THE ALLIANCE
FOR CHILD PROTECTION
IN HUMANITARIAN ACTION

Appendices: The Importance of Cross-Sectoral Responses

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When devising response strategies that promote the protection of children with disabilities in humanitarian contexts, it is important to consider the ways in which multiple factors interact and have an impact. Everything from genetics to societal attitudes can affect a child.

This dynamic interplay between a wide range of factors requires dynamic interplay between relevant sectors. Linking and coordinating services can drastically reduce stress on children and their families,[1] which can have wide-reaching impacts.

Furthermore, cross-sectoral collaboration that thoughtfully responds to child protection needs leads to higher-quality positive outcomes for children. Conversely, siloed responses that fail to consider child protection can lead to inefficiencies and even potentially increased harm for children,[2] while also risk excluding children with disabilities entirely.

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Overview of Cross-Sector Challenges and Opportunities for Including Children with Disabilities*

	Wash[3]	Education[4]	Health[5]	Nutrition[6]
Impact on Children with Disabilities	Facilities that do not take into consideration the needs of children with disabilities may threaten their privacy – and therefore potentially their safety and dignity – especially for girls with disabilities regarding menstruation. Inaccessible facilities/ programmes may create additional responsibilities for caregivers of children with disabilities.	Children with disabilities are excluded from education at higher rates, especially in emergencies – this is true even more so for displaced children with disabilities and girls with disabilities. Because of this increased educational exclusion, children with disabilities also have a higher likelihood of missing out on critical information and services (related to WASH, health, and nutrition, for example) that is often provided in educational settings.	Increased risk of psychosocial disorders or worsened pre-existing conditions for children with disabilities. Increased risk of violence and sexual violence for children with disabilities, particularly for girls with disabilities, that can lead to HIV, other sexually transmitted diseases, and injury.	A "cycle of malnutrition," wherein disability can lead to malnutrition (difficulty swallowing, absorbing nutrients, etc.), and malnutrition can also cause further and/or new disabilities. Lack of adequate caregiver knowledge can lead to malnutrition for children with disabilities, as can larger stigmas and discrimination.
What Leads to Exclusion for Children with Disabilities	Information on WASH and other related topics not being offered in a range of formats or conveyed in a range of settings outside traditional learning environments (where children with disabilities, especially in emergencies, often have less access). WASH staff incorrectly assume that it is too expensive to make WASH infrastructure fully accessible.	Parents (due to stigma) keeping children with disabilities hidden away or not recognising the importance of education for children with disabilities, reducing their participation. Children with disabilities being excluded from or made to feel unwelcome at child-friendly spaces and temporary education environments. Teachers lacking the ability to teach children	Data in health information systems not being reliable and/or disaggregated regarding disability. Lack of training across health care personnel hindering their ability to interact with and help children with disabilities. Incorrect beliefs leading to inadequate information regarding sexual relations and safe sex being shared with persons with disabilities.	Food distribution sites (and/or health facilities that provide nutrition) being inaccessibly located. Nutrition personnel/ professionals being unable to communicate with children and/ or caregivers with disabilities. Distributed food not being appropriate for children who need modified food consistency.

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What Leads to Exclusion for Children with Disabilities	Long lines and wait times at distribution sites making them unwelcoming for children with disabilities and their families. WASH supply distribution not including accessible toilets, hygiene kits, and other supplies for children with disabilities.	with disabilities, or school infrastructure, materials, or transportation being inaccessible.	Information regarding health – including available services – not being offered via a range of accessible channels/formats.	Nutrition programmes being located primarily in schools – where children with disabilities have a lower likelihood of being included, particularly in emergencies – and other institutions being overlooked for these services.
Example Action: **Incorporating Children with Disabilities into Existing Programmes**	Offer staff of WASH programmes training on hygiene and self-care needs for children with disabilities – skills like how to transfer a child from a wheelchair to toilet chair/accessible toilet, how to physically support a child who has trouble sitting independently, etc.	Support governments in building capacity for teacher training (pre-service and in-service) that will allow them to provide inclusive instruction (including adapting their communication style and providing more flexible instruction in the classroom).	Develop health-related information (including that related to HIV/AIDS prevention and other services) in at least two formats.	Certain measurements to ascertain malnourishment are misleading for particular children with disabilities (e.g., mid-upper arm circumference may not be accurate for wheelchair users who have built up upper arm muscles), leading to children not being accurately identified as needing supports – create alternative measurement methods, including visual assessment and/or lower leg length, when standard malnutrition measurements might be misleading.
Example Action: **Targeting Programmes to Children with Disabilities**	Create alternative toilet options for children who have difficulty reaching WASH facilities.	Create itinerant teaching programmes, such as home-based or mobile education programmes for displaced children or those who can't otherwise reach educational spaces.	Bring sexual and reproductive health programmes and services to children located in special schools and residential facilities.	Provide nutrition programmes targeted to institutions outside of traditional schools, such as residential institutions and/or orphanages.

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Relevant Example in Practice	Iraq: children and adults with disabilities (as well as other older adults) expressed a need for and lack of access to diapers. Handicap International undertook group interviews to identify affected families who could not afford disposable diapers and provided guidance for a tailor, who then made reusable diapers for families (two diapers and 20 cotton inserts each). In addition, the group provided training for recipient families on how to launder and care for the diapers: in some camps, Action Against Hunger provided hot water tanks to this end.	The State of Palestine: teachers in Rafah and Gaza cities were offered a training course on inclusive and adapted teaching methods as well as guidance on "inclusion links" – activities to facilitate interaction between students at special and regular schools as well as exchange between the teachers.	The Philippines: following Typhoon Haiyan in 2013, an international organisation trained and worked with local physical therapists to distribute wheelchairs, including checking for appropriate fit and providing guidance for recipients on how to use and maintain them.	Bangladesh: the World Food Programme prioritises persons with disabilities (as well as pregnant women and elderly individuals) in its food distribution, while also covering transportation costs to deliver food to those who cannot reach the sites.

**In addition to the sectors included in the table above, the series also includes a guidance note dedicated specifically to child protection, which can provide additional reading on this topic.*

Data collection processes often exclude or under represent the views of children with disabilities and their caretakers.

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1 Jack P. Shonkoff et al., "Leveraging the Biology of Adversity and Resilience to Transform Pediatric Practice," Pediatrics 147, no. 2 (2021), https://doi.org/10.1542/peds.2019-3845.
2 The Alliance for Child Protection in Humanitarian Action, Minimum Standards for Child Protection in Humanitarian Action, 2019 Edition (The Alliance for Child Protection in Humanitarian Action, 2019).
3 United Nations Children's Fund, Including Children with Disabilities in Humanitarian Action: WASH (UNICEF, 2017).
4 United Nations Children's Fund, Including Children with Disabilities in Humanitarian Action: Education (UNICEF, 2017).
5 United Nations Children's Fund, Including Children with Disabilities in Humanitarian Action: Health and HIV/AIDS (UNICEF, 2017).
6 United Nations Children's Fund, Including Children with Disabilities in Humanitarian Action: Nutrition (UNICEF, 2017).