Looking with a disability lens at the disaster caused by the Tsunami in South-East Asia

Based on document by CBM International, Ms Barbara Oosters, International Advocacy Officer/EU Liaison Officer

1. Disability in an emergency situation: why bother?[1]

1.1 Disability and emergency relief work

In any crisis, disabled people are likely to feel the negative impact of the crisis more keenly than other citizens. Their ability to cope and survive may be completely dependent on others, and the capacity of any family to support its disabled members is keenly tested in a crisis. Anecdotal evidence from acute emergencies suggests that disabled people suffer particularly high rates of mortality and morbidity. In addition to those who were disabled before the onset of the crisis, many more become disabled as a result of a range of factors:

- Poor medical care;
- Interruption of preventive health care programmes;
- Within displaced and refugee populations, disabled people are frequently abandoned and left behind
- People with impaired mobility who are able to flee may be subsequently become more dependent because wheelchairs and other aids were left behind
- Disabled people tend to be invisible to emergency registration systems. They are frequently left unregistered, which means that they fail to receive their basic entitlements to food, water and clothing and their specific needs are not met either.
- Frequently the breakdown of support structures within a disaster affected population endangers the position of disabled people. They may lose their ability to function independently and within their dignity.

Although the effect of the emergency is felt even stronger by disabled people and their relatives, the exclusion of PWDs in emergency situation is even stronger than in 'normal' situations.

It cannot be assumed that general distributions to the affected population will automatically reach the disabled members of that population, or that disabled people in a refugee camp will automatically have equitable access to whatever water is available. There are many reasons why disabled people are excluded, and unless agencies take specific actions, things will not change. Common reasons why disabled people fail to receive their entitlements include the following:

[1] Information for this chapter is taken from the training manual: *Disability, Equality and human rights: a training manual for development and humanitarian organisations*, Harris, A. and Enfield, S., Oxfam publication, Great-Britain, 2003.

- they are hidden by their families;

- they may not know there is a distribution because they cannot attend community meetings or cannot hear radio announcements and no provision has been made to inform them in any alternative way about their entitlements and available services;

- problems of access may be aggravated by poor terrain or lack of mobility aids, or (for people with impaired sight) assistance with orientation;

- emotional distress and or mental illness, often caused by the trauma of the crisis is another reason why people are prevented from gaining access to relief distribution for themselves and their families;

- disabled people and their families may not consider themselves to be capable of participating in micro-enterprises programmes.

1.2. Disability and the post-crisis reconstruction phase

Major reconstruction often follows emergency relief work, but planners often miss the opportunities to avoid recreating the inequitable status quo by adapting the design of the built environment to meet the needs of disabled people. For example, if schools are not rebuilt in a way that allows disabled children (both those who were previously disabled and the newly disabled) to attend school, this sends a damaging message to the disabled child and places limitations on his or her entire life. The long-term costs are high, since a disabled child who is prevented from going to school is far les likely to find employment and contribute directly to the national or local economy and will thus require lifetime assistance from the state or his or her family.

It is far more cost-effective to modify the plans for a new building at the outset than to adapt an existing building retrospectively to make it accessible. Depending on the type of building, providing full access facilities from the outset costs an average additional 1.12 per cent.

In the massive reconstruction efforts in Honduras after Hurricane Mitch not one foreign donor stipulated that accessibility codes be applied, although this would have required little or no additional cost. As a result, whole towns, including schools, were rebuilt with barriers to disabled people.

2. How to include disabled people in emergency plans? Some guidelines

Most of the following guidelines are based on a code of minimum standards set forth in the Sphere Project: Humanitarian Charter and Minimum Standards in Disaster-response.[2]

2.1. General guidelines:

- **Human-rights framework:** emergency responses must be set firmly within a human-rights framework, demonstrating a commitment to ensuring equitable and inclusive service delivery.

- **Main needs of disabled person are the same as anyone else**: many of the items that disabled people need in emergencies are no different from other peoples needs, but it is important to bear in mind that they might need some specific utilities. For example: it can be harder for people with physical impairments to keep warm, due to lack of movement and poor circulation, so they may have increased need for warm clothing, blankets, firewood. Enabling aids (hearing-aids and batteries; crutches etc.) should be provided.

- **Cross cutting issue: Disabled people –** In any disaster, disabled people – who can be defined as those who have physical, sensory or emotional impairments or learning difficulties that make it more difficult for them to use standard disaster support services – are particularly vulnerable. To survive a period of dislocation and displacement, they need standard facilities to be as accessible for their needs as possible. They also need an enabling social support network, which is usually provided by the family.

- **Prioritisation of disability issues is also a responsibility of donors**. Donors could require a disability analysis, as many now incorporate a gender perspective, as a condition for contracts. There is a particularly strong case for this to happen in the reconstruction phase after an emergency, since there is an opportunity for equal access facilities to be integrated from the very beginning, for example in the reconstruction of public buildings.
- **Representation**: the participation of disaster-affected people in decision-making throughout the project cycle (assessment, design, implementation, monitoring and evaluation) helps to ensure that programmes are equitable and effective. Special effort should be made to ensure the participation of a balanced representation of people within the assistance programme, including disabled people.

- **Communication and transparency*:*** the sharing of information and knowledge among all those involved is fundamental to achieving a better understanding of the problem and to providing coordinated assistance. The results of assessments should be actively communicated to all concerned organisations and individuals. Mechanisms should be established to allow people to comment on the programme e.g. by means of public meetings or

[2] www.sphereproject.org

via community-based organisations. For individuals who are homebound or disabled, specific outreach programmes may be required.

- **Train volunteers and agencies ahead of time**: It is commonplace in post-disaster situation for many services to be dispensed by volunteers. It is therefore important, where feasible, to train volunteers ahead of time in the basics of dealing with their fellow residents with disabilities.

2.2. Water, sanitation and hygiene promotion

- **Water and Sanitation Initial Needs Assessment Checklist**: How many people are affected and where are they? Disaggregate the data as far as possible by sex, age, disability etc.

- **Access and water quantity**: even if a sufficient quantity of water is available to meet minimum needs, additional measures may be needed to ensure that access is equitable for all groups. Some handpumps and water carrying containers may need to be designed or adapted for use by people living with HIV/AIDS, older and disabled people and children. All users should be fully informed of when and where water is available.

- **Water collection and storage*:*** people need vessels to collect water, to store it and to use it for washing, cooking and bathing. Children, disabled people, older people may need smaller or specially designed water carrying containers.

  Communal washing and bathing facilities: The numbers, location, design, safety, appropriateness and convenience of facilities should be decided in consultation with the users, particularly women, adolescent girls and any disabled people. The location of facilities in central, accessible and well-lit areas can contribute to ensuring the safety of users.

- **Excreta disposal: design, construction and use of toilets:**
  - **Indicators**: Toilets are designed, built and located to have the following features: they are designed in such a way that they can be used by all sections of the population, including children, older people, pregnant women and physically and mentally disabled people.
  - **Acceptable facilities*:*** successful excreta disposal programmes are based on an understanding of people's varied needs as well as on the participation of the users. It may not be possible to make all toilets acceptable to all groups and special toilets may need to be constructed for children, older people and disabled people e.g. potties, or toilets with lower seats or hand rails. The type of toilet constructed should depend on the preferences and cultural habits of the intended users, the existing infrastructure, the ready availability of water (for flushing and water seals), ground conditions and the availability of construction materials

2.3. Food security, nutrition and food aid

- **Food security: coverage, access and acceptability:** restricted physical access, may limit the participation of women, people with disabilities and older people. Overcoming these constraints involves identifying activities that are

within the capacity of these groups or setting up appropriate support structures.

- **General nutrition support: at-risk groups**
  - **Key indicators**: Families with chronically ill members, including people living with HIV/AIDS, and members with specific disabilities have access to appropriate nutritious food and adequate nutritional support; Community-based systems are in place to ensure appropriate care of people with disabilities.
  - **Disabled people** may face a range of nutritional risks which can be further exacerbated by the environment in which they are living. Nutritional risks include difficulties in chewing and swallowing, leading to reduced food intake and choking; inappropriate position/posture when feeding; reduced mobility affecting food access and access to sunlight (affecting vitamin D status); discrimination affecting food access; and constipation, particularly affecting individuals with cerebral palsy. Disabled individuals may be at particular risk of being separated from immediate family members (and usual care givers) in a disaster. Efforts should be made to determine and reduce these risks by ensuring physical access to food (including relief food), developing mechanisms for feeding support (e.g. provision of spoons and straws, developing systems for home visiting or outreach) and access to energy-dense foods.
  - **Community-based care*:*** care givers and those they are caring for may have specific nutritional needs: e.g. they may have a greater need to maintain hygienic practices which may be compromised; they may have fewer assets to exchange for food due to the costs of treatment or funerals; and they may face social stigma and reduced access to community support mechanisms. The availability of care givers may have changed as a consequence of the disaster e.g. due to family break-up or death, children and older people can become the main care givers. It is important that care givers be supported and not undermined; this includes feeding, hygiene, health and psychosocial support and protection. Existing social networks can be used to provide training to selected community members to take on responsibilities in these areas.

- **Malnutrition**
  - **Admission criteria:** individuals other than those who meet anthropometric criteria defining malnutrition may also benefit from supplementary feeding e.g. people living with HIV/AIDS or TB or those who have a disability. Monitoring systems will need to be adjusted if these individuals are included. In situations where emergency feeding programmes are overwhelmed with the numbers of individuals eligible for treatment, this may not be the best way to address the needs of these individuals, who will also remain at risk beyond the duration of the disaster. It may be better to identify alternative mechanisms for providing longer-term nutritional support e.g. through community home-based support.

- **Food aid management**
  - **Food handling**: although not an exhaustive list, those who require assistance with feeding usually include young children, older people, disabled people and people living with HIV/AIDS.

- **Food aid management, targeted distribution**: food aid should be targeted to meet the needs of the most vulnerable in the community, without discrimination on the basis of gender, disability, religious or ethnic background, etc
- **Food aid management, minimising security risks***:* food is a valuable commodity and its distribution can create security risks, including both the risk of diversion and the potential for violence. When food is in short supply, tensions can run high when deliveries are made. Women, children, elderly people and people with disabilities may be unable to obtain their entitlement, or may have it taken from them by force. The risks must be assessed in advance and steps taken to minimise them. These should include adequate supervision of distributions and guarding of distribution points, including the involvement of local police where appropriate.

- **Measuring Acute Malnutrition**: no guidelines currently exist for the measurement of individuals with physical disabilities and thus they are often excluded from anthropometric surveys. Visual assessment is necessary. MUAC measurements may be misleading in cases where upper arm muscle might build up to aid mobility. There are alternatives to standard measures of height, including length, arm span, demi-span or lower leg length. It is necessary to consult the latest research findings to determine the most appropriate way of measuring disabled individuals for whom standard weight, height and MUAC measurement is not appropriate.

2.4. Shelter and settlement:

- **Minimal accessibility needs**: Shelters must meet minimal accessibility levels so that all members of a community can find safety

- **Participation of affected households:** maximise opportunities for participation during construction, particularly for individuals lacking the required building skills or experience. Complementary contributions from those less able to undertake physically or technically demanding tasks can include site monitoring and inventory control, the provision of child care or temporary accommodation and catering for those engaged in construction works, and administrative support. Women with disabilities are particularly at risk from sexual exploitation in seeking assistance for the construction of their shelter.

- **Clothing and bedding**: additional changes of clothing should be provided where possible to people with incontinence problems, people with HIV/AIDS and associated diarrhoea, pregnant and lactating women, older people, disabled people and others with impaired mobility. Given their lack of mobility, older people and disabled people, including individuals with HIV/AIDS, may also require particular attention, such as the provision of mattresses.

- **Personal hygiene:** additional quantities of bathing and laundry soap should be provided where possible to people with incontinence problems, people with HIV/AIDS and associated diarrhoea, and older people, disabled people or others with impaired mobility.

- **Cooking and eating utensils: Appropriateness:** items provided should be culturally appropriate and enable safe practices to be followed. Cooking and eating utensils and water collection vessels should be sized to suit older people, people with disabilities and children as required.

2.5. Health services

- **Utilisation rate of health services:** attendance at health facilities will help to determine the utilisation rate. In analysing utilisation rates, consideration should also be given to gender, age, ethnic origin and disability, to ensure that vulnerable groups are not under-represented

- **Control of non-communicable diseases: mental and social aspects of health**
  - **Key social intervention indicators:** During the acute disaster phase, the emphasis should be on social interventions. All people, including disabled people, have access to an ongoing, reliable flow of credible information on the disaster and associated relief efforts; As soon as resources permit, all children, including disabled children, have access to formal or informal schooling and to normal recreational activities; all adults and adolescents are able to participate in concrete, purposeful, common interest activities, such as emergency relief activities.
  - **Key psychological and psychiatric intervention indicators**: Individuals experiencing acute mental distress after exposure to traumatic stressors have access to psychological first aid at health service facilities and in the community; Individuals with pre-existing psychiatric disorders continue to receive relevant treatment, and harmful, sudden discontinuation of medications is avoided.
  - **Information:** access to information is not only a human right but it also reduces unnecessary public anxiety and distress. Information should be provided on the nature and scale of the disaster and on efforts to establish physical safety for the population. Moreover, the population, including disabled people, should be informed on the specific types of relief activities being undertaken by the government, local authorities and aid organisations, and their location.

To conclude: By including disability as a factor in assessments and using a variety of approaches to ensure that all people can obtain the relief to which they are entitled, it is possible to ensure that disabled people are included. This will lead to fuller, more effective compliance with the mandates and the humanitarian obligations of every relief and development agency.