatments. These people, who are experiencing the condition of disability for the first time, should be able to accept their new situation and gradually build resilience skills.

2.4. Guiding principles and strategy in humanitarian programmes for disability

People with disabilities are therefore more vulnerable in emergency situations, which in turn may aggravate the pre-existing disability, and/or produce new physical and mental disabilities. Consequently, it is **important to direct humanitarian aid to the protection and rescue of people with disabilities** right from the earliest stages of the emergency response. But this is not easy to do. In fact, both due to the complexity and multiplicity of contexts in which humanitarian aid programmes are implemented, and also due to the different types of disabilities, each of which require specific competences.

However, it is possible to establish **guiding principles** in **humanitarian action**, aimed at protecting the life and **dignity of people with disabilities in emergencies**. Humanitarian action by Italian Cooperation will be implemented according to a model that recognises the principle of **equality** of all people, and is aimed at not only protecting but also promoting the rights of people with disabilities through their social inclusion.

The basic paradigm is to ensure the human dignity of each person, **eliminating all forms of discrimination**, ensuring equal opportunities and **helping everyone to express their own skills and potential**. Disability is not an insurmountable barrier to living an independent life. It is a condition that is surmountable by removing barriers and above all by promoting the human being who, by being put in the conditions to fully enjoy their human rights, will be able to participate actively in social, economic

[20] *Psicologia dell'Emergenza e dell'Assistenza Umanitaria*, Semestrale della Federazione Psicologi per i Popoli, n. 6, September 2011.
[21] *Ibid.*

and cultural life. This also means involving people with disabilities and their associations in defining and managing activities related to humanitarian aid.

Therefore, in this model the key word is "**inclusion**". The humanitarian strategy for people with disabilities should be based on a participatory approach that is inclusive of people with disabilities, their families and the organisations that represent them, right from the design stage of programmes and interventions. This approach is not founded on a medical or welfare model: rather, it is aimed at **improvement of the people's skills and capacities**, advocacy for protection of their rights and inclusion in activities that involve the rest of the population. In addition to **interventions specifically targeted at people with disabilities**, **mainstreaming** is also crucial. This means that humanitarian aid programmes will have to consider, in the needs analysis during the early stages of an emergency, the needs of the entire target population – including people with disabilities. For example, in planning relief efforts for refugees with temporary shelters, these will have to be built taking into account the specific needs (physical, sensory or intellectual) of people with disabilities, in terms of both accessibility of spaces and environments, and availability of services and community activities.

The human rights-based approach is far more **sustainable** than the medical model insofar as, by strengthening the dignity, **independence** and inclusion of people with disabilities, it will improve their autonomy and **resilience**, enabling them to **contribute actively** to the development of society or, in the case of emergencies, **to response plans and community rehabilitation**.

Chapter 3. Inclusion of disability within humanitarian aid programmes

3.1. Programme management

The inclusion of disability in humanitarian aid programmes must be implemented progressively, both at a central level—by improving planning and strategic management skills—and at local level, by building capacity to manage projects in the field.

Specifically, it should be emphasised that **the participation of associations for people with disabilities and their families** is crucial. These associations must be involved in the management of humanitarian aid programmes from the stage of identification and formulation of interventions, through to the evaluation of such interventions.

3.1.1. Mainstreaming and *ad hoc* programmes

In order to meet the needs of people with disabilities, planning of humanitarian aid must be **defined together with representative organisations and relevant experts**. Participation in decision-making processes concerning issues that affect people with disabilities is fundamental to a proper needs analysis, and also constitutes an important opportunity for capacity building and the involvement of organisations, as stated in paragraph 3, Article 4 of the CRPD[22] and recently confirmed by the *Sendai Framework for Disaster Risk Reduction 2015/2030.* Moreover, some actions can be carried out only with their collaboration, such as the drafting of descriptive maps of places where people with disabilities live, with a view to facilitating fast relief.

Forms of cooperation and respective responsibilities, depending on available resources, should be defined. In addition, **it is important to overcome the "two times" logic (first aid interventions initially, followed by special interventions), by trying to include the rights and needs of people with disabilities within ordinary interventions**. That means taking a mainstreaming approach and identifying actions targeted at the whole population involved in the disaster, including people with disabilities, starting from first aid.

[22] CRPD, art. 4, third subparagraph: *"*In the development and implementation of legislation and policies to implement the present Convention, and in other decision-making processes concerning issues relating to persons with disabilities, States Parties shall closely consult with and actively involve persons with disabilities, including children with disabilities, through their representative organizations".

Besides mainstreaming actions, **programmes specifically targeting people with disabilities** should be established, granting human and financial resources to protect beneficiaries and promote their rights. In particular, specific activities should be directed towards vocational training, employment support, inclusive education, awareness and the removal of all discriminations that limit the human rights of people with disabilities.

To facilitate the **phase of first aid and emergency**, it is important to prevent and manage risk, by creating accessible warning systems (in order to reach all people quickly, including those with disabilities), mapping the presence of people with disabilities, adjusting procedures and means of evacuation and first aid, planning accessible places and camps, and making services accessible and even dedicated or customised (health care, personal assistants, medication, diets, etc.).

Post emergency programmes should be based on the model of **Community Based Rehabilitation (CBR)**[23]. In other words, community resources should be activated, because they are a fundamental support to ensure a rapid and effective response, as well as to strengthen resilience to disasters. Indeed, local communities have enough information, skills, expertise and human resources to face the problems resulting from a disaster. The model of "Community Based Rehabilitation" or "Community Based Inclusive Development" is an appropriate response to activate hard-hit communities, both in emergency locations and in refugee camps for displaced people.

3.1.2. Staff training

Staff training for first aid is essential. Firstly, **managers of humanitarian aid should be trained** to ensure adequate responses to the needs of people with disabilities. Secondly, **ongoing training plans for all staff** should be defined, in cooperation with organisations for people with disabilities. Practical and theoretical training must become part of general training for aid workers.

3.1.3. Adjustment of equipment and means

It is crucial to adapt **equipment and means to ensure proper responses**, which should always be carried out in close coordination with organisations for people with disabilities and their experts. Along with tools to handle emergency situations (aids, communication tools) and health and social services for children, it is necessary to provide means of evacuation (transport provided with scissor lifts, mobile ramps), flexible solutions to make camps and shelters accessible (with ramps and moving walkways,

[23] http://www.who.int/disabilities/cbr/guidelines/en/

accessible toilets, beds for specific needs), equipment for special diets (diabetic, coeliac), and tools for inclusion in community and educational activities.

3.1.4. Statistics

An important area of focus is **census** of people with disabilities and identification of their needs, including the collection of disaggregated data. Scant information and data are available about people with disabilities involved in situations of natural and/or man-made disasters. Up to now, data on disability (whether the disability is a pre-existing condition, or a result of the disaster) has been not included in data collection relating to humanitarian aid. According to the conclusions of the UN World Conference on Disaster Risk Reduction (Sendai, 2015), it is vital to identify and disseminate "**disaggregated data, including by sex, age and disability**, as well as on the easily accessible, up-to-date, comprehensible, science-based, non-sensitive risk information, complemented by traditional knowledge"[24]. Statistical sheets should therefore be able to identify and map the presence of people with disabilities, reporting—besides population records—the type of disability, specific needs linked to operational diversity, and necessary services and interventions. The mapping work must take into account any cultural barriers, preventing identification of disability. Collected data must be included in the planning and monitoring of humanitarian aid programmes.

3.1.5. Establishment of an operating unit and of a working group

The central and local establishment of a **focal point on** disability is strongly recommended, in order to mainstream the issue of disability within humanitarian aid programmes and to manage specific actions for people with disabilities. The focal point will benefit from the cooperation and expertise of people with disabilities, experts, institutions and organisations. It will be also useful to put such skills together into a **working group**, in which people with disabilities will be involved in decision-making processes. Specific awareness campaigns should also be promoted among public and private institutions, in order to identify and train stakeholders.

[24] *Sendai Framework for Disaster Risk Reduction* 2015-2030, Art. 19: *"Disaster risk reduction requires a multi-hazard approach and inclusive risk-informed decision-making based on the open exchange and dissemination of disaggregated data, including by sex, age and disability, as well as on the easily accessible, up-to-date, comprehensible, science-based, non-sensitive risk information, complemented by traditional knowledge".*

3.2. Differentiation within disability conditions

Within the group of people with disabilities there are many differences. Indeed, in addition to the condition of sensory, mental and intellectual disability, they are involved—to varying degrees—in processes of impoverishment, and have therefore acquired different resilience tools. Moreover, the context of life and relationships can positively or negatively influence their ability to participate. Having said that, appropriate behaviours should be defined for different conditions of disability, to make people with disabilities feel welcome and adequately treated.

3.2.1. Intellectual and relational disability

People with intellectual and relational disabilities are an extremely diverse group. In general, these people do not perceive danger and not always correctly read warning signs and signals. A large proportion of people with intellectual disabilities better understand a simplified language, with short sentences and simple words that describe one action at a time and provide the information necessary to help them. Such people are emotionally impressionable and so it is important that operators maintain a calm and soft-spoken demeanour. Relatives or familiar acquaintances facilitate both communication and willingness to cooperate.

The above considerations should especially be born in mind when communicating with people with autism spectrum disorders who have difficulty in terms of communication skills and social interaction.

3.2.2. Physical disability

People with physical disabilities also present different conditions. For example, they can have mild walking difficulty, or the need to make use of mobility aids such as crutches, canes, walkers or wheelchairs, or the inability to move independently, being dependent on electric mobility devices, stretchers or other complex systems of mobility. If they were not injured in the disaster, in triage they must be assisted at the same time as fully able citizens, encouraging their mobility through accompaniment. The possibility of being carried in the arms should be considered only in case of imminent danger. It is also good practice to ensure that the assisted person can keep using their own mobility aid, which—being customised—is often irreplaceable with other similar aids. Wheelchair users should be evacuated with suitable means and accommodated in accessible facilities that guarantee their mobility, especially in as regards sanitation. If accommodated in tents, the camp should be designed so that such people are in tents next to services (toilets, canteens, infirmary) so as to ensure accessibility.

3.2.3. Psychosocial disability

People with psychosocial disabilities often do not live in the community, because they are left alone or are accommodated in dedicated facilities such as psychiatric hospitals or asylums. In this case, interventions should be coordinated with the staff of the facility concerned. Of course, the specific condition will be unique in every case and requires special care and attention in the communication and in the relationship, also in consideration of the fact that the crisis will have exacerbated already problematic behavioural situations. Evacuation and subsequent aid should, if possible, involve the care staff formerly responsible for the person in question. Temporary shelter must be designed with expert staff.

3.2.4. Sensory disability

In emergencies, communication with deaf people should be adjusted to different contexts of intervention. With regards to alerts in dangerous situations, deaf people can be informed via their mobile phone. To do so requires the adoption, in collaboration with representative organisations for people with sensory disabilities, of early warning systems conveyed through mobile phones, which are already used in some contexts. During rescue, if possible, it is important to talk to deaf people, always looking at them, at a distance of no further than one and a half meters, in order to facilitate lip-reading in their mother tongue. The alternative is to be assisted by local staff. When communicating, it is helpful to use facial expressions to emphasise the most important elements of speech and to pronounce words correctly and at moderate speed. It will be also useful to ensure that the response force includes an interpreter of the national sign language.

In many developing countries, blind people are assisted by children, who are adept at fulfilling a guidance and support role. When dealing with blind people, it is important to tell them that you are present and to describe the situation that they are in, communicating the kind of help to be implemented and acquiring their consent. Blind people must be able to freely choose whether to be taken under the arm or to lean on a shoulder, while being kept informed about the type of flooring or obstacles along the way. Moreover, blind people must never be left alone and must always be entrusted to someone who remains close and can reassure them. In case of temporary shelter, a reference person should be ensured and a clear description of spaces and services in the collection centre should be offered, with a guided tour of spaces and services available.

3.3. Risk management and disability

Even in terms of risk management, it is essential to take into account the needs of people with disabilities, consulting relevant experts and organisations. This principle is reaffirmed by the conclusions of the UN Conference on Disaster Risk Reduction (Sendai, 2015). The conclusions state that "people with disabilities and their organisations are critical in the assessment of disaster risk and in designing and implementing plans tailored to specific requirements, taking into consideration, inter alia, the principles of universal design". The document underlines the need to "strengthen **women and people with disabilities** to lead publicly and promote a response based on gender equality and **universal accessibility**, having as a key approach to recovery, rehabilitation and reconstruction". The same suggestions are included in the Conclusions of the EU Council for the Inclusion of Disability in Disaster Management, approved on 25 February 2015 and supported by Italy.

The principle ideal is to establish coordination between the project managers and organisations for people with disabilities and their experts in the field of emergency. This coordination is aimed at defining (and/or updating) prevention, mitigation and response plans in an emergency, taking into account the needs of people with disabilities, in respect of their rights and requirements. Specific agreements can also be drawn up to allow the rapid activation of partnerships with experts in the field, ensuring the exchange of information, the identification of priorities in which action is needed, the use of materials and appropriate solutions.

Chapter 4. Experiences and good practices

Around the world there are experiences in which people with disabilities have been included in humanitarian aid programmes. These interventions took into account the cultural and material contexts in which they were implemented, finding useful and workable solutions to address the rights and needs of people with disabilities. That is why we speak of appropriate practices that, in order to be replicated in other contexts, require compliance with the cultural, social, political and technical elements of the specific situation. The following list provides a number of concrete examples that could inspire other similar experiences and encourage public and private stakeholders in humanitarian projects to respond appropriately to this new group of beneficiaries, namely people with disabilities.

4.1. Skill enhancement for people with disabilities

Italian Cooperation and AVSI in Jordan (2012/2013). Italian Cooperation has funded humanitarian aid programmes for a number of years, addressing Palestinians in refugee camps in Jordan, including people with disabilities. Besides physical rehabilitation and physiotherapy staff training activities at the Centre for People with Disabilities in Jerash refugee camp, interventions have been implemented in support of young people with mild physical and mental disabilities, aimed at generating income and getting them into the labour market.

In particular, a mosaic workshop was created, resulting in the creation of craft products that are highly appreciated in national exhibitions and local markets.

Moreover, the carpentry workshop of the camp's Centre for People with Disabilities was re-enabled and supported by training activities. The workshop, which is still active in training and woodworking, produces toys, furniture for schools, doors and window frames. In this way, it is possible to generate income for people with disabilities employed in carpentry, as well as income for the sustainability of the centre itself, which conducts physiotherapy activities, besides training.

Italian Cooperation and EducAid RIDS in Palestine (2015/2016). The Peer Resilience project aims to improve the resilience of the Palestinian population of the Gaza Strip in emergency situations, such as the recent military operation Protective Edge. It takes action to deal with physical and psychological trauma affecting people with disabilities during and after disasters, with particular attention to people who acquire a disability as a result of catastrophic events. In addition to psychological support and health care for people with disabilities arising from the conflict, the intervention will train ten peer counsellors with disabilities to deal with problems in emergency situations and to create a support office for people with disabilities in the Gaza Strip. This project is particularly innovative because it enables people with disabilities to react positively to their new psychophysical condition, developing useful skills for employment and gaining a significant role in the community.

4.2. Mainstreaming

Italian Cooperation and AVSI in Jordan (2013/2014). As part of programmes addressing Syrian refugees in Jordan, and together with the Italian NGO AVSI, Italian Cooperation carried out projects which—besides providing medical and psychosocial support—paid particular attention to inclusion. They include the creation of accessible play areas that were designed to be used by children with disabilities and which were equipped with specific protective barriers, artificial grass carpeting and steel structures with plastic coatings for the safety of children with disabilities.

4.3. Involvement of people with disabilities and establishment of working groups

Italian Cooperation and AISPO in Palestine (2013-2014). In Palestine, in conjunction with the NGO AISPO, Italian Cooperation implemented a project for the social protection of children with disabilities, victims of violence or those suffering from **post-traumatic stress** disorder (PTSD). The AISPO project introduced the programme MOVE (Mobility Opportunity Via Education — MOVE for learning and life), which was designed to develop individual autonomy, mobility and learning ability. This development

takes place using minimum technology and maximum participation of family members, social workers and teachers of children with severe and multiple disabilities.

Together with parents, the programme establishes autonomy targets: being able to sit, to stand and, if possible, to try and walk. The activities were implemented in close coordination with local authorities and the ASSWAT network, made up of relatives of children with disabilities, in addition to a coordination group of community and representative organisations for people with disabilities. The broad community and institutional involvement—especially in the field of education—has been especially crucial for outreach and information activities on the rights of people and children with disabilities, and the prevention and diagnosis of abuses.

CBM in the Philippines (2013). The NGO CBM has a specific unit (Inclusive Emergency Response Unit – IERU) that intervenes in humanitarian emergencies, with a focus on people with disabilities, and actively engaging local associations for people with disabilities. In the Philippines, ADPI (Association of People with Disabilities) was involved as a local partner, planning and coordinating the distribution of aid within the "Aging and Disability Focal Points" (ADFPs) programme. ADPI also dealt with the mainstreaming of people with disabilities in first aid intervention. This intervention has been replicated in other disaster-affected areas (Nepal, Madagascar, Malawi and Pakistan).

4.4. Statistics and dissemination of information

Italian Cooperation and AISPO in Iraq (2014-2015). In Iraq, Italian Cooperation and the NGO AISPO started a programme of assistance to displaced people and Syrian refugees in the Autonomous Region of Kurdistan. The project, adopting a community- and human rights-based approach of mainstreaming, aims to enhance assistance services for the most vulnerable people, including those with disabilities, housed in the

Domiz and in IDP Khankhe camps. To this end, a questionnaire was prepared to map the needs of the target group, as part of a tent-to-tent survey conducted by health and social community-based workers (refugees and displaced people) to identify people with disabilities and chronic diseases, according to international standards. The analysed data was included in a report that provides all field workers (local authorities, UN agencies and NGOs) with the necessary data and useful suggestions for strategic planning of interventions targeting vulnerable groups. This data also forms the basis for the design of a new and broader intervention of the Italian Cooperation for the period 2015/2016.

Technical University of Marche (2015). The Technical University of Marche developed a Vademecum entitled Disability and Emergency Management, which identifies vital information to assist people with disabilities in emergency situations, with particular attention for those who attend university, especially students.

4.5. Staff training

Italian Cooperation and AIFO in Indonesia (2005-2006). Following the Indian Ocean tsunami in 2004, the Disability and Emergency project, implemented in conjunction with local authorities and national organisations for people with disabilities, helped to strengthen the health and social care system in Aceh Nad Province with regards to disability. It also aimed to improve staff technical capacities in central and district health systems, as well as in health centres. In addition to data collection, training and awareness-raising activities were carried out for health personnel and local officials. Moreover, people with disabilities and their families were supported through targeted interventions, and representative organisations for people with disabilities were empowered. The project, which was later extended to other areas of Indonesia, adopted a community-based rehabilitation approach, involving the entire community as a valuable network of mutual support.

4.6. Adjustment of equipment and means

Italian Cooperation and ICU in Jordan (2014-2015). The project, carried out by the NGO ICU in Jordan as

part of humanitarian aid programmes financed by Italian Cooperation, was entirely dedicated to the assistance to amputee adults and children in two centres set up specifically in the governorates of Irbid and Amman. The project included the supply, installation and adaptation of prosthetic limbs, a programme of physiotherapy rehabilitation and psychological support for assisted amputees. In addition, it also led to the creation and equipping of two prosthesis centres, one of them stationary and the other one mobile, as well as intensive ongoing training for three physiotherapists and two psychologists in the rehabilitation centres. Finally, next winter a multidisciplinary non-competitive sports event organised for people with disabilities will take place in Amman. The activities will also continue during the period 2015/2016, thanks to funding from a new project that is a continuation of the former intervention.

Italian Cooperation and CISS in Palestine (2013-2014).

The project, developed in the Gaza Strip, supported children affected by Post Traumatic Stress Syndrome (PTSD) resulting from the loss and/or destruction of their home, or the death and/or wounding of family members. The project enhanced services of psychosocial, educational and psychological support in children's play centres, hospitals and in the home. The project included the provision of staff training as well as the creation of children's play centres—safe spaces to receive recreational and educational activities, and also for therapies—and a mobile clinic for home medical visits.

Attachment 1. Glossary

Accessibility and Universal Design: in order to ensure equal opportunities, it is necessary to remove barriers and obstacles that prevent full participation in society and access to goods and services. Accessibility means that everyone should have access to "different societies and environments, to services, activities, information and documentation" (Standard Rules). As the experience of disability belongs to mankind, society must design and programme all of its activities and policies to include all citizens. The universal design approach makes it possible to take into account the characteristics of all the people of a community and of a nation. Universal design means the design of products, environments, programmes and services that can be used by all people, to the greatest extent, without the need for adjustment or specialised designs. Universal design does not exclude assistive devices for particular groups of people with disabilities, where needed.

Humanitarian aid: humanitarian activities as a result of catastrophic events, whether man-made or natural, are intended to protect human life, relieve or prevent suffering and preserve human dignity, when local governments and agents are unable or unwilling to assist population. Humanitarian aid also includes interventions aimed at reducing risk of disasters and activities of human and institutional capacity building, to prevent and mitigate the impact of disasters and strengthen the response. These actions of capacity building and institution building are vital to save lives and ensure that communities increase their resilience to emergency.

Disaster: a serious disturbance of the functioning of a community or a society, involving widespread loss and property, economic or environmental damage, which exceeds the capacity of the affected community to cope without aid.

Disability: disability is a social relation between personal characteristics and the major or minor capacity of society to take them into account. Disability is not a personal condition, but depends on environmental and social factors and on individual factors. Disability is a condition that every person experiences during the course of their own life (in childhood, old age and in different situations) and belongs to all mankind. Disability is an evolving concept, related to the cultural and material conditions of each country.

In emergency situations everyone experiences changes of lifestyle, environment and social behaviours. As a result, the number of people with disabilities increases and means of accessibility are often destroyed.

Human diversity: the condition of disability is an experience that all human beings have undergone, are undergoing and will undergo. It is therefore important to regard disability as one of the features of human diversity. The history of negative cultural vision and treatment that some characteristics of human beings have undergone over the centuries has produced a negative social stigma on people with disabilities, thus labelling these features (as well as the people bearing them) with a socially undesirable mark. Hence, regarding disability as one of the many differences that distinguish human beings helps to remove the negative social stigma.

Equal opportunities: being excluded and often segregated, people with disabilities do not enjoy the same freedom of choice and opportunities as other people do. Equal opportunities mean that the needs

of each and every individual are equally important and must be the basis for the planning of societies. Consequently, all resources must be employed in such a way as to ensure that every individual has equal opportunities to participate in society. In emergency situations, solutions should be offered to allow people with disabilities to receive the necessary assistance without any discrimination.

Humanitarian Aid Phases:

> **"relief"** phase, in which the aim is to save lives and limit the exacerbation of the victim's conditions. This phase aims to respond to the basic needs of populations affected by the humanitarian crisis immediately after the event. It requires urgent interventions both through the transport of food, medicines and other basic goods under humanitarian aid programmes, and through the provision of grants to international organisations in response to humanitarian appeals;
>
> **"recovery and rehabilitation"** phase, aimed at ensuring or restoring adequate socio-economic conditions and the safety of people who, despite having received humanitarian aid initially, need additional assistance with rehabilitation, reconstruction or protection due to lasting instability;
>
> **"LRRD – Linking Relief and Rehabilitation to Development"**, designed to gradually replace emergency aid and facilitate the transition to development in the medium and long term.

Social impoverishment and empowerment: disability is a cause and an effect of poverty. The different treatment reserved to people with disabilities has produced a social impoverishment in terms of access to rights, goods and services, which is often associated with and further exacerbated by economic poverty, which ultimately triggers off a negative cycle leading to social exclusion. For this reason, people with disabilities account for almost half the world's poor, given that more than 80% of these people live in economically disadvantaged countries. To break this vicious circle it is necessary to act both by changing society's approach towards people with disabilities, and through individual, social and political empowerment measures. Empowerment means the increase of knowledge and skills, with full participation in decision-making processes in society.

Social inclusion: to transform an excluding and discriminating society, it is necessary to build inclusive societies in which everyone can participate and contribute to social development. **Integration** refers to the adjustment of people with disabilities in society to the rules that are already established by the community that welcomes them. Conversely, **inclusion** is a process that enables included people to have the same opportunities and power to organise society as any other person. Inclusion is a right based on full participation of people with disabilities in all fields of life, on an equal basis to others, without discrimination, respecting human dignity and enhancing human diversity through appropriate interventions, removing barriers and prejudices and supporting mainstreaming.

Multi-discrimination: discrimination affects people on the basis of their characteristics, which are subject to differentiated treatments, prejudices, obstacles and barriers that limit full participation in society. When characteristics related to gender, race, culture, religion, political opinions, age and disability conditions are added together and combined, they produce multiple discriminations that make people with those characteristics more vulnerable. For example, women with disabilities have strongly

limited access to rights, goods and services and social participation.

Non-discrimination: the medical model of disability has spawned different approaches and treatments for people with disabilities compared with other people. In so doing it has led to the development of solutions and actions that impoverish people with disabilities. Each unjustifiably different treatment is, in fact, a violation of human rights. People with disabilities have the right to remain within their local communities and receive the support they need within the ordinary education, health, employment and social services structures. The anti-discrimination laws, which also protect people with disabilities, ban any form of discrimination on the grounds of disability, through a legal basis that provides for the removal of the discriminatory conditions, using reasonable accommodation.

Participation: building of an inclusive society implies that excluded people are the protagonists of the inclusion process, as experts regarding the way that society must treat them. This means that people with disabilities have to be involved, with equal opportunities to other members of society, in the decision-making of all policies, actions and programmes related to them. The participation of people with disabilities and organisations representing them becomes a necessary methodology, based on the right expressed in the slogan "**nothing about us without us**".

Community-based rehabilitation (CBR): community-based rehabilitation is a strategy for promoting and protecting the rights of people with disabilities, through implementation of community-based programmes aimed at rehabilitation, to promote equal opportunities, non-discrimination and social inclusion of all people with disabilities. CBR is implemented through the empowerment of people with disabilities themselves, their families, their organisations and communities, and through appropriate health, educational, professional and social facilities. CBR is evolving towards "community-based inclusive development", a methodology for the sustainable development of communities based on enhancement of their strong points.

Inclusive development: disadvantages and lack of equal opportunities for people with disabilities are caused by mechanisms of discrimination and social exclusion, which the United Nations Convention has made clear. Hence the need to promote inclusive development, which does not produce mechanisms of social and economic impoverishment, but ensures respect for the human rights of all citizens.

Independent life: people with disabilities have the same human rights as all people and must be empowered in the acquisition of autonomy, self-determination, independence and interindependence. The movement for independent life, created in the United States of America in the late 1960s, arose as a result of these demands. It then spread throughout the world, defining its own philosophy and solutions, such as centres for independent life and assistance.

Attachment 2. Performance indicators

The World Conference on Disaster Risk Reduction (Sendai, 14-18 March 2015) underlined the need to include, among indicators linked to natural and human disaster situations, indicators linked to recognising the impact of such events on the status of people with disabilities, with appropriately disaggregated data.
Nowadays, there is no standard indicator accepted by the UN or by the European Union and this issue is still under discussion internationally.
It is hoped in this respect:

- ✓ inclusion in the OECD-DAC classification of items about projects addressed or that include people with disabilities, in order to have an international survey on the incidence of this target on total emergency funding;
- ✓ collecting and processing—in any disaster situation that involves humanitarian aid—data and statistics on people with disabilities involved in catastrophic events, on the number of people involved and the people who acquire an operational limitation, on the number of deaths, on the amount/quality of aid provided and on the type of actions and services provided. This data should be disaggregated according to type of disability, age, gender and any other relevant information to properly describe the area of disability;
- ✓ collecting and processing of positive relief and post-emergency assistance methods, indicating whether they are shared in mainstreaming methods.
- ✓ description of problems emerged during the interventions.

The above information, collected in periodic reports, will gradually provide the essential elements to define international standard indicators for all emergency situations and disasters.

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