UNDP Discussion Paper on the Convention on the Rights of Persons with Disabilities (CRPD) and its Implication in Crisis Prevention and Recovery

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Please note that this paper is the intermediate version, not the final, because we still try to include comments from disability specialists from UN agencies and other institutions who kindly shared their opinions on our first version.

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1. Executive Summary

This discussion paper aims to provide a *crisis prevention and recovery (CPR) responsive analysis* of the Convention on the Rights of Persons with Disabilities\(^1\), with a specific focus on gender. It tries therefore to look at both *preparedness and response* to disability issues in crisis situations.

While it offers a view derived from victim assistance in mine action, it discusses the possible transformation of this one area of intervention to a more sustainable and comprehensive CPR approach for persons with *physical, sensory and mental disabilities* caused by *landmines/ERW* (explosive remnants of war), *SALW* (small arms and light weapons) and *(sexual) violence* in conflict and in post-conflict situations, and also considers the implications of the Convention for people disabled by *natural disasters*.

It is important to note that the *early recovery* period is an opportunity to bring changes and adapt holistic approaches that include persons with disabilities. Particularly, there is a need to address accessibility issues in early recovery planning processes, by adopting “*Building back better policies*”.

Disability is one of the key *cross-cutting issues* in crisis prevention and recovery including gender, HIV/AIDS and environment.

The paper is designed to support *assessment and programming* activities to be implemented on behalf of persons with disabilities in crisis situations.

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\(^1\) In this paper we often use the term “Disability Convention”, than “the Convention on the Rights of Persons with Disabilities”. 
2. Persons with Disabilities

In the Disability Convention, the term “persons with disabilities” is used, rather than “disabled persons”. The former “recognises people before disabilities”\(^2\).

According to the Disability Convention, the definition of persons with disabilities is “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” (Article 1). This can include a variety of impairments such as hearing, seeing, learning, mental, or psychosocial impairments, as well as other physical impairments. It also means that the range of disability causes is extremely wide. However, what unites them is the outcome - exclusion or restriction on the basis of disability and the inability to execute their individual rights as citizens of their countries.\(^3\)

**Vulnerability of Persons with Disabilities in Crisis Situations**\(^4\)

In any crisis, disabled people are likely to feel the negative impact of the crisis more keenly than other citizens, and their ability to cope and survive may be completely dependent on others.\(^5\) People with disabilities tend to be overlooked in relief operations and response activities, and those who are not directly injured by the crisis are forgotten and left aside. People with disabilities living in refugee or IDP situations may be even less visible.

In addition, vulnerabilities of disabled people differ greatly depending on their:
- Sex;
- Age;
- Location (rural or urban); and
- Level of poverty

There are a number of factors that make people with disabilities more vulnerable than others in a crisis situation.

**Invisibility: Sources of Marginalisation**

A fundamental problem for most persons with disabilities is that they are not able to leave their homes, nor to participate in key settings such as schools, employment, and normal social life. This invisibility in turn leads to a massive underestimation of their numbers to little sensitivity to their needs and abilities, and to inadequate actions to address these constraints. Invisibility has also led to a marked lack of political power for this group, despite their substantial numbers.\(^6\)

In particular, 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.\(^7\)

\(^4\) Most of information in this sub-section is taken from: WHO/ILO/UNESCO (2007), *CBR Guidelines: CBR and Crisis Situations*, which is still in a review process.
\(^7\) Oosters, Barbara (2005), *op. cit.*, p. 1.
Lack of Awareness

People with disabilities and their families often lack awareness and information about crisis situations. This can prevent them from anticipating and/or comprehending the crisis and its consequences. Deaf people for example complain that they did not have information about critical events happening in their communities.

Lack of Access to Services

It is generally observed that access issues are not the same in urban and rural areas. People with disabilities living in rural areas are likely to have more difficulties in having access to even basic services.

Because of inadequate physical accessibility, loss of mobility aids or personal assistants or communication difficulties, people with disabilities are often deprived from rescue and evacuation services, safe location or adequate shelter, water and sanitation and other relief services. During armed conflicts, attempting to reach a school, clinic or hospital can take many hours, require expensive transportation, and/or involve crossing rough roads and mountainous passes. For people with wheelchairs or crutches or limited sight, this can create insurmountable problems.

Economic Vulnerability

Given the high rates of unemployment in most countries affected by or recovering from conflict, and because they often face obstacles to mobility, people with disabilities are particularly disadvantaged in finding work. This economic vulnerability of people with disabilities and their families severely influence their quality of life for a long time.

Mental Health Risks

Due to the crisis itself or to the loss of family members and assets, the population suffers from anxiety, fear, panic, confusion, frustration and depression. Emotional distress and trauma may affect people with disabilities more severely than others and can have potential long-term consequences.

Changing Priorities

Priorities of families and communities change as a result of the crisis. Even in situations where positive changes in attitude toward disability have taken place earlier, people with disabilities become a lower priority. The family’s limited resources might not reach the person with disability. Provision/acquisition of assistive devices and medications, schooling, and transport are the areas that suffer most.

Increased Discrimination

In crisis situations, recognition of the rights of people with disabilities deteriorates. They often become more marginalised than usual, and families have less time and resources for them. Sometimes people with disabilities are used and abused to access more relief items.
Differential Needs of Persons with Disabilities

Within people with disabilities, people have specific needs depending on their age, gender and impairment. Failure to recognise these differing needs can result in lack of vital assistance and their further marginalisation.

People with Sensory Impairments (Communication Disability)

People with visual or hearing impairments may have difficulties noticing warning signals and quick evacuation routes during a disaster situation. They may have difficulties in understanding how to access relief assistance. The physical changes in the environment will make difficult for people with visual impairment to find their ways, resulting in a decrease in their autonomy. There should be appropriate alarm systems and security measures along with personnel assistance to help them to move around and access mainstream services.

People with Physical Impairments (Locomotion Disability)

People with mobility limitations might have difficulties in keeping themselves warm due to lack of movement and poor circulation. They need warm clothing, blankets or firewood. They may also need assistance in evacuating an unsafe terrain, accessing relief shelters and using latrines. Physical assistance, assistive devices and installation of ramps are necessary to ensure they are not disadvantaged or trapped in a dangerous situation.

People with Intellectual Impairments (Mentally-related Disability)

People with intellectual impairments may find it difficult to understand and act on instructions. It is important to provide relevant information in a manner which they can understand, such as using simple language or pictures, or speaking very slowly and clearly.

Women and Girls with Disabilities

Article 6 (Women with disabilities) stipulates that “States Parties recognise that women and girls with disabilities are subject to multiple discrimination, and in this regard shall take measures to ensure the full and equal enjoyment by them of all human rights and fundamental freedoms”.

The consequences of disabilities are particularly severe for women and girls with disabilities who are also subject to social, cultural, economic and political disadvantages due to gender discrimination. Girls and women with disabilities are left marginalised, neglected and are often considered a burden.

Moreover, a woman may become disabled due to an abuse of her rights. It is estimated that over 100 million girls and women in more than 28 countries in Africa alone are disabled as a result of female genital mutilation.

In order to address the specific needs of women and girls in mine action operations UNMAS has for instance suggested the following measures to facilitate women and girls injured in mine/ERW accidents to have access to emergency and continuing care:

- Provide transportation to ensure better access to emergency and follow-up care;
- Engage same-sex staff in prosthetic workshops to assist survivors;

Most of information in this sub-section is taken from: WHO/ILO/UNESCO (2007), CBR Guidelines: CBR and Crisis Situations, which is still in a review process.


Ibid.

Ibid.
• Provide privacy for patients during their physical exams and consultations; and
• Make appropriate accommodations and arrangements (including for guardians or chaperones) to ensure that women and children are able to obtain treatment, particularly if they must travel from their homes.\textsuperscript{12}

The issue of women and girls with disabilities will be examined in detail in Section 8.

\textbf{Children with Disabilities}

\textbf{Article 7 (Children with disabilities)} indicates that “States Parties shall take all necessary measures to ensure the full enjoyment by children with disabilities of all human rights and fundamental freedoms on an equal basis with other children”.\textsuperscript{12}

Children who live with disabilities are among the most stigmatised and excluded of all the world’s children. Misunderstanding and fear of children with disabilities result in their marginalisation within the family, community and at school. The discrimination they suffer leads to poor health and education outcomes; affects the self-esteem and chances for participation and interaction with others, and puts them at higher risk for violence and exploitation.\textsuperscript{13}

There is often an absence of \textit{educational opportunities} for children with disabilities particularly due to prejudices regarding their integration into normal schools and a lack of understanding of their capacities.\textsuperscript{14} 90\% of children with disabilities in developing countries do not attend school, according to UNESCO.\textsuperscript{15}

In times of insecurity, children with disabilities are often the first to be abandoned by families and the last to receive emergency relief; they also face a far higher risk of becoming \textit{victims of abuse} and neglect than other children, and are more likely to be exposed to the risk of longer term psycho-social disturbances that this may give rise to.\textsuperscript{16}

When it comes to the danger of \textit{landmines} and unexploded ordnance, children are often intrigued by their sometimes colourful and curious designs. Butterfly mines and cluster bombs hold a fatal attraction for many young children. Simply being a child, with a natural curiosity and desire to play, touch, seek and explore, is risky in an environment contaminated with explosive remnants of war.\textsuperscript{17}

\textbf{Older Persons with Disabilities}

Elderly persons in general will be more likely to have impairments as a result of ageing. In addition, people with disabilities who are ageing will be at greater risk and will have increased needs of support in times of crisis. For example, they may have hearing/vision difficulties, may be disorientated or have mobility limitations that affect their ability to understand and follow security measures.

As stated by UNHCR, older persons with disabilities can be seen as a burden to their community, thereby increasing the sense of \textit{stigma and isolation}.\textsuperscript{18}

\begin{itemize}
  \item UNICEF (2007), \textit{op. cit.}, p. 2.
  \item Clark, Lance (2007), \textit{op. cit.}, p. 4.
  \item UNICEF (2007), \textit{op. cit.}, p. 19.
  \item UNICEF, \textit{UNICEF in emergencies: Landmines}, \url{http://www.unicef.org/emerg/index_landmines.html}
  \item UNHCR (2007), \textit{op. cit.}, p. 3.
\end{itemize}
In general, relief workers working with older persons tend to maintain a vision of “vulnerability and dependence”. This has resulted in measures which are limited to assistance-based activities rather than targeted action to build their potential capacities.\footnote{UNHCR (2007), \emph{op. cit.}, p. 9.}
3. Convention on the Rights of Persons with Disabilities

**What is the Disability Convention?**

The Convention on the Rights of Persons with Disabilities, adopted on 13th December 2006, is the first human rights treaty of the 21st Century. As a result of this landmark Convention, disability is now moving up on the international agenda, with far greater visibility than before. Skilfully used, the Convention could allow a significant improvement in the treatment of the estimated to be 650 million disabled people in the world.

As of 23 October 2007, **118 countries have signed** the Convention and 7 countries have ratified it. It could enter into force by early 2008, once ratified by 20 countries.

The Convention was drafted with unprecedented civil society participation. Disabled People’s Organisations (DPOs), true to their slogan “**Nothing about us without us**”, were the real movers of the negotiation process and their expertise was key to its success.

The Convention marks a **shift in thinking about disability from a charity or social welfare concern to a human rights issue**. It covers a number of key areas in crisis prevention and recovery activities, such as:

- Freedom from exploitation, violence and abuse;
- Access to justice;
- Rule of law;
- Accessibility and Mobility;
- Health and Rehabilitation;
- Education;
- Employment; and
- Participation in political and public life, etc.

The **social model of disability**, which is explicit in the Convention, focuses on the diverse barriers posed to persons with impairments by their environment (rather than their bodily impairments), including the attitudes and prejudices of society, policies and practices of governments, and the structures of the health, welfare and education systems.

The countries that sign up to the Convention will have to **enact laws and other measures** to improve disability rights and also agree to get rid of legislation, customs and practices that discriminate against disabled people. Access to public spaces and buildings as well as transport, information and communications will also have to be improved.

The 118 signatories to the treaty so far include 67 countries that have also signed the **Optional Protocol**. These countries will need to report regularly on their progress in implementing the Convention, to the Committee on the Rights of Persons with Disabilities. The Protocol affords citizens in signatory countries the possibility of launching an **individual complaint** to the Committee if the government fails to deliver on its obligations and there are no more national options for action left.

**Eighty per cent of persons with disabilities live in developing countries**, according to UNDP. In countries ratifying the Disability Convention, demand for UN agency support in the process of implementation will increase, such as in the review of national legislation and policies to ensure compliance with the Convention’s provisions and in the development of sector-specific responses.

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Human Rights-Based Approach of the Convention: States’ Responsibilities

The Disability Convention adopts human rights-based approach, and thus, provides a clear framework for States on how to protect the rights of their citizens with disabilities.

According to the Office of the United Nations High Commissioner for Human Rights, a human rights-based approach is a conceptual framework for the process of human development that is normatively based on international human rights standards and operationally directed to promoting and protecting human rights. It seeks to analyse inequalities which lie at the heart of development problems and redress discriminatory practices and unjust distributions of power that impede development progress.21

Based on the Disability Convention, we could promote good governance and legal issues in favor of disabled people, by encouraging governments to tackle disability issues as a broad social and development problem, and not just as a specific and temporary assistance to persons with disabilities caused by landmines/ERW, small arms, violence or natural disasters.

It is also important to support governments in reviewing national legislation and policies to ensure compliance with the Convention’s provisions and to promote equal justice and rule of law for all.

Additionally, we could contribute to help governments to make appropriate decisions on resources allocation aimed at ensuring equal rights, opportunities and conditions for persons with disabilities.

Map and Signatories to the Convention

As of 23 October 2007, we can count:
- 118 signatories to the Convention;
- 7 ratifications of the Convention;
- 67 signatories to the Optional Protocol; and
- 3 ratifications of the Protocol.22

Detailed information on signatories can be found at the UN enable website.

See below the map of signatures and ratifications as of 23 October 2007.

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Principal Conventions on Human Rights in Crisis Situations

The United Nations system has facilitated a series of instruments on human rights, which overlap as seen in the diagram above. Especially, the Disability Convention will benefit mine survivors and reinforce the Mine Ban Treaty, by focusing on all persons with disabilities and addressing their rights in detail.

All these conventions have particular implications in crisis situations. It would be interesting to see how we could interpret the Disability Convention vis-à-vis its role in crisis prevention and recovery.

It would be also important to look at the list on “Stipulation of Disability Issues in Conventions, Declarations and Resolutions on Human Rights” (Annex 1).

4. Implications of the Disability Convention in CPR Activities

Implications of the Convention in CPR Activities

What is the implication of the Disability Convention in CPR activities? A suitable entry point is survivor assistance in mine action operations, since the fact that a number of people become disabled every day because of the landmine scourge in conflict and post-conflict situations has already given rise to a well-developed set of response mechanisms. These could be reviewed and where appropriate, adapted to assist survivors of other disabling events. They could also form the basis for a comprehensive assistance approach that reaches all people with disabilities, not only those who survive landmines.

Taking its cue from the Disability Convention, and based on its sustainable approach in mine action, we might be able to start tackling the issues of persons with disabilities more broadly and sustainably, whether disabilities are caused by landmines/ERW, SALW, (sexual) violence or environmental disasters. We could also contribute to establish inclusive development processes after crisis situations by integrating the needs and concerns of persons with disabilities during the early recovery phase as well as adopting “Building back better policies”.

In addition, the Disability Convention is a vehicle to improve the rights and quality of life of all people, not only persons with disabilities. For example, elevators and ramps provide more options for everyone, including elderly people with limited mobility.23

Disability in “Situations of Risk and Humanitarian Emergencies”

The Disability Convention provides some guidance on emergency and conflict contexts in the Preamble (u):

“Bearing in mind that conditions of peace and security based on full respect for the purposes and principles contained in the Charter of the United Nations (...) are indispensable for the full protection of persons with disabilities, in particular during armed conflicts and foreign occupation …”

and in Article 11 (Situations of risk and humanitarian emergencies),

“States Parties shall take (...) 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”.

In both references, however, the need for special protection of people with existing disabilities is the only point made. There is no attention drawn to the need to proactively prevent disabilities in crisis situations, and even more problematically, no reflection on the fact that both natural disasters and armed violence are a leading cause of disability.

Strategies for Working with People with Disabilities in Crisis Settings

Basically five strategies to work with people with disabilities in crisis setting have been examined including; the twin-track approach, community based rehabilitation (CBR), outreach programmes, inclusion and empowerment of disabled people’s organisations.

The Twin-Track Approach\textsuperscript{24}

The Twin-Track Approach, developed by DFID, entails the inclusion of an active consideration of disability issues in the mainstream of development co-operation work, and looking for opportunities to support more focused activities, including direct support to organisations of disabled people and to initiatives aimed specifically at enhancing the empowerment of people with disabilities.

Strengthening disability work through the twin track approach should help provide an enabling environment for people with disabilities to achieve greater livelihood security, greater equality, full participation in the life of the community, and more independence and self-determination.

\[
\text{Source: DFID (2000), Disability, Poverty and Development, London: DFID, p. 11.}
\]

Community Based Rehabilitation (CBR)

Originally developed by WHO in the 1970s, Community-based rehabilitation (CBR) is a widely used method of working with persons with disabilities. “CBR is a strategy within general community development for the \textit{rehabilitation, equalisation of opportunities and social inclusion of all people with disabilities}. CBR is implemented through the combined efforts of people with disabilities themselves, their families, organisations and communities, and the relevant governmental and non-governmental health, education, vocational, social and other services”\textsuperscript{25}.

To make CBR effective, society as a whole must be persuaded to take collective responsibility for members of their community with disabilities. According to the CBR concept, most problems facing adults and children with disability could be \textit{solved at the community level, with support from national and regional levels}\textsuperscript{26}.

Outreach Programmes\textsuperscript{27}

These are activities that have their origin in institutions like hospitals, rehabilitation centres or special education units. Professionals from these institutions travel to the community, providing services at the community level.

The main difference between CBR and Outreach programmes is the underlying attitude towards disability. In the CBR concept the human rights perspective is strong. Social integration, participation and empowerment of people with disability are corner stones, while Outreach

\textsuperscript{24} DFID (2000), op. cit., p. 11.
\textsuperscript{27} Ibid.
activities are based upon a professional, often **medical point of view** and deal mostly with the **individual problem** of the person with disability.

**Inclusion**

Inclusion means that whenever there are activities planned for adults and children, consideration about the adults and children with disabilities should be automatic. The term “inclusion” should not be confused with the term “integration” which refers to the process of returning to his/her community someone who previously has been segregated. Inclusion refers to the **maintenance of the individual in the natural environment, thus avoiding initial segregation**.\(^{29}\)

The early recovery phase offers an opportunity to create an environment that would be inclusive of all the populations, including persons with physical and mental disabilities.

**Empowerment of Disabled People’s Organisations (DPOs)** \(^{29}\)

Disabled People’s Organisations (DPOs) participated actively in the negotiations of the Disability Convention. Indeed, “the Convention would simply not have come into existence without their efforts, and their call for **nothing about us without us** conveys the position that persons with disabilities can and must be central players in addressing the needs and potentialities of this population”\(^{30}\). Consequently, Article 4 (3) stipulates that “States Parties shall closely consult with and actively involve persons with disabilities, including children with disabilities, through their representative organisations.”

People with disabilities are equal members of the community and as such they should **participate in the crisis management process** in order to ensure that their needs are met. People with disabilities and their representative organisations should participate throughout the crisis management process: in planning of disaster management, in implementing the immediate response and in the reconstruction and recovery phase. They should take part in the decision-making process to ensure an equitable and effective crisis preparedness and response.

The growth of a democratic, representative disability movement is one way to help **ensure that government provision is appropriate** to the needs and rights of people with disabilities, as well as to **change public attitudes** towards this end. Also, where government commitment is weak, national and international organisations in civil society, particularly DPOs have an important role to play in awareness raising and advocacy.\(^{31}\)

**Suggested Actions in Crisis Prevention and Recovery** \(^{32}\)

How and in which areas can we intervene, based on the Disability Convention?

Some of the actions suggested in this sub-section are drawn from the **Sphere Project (Humanitarian Charter and Minimum Standards in Disaster Response)**.\(^{33}\)

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\(^{29}\) Some of information in this part is taken from: WHO/ILO/UNESCO (2007), CBR Guidelines: CBR and Crisis Situations, which is still in a review process.


\(^{32}\) Please note that all the articles cited in this section refer to the Disability Convention.

Data Collection

Responding to the historical lack of data available regarding persons with disabilities, Article 31 (Statistics and data collection) addresses the need to collect data and statistics not only to monitor implementation of the Convention, but also to facilitate its implementation by supporting the formulation of policies to give effect to the obligations of the Convention. When collecting and developing data on persons with disabilities, it is very important to disaggregate by sex, age and type of impairments.

As noted by some of the DPOs that participated in the discussions of the Convention, however, all such information collection activities should be consistent with internationally accepted norms and ethical principles, in order to ensure respect for the privacy of individuals about whom data is collected.

It would be interesting here to draw lessons from the “proGres” registration system of UNHCR, which has provided the organisation with a valuable tool for identifying the needs, risks and capacities of older persons and persons with disabilities in a situation of displacement. Where it has been installed, staff have access to disaggregated data on the registered populations: they can identify individuals with specific protection and assistance needs and track services provided, such as cash grants, education and medical assistance.

Freedom from Exploitation, Violence and Abuse

As underlined in Article 16 (Freedom from exploitation, violence and abuse), we could help countries in crisis situations to:

- Protect persons with disabilities, both within and outside the home, from all forms of exploitation, violence and abuse, including gender-based violence;
- Prevent all forms of exploitation, violence and abuse by ensuring appropriate forms of gender- and age-sensitive assistance and support for persons with disabilities and their families and caregivers, including through the provision of information and education on how to avoid, recognise and report instances of exploitation, violence and abuse;
- Promote the physical, cognitive and psychological recovery, rehabilitation and social reintegration of persons with disabilities who become victims of any form of exploitation, violence or abuse; and
- Put in place effective legislation and policies, including women- and child-focused legislation and policies, to ensure that instances of exploitation, violence and abuse against persons with disabilities are identified, investigated and prosecuted.

Shelter and Settlement

To allocate shelters to persons with disabilities, we need to:

- Make sure that sites/communication/information, including water sources and sanitation facilities, are accessible to all community members and that signals are understandable by all;
- Ensure that households with disabled and elderly members are located nearest to basic services – especially latrine blocks and water points; and
- Try to reunite people with disabilities with their caregivers or relatives in the shelter.

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36 UNHCR (2007), op. cit., p. 5.
37 Some of information in this part is taken from: WHO/ILO/UNESCO (2007), CBR Guidelines: CBR and Crisis Situations, which is still in a review process.
Additionally, we should take into account:

- **Clothing and bedding**: additional changes of clothing and mattresses should be provided where possible to people with incontinence problems;

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

- **Cooking and eating utensils**: 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; and

- **Participation of affected households**: maximise opportunities for participation during construction, particularly for individuals lacking the required building skills or experience. Women with disabilities are particularly at risk from sexual exploitation in seeking assistance for the construction of their shelter.

**Accessibility / Personal Mobility**

Addressing **Article 9 (Accessibility)**, it is important to identify and eliminate obstacles and barriers and ensure that persons with disabilities can access their environment, transportation, public facilities and services, and information and communications technologies.

It is also crucial to develop **national accessibility guidelines** and standards and to ensure accessibility for persons with disabilities, either through the removal of existing barriers to accessibility, or the avoidance of new barriers. Such considerations are particularly relevant for projects impacting country infrastructure, such as transportation and telecommunications projects. We need to address accessibility issues in early recovery planning processes, by adopting “Building back better policies”.

Moreover, **Article 20 (Personal mobility)** suggests facilitating affordable personal mobility, training in mobility skills and access to mobility aids, devices, assistive technologies and live assistance.

**Health / Rehabilitation**

**Article 25 (Health)** and **Article 26 (Habilitation and rehabilitation)** need to be addressed by striving for the highest attainable standard of health without discrimination on the basis of disability and by providing comprehensive habilitation and rehabilitation services in the areas of health, employment, education and social services, respectively.

Addressing **health risks** in crisis situations, we need to make sure:

- People with disabilities have access to health prevention programme (vaccination, hygiene, etc.) and emergency health services provided to the community and that they have sufficient food to keep a reasonable state of health;

- A referral system is in place and that people with disabilities or injuries in needs of primary or secondary care have access to it.

Concerning **habilitation and rehabilitation**, we should shift “from a professional-centered approach to one in which the disabled person is the prime decision-maker in establishing their own habilitation and rehabilitation goals and objectives”.

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40 Some of information in this part is taken from: WHO/ILO/UNESCO (2007), CBR Guidelines: CBR and Crisis Situations, which is still in a review process.
Children and adults with disabilities tend to have much less access to education at any level than their non-disabled peers. The exclusion of disabled persons from education results in life-long barriers to meaningful employment, health, political participation, etc.

In order to address Article 24 (Education), we could contribute to:

- Remove legislative barriers to the inclusion of persons with disabilities in mainstream education settings;
- Increase the accessibility of the educational spaces of disabled people, developing inclusive curricula and providing adequate learning assistance, at the stage of early recovery; and
- Provide adequate accommodation systems in formal education, vocational training, adult education and alphabetisation, etc.

**Work and Employment**

People with disabilities usually have a higher rate of unemployment than the rest of the population. This may be due to lack of adequate education or training, lack of motivation, preconceived ideas about people with disabilities on the part of employers, lack of physical accessibility to the workplace, and lack of adequate transportation. It is estimated that “80 per cent of all people with disabilities of working age are unemployed.”

Article 27 (Work and employment) addresses the need of States Parties to recognise the right of persons with disabilities to work, on an equal basis with others, and prohibits discrimination on the basis of disability in all matters of employment, including the “conditions of recruitment, hiring and employment, continuance of employment, career advancement and safe and healthy working conditions.” Furthermore, States Parties must ensure the provision of reasonable accommodation to disabled persons in the workplace.

We could contribute to help States to resolve employment problems of persons with disabilities caused by conflict and natural disaster through:

- Identifying employment opportunities for persons with disabilities;
- Promoting recruitment actions for persons with disabilities;
- Developing job skills and adaptive mechanisms for persons with disabilities (for example, work at home via use of IT where possible); and
- Promoting allocation of a percentage of posts in governments and social responsible businesses for persons with disabilities.

**Economic Inclusion: Funding Mechanisms for Self-Employment**

It is estimated that 10-12 per cent of the world’s population has some kind of disability and that 82 per cent of them live below the poverty line. Being able to earn a stable income is therefore a main priority for people with disabilities. Economic activity is also one factor that enhances self-fulfilment and self-esteem. Work offers them the opportunity to be recognised as contributing members of their families and communities.

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42 Ibid., pp. 13-14.
46 Clark, Lance (2007), op. cit., p. 11.
Like the rest of the population in developing economies, however, people with disabilities often turn to self-employment because of a lack of opportunities in the job market. Although many would prefer to have a job with a regular income, self-employment is often the only option available, as seen in the following table on comparison of self-employment for people with disabilities in developing and developed countries:

<table>
<thead>
<tr>
<th></th>
<th>Developing Countries</th>
<th>Developed Countries</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self employment (mostly in the informal sector)</td>
<td>80%</td>
<td>3%</td>
</tr>
<tr>
<td>Formal employment</td>
<td>20%</td>
<td>97%</td>
</tr>
</tbody>
</table>

Source: Harris, C (1997), "El autoempleo de las personas con discapacidad en países en desarrollo", in: IDRC Reports.

Many people with disabilities are involved in shops, craft workshops, street vending, tailoring, carpentry, farming or agricultural activities, etc. A considerable number of people with disabilities in developing countries live in rural areas and thus, attention should be given to rural livelihoods economic inclusion programmes for people with disabilities.

To help reduce poverty among people with disabilities, in this case through access to microcredit for self-employment, two main approaches could be used:

1. **Inclusion in mainstream microfinance institutions** through a variety of schemes, including raising awareness among microfinance staff, establishing partnerships for cooperation, adapting methodologies, or simply by supporting people with disabilities to submit their loan applications; and

2. **Provision of financial services by organisations of/for people with disabilities themselves**. Some organisations affirmed that inclusion in microfinance institutions was a long-term goal, but that this would not respond to current pressing needs for loans.48

It is important to note that the decision on the use of grants or loans depends on the individual’s strengths and weakness, level of formal education, prior experience, and repayment capacity; but also on the potential sustainability of the enterprise and the market conditions.

In addition, some people with severe disabilities may require, not only the above income generation support, but also social assistance, such as special safety nets and social security programmes, both public and private, to cover their special needs. It is also important to look at the position of a person with disabilities in the community network and economic safety net: persons with disabilities who don’t receive any money from relatives or allowances, or don’t have any social activity/responsibility could be considered more vulnerable than other people with disabilities.

**Landmine survivors** have affirmed that their main priority is to earn an income and to contribute to their families’ well-being; often, economic inclusion is considered even more important than medical care and mobility per se. Economic inclusion is important to guarantee the independence of landmine survivors, but also to help them maintain their place as productive members of the community. For those who want to start a business, the main obstacle is often the lack of access to capital. There is growing recognition that facilitating access to existing micro-finance is an important step for inclusion.49
Livelihoods

Article 28 (Adequate standard of living and social protection) is of particular relevance, given that there is a clear indication that persons with disabilities are more likely to be caught in a vicious cycle of poverty and disability, each of which is both a cause and consequence of the other.

The article focuses on ensuring equal access by persons with disabilities to adequate food, clothing, housing (including public housing programmes), clean water, retirement benefits and programmes, social protection and poverty reduction programmes, etc.

Food and Nutrition

As indicated in Article 28 above, food and nutrition is an important aspect of adequate standard of living.

In order to provide adequate nutrition support to people with disabilities affected by conflict and natural disaster, we need to acknowledge that they 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. 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.

For community-based support, care givers and those they are caring for may have specific nutritional needs. For example, they may have fewer assets to exchange for food due to the costs of treatment or funerals or face social stigma and reduced access to community support mechanisms.

In terms of food aid management, it is indispensable to bear in mind that food 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. Here, the security sector reform (SSR) could play an important role in advocacy, awareness raising and training of security sector institutions and actors.

Water and Sanitation

Equal access to clean water for persons with disabilities is also stipulated in Article 28 (Adequate standard of living and social protection).

In crisis situations we need to conduct an initial assessment of the special needs of persons with disabilities in water and sanitation by disaggregating the data by sex, age and type of disabilities.

Some hand pumps and water carrying containers may need to be designed or adapted for use by older and disabled people and children. All users should be fully informed of when and where water is available.
The numbers, location, design, safety and appropriateness of communal washing and bathing 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.

Toilets are designed, built and located in such a way that they can be used by all sections of the population, including disabled people, children, older people, pregnant women, etc.

**National Planning and Policy Development**

We could support governments in elaborating national plans and intervention strategies for persons with disabilities in crisis situations.

First of all, we need to ensure that issues of persons with disabilities are integral parts of national development strategies, such as the Poverty Reduction Strategy, and nationalised MDGs.

It is also relevant to support policy development, such as drafting of national disability strategies and action plans, as well as disaster preparedness plans that are inclusive of persons with disabilities, through supporting line ministries on disabilities and active participation of DPOs (Disabled People’s Organisations). We could also support governments in conducting studies on “policy implementation gaps” related to persons with disabilities.

Additionally, in the framework of ongoing decentralisation processes in many crisis-affected countries, we could support local governments or administrations in mainstreaming disability issues in these processes. It would be important to support appropriate development of community based social services at local level, as well as to advocate for appropriate budgeting and monitoring of local expenditures to ensure that a fair proportion of funds is dedicated to disability-related services.

**Rule of Law / Access to Justice**

**Article 12 (Equal recognition before the law)** promotes the rule of law. We could promote the following in this area:

- Comprehensive inclusion and anti-discrimination laws;
- Support and training for judicial, ombudspersons, equality bodies, etc. in charge of the implementation of equality policies and affirmative measures.

**Article 13 (Access to justice)** seeks to respond to the historic exclusion of persons with disabilities from the justice system. For example, disabled persons are often denied the opportunity to serve as jurors, and those who are victims of crime are often unable to seek redress, either because the police or other officials do not know how to accommodate them, or because their experiences are discounted out of hand, or even because of explicit prohibitions on their participation as witnesses. As required in Article 13, we could help governments to ensure effective and equal access to justice for persons with disabilities, through the provision of accommodations and the facilitation of their effective role as direct and indirect participants, including as witnesses, in all legal proceedings and also to promote appropriate training on disability issues for those working in the field of administration of justice, including police and prison staff.

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54 Some of information in this part is taken from: WHO/ILO/UNESCO (2007), CBR Guidelines: CBR and Crisis Situations, which is still in a review process.
In crisis situations it is crucial to advocate for the rights of people with disabilities, to prevent human rights violations against them and to document these violations when they occur, in cooperation with DPOs and other civil society networks.

**Participation in Political and Public Life**

**Article 29 (Participation in political and public life)** stipulates that “States Parties shall guarantee to persons with disabilities political rights and the opportunity to enjoy them on an equal basis with others…”.

We could help governments to promote political participation of persons with disabilities through:
- Facilitating access to polls by removing obstacles;
- Informing them of voting dates by using Braille and sign language;
- Conducting voter education; and
- Promoting advocacy for the rights of persons with disabilities to vote and to participate in political life, as members of parliaments and governments.

**Proactive Empowerment of DPOs**

**Article 4(3) (General Obligations)** calls for States Parties to “closely consult with and actively involve persons with disabilities, including children with disabilities, through their representative organisations,” 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.”

Taking advantage of its worldwide networks and extensive experience of partnership with civil society organisations (CSOs), we could contribute to empower Disabled People’s Organisations (DPOs) through:
- **Supporting networks** among DPOs and with other CSOs, and supporting regional and global cooperation and advocacy;
- Providing technical assistance and support for development of strategies and actions for increasing the political organisation and strength of persons with disabilities, and the receptivity of key government and political actors to their issues and messages.57

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5. Priority Areas of Intervention for Conflict Prevention and Recovery

In this section, we would like to examine the linkages between disability issues and some of the priority areas of CPR (conflict prevention and recovery), with examples of specific project activities for persons with disabilities in crisis situations.

Mine Action and Disability

Survivor Assistance towards a Broader Development Approach

Mine action is not so much about landmines as it is about people and their interactions with environments affected by landmine and ERW (explosive remnants of war). Its aim is humanitarian and developmental: to recreate an environment in which people can live safely; in which economic and social well-being can occur free from the constraints imposed by landmines; and in which the medical and socio-economic needs of victims are addressed. The work of UNDP tries to help create the conditions for post conflict recovery and promote the resumption of normal economic activity, reconstruction, and development.

UNICEF works also to ensure that initial mine action responses and life-saving assistance move rapidly toward medium and long-term solutions. This is done with an emphasis on community participation.

A key lesson learned from the landmines process is that whilst a disability-specific track might be required, it also needs to be part of the overall health, poverty reduction and development plans and not developed in isolation or competition with often limited resources.

As affirmed by Handicap International, it is fully recognised that assisting landmine victims and improving the situation of people with disabilities in general are very closely related.

Disability is not simply a health concern. It is a cross-cutting issue that includes health, education, social welfare, employment and accessibility related to communication, transport, infrastructure as well as water and sanitation. Interventions for people with disabilities need to be comprehensive and aimed at their social participation and, ultimately, integration into mainstream programming. The needs of people with disabilities are to be considered before, during, and after emergency.

Conflict is one of the preventable causes of disabilities. In the past much of the emphasis on disability in post conflict countries has been concentrated on the emergency phase after the conflict, and often with a focus limited to land mines. Unfortunately the problem is broader and deeper. As a consequence, in the recent years, the actors operating in this field have embraced a holistic approach which includes: data collection and analysis, emergency medical care, continuing medical care, physical rehabilitation, prostheses and assistive devices, psychological

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58 Some of information in this part is taken from: WHO/ILO/UNESCO (2007), CBR Guidelines: CBR and Crisis Situations, which is still in a review process.
60 UNICEF, UNICEF in emergencies: Landmines (op. cit.)
and social support, employment and economic integration, capacity building and sustainability, legislation and public awareness, accessibility interventions/policy.\textsuperscript{63}

Before looking at the linkages between disability issues and other challenges related to conflict and natural disaster, it would be useful to analyse and benefit from experience of \textit{victim assistance in mine action}, which has been the pioneer of assistance to persons with disabilities in crisis situations.

\textbf{Challenges Encountered in Providing Appropriate Services for Mine Survivors and other Persons with Disabilities} \textsuperscript{64}

Victim assistance practitioners from mine-affected States reaffirmed some of the challenges encountered in providing adequate and appropriate services for mine survivors and other persons with disabilities, including:

\begin{itemize}
  \item Disability often not seen as a priority by policy makers;
  \item Lack of inclusion of persons with disabilities in decision making processes;
  \item Lack of capacity to address disability issues at all levels including within the governmental and non governmental sectors;
  \item Existing services are not meeting their needs in terms of both quantity and quality;
  \item Lack of awareness and accessibility to services;
  \item \textbf{Absence of a holistic approach to providing assistance}; and
  \item Poverty and lack of development in affected communities hindering the economic reintegration of survivors.
\end{itemize}

Mine survivors are not a problem to be solved. They are entitled with the same human rights as their non-disabled peers. They are assets with the capacity to be productive contributors to their societies. The challenge is to provide the environment and opportunities that will enable mine survivors and other people with disabilities to reach their full potential to contribute to their communities.

\textbf{What Kind of Compensation for Mine Victims and for What Kind of Injury}\textsuperscript{65}

As victims of mine accidents often suffer from permanent disability, they need special provisions in their daily life. The person’s deficiencies and limited capacity to allow him/her to participate fully within the society should be compensated. Compensation could be claimed according to the kind of damages and injury suffered by mine victims.

\textbf{Physical injuries}

Compensation should at least cover \textit{medical expenses and rehabilitation} and care over the long term and be assessed on the basis of the following criteria:

\begin{itemize}
  \item Pre-hospitalisation assistance and care (evaluation, first aid, and transportation);
  \item Hospital care (medical care, surgery, post-operative care and pain management); and
  \item Rehabilitation (physiotherapy, occupational therapy, prosthetic appliances and technical aids, and psychological support).
\end{itemize}

\textsuperscript{65} Handicap International (2005), \textit{op. cit.}, pp. 39-40.
Injury to economic interest

Compensation for economic loss is difficult to assess and should be estimated on a case-by-case basis according to the victim’s family circumstances and his/her professional situation (income) before the accident. Compensation should allow the victim to reintegrate in the professional and social life: professional redeployment, skills and vocational training, and income generating projects. Funeral expenses for deceased victims should also be taken into account.

The presence of mines in an area may force individuals or communities to relocate. The amount of compensation should cover the economic loss for the individuals and communities and the socio-economic consequences caused by the relocation. In these particular cases, collective compensation may be more appropriate.

Psychological injury

Compensation for psychological injury is certainly the most difficult to estimate: by “psychological injury” we mean the trauma suffered by the survivors or the victim’s family. In the case of survivors, it is worth remembering that social exclusion of the victim due to the social burden of disability can constitute a cause of psychological vulnerability.

A compensation for the direct victims’ families should take into account the degree of relationship and the potential witnessing of the accident by a family member. The witnessing of an accident by a family member is a factor to be included in the calculation of compensation.

Prosthetics and Orthotics Services

Restoring personal mobility to individuals with disabilities is critically important. If services are not provided promptly, it may be increasingly difficult to achieve positive outcomes.

The sooner persons with disabilities can receive services, the more successful rehabilitation will be. Even so, the supply of orthopaedic devices does not fall into the category of life-saving work.

Field operations are normally not carried out during the emergency phase of a conflict or a natural disaster when the security of staff cannot be assured. However, much planning and preparation should be initiated in this phase. This will allow starting field work immediately as improved security allows:

- Work with the national or local government to the degree possible;
- Support the planning of P&O (prosthetics and orthotics) services during the emergency phase: the emergency phase can in itself present an opportunity to put disability and P&O issues on the agenda;
- Make sure that the projects fit into national long-term development plans and are integrated into national service activities;
- Consider carefully the technologies to use: the preferred approach during an emergency is to provide permanent prostheses and orthoses based on a technology that is the same or compatible with devices produced in the long-term, such as devices manufactured locally; and
- Ensure follow-up of service users: if emergency outreach services are provided from mobile or temporary clinics with technologies that allow instant fitting, follow-up is likely to be even more important than when permanent services are provided.

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Box1: UNDP's Project on Return and Resettlement of Landmine Victims from Internally Displaced Camps in Uganda

Let us look at a UNDP’s project in victim assistance (January 2007 and December 2008), which is aimed at assisting the return and resettlement of landmine victims from internally displaced camps in Uganda.

The implementing partner is the Ministry of Gender, Labour and Social Development, in close collaboration with Landmine Survivors Association, National Council for Disability and Uganda Mine Action Centre. The targeted beneficiaries are internally displaced persons (IDPs) who are landmine survivors.

In response to a presidential decree on the resettlement of IDPs to secure areas, the above Ministry and UNDP have been establishing a structure to support the successful return of internally displaced landmine victims to their communities. The structure is intended to prevent the segregation of and discrimination against landmine victims during early return, resettlement and recovery while simultaneously protecting and reducing the potential loss of land.

Activities:

- Establish structures within the return process to ensure equal opportunities for landmine survivors;
- Identify landmine survivors at IDP camps, seek to protect their land rights and develop support structures for them to return home;
- Build community networks to assist landmine victims and their families;
- Provide support supplements for shelter based on individuals needs;
- Establish agricultural options for landmine survivors;
- Monitor the return process along with the provision of assistance required by landmine victims and their families for the first six months of return; and
- Link landmine victims to other victim assistance structures with special attention to gender.

Expected Outcomes:

- Landmine victims will be fully reintegrated into their communities;
- An increased number of internally displaced landmine victims will be reintegrated;
- Support structures by the responsible ministry will be operational prior to the return of landmine victims;
- Increased monitoring will be documented within the national surveillance network.

Small Arms and Light Weapons and Disability

Disability Caused by Gun Violence

A significant number of people with disabilities have injuries as a result of gun violence. The relationship between the use of firearms and disability is very visible. Many of the people who don’t die from gun violence become permanently disabled.68

However, little attention is given to the consequences of gun violence in the international policy arena of small arms control. Beyond physical injury, firearms-related violence is likely to have psychological consequences at a number of levels, including affect (anxiety, anger), cognitions

67 UNDP, Return and Resettlement of Landmine Victims from Internally Displaced Camps (in Uganda), http://mineaction.org/project.asp?pr=263. The UNDP staff, who was directly in charge of this project, does not work any more on the project, so before the completion of this paper we could not obtain more detailed information, for example on the number of IDPs to target.

(e.g., trust and perceptions of safety), and \textit{behaviour} (e.g., buying weapons for protection, avoidance, withdrawal). These reactions affect the victim's social behaviour and the community in which he/she lives and works. As both victims and perpetrators demonstrate similar psychological symptoms as a result of their exposure to violence, the \textit{division between ‘victim’ and ‘perpetrator’ becomes blurred}. Addressing the psychological impacts of gun violence is necessary to break this cycle.\footnote{Centre for Humanitarian Dialogue (2006), \textit{Trauma as a consequence - and cause - of gun violence}, unpublished background paper commissioned from Vivo international, p. 1.}

Also, physically injured trauma victims who experience difficulty carrying out every-day functions need intensive care and assistance, and in many cases this responsibility is adopted by family members. \textbf{Caregivers} responsible for severely ill patients are themselves at risk of developing health problems.\footnote{Centre for Humanitarian Dialogue (2006), \textit{Trauma as a consequence - and cause - of gun violence}, unpublished background paper commissioned from Vivo international, pp. 4-5.} Whilst the majority of victims of gun violence are men and boys, “a large proportion of care falls on \textbf{women – mothers, wives, sisters, partners} – often decreasing their opportunities to engage in economic activities, and contributing to the deterioration of their own health”\footnote{ICRC (2001), \textit{Women and War: Health fact sheet}, www.icrc.org, cited in: Centre for Humanitarian Dialogue and Inter-Parliamentary Union (2007), \textit{Missing pieces: A guide for reducing gun violence through Parliamentary action}, Handbook for parliamentarians No. 12, Geneva, p. 72, http://www.hdcentre.org/datastore/Small%20arms/Missing_Pieces/MPforparl_Eng.pdf}. Yet these actors are more often than not, overlooked and under-resourced in the life-long help they provide.\footnote{Centre for Humanitarian Dialogue and Inter-Parliamentary Union (2007), \textit{op. cit.}, p. 72.}

It is also critical to note that \textbf{women are subject to a disproportionate range of non-fatal threats} involving the misuse of small arms, often commensurate with their low status or lack of legal protection in many contexts, whether in peace or war. Guns do not necessarily have to be fired to pose a serious security threat and are often used to threaten. \textit{Gun ‘brandishing’} (prominently displaying, waving, or drawing attention to the weapon) is a common form of intimidation, especially against women.\footnote{Ibid., p. 82.}

In the context of \textbf{gun injury prevention}, it is important to reduce the likelihood of impairment or, when it has occurred, preventing further negative physical, psychological and social consequences. Rehabilitation refers to efforts to enable individuals to reach an optimal level of functionality, providing them with tools to change their life. These can include infrastructure and devices to compensate for the disability, or facilitating (re)adjustment into communities. Finally, the equalisation of opportunities is the process by which society makes health and social services, the environment, cultural life, and educational and work opportunities equally available to all its members.\footnote{Ibid., p. 67.}

A key lesson learned from the landmines process is that assistance strategies need to be \textbf{part of the overall health system} of a nation and not developed in isolation or competition with often limited resources. “It is equally important to identify institutional policies guiding service provision to victims of violence, for example in hospitals, specialised medical and forensic services, police stations and counselling centres.”\footnote{Butchart A et al (2004), \textit{Preventing Violence}, p. 64, cited in: Centre for Humanitarian Dialogue and Inter-Parliamentary Union (2007), \textit{op. cit.}, p. 71.} Assistance to survivors of gun violence raises the same challenge – identifying where support services and assistance can be integrated into existing systems using approaches that would develop, strengthen or re-orient services, rather than creating vertical specialised services in resource-limited settings.\footnote{Centre for Humanitarian Dialogue and Inter-Parliamentary Union (2007), \textit{op. cit.}, p. 71.}
Box 2: HDC’s Study on Survivors of Gun Violence in El Salvador

In early 2006 the Centre for Humanitarian Dialogue (HDC) commissioned an exploratory study of the needs of survivors of gun violence in El Salvador. Six survivors and five staff members at the Institute for the Rehabilitation of the Disabled (ISRI), a rehabilitation institute for people with disabilities, were interviewed. Although not statistically significant, interviews provide an interesting snapshot of the situation of survivors of gun violence.

About 50% of the total patient intake in the above rehabilitation institute consists of people with firearm-related injuries. Staff interviewed indicated that since the civil war there has been little change in the severity and type of injury sustained by people surviving armed violence: although there are now fewer patients requiring limb amputations due to anti-personnel landmines, the number of patients with spinal cord injuries and a range of associated injuries as a result of a gunshot wound is still significant.

The study reveals the tremendous hardships experienced both by the survivors of armed violence and their caretakers. This includes the physical impact of the disability such as the loss of mobility, as well as the mental health impacts such as feelings of helplessness, depression and denial.

For all survivors interviewed the most significant impact of their injury is the difficulty of accepting the inability to work, earn money and provide for the family. When asked what kind of assistance would help them recover, the two elements most often cited both by survivors and health workers alike are:

- Financial support to help with the burden of medical expenses while providing for the family; and
- Support in finding employment and assisting with vocational training.

DDR and Disability

Ex-Combatants with Disabilities in DDR Processes

Disabled ex-combatants are understood to be the victims of armed struggle, civil war or war-time atrocities resulting in physical, physiological or psychological injuries. Disability may be caused by bullets, grenades, land mines, bombs and torture.

Disabled soldiers are considered one of the most difficult categories to reintegrate. Generally, they are far away from their origin communities at the end of the conflict and have neither the resources nor the physical capacity to return there. Due to their disability they are unable to generate any income without an intensive training and rehabilitation.

Ex-combatants who have been wounded or disabled in action, or have become chronically ill due to combat exposure, deserve to be cared for. Post-conflict governments should assume full responsibility in providing medical care, rehabilitation facilities and vocational training that is geared to their specific needs, as well as support in terms of providing credits, jobs, housing and farming opportunities. Disabled ex-combatants should have the opportunity to access specialised counseling support to assist with rehabilitation and slowly attain reintegration in the DDR process. Before they are discharged, a medical specialist should perform a proper categorisation of their disability.

78 Translation of “Instituto Salvadoreño de Rehabilitación de Inválidos”.
Employment opportunities are very rare in a post-conflict country’s labour market. Disabled ex-combatants have to compete with able-bodied annual school leavers for the same limited number of jobs. In order for disabled ex-combatants to reintegrate economically into the mainstream they have to earn a living, be it wage employment or otherwise, or a combination of different sources of income.

When disabled ex-combatants in Rwanda were asked if they encountered any problem with their families, 106 out of the 240 respondents answered positively. The reasons given are land disputes, poverty and their disability. 72.5 % of the respondents felt they were treated as inferior, because of their disability and the nature of the chronic illness that impairs them from being productive.

In some DDR programs, acceptance to a program requires the possession of a weapon (the most often used, sometimes the only, criteria for acceptance on the DDR). This can exclude various groups, including disabled, female and child ex-combatants, who are the most vulnerable above all. Thus, it is necessary to define a number of selection criteria that are transparent, easy to understand, unequivocal and applicable to all the participants in a DDR program. More so, some actors promote the idea that DDR is only a security concern. However, if the sole objective is security, then DDR is limited to “getting potentially dangerous elements out of society”. In that approach child soldiers, teenage mothers, ex-combatants with disabilities and other “potentially less violent” groups will not receive the attention and funds required for their reintegration.

Efforts should be made to incorporate disabled ex-combatants at all levels of program implementation. If there are failures to deliver in these areas over the medium and long term there may well be increasing criminality and tensions among ex-combatants, with serious consequences for post-conflict countries.

The following solutions are being proposed to address these problems:

- Facilitate the settlement of disabled ex-combatants near their family or kin so they can access this important resource towards their social and economic reintegration;
- Promote and assist in the economic integration of disabled ex-combatants and affected civilians through mainstream training and income-generation programs;
- Provide rehabilitation and support services at the community level, including for example information and referral systems, counseling and peer support, skills training, accessible transport;
- Adapt tools and workplace accessibility to make it easier for people with physical disabilities to be more productive in agricultural and other manual jobs;
- Provide technical aids and assistive devices such as crutches, wheelchairs, glasses, white canes and hearing aids as well as adapting equipment or communication methods, including Braille typewriters and sign language interpretation; and
- Design reintegration programs through a participatory process which involves ex-combatants and communities, local and national authorities and other non-governmental actors in planning and decision making from the earliest stages.

Box 3: UNDP’s Project to Support Injured Ex-combatants in the Democratic Republic of Congo

It would be interesting to look at a concrete example of a UNDP’s project for supporting injured (disabled) ex-combatants in the Democratic Republic of Congo (DRC), implemented between November 2002 and December 2005.

The specific objectives of the project aimed to:
- Provide medical care and support, as well as professional training, to 2000 injured ex-combatants;
- Promote the social and economic integration of 2000 injured ex-combatants who are demobilised, treated and trained; and
- Reinforce the capacities of the government to systematically respond in a sustainable way to the needs of demobilised ex-combatants and other vulnerable groups.

The 2006 evaluation report noted the following impacts of the project:
- DDR processes of ex-combatants was facilitated by this project, since it aimed at supporting injured ex-combatants, most difficult categories to reintegrate;
- The fact that the project targeted them contributed to reduce their feeling that they had been sacrificed physically for the nation, without benefiting from any adequate compensations;
- Their socio-economic reintegration into communities was partly promoted;
- The project contributed to sensitis the host communities of ex-combatants;
- Injured (or disabled) ex-combatants received appropriate medical treatments;
- The medical infrastructures and services were ameliorated for injured ex-combatants;
- A framework and juridical instruments of reference for their demobilisation is now available;
- The project collected and analysed information on the characteristics of injured ex-combatants at administrative, medical, social and economical levels.

Natural Disaster and Disability

Disability in Natural Disaster Settings

In natural disaster settings, people with disabilities are more vulnerable than others and have specific needs. At each of the 3 stages of the Disaster Cycle (Pre-disaster, During the disaster, and Post-disaster) and in their associated disaster risk reduction processes (Prevention/preparedness, Emergency response, and Recovery/reconstruction, respectively), their specific needs have to be considered properly to ensure adequate and appropriate intervention.

In this light, it is important to:
1. Understand the issue by determining, among other things, the number, needs and capacities of disabled people;
2. Assess the organisational capacity of the society to respond to the specific needs of disabled people in emergency settings; and
3. Plan and implement sound disaster risk reduction strategies before disasters happen.

How can we then intervene effectively for people with disabilities at each stage of the Disaster Cycle?

Pre-disaster: Preparedness, Prevention

This period, which can last for many years and offer many opportunities, is often neglected. Pre-disaster circumstances are the best conditions for the implementation of actions that enable governments to prevent or reduce the risks of disasters. These actions have to be taken at the legal, institutional, and financial levels.

At the legal level, legislation should be elaborated to promote and facilitate the protection of disabled people, as well as to prevent people from getting disabled. These activities can include, for example, special access and exit facilities for disabled people in public buildings and the provision of favourable conditions for disabled people to build disaster proof houses.

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Most information in this section comes from the guidance of Mr. Carlos Villacis of DRT/BCPR/UNDP.
At the institutional level, relevant institutions should have response mechanisms to attend the special needs of disabled people. They could include emergency coordination and rescue teams that are trained specially for assisting disabled people. It is also important to create systems that provide disabled people with the necessary disaster-preparedness information and facilitate communication in time of disaster.

Financially, schemes should be developed to give priority to people with disabilities in terms of access to credits and/or economic activities that increase their safety against disasters.

There are also a number of risk reduction activities relating to infrastructure and planning that should be implemented at the pre-disaster stage in response to the special needs of disabled people. Concrete examples include the creation of disability-friendly transportation systems with special exits in case of emergency.

In addition, disabled people should be provided with accommodation at shelters and camps for disaster-displaced people. After a disaster, these facilities are usually not enough and often very crowded. Every effort should be made to avoid disabled people from getting excluded; every camp or shelter should define some specific percentage reserved for lodging disabled people adequately. Moreover, shelters should eliminate all the barriers that could prevent them from the benefit of these services.

Also, the “development of early warning systems could be fundamental to save lives when disasters occur, but more technical development in some regions is needed in order to achieve equal access to such measures”.

Furthermore, proper planning and risk reduction measures will reduce the damage caused by disasters and, in this way, reduce the likelihood of more people getting disabled. Examples from the past demonstrate the need for appropriate preparedness. During the 1998 Armenia earthquake in Colombia, for example, the buildings of the Central Police Station, the fire station and the hospital of Armenia City collapsed. As a result, the security-provision systems that were supposed to protect citizens were not only leaving people unprotected but also causing injury, death and disability. By applying proper planning and construction, these security-provision systems could not only have protected the occupants of their buildings but also would have ensured the provision of security to the community at large and reduced significantly the human impact.

The implementation of the above suggested activities will require some funding. Specific funds for conducting these activities should be incorporated in the regular budgets of governments and relevant organisations, both national and international. Though implementing activities that address the needs of disabled people may be more costly, these additional expenses should be seen as an investment to protect human lives and to ensure the basic rights to security to which all humans are entitled.

Emergency Response: During and Immediately after a Disaster

Emergency response often takes place in a very short period and usually involves high expenditures. The more disastrous the event is, more funding is usually made available by the international community. This very high level of funding contrasts sharply with the difficulty to obtain funds for pre-disaster activities that could have reduced significantly the human and financial impacts of the event.

When providing emergency response, it is important to distinguish the different needs of already and newly disabled people. People who were disabled before disasters know how to live with their special situation, whilst newly disabled people can be totally confused during or after a disaster.

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disaster. These newly disabled people will then need training, information/knowledge, funding and psychosocial assistance to live with their new situation.

Special considerations should also be given to the different type of disabilities. In the context of emergency, in particular, people with physical disabilities may require very different and specialised assistance compared to the one required by people with mental disabilities, for example.

Also, we should bear in mind that “engaging stakeholders such as Disabled People’s Organisations (DPOs), relief agencies, local communities and others is an important factor that determines the success of the emergency response/relief endeavour”\(^{84}\).

**Post-Disaster: Recovery, Reconstruction**

While disasters bring destruction and losses, they may also provide an opportunity to re-build properly and correct past mistakes, in the framework of “Building back better policy”. This also applies to the specific case of disabled people.

However, planners often miss the opportunities to avoid recreating the inequitable status and to meet the needs of disabled people. For example, “if schools are not rebuilt in a way that allows disabled children to attend school, this sends a damaging message to the disabled child and places limitations on his or her entire life”\(^{85}\).

In addition, it is very important to note that post-disaster approaches are sustainable only if psychosocial problems are addressed.

The reconstruction process, carefully thought and planned, can provide huge opportunities to consider and incorporate special needs of already and newly disabled people. Lessons from a disaster should also be applied to prevent people from getting disabled in next disaster contexts.

Disaster risk reduction processes require long-term efforts and sustainable planning to reduce risk to acceptable levels. To effectively protect human lives, property and the development process, a strong political commitment by governments should be accompanied by the necessary legal, institutional and financial frameworks and the strong support of the international community.

**Box 4: World Bank’s Disability Project in Post-Earthquake Pakistan**\(^{86}\)

The 7.6 magnitude earthquake that hit Pakistan on 8 October 2005 devastated one of the most remote mountainous parts of the world and one of the poorest parts of Pakistan. According to the joint ADB-World Bank Needs Assessment, approximately 73,000 people died and more than 70,000 have been severely injured or disabled. Many injured had amputated limbs or severe spinal cord injuries that left them paralysed. Preliminary estimates show a large population affected by physical or mental disorders and disabilities, including post-traumatic stress and trauma.

Besides those newly disabled because of the earthquake, persons already disabled have sometimes lost their support systems and whatever services they were getting before the earthquake.

In response to the earthquake, the Government of Pakistan has set up a Central Management Unit for disability efforts in the earthquake-affected areas. The proposed project is consistent with their strategy documents and will be implemented in coordination with this Unit.

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\(^{84}\) World Bank (2006), *op. cit.*, p. 3.

\(^{85}\) Oosters, Barbara (2005), *op. cit.*, p. 2.

The project has three components:

1. Provision of services, mobilisation and empowerment of people with disabilities and mental health issues and their families:
   - Community-based rehabilitation will target persons with disabilities, their families and communities through social mobilisation and other community-based activities aimed at raising awareness and knowledge;
   - Specialised institution-based rehabilitation services will be provided by specialised service;
2. Capacity building for service providers and civil society organisations:
   - Sensitisation of the project and partner organisations management;
   - Training of disability social workers;
   - Capacity building of specialised service providers (institutions);
   - Support to community-based organisations for proposal writing; and
3. Project management, monitoring, and evaluation.

High priorities in the short run would include medical care and treatment of unattended medical needs such as wounds, injuries and injury-related diseases as well as prosthetics, especially artificial legs, to restore mobility and to reduce and mitigate the risk of longer term disability and impoverishment due to disability.

Psycho-social counselling to mitigate post traumatic stress syndrome disorders is also necessary to allow individuals and communities to resume and restore social and economic livelihoods and to avoid the development of more severe mental health disorders including depression and mental illness per se.

The project aims to achieve the following outcomes in its primary target area:

- Improved quality of life of the targeted persons with disabilities, as indicated by their better health, improved mobility, increased capacity to take care of themselves and participate in social and economic life;
- Improved mental health of the targeted victims through easing and relieving their post-traumatic stress and disorders;
- Improved and increased capacity of the community-based service providers, as well as that of specialised institutions, to provide good quality rehabilitation services to the persons with disabilities; and
- More enabling environment and increased social mobilisation of the persons with disabilities, their families and communities to take action on disability.
6. Mental Health and Psychosocial Support in Emergency Settings

Because of the elevated incidence of psychological harm after a crisis, this paper suggests that we should proactively integrate mental health and psychosocial support in contexts of conflict, post-conflict or natural disaster, taking into account that vulnerability to mental and psychosocial problems can be extremely widespread in the aftermath and has long-term impacts on recovery.

Most of the information in this section is drawn from *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings*.

**Causes of Mental Health and Psychosocial Problems**

What are the causes of mental health and psychosocial problems in emergencies?

Firstly, problems of a predominantly social nature, including:
- Pre-existing (pre-emergency) social problems (e.g. extreme poverty; belonging to a group that is discriminated against or marginalised; political oppression);
- Emergency-induced social problems (e.g. family separation; disruption of social networks; destruction of community structures; gender-based violence); and
- Humanitarian aid-induced social problems (e.g. undermining of community structures or traditional support mechanisms).

Secondly, problems of a predominantly psychological nature, including:
- Pre-existing problems (e.g. severe mental disorder; alcohol abuse);
- Emergency-induced problems (e.g. grief; non-pathological distress; depression and anxiety disorders, including post-traumatic stress disorder (PTSD)); and
- Humanitarian aid-related problems (e.g. anxiety due to a lack of information about food distribution).

**People at High Risk**

It is not an exaggeration to say that everyone surviving a crisis situation is at increased risk of mental health and psychosocial problems in diverse emergencies, although this may manifest itself in different ways because of individual resilience and also as a result of differences in sex, age, location, education, poverty, and so on.

It is important to present which members of which groups may be vulnerable and to think about when they may be more or less vulnerable, or more or less resilient, to psychological trauma. While sex and age are usually associated with different forms of vulnerability, people may also become vulnerable for other reasons that are specifically caused by crisis situations. Some ways to think about the question of vulnerability are suggested below:
- **Women** (e.g. pregnant women, mothers, single mothers, widows and, in some cultures, unmarried adult women and teenage girls);
- **Men** (e.g. ex-combatants, idle men who have lost the means to take care of their families, young men at risk of detention, abduction or being targets of violence);
- **Children** (from newborn infants to young people under 18 years of age), such as separated or unaccompanied children (including orphans), children recruited or used by armed forces or groups, trafficked children, children in conflict with the law, children engaged in dangerous labour, children who live or work on the streets and undernourished children;

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88 Ibid., pp. 2-3.
• Elderly men and women (especially when they have lost family members who were caregivers);
• Extremely poor people;
• Refugees, internally displaced persons (IDPs) and migrants in irregular situations (especially trafficked women and children without identification papers);
• People in the community with pre-existing, severe physical, neurological or mental disabilities or disorders;
• People in institutions (orphans, elderly people, people with neurological/mental disabilities or disorders);
• People who have been exposed to extremely stressful events/trauma (e.g. people who have lost close family members or their entire livelihoods, rape and torture survivors, witnesses of atrocities, etc.);
• People experiencing severe social stigma (e.g. untouchables/dalit, commercial sex workers, etc.); and
• People at specific risk of human rights violations (e.g. political activists, ethnic or linguistic minorities, people in detention, etc.).

How to Intervene?  

A common error in work on mental health and psychosocial well-being is to ignore individual and community resources and to focus solely on people’s deficits (weaknesses, suffering and pathology). Although at-risk people need support, they often have capacities and social networks that enable them to contribute to their families and to be active in economic, social, religious and political life. Additionally, affected groups have assets or resources that support mental health and psychosocial well-being. The nature and extent of the resources available and accessible may vary with age, gender, the socio-cultural context and the emergency environment.

We can collaborate with governments and civil society organisations to elaborate tools and policies that would:
1) enable vulnerable individuals and communities to ameliorate their existing capacities, resources and networks; and
2) prevent existing vulnerabilities from being exacerbated in crisis situations.

Psychic trauma is systematically one of the challenges encountered in crisis situations. In the area of community-based rehabilitation (CBR), it is important to:
• Visit people with disabilities and their families regularly in their homes; listen to their problems and frustrations and provide support and encouragement;
• Make sure people with disabilities and their families have access to mainstream psycho social support and that specific measures are in place to allow their participation such as sign language translation;
• Include children with disabilities in activities designed to relieve the pressures on them: individual and group self-expression workshops, painting, drama, art contests, recreational child-to-child activities, production of educational toys, etc; and
• When situations are very stressful, provide psychological support for CBR workers themselves (i.e. speaking groups) so that they can talk about the situation and have support from a psychologist or from the peer group.

90 Some of information in this sub-section is taken from: WHO/IL0/UNESCO (2007), CBR Guidelines: CBR and Crisis Situations, which is still in a review process.
91 Inter-Agency Standing Committee (IASC) (2007), op. cit., pp. 4-5.
92 Ibid., p. 5.
7. Gender and Disability in Crisis Settings

Women and Girls with Disabilities

In Article 6 of the Disability Convention, women and girls with disabilities are recognised to be multiply disadvantaged, experiencing exclusion on account of their sex and their disabilities.

Both within and outside the home, they are often at greater risk of violence, abuse, exploitation, or maltreatment. They are less able to defend themselves physically and, in some cases, unable to articulate the fact of abuse. In conflict situations, "where physical and sexual violence tends to take place outside the home, disabled women are also at greater risk of abuse than non-disabled women"93.

The issue of women carers of severely disabled children and adults is also a gender and disability issue. Women provide most of the agricultural labour in the South. Caring for a severely disabled child further increases the workload of women living in extreme poverty, and takes valuable time away from the daily struggle for survival. In addition, mothers are often ostracised by their communities for having a disabled child.94

Progress on MDG 3 regarding promoting gender equality and empowerment of women is being markedly hampered by the fact that large numbers of women and girls with disabilities are encountering a disproportionately high level of obstacles ranging from access to education and employment to problems with protection and violence.95

States who will sign up to the Convention should take all appropriate measures to ensure the full development, advancement and empowerment of women and girls with disabilities, and women and girls who are caretakers, for the purpose of guaranteeing them the exercise and enjoyment of the human rights and fundamental freedoms set out in this treaty.

Impacts of Landmines and Disabilities on Women and Girls

There are a number of negative impacts of disabilities caused by landmines on women and girls in conflict and post-conflict contexts.

Evidence from the ILO study in Cambodia illustrates the gender dimension of disability as disabled men relied on their wives for support, while disabled women were abandoned by their partners or had difficulty in finding one.96

Many post conflict countries affected by mines have a disproportionate number of women headed household; challenges faced by women in finding employment are compounded if they have disability.97 In areas where employment opportunities are minimal, where people with disabilities are stigmatised or there is a shortage of training and rehabilitation facilities, mine survivors face enormous challenges. As stated by UNIFEM, in most agrarian societies the loss of a limb makes it almost impossible for a person to find work, and women, in particular, may be ostracised because they are perceived as being "damaged".98 In addition, women are likely to have to care for injured

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94 Ibid., p. 10.
97 Landmine Survivors Network, Gender, Victim Assistance and Advocacy, pp. 1-2.
spouses and children, but these female caregivers often will not have access to safe and equitably paid employment.\textsuperscript{99}

Quick care is important for saving lives and reducing disability. Priority is however often given to military personnel (most often male) than to civilians.\textsuperscript{100} In addition, males are prioritised to receive prosthetic devices and services because seen as a “better” investment, while women and girls face greater difficulty in accessing medical care and physical rehabilitation services.\textsuperscript{101}

Furthermore, the Landmine Survivors Network affirms that cultural restrictions prevent, in some countries, women from seeing male health practitioners unless accompanied by male relative, limiting their access. Also, responsibility of household tasks and caring for children may prevent them from accessing services.\textsuperscript{102}

Landmines, or the perceived threat of landmines, may further restrict women’s mobility. The presence or threat of mines/ERW can compromise women’s ability to carry out survival tasks such as collecting water and tending crops, or alternatively to engage in new economic activities outside the domestic sphere.\textsuperscript{103}

**HIV/AIDS and Women with Disabilities\textsuperscript{104}**

Women with disabilities tend to be vulnerable to HIV/AIDS for several reasons.

First of all, disabled women could be vulnerable to HIV/AIDS from men claiming to support them, often their husbands, who take advantage of their wives’ disabilities and have extra-marital affairs. Once the disabled woman is HIV-positive, the man would send her away to her parents or relatives to take care of her until death. He will refuse the responsibility of bringing HIV into the marriage.

In some cultural contexts there is a belief that “having a sex with a disabled woman or girls cures HIV”, and this is leading to numerous rapes. The Girl Child Network reports that children as young as two years are being sexually abused by caregivers or close relatives who believe in this HIV/AIDS “cure”.

Also, the fact that information on HIV/AIDS is not available in Braille or sign language increases the risk of contracting this disease for persons, especially women, with visual or hearing impairments.

Moreover, we should not ignore that a number of women and girls contract HIV/AIDS, because of sexual violence, especially rape, in conflict or post-conflict situations. This will be examined in detail later.

**Sexual and Reproductive Rights**

Many women do not have full possession of their own bodies. This results in them not being able to plan their lives, which jeopardises their health and lives.\textsuperscript{105}

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\textsuperscript{100} UN/Department for Disarmament Affairs and Department of Peacekeeping Operations/Mine Action Service (2001), op. cit., p. 3.

\textsuperscript{101} Landmine Survivors Network, op. cit., pp. 1-2.

\textsuperscript{102} Ibid.

\textsuperscript{103} Huckerby, Gemma and Takeshita, Mugiho (2007), op. cit.

Sexual and reproductive rights are constantly under attack and questioned by cultural, religious and ethnic movements trying to control women’s behaviour and lives.\textsuperscript{106}

According to UNFPA, complications during pregnancy and childbirth are a leading cause of death and disability among women of reproductive age in developing countries. For every woman who dies, roughly 20 more suffer serious injury or disability — between 8 million and 20 million a year. A mother’s disability can diminish her contributions to both the family and the economy in the struggle against poverty.\textsuperscript{107}

The World Bank indicates that rape and domestic violence are major causes of disability and death among women of reproductive age in both developed and developing countries.\textsuperscript{108} They are risk factors for a number of disease conditions such as sexually transmitted diseases (STDs), depression and injuries.\textsuperscript{109}

Women’s reproductive health problems during conflict range from life threatening pregnancies, injuries from gender-based violence to the lack of sanitary supplies for menstruation. During and after conflicts women’s sexual and reproductive rights tend to be neglected.\textsuperscript{110}

International donors have failed to fully recognise and address women’s health needs and its consequences. In conflict-affected countries such as Burundi and the Democratic Republic of Congo (DRC), women’s sexual and reproductive health services are seriously lacking in resources. During conflicts health clinics and services are badly affected which makes it harder to provide healthcare for all. Moreover, sexual and reproductive health services are often neglected despite proof of mass rape and that women and children are increasingly affected by conflicts.\textsuperscript{111} In DRC, for example, tens of thousands of women and girls were raped during the conflict (1996–2003), and in 2005 in the Eastern parts of the country there were only two hospitals with one or two gynaecologists and medical equipment capable of treating the serious physical injuries caused by rape.\textsuperscript{112}

\subsection*{Gender-Based Violence}

In many countries that have suffered violent conflict, the rates of interpersonal violence remain high even after the cessation of hostilities – among other reasons because of the way violence has become more socially acceptable and the availability of weapons.\textsuperscript{113} High levels of sexualised violence against women are usually maintained after a conflict has ended officially.\textsuperscript{114} Guns may be used to facilitate different forms of abuse, including gender-based violence. The tension between families and returning ex-combatants can be extreme and increased domestic violence is common.\textsuperscript{115}

In violent conflict combatants are unfettered by normal restraints and have the power to subject civilian women and girls to their demands. The rampancy of rape in war suggests male sexual

\textsuperscript{106} Jacobson, Agneta Söderberg et al. (2005), Security on whose terms? If men and women were equal, Stockholm: The Kvinna till Kvinna Foundation, p. 39, \url{http://www.iktk.se/publikationer/rapporter/pdf/Security.pdf}


\textsuperscript{108} UNFPA, Reproductive Health Fact Sheet, \url{http://www.unfpa.org/swp/2005/presskit/factsheets/facts_rh.htm}


\textsuperscript{110} UNFPA, Violence Against Girls and Women....

\textsuperscript{111} Ibid.

\textsuperscript{112} Jacobson, Agneta Söderberg et al. (2005), \textit{op. cit.}, p. 40.


opportunism. Evidence supporting this notion includes numerous testimonies from conflict areas in the Democratic Republic of Congo, Uganda and Liberia, where women have been abducted and enslaved as “bush wives” to cook, clean and provide sexual services to single or groups of men. In fact, many women affiliated with fighting forces are often the last to be released, if they are released at all, by militaries during the DDR process because of their value to the group. This leads their being left out of DDR processes and often has very negative ramifications for their reintegration into society, let alone the continued denial of their rights.116

During the last decade the international community and the media has given more attention to rape as a weapon of war and some important steps have been taken. In November 1998 a crucial landmark was set when the prosecutor at the International Criminal Tribunal for Rwanda (ICTR) for the first time in history defined rape as a crime under international law stating that rape on its own can be a crime against humanity.117 The sentence in ICTR was part of a shift in international law regarding women’s rights in war and conflict. With the Rome statute from 1998 establishing the permanent International Criminal Court, rape, forced prostitution, sexual slavery, forced pregnancy and forced sterilisation can be labelled as crimes against humanity and war crimes.118

But there is a long way to go for women to have access to and gain justice and for the violence to stop. Rape and sexual violence is an integrated part of conflicts, and it is used as a strategic weapon of war to punish, inflict fear, to eradicate the future of the enemy and to humiliate men by sending a message that they cannot protect “their” women. After being raped women face new hardships, not just from the direct physical injuries but also from the psychological impact which increases by the risk of being infected by HIV/AIDS or having an unwanted pregnancy. The stigma attached to rape threatens women who speak out about the abuses to be abandoned by their husbands, ostracised by the community, left with no economic assets or income.119

As a result of the systematic and exceptionally violent gang rape of thousands of Congolese women and girls, doctors in the DRC are now classifying vaginal destruction as a crime of combat. Many of the victims suffer from traumatic fistula – tissue tears in the vagina, bladder and rectum.120 Additional long-term medical complications for survivors may include uterine prolapse (the descent of the uterus into the vagina or beyond) and other serious injuries to the reproductive system, such as infertility, or complications associated with miscarriages and selfinduced abortions.121 Rape victims are also at high risk for sexually transmitted infections. Untreated, these infections can cause infertility – a dire consequence for women in cultures where their value is linked to reproduction.122

Thus, victims of gender-based violence first need medical treatment. But the woman herself does not or cannot always prioritise seeking medical help for treating problems caused by the violence. As sexual and reproductive rights are difficult to talk about and since gender-based violence is often connected with stigma, the feeling of shame might stop her.123

For those who are subject to discrimination by family and community, and who also do not receive basic psychological support, the emotional effects of their violation may be as debilitating as any physical injuries. Amongst many rape survivors in Rwanda, a woman, who was gang raped and beaten unconscious during the genocide, woke up only to witness the killing of people all around her. Ten years later, she says124:

117 The prosecutor versus Jean-Paul Akayesu, case no ICTR-96-4-T. paragraph 597, cited in: Jacobson, Agneta Söderberg et al. (2005), op. cit., p. 43.
118 Jacobson, Agneta Söderberg et al. (2005), op. cit., p. 43.
119 Ibid., pp. 40-41.
123 Jacobson, Agneta Söderberg et al. (2005), op. cit., p. 40-41.
124 OCHA/IRIN (2007), op. cit., p. 27.
“I regret that I didn’t die that day. Those men and women who died are now at peace, whereas I am still here to suffer even more. I’m handicapped in the true sense of the word. … I regret that I’m alive because I’ve lost my lust for life. We survivors are broken-hearted. We live in a situation which overwhelms us. Our wounds become deeper every day. We are constantly in mourning.”

Rape has long-term consequences on women’s mental and physical health if not adequately treated. When the physical health problems have been addressed, time must also be given for the women to overcome the trauma and continue with their lives. For this reason, many women’s organisations create women’s centres, safe spaces, where women can meet and talk about their experiences during the conflict.

Financial reparations to victims of sexual violence are frequently recommended in commission reports, truth and justice inquiries and human rights reports. During 2006, members of parliament in Sarajevo agreed to consider new legislation to establish a reparations system for victims who were raped during the 1992-1995 Bosnian war. The measure, which would pay out a monthly disability pension of between 70 and 200 euros per victim, is the first of its kind to be considered in the region and is expected to compensate an estimated 5,000 women already registered as rape victims in Bosnia.

Stop Rape Now - UN Action against Sexual Violence in Conflict is a joint initiative of 10 UN system entities, with the goal of ending and responding to sexual violence in crisis and recovery situations. In concert with national governments and non-governmental organization (NGO) partners, UN Action aims to:

- Build upon and amplify existing UN efforts to end sexual violence in conflict;
- Generate public and political outrage about the growing use of sexual violence as a means of conducting warfare;
- End impunity for sexual violence in conflict;
- Ensure a comprehensive range of services for survivors of sexual violence; and
- Address the longer term impacts of sexual violence on national and community recovery efforts.

Disability and “UNDP’s Eight-Point Agenda for Women’s Empowerment and Gender Equality in Crisis Prevention and Recovery”

This sub-section examines how the Disability Convention and disability issues can be supported and mainstreamed in concert with UNDP's Eight-Point Agenda (8PA) in crisis prevention and recovery activities.

- 8PA-1: Strengthen Women’s Security in Crisis
- 8PA-2: Advance Gender Justice

Article 16 of the Convention states that “laws and administrative measures must guarantee freedom from exploitation, violence and abuse. In case of abuse, States shall promote the recovery, rehabilitation and reintegration of the victim and investigate the abuse”.

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126 Jacobson, Agneta Söderberg et al. (2005), op. cit., p. 40.
127 Ibid., p. 45.
128 OCHA/IRIN (2007), op. cit., p. 120.
129 DPKO, OCHA, OHCHR, UNDP, UNFPA, UNHCR, UNICEF, UNIFEM, WFP and WHO.
Women and girls with disabilities are particularly vulnerable to abuse. A small 2004 survey in Orissa, India, found that virtually all of the women and girls with disabilities were beaten at home, 25% of women with intellectual disabilities had been raped and 6% of disabled women had been forcibly sterilised. Additionally, disabled women and girls are in general less likely to obtain police intervention, legal protection or preventive care.

Such evidence points to the urgent need for UNDP to help states to establish legislative and administrative measures which prevent these cruel treatments, punish severely the perpetrators, and offer redress to the victim/survivor.

Furthermore, UNDP will have to make an effort, through its policy advices to governments and its operations in the field, to integrate into local communities disabled former combatants (male and female) and child soldiers, girls sexual slaves of war, as well as men and women with disabilities caused by landmines/ERW, SALW, (sexual) violence, natural disaster, etc.

- **8PA-3: Expand Women’s Citizenship, Participation and Leadership**
- **8PA-4: Build Peace with and for Women**
- **8PA-5: Promote Gender Equality in Disaster Risk Reduction**

There is a need to reinforce disabled women’s skills and networks to promote their leadership and participation in the social, political, and economic spheres in conflict, post-conflict or natural disaster contexts. This will enable their points of view taken into account by governments in policy and decision-making and increase understanding of their needs by the society at large.

Additionally, UNDP could encourage political participation of women with disabilities, not only as voters, but also as members of governments and parliaments in order to speak out their own concerns, rights and experiences.

Women, as primary caregivers of youth and children, and as peace activists, are important drivers for risk education on the prevention of injury arising from small arms misuse, on mine risk education, on conflict prevention and peace building, and on disaster risk reduction. They are usually well-placed to convey such messages to diverse members of a community and should be empowered to do so.

- **8PA-6: Ensure Gender-Responsive Recovery**

If they are not disabled themselves, women are likely to have to care for injured or disabled spouses and children, but these women do not often have access to safe and equitably paid employment. The burden of poverty on families who care for persons with disabilities is immense, and is disproportionately shouldered by females.

Women who become disabled are at risk of divorce, abandonment or ‘unmarriageability’ in certain societies, if they cannot any longer engage in physical labour and childrearing. Those women are condemned to extreme destitution and its associated risks, such as increased vulnerability to all forms of violence.

Therefore, it is crucial to ensure that women with disabilities, whether caused by landmines, small arms, (sexual) violence or natural disasters, can have access to assets, such as land and credit, employment, social protection, dignified and sustainable livelihoods. Given the greater likelihood of disabilities after a crisis, and with our knowledge that crisis situations give rise to or exacerbate poverty, recovery efforts should be doubly committed to sustainably alleviating all forms of disability-related poverty.

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Moreover, the reconstruction phase after crisis, whether conflict or natural disaster, should be planned in a gender-sensitive way to improve for example **lights, ramps and access to water points** so that women and girls could lead a safer and more sustainable life than before.

- **8PA-7: Transform Government to Deliver for Women**
- **8PA-8: Develop Capacities for Social Change**

UNDP might be able to play an important role in promoting **good governance in disability issues**, by providing governments with policy advice and better advocacy platforms. States could be guided to **plan and allocate their budgets to promote gender and disability-sensitive measures**, so that girls and women with disabilities and female caregivers of disabled persons can lead a secure and sustainable life.

We could also encourage States to adopt **policies and laws aimed at building the skills and capacities of disabled women and men** to earn a dignified livelihood, while considering the impacts of gendered division of labour in different cultural contexts.
8. Key Recommendations

- Support crisis affected countries in elaborating **gender and disability-sensitive laws** and measures as integral part of their national development policy.

- Help decision-makers to address the **fundamental vulnerabilities** of persons with disabilities in crisis situations.

- Include actions for both **preparedness and response to disabilities** issues in conflict, post-conflict and natural disaster settings.

- Promote “**Building back better policies**” in the **early recovery** period of the reconstruction.

- Take into account **differential needs of persons with disabilities depending on sex, age and type of impairments**, in every stage of the project cycle (assessment, programming, implementation and evaluation/monitoring).

- Integrate specific actions on behalf of **children, older persons and women with disabilities**.

- Pay attention to the **causes of disabilities** (landmines/ERW, small arms and light weapons, sexual violence, natural disasters, etc.).

- Provide **mental health of and psychosocial support** to the populations affected by crisis situations.

- Promote **sustainable empowerment of persons with disabilities and of Disabled People’s Organisations (DPOs)** and ensure their **participation in decisions** concerning issues that affect them.
Bibliography


Landmine Survivors Network, *Gender, Victim Assistance and Advocacy*, background paper.


## Annex1: Stipulation of Disability Issues in Conventions, Declarations and Resolutions on Human Rights

<table>
<thead>
<tr>
<th>Convention / Treaty / Declaration / Resolution / Framework</th>
<th>Year</th>
<th>Stipulation of Disability Issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Universal Declaration of Human Rights 133</td>
<td>1948</td>
<td>25-(1) Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age (…)</td>
</tr>
<tr>
<td>Declaration on the Protection of Women and Children in Emergency and Armed Conflict 134</td>
<td>1974</td>
<td>No</td>
</tr>
<tr>
<td>Treaty for the Rights of Women (CEDAW: Convention on the Elimination of All Forms of Discrimination against Women) 135</td>
<td>1979</td>
<td>No</td>
</tr>
<tr>
<td>Convention on the Rights of the Child 136</td>
<td>1989</td>
<td>2-1. States Parties shall respect and ensure the rights set forth in the present Convention to each child within their jurisdiction without discrimination of any kind, irrespective of the child’s or his or her parent’s or legal guardian’s race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status. 23.1. States Parties recognise that a mentally or physically disabled child should enjoy a full and decent life, in conditions which ensure dignity, promote self-reliance and facilitate the child’s active participation in the community. (Other mentions in Art. 23)</td>
</tr>
<tr>
<td>Beijing Declaration and Platform for Action (Fourth World Conference on Women: Action for Equality, Development and Peace) 137</td>
<td>1995</td>
<td>32. Intensify efforts to ensure equal enjoyment of all human rights and fundamental freedoms for all women and girls who face multiple barriers to their empowerment and advancement because of such factors as their race, age, language, ethnicity, culture, religion, or disability, or because they are indigenous people</td>
</tr>
<tr>
<td>Mine Ban Treaty (Convention on the Prohibition of the Use, Stockpiling, Production and Transfer of Anti-Personnel Mines and on their Destruction) 138</td>
<td>1997</td>
<td>No</td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th>Convention / Treaty / Declaration / Resolution / Framework</th>
<th>Year</th>
<th>Stipulation of Disability Issues</th>
</tr>
</thead>
</table>
| **Beijing +5 (23rd Special Session of the General Assembly on "Women 2000: Gender Equality, Development and Peace for the Twenty-first Century")**\(^{139}\) | 2000 | 41. Many of the actions identified specific groups of women as their primary target:  
  a. older women/aging  
  b. adolescents/young women  
  c. refugees/asylum seekers  
  d. indigenous women  
  e. entrepreneurs/self employed  
  f. migrant women  
  g. rural women  
  h. **disabled** women  
  i. female household heads |
| **Resolution 1325 on Women, Peace and Security**\(^{140}\) | 2000 | No |
| **Hyogo Framework for Action 2005-2015: Building the resilience of nations and communities to disasters (HFA)**\(^{141}\) | 2005 | 4-(ii)-(g) Strengthen the implementation of social safety-net mechanisms to assist the poor, the elderly and the **disabled**, and other populations affected by disasters. Enhance recovery schemes including psycho-social training programmes in order to mitigate the psychological damage of vulnerable populations, particularly children, in the aftermath of disasters. |
| **Beijing +10 (Declaration on the Status of Women)**\(^{142}\) | 2005 | No |
| **Resolution 1612 (on Children and Armed Conflict)**\(^{143}\) | 2005 | No |
| **Geneva Declaration on Armed Violence and Development**\(^{144}\) | 2006 | No |
| **Disability Convention (Convention on the Rights of Persons with Disabilities and Optional Protocol to the Convention)**\(^{145}\) | 2006 | Yes |

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\(^{139}\) Beijing +5 Process and Beyond, New York, 5-9 June 2000,  

\(^{140}\) UN Security Council Resolution 1325 on Women, Peace and Security, New York, adopted on 31 October 2000,  

[http://www.unisdr.org/eng/hfa/hfa.htm](http://www.unisdr.org/eng/hfa/hfa.htm)

\(^{142}\) Beijing +10 (Declaration on the Status of Women), New York, 28 February to 11 March 2005,  

\(^{143}\) UN Security Council Resolution 1612 (on Children and Armed Conflict), New York, adopted on 26 July 2005,  

\(^{144}\) Geneva Declaration on Armed Violence and Development, Geneva, proclaimed on 7 June 2006,  

\(^{145}\) Convention on the Rights of Persons with Disabilities and Optional Protocol to the Convention (Disability Convention), New York, adopted on 6 December 2006,  
Annex 2: UN System and Persons with Disabilities

The following list is on the website of “UN enable”. It covers only UN agencies and international organisations tackling disability issues more from development perspectives and does not seem to include other UN agencies working on this issue from CPR approaches. Neither UNICEF, UNIFEM, UNFPA, UNMAS, UNHCR, nor UNDP is on this list.

This might suggest that there is an urgent need for the coordination of activities and strategies on disability issues in crisis situations, within the framework of IASC (Inter-Agency Standing Committee). The Cluster Working Group on Early Recovery (CWGER) could provide a good starting point.

Disability and Development
- Secretariat for the Convention on the Rights of Persons with Disabilities
- World Bank

Disability and Human Rights
- Office of the High Commissioner for Human Rights [OHCHR]

Disability and Education
- UNESCO

Disability and the World of Work
- International Labour Organisation [ILO]

Disability and Health
- Disability and rehabilitation [WHO]
- Mental Health in Primary Care [WHO]
- Prevention of blindness and deafness [WHO]

Rural Disabled
- Food and Agricultural Organisation [FAO]

Disability Definition and Statistics
- Disability Statistics
  - United Nations Statistics Division
  - ESCAP Statistics Division
- International Classification of Functioning, Disability and Health [ICF]

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## Annex 3: List of UN Agencies and Organisations Contacted for the Elaboration of the Discussion Paper

<table>
<thead>
<tr>
<th>Name</th>
<th>Organisation</th>
<th>Position</th>
<th>Talking points / Resources</th>
</tr>
</thead>
</table>
| Paula Claycomb      | UNICEF                                            | Senior Advisor, Landmines and small arms team | • UNICEF is very interested in expanding support to children with disabilities, including victim assistance in mine action.  
• Sent us many contacts and resources, e.g. from Landmine Survivors Network, Handicap International. |
| Helen Schulte       |                                                   | Focal point on Disability, Child protection section | • Discussed on some examples of disabilities in disaster contexts (Tsunami in Sri Lanka, Post-earthquake intervention in Pakistan).  
• Gave us a number of contacts and resources e.g. from World Bank, Access for All Campaign.  
• Sphere Project. |
| Shelley Inglis      | UNMAS (UN Mine Action Service)                    | Policy Coordination Officer                  | Contributed with the following:  
• Project proposal for developing tools to engage national directors of Mine Action Centres in advocacy for ratification of the Disability Convention, with Landmine Survivors Network;  
• Document on Victim assistance and Disability. |
| Alana Officer       | WHO                                               | Coordinator, Disability and Rehabilitation    | Contributed with the following:  
• WHO Disability and Rehabilitation Action Plan 2006-2011, etc.  
Discussed the CBR guidelines being developed in partnership with ILO and UNESCO which include a section on CBR and crises situations. |
<p>| Chapal Khasnabis    |                                                   | Technical Officer (Community based rehabilitation, Assistive devices) |                                                                 |</p>
<table>
<thead>
<tr>
<th>Name</th>
<th>Organisation</th>
<th>Position</th>
<th>Talking points / Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Giacomo Solari</td>
<td>Swiss Agency for Development and Cooperation</td>
<td>Programme Officer, Humanitarian Aid - Mine action</td>
<td>Discussed on <strong>victim assistance and broader development approaches needed</strong> for persons with disabilities in crisis settings.</td>
</tr>
<tr>
<td>Cate Buchanan</td>
<td>Centre for Humanitarian Dialogue</td>
<td>Project Manager, Human Security and Small Arms</td>
<td>Gave us a number of useful resources on disability issues in conflict, post-conflict and natural disaster settings, especially on <strong>gun violence and disabilities</strong>.</td>
</tr>
</tbody>
</table>
| Kirsten Young         | Landmine Survivors Network (LSN)       | Director of Advocacy and Rights               | Discussed on:  
  - **Implications of Disability Convention Articles for CPR activities**;  
  - Processes of the negotiations and the adoption of the Convention, etc. |
| Misty Buswell         | Save the Children                     | Advocacy and Program Officer                  | Provided some resources on **children with disabilities in crisis situations**. |
| **UNDP**              |                                       |                                               |                                                                                           |
| Kathleen Cravero      | UNDP/BCPR in New York                  | Assistant Administrator and Director          | Advised that the paper should be clearly linked to:  
  - **Victim/survivor assistance (landmines, disaster, sexual violence, etc.)**;  
  - ‘Disability-friendly' recovery as part of our **building back better policy**. |
| Sara Sekkenes         |                                       | Senior Programme and Development Advisor      | Explained the Disability Convention and necessary **governments’ strategies** for addressing disability issues in crisis contexts. |
| Melissa Sabatier      |                                       | Programme Officer, Mine Action                | Commented on the **stipulation of emergency and conflict settings** in the Disability Convention. |
| Reuben McCarthy       |                                       | CPR Regional Adviser                          |                                                                                           |
| Jennifer Worrell      | UNDP/BCPR in Geneva                    | Chief, Early Recovery and Cross-cutting Issues Team | **Overall supervision** of the work. |
| Vanessa Farr          |                                       | Senior Gender Advisor                         | **Continuous supervision and directions** in the elaboration of this paper. |
| Momodou Touray        |                                       | Economic Recovery Advisor                     | Some advices on **economic inclusion** of disabled people. |
| Yasmine Sherif        |                                       | Senior JSSR Advisor                           | Advised to integrate the issue of **disabilities caused by sexual violence** in conflict and post-conflict settings. |
| Carlos Villacis       |                                       | Global Risk Identification Programme Coordinator | Guided how to address disability issues, **before, during and after natural disasters**. |
| Ola Almgren           |                                       | Senior Recovery Advisor                       | General advices on how to integrate disaster aspects into disability issues. |
| Fenella Frost         |                                       | Global Disaster Reduction Programme Coordinator |                                                                                           |
| Caroline Borchard     |                                       | Regional Risk Reduction Associate             |                                                                                           |
| Augusta Angelucci     | UNDP in the Democratic Republic of Congo | Senior Gender Advisor                         | Provided the evaluation report of UNDP’s project on **injured (disabled) ex-combatants in the Democratic Republic of Congo** (DRC). |
| Caroline Schaefer     |                                       | Programme Officer                             |                                                                                           |