NUTRITION

WFP
World Food Programme

SAVING LIVES
CHANGING LIVES

WFP Guidance

Inclusive Nutrition Programming for Persons with Disabilities

May 2021

About the guidance

Nutrition and disability are intimately interrelated through various points of convergence. Malnutrition can be a cause, a contributor, or a consequence of disability, and persons with disabilities are at increased risk of being malnourished.

Nutrition services and programmes can act as entry points that accommodate, address and, in some cases, prevent disability. Concurrently, disability programmes can serve to improve nutrition for the women, men, girls and boys they serve.

It is imperative that the World Food Programme (WFP) adopts a disability inclusion approach in all nutrition programmes and services, through mainstreamed and targeted actions that address the needs, rights and protection of persons with disabilities.

The United Nations Disability Inclusion Strategy 2019 requires that WFP ensures the rights of persons with disabilities are embedded in all programmes and projects. Disability inclusion is also central to the 2030 Agenda for Sustainable Development plan of action requirements to achieve truly transformative, inclusive and sustainable development outcomes. This is in accordance with the WFP Nutrition Policy 2017 – 2021 and global normative frameworks.

In this document 'disability inclusion' refers to the meaningful participation of persons with disabilities in all their diversity, and the promotion and mainstreaming of their rights through consideration of disability-related perspectives in the design, implementation and evaluation of nutrition programmes, in compliance with the United Nations Convention on the Rights of Persons with Disabilities.[1]

Purpose and scope of the document

The purpose of this document is to provide clear, concise, practical guidance for effectively designing and implementing programmes with nutrition components to ensure they are disability inclusive, with a focus on low and middle-income country contexts. It reflects globally informed best practice guidance on persons with disabilities, drawn from reviews of literature and broad consultations with key WFP representatives and key external stakeholders. It is a living document, to be updated as required.

A list of resources is provided in the annex, along with definitions of concepts used in the document.

The guidance focuses on the links between undernutrition and disability, although it is important to note that overnutrition-associated conditions (such as diabetes) are also increasingly important causes of disability.

The document is presented in two parts:

- Understanding disability and nutrition
- Inclusive nutrition programming for persons with disabilities

This is not a standalone document; it should be used together with other WFP documents and global resources that are relevant to ensuring appropriate, quality programming inclusive of persons with disabilities.

1 In 2013, an estimated 80% of persons with disabilities lived in developing countries. UN. 2006. Convention on the Rights of Persons with Disabilities

Key audience for the guidance

All WFP functional areas have a role to play in ensuring nutrition is adequately integrated into WFP responses, and that nutrition programmes are disability inclusive.

The Inclusive Nutrition Programming for Persons with Disabilities Guidance is intended to support WFP staff globally, at all levels and functional areas, who contribute directly or indirectly to nutrition interventions, especially nutrition, school feeding and food assistance advisers/ officers, programme managers, and designated disability inclusion focal persons.

It is also relevant for any of WFP's partners in the field, including government, civil society organizations, international/non-governmental organizations and the private sector who have an interest in WFP's programming.

Contents

Acknowledgements

Author: Deborah Joy Wilson

Inclusive Nutrition Team Lead

Nutrition Division

World Food Programme

Rome. Italy

For more information contact:

World Food Programme

Nutrition Division (NUT)

Via Cesare Giulio Viola, 68

nutrition@wfp.org

wfp.org/nutrition

May 2021

PART 1: UNDERSTANDING DISABILITY AND NUTRITION

INTRODUCTION

Approximately 15% of the world's population (or 1 in 7 people) experience some form of disability, of whom 2-4% experience significant difficulties in functioning.[2,3] In 2013, an estimated 80% of persons with disabilities lived in developing countries.[4] Disability disproportionately affects women, older people, and poor people. Persons from poorer households, indigenous populations and those in ethnic minority groups are also at significantly higher risk of experiencing disability.[5] Persons with disabilities have more likely to have poorer health outcomes, lower education achievements, less economic participation and higher rates of poverty than people without disabilities. [6,7] Households with members with disabilities are more likely to suffer from food insecurity due to more constrained economic resources, limited working opportunities, extra demands for health services and time spent on care work.

Disability can lead to malnutrition, and conversely malnutrition can cause or contribute to a variety of disabilities. Countries with high levels of malnutrition and nutrient deficiency often report higher rates of disability and developmental delays.[8]

It is imperative that the World Food Programme (WFP) adopts a disability inclusion approach in all nutrition programmes and services as persons with disabilities have the same rights as all other people; effective development assistance and humanitarian action requires that no-one is left behind; persons with disabilities face specific risks and vulnerabilities; and disability inclusion makes economic sense.

Defining 'persons with disabilities'[9,10]

The United Nations (UN) Convention on the Rights of Persons with Disabilities[11] (CRPD) defines persons with disabilities as including "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"[12]. The CRPD and the UN Convention on the Rights of the Child[13] recognize that persons with a disability have the same right to food and nutrition as those without a disability.

The World Health Organization (WHO) defines 'disability' as "an umbrella term for impairments, activity limitations and participation restrictions, denoting the negative aspects of the interaction between an individual (with a health condition) and that individual's contextual (environmental and personal) factors."

> Impairments are health-related problems with body structure or function, due to genetic factors, disease, illness or injury. Impairment may be present from birth (congenital) or acquired later in life.
>
> Impairment is the term used for an individuals' condition, irrespective of whether the person experiences limitations in his or her life activities.
>
> Four key impairment types, based on the domains of functioning affected, are: physical (involving movement or mobility), sensory (including vision, hearing or communication/ speech), intellectual (considering conceptual, social and practical domains), and mental/psychosocial (including chronic severe mental disorders or psychosocial distress).

2 Disability disproportionately affects women, older people, and poor people. Persons from poorer households, indigenous populations and those in ethnic minority groups are also at significantly higher risk of experiencing disability. https://www.worldbank.org/en/topic/disability
3 https://www.who.int/health-topics/disability#tab=tab_1
4 UN. Fact sheet on persons with disabilities. https://www.un.org/development/desa/disabilities/resources/factsheet-on-persons-with-disabilities.html
5 http://www.emro.who.int/health-topics/disabilities/index.html
6 https://www.who.int/features/factfiles/disability/en/
7 https://www.un.org/development/desa/disabilities/resources/factsheet-on-persons-with-disabilities.html
8 Groce N, Challenger E, et al. 2014. Malnutrition and disability: unexplored opportunities for collaboration. Paediatrics and child health
9 https://www.disabled-world.com/definitions/disability-definitions.php
10 https://www.who.int/docs/default-source/classification/icf/drafticfpracticalmanual2.pdf?sfvrsn=8a214b01_4
11 UN. 2006. UN Convention on the Rights of Persons with Disabilities
12 https://www.ohchr.org/EN/HRBodies/CRPD/Pages/ConventionRightsPersonsWithDisabilities.aspx#1
13 UN. 1989. The United Nations Convention on the Rights of the Child

A variety of measurement tools are available[14]

It is important to identify societal, environmental and institutional barriers faced by persons with disabilities, and to address the barriers or provide reasonable accommodation or provide for exceptional needs, so that persons with disabilities have access to services, programmes, information, commodities and food on an equal basis to non-disabled persons. Barriers can differ depending on the types and severity of impairment. The intersectionality of disability, age, gender, ethnicity, location and race, among other factors, can further increase the barriers, creating compounding inequalities or disadvantages.

World Food Programme (WFP) staff need to understand the barriers and to facilitate the inclusion of persons with disabilities.

Persons with disabilities are not a homogenous group they have different impairments, needs and capabilities, based on their individual personal factors and diversity of experience.

While disability correlates with disadvantage, not all people with disabilities are equally disadvantaged. Disadvantage is influenced by their specific impairment and the context in which they live.

UNDERSTANDING MALNUTRITION AS A CAUSE AND CONSEQUENCE OF DISABILITY

Malnutrition can contribute to disability

At numerous points throughout an individual's lifecycle, malnutrition can cause or contribute to a variety of different physical, sensory, intellectual, or mental health disabilities.[15]

- Maternal malnutrition (macronutrient and micronutrient deficiencies) prior to and during pregnancy can increase the risk of the infant being born prematurely and at increased risk for physical, neurological and/or cognitive impairments. For example, iron deficiency can result in poor foetal growth; iodine deficiency can contribute to irreversible brain damage; vitamin D deficiency is associated with poor foetal skeletal growth; folic acid deficiency may contribute to development of a neural tube defect.[16]
- Poor nutrition in early childhood compromises physical, sensory and intellectual development, and may lead to learning disabilities. For example, considering micronutrients, severe vitamin A deficiency (xerophthalmia) causes blindness; anaemia affects mental and motor development; iodine deficiency disorder is associated with cognitive impairment.[17,18]
- Adults and older people are impacted by the accumulated effects of poor nutrition throughout their life, which can contribute to non-communicable diseases (metabolic diseases, rheumatic conditions, weak bones, others) and associated physical and cognitive disability.

14 https://academic.oup.com/heapol/article/27/5/357/749458
15 Maulik PK, Darmstadt GL. 2007. Childhood disability in low- and middle-income countries: overview of screening, prevention, services, legislation, and epidemiolgy. Pediatrics. 120 (Suppl 1): S1–55
16 Duncan B et al. 2017. Nutrition and health in a developing world. Chapter 24
17 https://academic.oup.com/ajcn/article/69/1/115/4694155
18 Courtright P, Hutchinson AK, Lewallen S. Visual impairment in children in middle- and lower-income countries. Arch Dis Child. 2011; 96(12): 1129-34

- Obesity increases the risk of metabolic disease and stroke, leading to disability-adjusted life years.[19]

Malnutrition also impairs the immune system function, rendering a person more susceptible to infection, and some infections can cause disability when treated incorrectly or too late.

Disability can increase the risk of malnutrition

Individuals who are born with or acquire a disability often face significant issues related to nutrition. Causal pathways by which disability contributes to malnutrition (undernutrition or overweight/ obesity) depend on the type and severity of the disability and contextual factors. These could be medical (illness); anatomic, motor/ mechanical or sensory (food access, preparation, self-feeding, sucking, chewing, swallowing); digestive/ gastro-intestinal (malabsorption, reflux); educational (including literacy level; lack of knowledge and skills of caregivers), environmental, attitudinal and socio-cultural (such as stigma, discrimination, neglect, exclusion, gender inequity); and institutional resulting in poor feeding/dietary and caregiving practices leading to inappropriate quantity and quality of required nutrients. Some specific impairments may also increase nutritional needs.

- Children, adolescents and women of childbearing age with disabilities have poorer overall nutritional status than their peers without disabilities.[20] This may result in poorer health and development, leading to a perpetuating cycle of sub-optimal nutrition, disability and worsening health status.
- Children with disabilities are 3x times more likely to be underweight and nearly 2x more likely to experience stunting and wasting.[21,22,23]
- Persons with certain physical disabilities are less mobile and therefore at risk of becoming overweight. Persons with certain types of intellectual or mental health disabilities may have eating disorders which place them at greater risk of becoming overweight.
- Disability may also be a risk factor for non-communicable diseases, thereby indirectly related to nutrition.

The intersectionality of multiple inequalities or disadvantages related to gender, age, race, ethnicity, location and other factors can increase the risk of poor health and nutrition outcomes for persons with disabilities.

Women with disabilities tend to experience more stigma and discrimination than women without disabilities. For example, women with disabilities are at greater risk of experiencing sexual violence compared to their counterparts without disabilities. Women with disabilities can often face more discrimination than men with disabilities. Gender and disability therefore intersect.

19 Dai H, et al. 2020. The global burden of disease attributable to high body mass index in 195 countries and territories, 1990–2017: An analysis of the Global Burden of Disease Study
20 Holden J, Corby N. 2019. Disability and nutrition programming: evidence and learning. Disability inclusion helpdesk report No. 6. UKAID
21 Tropical Medicine and International Health. 2018. The association between malnutrition and childhood disability in low- and middle-income countries: systematic review and meta-analysis of observational studies
22 Gottlieb CA, Maenner MJ, Cappa C, Durkin MS. 2009. Child disability screening, nutrition, and early learning in 18 countries with low and middle incomes: data from the third round of UNICEF's Multiple Indicator Cluster Survey (2005–06). Lancet. 374:1831–9
23 Kerac M et al. 2014. The interaction of malnutrition and neurologic disability in Africa. Semin Pediatr Neurol 2014;21:42–9

Conceptual framework of how malnutrition and disability relate and interact

The conceptual framework (Diagram 1) highlights how disability can be caused by malnutrition, considering the immediate factors operating at the individual level: through lack of micronutrients or macronutrients, or exposure to high concentrations of antinutrients[24] (which leads to, for example, poor nutrient absorption or neurological damage).[25]

Also, having a disability can lead to malnutrition, due to decreased nutrient intake, increased nutrient loss, and need for increased nutrients, which can put persons at risk of further complications. Countries with high levels of malnutrition and nutrient deficiency often also report higher rates of disability and developmental delays.[26]

Environmental, socio-cultural and institutional influencing factors are discussed later in this document.

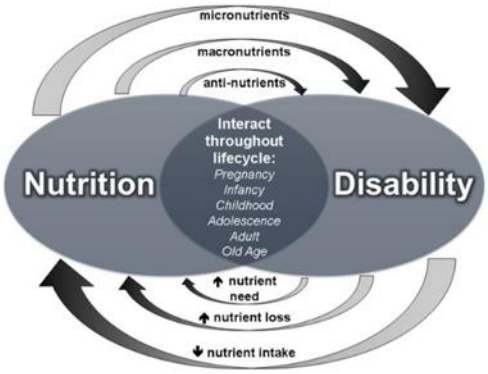

Diagram 1: Conceptual framework of how malnutrition and disability relate and interact. Adapted from Kerac et al.[27]

In Uganda, persons with disabilities, and their households, are increasingly being left behind.

A household survey found that 8.5 per cent of Ugandans have a disability. The prevalence of disability increases sharply with age, with around 40 per cent of older persons aged 65 years and above have a disability, rising to 57 per cent among those aged 80 years and above. However, since Uganda has a young population, currently the highest numbers of people with disabilities are below the age of 15 years. In Uganda, there is little variation between impairments for children, however, adults (aged 18 years and above) have the most difficulty with seeing (4.5 per cent) followed by walking (4 per cent). Furthermore, roughly one-third of all children and adults with disabilities have difficulties in more than one domain.

Stunting and other malnutrition or undernutrition related issues remains a significant problem in Uganda. The household survey found that close to 15 per cent of households with persons with disabilities have a poor dietary diversity consumption, and 55 per cent have either a low or a medium dietary diversity score. This is 2 percentage points more than households with no members with a disability.[28]

24 Antinutrients are natural or synthetic compounds that interfere with the body's absorption of nutrients
25 Nzwalo H, Cliff J. 2011. Konzo: from poverty, cassava and cyanogen intake toxico-nutritional neurological disease. PLOS Neglected Tropical Diseases, Vol 5(6) e1051
26 WHO. 2012. Developmental Difficulties in Early Childhood.
27 Groce et al. 2014. Malnutrition and disability: unexplored opportunities for collaboration. Paediatr Int Child Health. Apr; 34(4): 308–314 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4232244/
28 Uganda Ministry of Gender, Labour and Social Development. 2020. Situational analysis of persons with disabilities in Uganda.

UNDERSTANDING NUTRITIONAL VULNERABILITY

Individual impairments as risk factors for inadequate nutritional status

Feeding is a complex sensorimotor process that involves integration between the nervous system and the muscles and is affected by environmental factors. Any deficit in structure and/or function can lead to poor eating practices and nutritional status; these vary due to each person's level of nerve and muscle involvement, cognitive or mental processes, and sensory, emotional, and communication skills, which may change as the person ages. Many feeding difficulties pose serious health risks, including aspiration, which can be fatal.

Critical causal links between individual's nutrition and physical, sensory, mental health/psychosocial and intellectual impairments are presented below.

Sociocultural, environmental and institutional risk factors for inadequate nutrition at the individual level are presented in the following section.

Physical: Anatomic or functional difficulties

Difficulties increase with the severity of physical disability. Limited functional abilities, muscle control or coordination problems, including oral-motor skills, contribute to difficulty or inability to independently access and prepare food, sit up, to effectively eat from a spoon, utensil or cup, and to chew and swallow food.

Digestive problems (vomiting, gastro-oesophageal reflux, constipation), aspiration and nutrient malabsorption can occur in persons with certain impairments or medical conditions. Persons with difficulty swallowing may be more at risk of dehydration.

Insufficient intake of energy and nutrients may lead to -further- muscle wasting and loss of function. This in turn increases risk of further debilitating and recurring infections, including infections of pressure sores caused by immobility.

Special equipment for feeding and/or special positioning during feeding may be required. A quality diet is required to support muscle strength and for healing and control of infections. Persons unable to absorb and use the nutrients require high calorific or special diets in order to maintain strength and health

Sensory

Sensory processes (i.e. the way foods look, smell, taste and feel on the hands, lip, and inside of the mouth) may impact what, where and how a person eats.

Vision and hearing impairments can affect balance and reduce mobility, which may constrain the ability to access and prepare meals, and may also lead to increased dependence on others, social isolation and eating alone, as well as decrease appetite, and may reduce access to information and services.

Example: People with albinism have impairment in the production of melanin, the pigment that colours skin, hair and eye; this can contribute to multiple disabilities, associated with vision impairment and discrimination.

Mental / Psychosocial health

Behavioural issues may interfere with adequate or safe feeding. Examples include a lack of focus during mealtime, food refusal, selective eating (by type, texture, temperature, location, feeder, or a combination of these), spitting out food, over-eating, or eating too fast resulting in gagging or choking. Poor psychosocial health can lead to anorexia, loss of motivation or will to prepare food, and imbalanced, restricted or low food intake. Pica behaviour can occur in persons with mental disabilities. Additionally, withdrawal from social contexts can limit access to health and nutrition services and learning and peer support activities.

in persons with mental disabilities.[29] Additionally, withdrawal from social contexts can limit access to health and nutrition services and learning and peer support activities.

Intellectual

Poor ability to process information, dementia and short-term memory loss may lead to confusion and disorientation and difficulty to obtain and prepare foods, contributing to imbalanced food intake or forgetting to eat. The inability to communicate feelings of hunger, food preference and fullness, and to understand expectations related to eating may also affect the feeding process and thereby nutrient intake.

When persons with moderate to severe disabilities need support and extra time to feed this can cause added stress for the caregiver, which in turn promotes unresponsive feeding practices, and leads to stressful mealtimes for both caregiver and person.[30]

Examples of physical impairments and feeding difficulties that can lead to insufficient quality or quantity of food intake, aspiration and aversive mealtime experiences.

- Infants with **Clefts (lip/palate)** can experience nasal regurgitation, poor suction, excessive air intake, frequent burping, and prolonged feeding times.[31]
- Persons with **Down's Syndrome** can have a small oral cavity and delayed development of teeth, which can cause difficulties chewing.[32]
- Persons with **Cerebral Palsy, Spina Bifida, Multiple Sclerosis or other neurological disorders** may have difficulties with eating, swallowing or gastroesophageal reflux, and may suffer from constipation, aspiration of food or liquid and have the potential for dehydration.[33,34]
- Persons with an **Autistic Spectrum Disorder** (ASD) commonly show behavioural problems when feeding and be particularly sensitive to texture, taste, smell and noise, which will affect what and where they eat.[35]
- Persons with **Attention Deficit/ Hyperactivity Disorder** (ADHD) have shown a tendency to have irregular eating patterns, diminished preference and hence intake of fruits and vegetables.[36]
- **Older persons** can face a decline in their mobility, vision or hearing, and dentition, impacting on their ability to access, prepare, chew and swallow food.

Barriers to accessing services and resources faced by persons with differing disabilities

The context or circumstances can render a person with disabilities nutritionally vulnerable. Individual, attitudinal, environmental and institutional barriers that limit or exclude persons with differing impairments from equitably accessing resources and services, may fully or partially contribute to their sub-optimal nutrition. Examples of

29 Pica is a feeding disorder characterised by repeatedly eating inedible objects (e.g. cigarette ends, paint chips, faeces, paper and dirt) over a period of one month or more. Pica is one of the most dangerous eating difficulties for people with disabilities. Eating inedible objects may lead to physical consequences such as gastrointestinal obstruction, choking, illness and poisoning. The likelihood of pica occurring increases the more severe the level of learning disability.
30 Rabaey P. 2018. A review of feeding interventions for children with disabilities: implications for institutionalised settings
31 Shetty S, Khan M. 2016. Feeding considerations in infants born with cleft lip and palate
32 http://www.intellectualdisability.info/physical-health/articles/dental-problems-in-people-with-downs-syndrome
33 https://www.ninds.nih.gov/Disorders/All-Disorders/Swallowing-Disorders-Information-Page
34 Duncan B et al. 2017. Nutrition and Health in a developing world. Chapter 24
35 Cermak SA, Curtin C et al. 2010. Food selectivity and sensory sensitivity in children with autism spectrum disorders. J Am Diet Assoc. 110(2): 238-246
36 Duncan B et al. 2017. Nutrition and Health in a developing world. Chapter 24

these barriers are presented below.

Individual

- **Intersecting and compounding forms of inequity or disadvantage** depending on individual impairment type and severity related to:
  - Universal fixed identity factors such as age, sex, disability and health status.
  - Contextual factors such as language, caste, race, ethnicity, religion, location, migration and refugee status, family situation, among others.
  - Economic factors, with rates of poverty being disproportionate among persons with disabilities -whereby disability adds to the risk of poverty and conditions of poverty increase the risk of disability.[37] Persons with disabilities have disability-specific costs and are commonly disadvantaged accessing employment/ livelihoods and financial services.

Environmental

- **Geographical proximity** can limit physical access to services and facilities/ sites due to mobility and economic constraints.
- **Design of shelters or distribution points** may not be easily or safely accessible for persons with visual and mobility impairments.
- **Security and personal safety concerns** accessing services and facilities and to the theft of rations and supplies, especially when persons are displaced from usual support networks.

Attitudinal

- **Prejudice, discrimination, stigma and sociocultural barriers** may perpetuate persons with disabilities being segregated, excluded or receiving suboptimal care from society and services, and to being denied voice, autonomy and dignity; this may be heightened for specific sub-groups (e.g. women and girls).
- **Perceptions and beliefs that persons with disabilities are of lower status or worth than others**, which may result in them not having equal access to an adequate quality and quantity of food and access to services as the persons without disabilities.
- **Negative and derogatory language** related to disability, which reinforces attitudinal barriers.
- **Poor knowledge of persons with disabilities and caregivers**, which may affect feeding/dietary and care practices.
- **Competing time and energy demands on responsibility of caregivers** feeding persons unable to self-feed falls most heavily on female members of the household, who also have competing chores; this may result in the person receiving insufficient food.

Note: Attitudinal barriers can exist at interpersonal, community, institutional and policy levels.

37 Elwan, A. 1999. Poverty and Disability: A Survey of the Literature, Social Protection Discussion Paper Series, No. 9932, The World Bank, Washington, D.

- **Institutional**
  - **National policies, strategies and guidelines do not reflect disability inclusion** or 'reasonable accommodation'.
  - **Lack of available accurate impairment (and age and sex)-disaggregated data**, therefore specific vulnerabilities, needs and capacities are not identified.
  - **Disabilities indicators not included in programme monitoring frameworks.**
  - **Methods of data collection vary widely, and countries identify and measure disability in different ways;** some consider only physical ailments while others include mental health. In some societies, data collection on disability is stymied by stigma (or associated with black magic or witchcraft), resulting in impairments (especially mental health and intellectual impairments) not being disclosed or recognized; this leads to underreporting (and thereby mismanagement) of disabilities.
  - **Lack of personnel with technical and management understanding and expertise from a disability perspective.** Disability is often seen as a specialist subject, therefore not mainstreamed into education, including that of health and nutrition staff and volunteers.
  - **Limited availability of specialist health services** for persons with disabilities. Centralisation of nutrition and disability specialist services in urban, compared rural, areas.
  - **Persons with disabilities not adequately or appropriately involved** in decisions that directly affect their lives, or not able to express their opinions and ideas on an equal basis with others.
  - **Communication (including information, education, counselling) approach and methodology not appropriate** for persons with differing impairments (e.g. visual, audio, oral, reading, mental). This can restrict the ability of persons to express themselves and to access to information (e.g. entitlements, key messages), services (e.g. health and nutrition) and distributions (e.g. food, water, hygiene items).
  - **Programme activities, such as trainings, nutrition, food transfers, social safety nets, livelihoods, exclude or are not designed with consideration of** the specific challenges, capacities and needs of persons with differing impairments.
  - **Lack of contextualised and standardised screening tools** for disability. Anthropometry assessment methods not adapted for persons with physical disabilities. For example, the mid-upper arm circumference (MUAC) measure may be misleading where the upper arm muscle has built up (such as for some wheelchair users).[38]
  - **Support not provided to caregivers** of persons with disabilities who are not be able to join distributions, food-for-work or livelihoods programmes; this can reduce their access to food. Additional barriers further compound this when the caregiver also has a disability.
  - **Food programmes often overlook institutions and orphanages**, yet persons with disabilities disproportionately make up their populations.[39]

38 https://reliefweb.int/sites/reliefweb.int/files/resources/Humanitarian_inclusion_standards_for_older_people_and_people_with_disabi....pdf
39 https://resourcecentre.savethechildren.net/node/13765/pdf/unicef_nutrition_english.pdf

- Preserving the health and welfare of a person with a disability may be considered of lower priority than preserving those of a non-disabled, which can lead to harmful and neglectful practices. For example, in some societies:
    - Persons with disabilities may be given less nutritious or smaller quantities of food, or not prioritised for healthcare, compared non-disabled siblings, especially in contexts of extreme poverty, due to families considering limited resources should be devoted to persons who have a greater chance of surviving and contributing to the household.
    - Mothers of new-borns with a disability may be discouraged from breastfeeding, assured by family and healthcare staff that the child will die anyway or be a burden through life. This becomes self-fulfilling.
- Persons with disabilities are more likely to be denied access to health care and four times more likely to report being treated poorly in the healthcare system.[40]
- Children with disabilities admitted and treated for malnutrition have been found to be more than 2x more likely to die than children without disabilities. This may be due to delayed presentation at the health or nutrition facility; suboptimal care; more severe malnutrition at admission; and lack of follow-up post-discharge from the nutritional treatment facility.[41] Underlying factors (such as infections or neglected health care needs of the child, in particular those with severe impairments) may exacerbate the malnutrition and play a role in leading to higher risk of death.[42]

DISABILITY INCLUSION IN THE GLOBAL AGENDA

The following global normative frameworks address the needs, rights and protection of persons with disabilities:

- **United Nations Disability Inclusion Strategy** (2019):[43,44,45] The strategy defines UN entities, and country teams requirement to monitor progress and address gaps and other challenges for mainstreaming disability inclusion in operations and programming, both at headquarters and in the field, with the ultimate goal to achieve equality of outcomes and foster an inclusive culture within the UN system. Through the Strategy, the United Nations system will systematically embed the rights of persons with disabilities into its work, both externally, through programming, and internally within the organization, and will build trust and confidence among persons with disabilities to ensure that they are valued and their dignity and rights are respected and that, in the workplace, they find an enabling environment in which to fully and effectively participate on an equal basis with others.

40 https://www.who.int/news-room/fact-sheets/detail/disability-and-health

41 Kerac M. et al. 2012. Impact of disability on survival from severe acute malnutrition in a developing country setting – a longitudinal cohort study. Archives of Disease in Childhood, Vol 97

42 WHO. 2012. Developmental Difficulties in Early Childhood

43 Convention on the Rights of Persons with Disabilities (CRPD) | United Nations Enable

44 https://www.un.org/en/content/disabilitystrategy/assets/documentation/UN_Disability_Inclusion_Strategy_english.pdf

45 OHCHR | SDG - CRPD Indicators

The UN Disability Inclusion Strategy 2019 requires that WFP ensures the rights of persons with disabilities are embedded in all programmes and projects -including those relevant to nutrition.[46]

WFP's broad obligations regarding disability inclusion are defined in the 'WFP disability inclusion road map (2020-2021). WFP Disability Inclusion Platform.[47]

- **Charter on Disability Inclusion in Humanitarian Action:**[48] By endorsing this charter from the 2016 World Humanitarian Summit, WFP committed to providing humanitarian action inclusive of persons with disabilities. This means working to remove the barriers persons with disabilities are facing in accessing relief, protection and recovery support, and ensure their participation in the planning, implementation and monitoring of our humanitarian programmes.
- **Sustainable Development Goals (SDGs) 2030 Agenda** (2015):[49,50] Disability is referenced explicitly in various parts of the SDGs and implicated in others. Disability is a development priority because of its higher prevalence in lower-income countries. To achieve truly transformative, inclusive and sustainable development outcomes it is essential to recognize and address the exclusion and nutritional vulnerability, needs and capacities of persons with disabilities and to target them through policies, guidelines and programmes that are sensitive and responsive to them.
- **The Sendai Framework for Disaster Risk Reduction 2015-2030** (2015):[51] Persons with disabilities are particularly vulnerable during natural disasters, extreme climate events, conflict and humanitarian emergencies.[52] Accessibility should be factored into its disaster risk reduction preparedness and programming, with an understanding how persons with disabilities are disproportionately affected by disasters.
- **United Nations Convention of the Rights of Persons with Disabilities** (2006):[53] The convention underscores that persons with disabilities have the right to receive essential nutrition, healthcare, education and social protection services, and the importance of preventing discrimination on the basis of disability.
- **Universal Declaration of Human Rights, Article 25** (1948):[54] The rights of persons with disabilities to have physical access to adequate food, as a key determinant of nutritional status.
- **United Nations Convention on the Rights of the Child** (1989):[55] Children with disabilities have adequate nutrition.

46 WFP. 2020. Disability Inclusion Road Map 2020-2021
47 Disability Inclusion | WFPgo
48 http://humanitariandisabilitycharter.org/
49 https://www.un.org/development/desa/disabilities/about-us/sustainable-development-goals-sdgs-and-disability.html
50 https://www.un.org/disabilities/documents/sdgs/disability_inclusive_sdgs.pdf
51 https://www.preventionweb.net/files/43291_sendaiframeworkfordrren.pdf
52 https://social.un.org/publications/UN-Flagship-Report-Disability-Final.pdf
53 https://www.ohchr.org/EN/HRBodies/CRPD/Pages/CRPDIndex.aspx
54 https://www.ohchr.org/EN/Issues/ESCR/Pages/Food.aspx
55 https://www.ohchr.org/en/professionalinterest/pages/crc.aspx

Why is it essential to address persons with disabilities for achievement of the SDGs?[56]

SDG 1: No poverty: Persons with disabilities are more likely to live in poverty than persons without disabilities due to barriers in society such as discrimination, limited access to education and employment and lack of inclusion in livelihood and other social programmes.

SDG 2: Zero hunger: In developing countries, persons with disabilities and their households are more likely to not always have food to eat, compared to persons without disabilities and their households.

SDG 3: Good health and well-being: Persons with disabilities are more likely to have poor health and generally have more standard and impairment-related healthcare needs than others; they are therefore more vulnerable to the impact of low quality or inaccessible health-care services than others.

SDG 4: Inclusive and equitable quality education: Persons with disabilities are less likely to attend school and complete primary education and more likely to be illiterate than persons without disabilities.

SDG 5: Gender equality and empowering of women and girls: Women with disabilities are more likely to have unmet needs for health care and to be illiterate; they are less likely to be employed.

SDG 6: Clean water and sanitation: Persons with disabilities, especially those living in low-income countries, encounter challenges in access to water, sanitation and hygiene, including physical, institutional, social and attitudinal barriers.

SDG 8: Decent work and economic growth: Persons with disabilities are more likely to have limited access to the labour market. Employed persons with disabilities tend to earn lower wages, than their counterparts without disabilities.

SDG 10. Reduced inequalities: Persons with disabilities face persistent inequality in social, economic and political spheres and are disadvantaged in all areas covered by the SDGs.

SDG 11: Inclusive, safe and sustainable cities and communities: Transportation systems, public spaces and facilities and businesses are not always accessible for persons with disabilities.

SDG 17: Partnerships for the goals: Lack of disability disaggregated data and research on persons with disabilities severely constrains their vulnerabilities and needs being identified and appropriately responded to.

56 https://social.un.org/publications/UN-Flagship-Report-Disability-Final.pdf

PART 2. INCLUSIVE NUTRITION PROGRAMMING FOR PERSONS WITH DISABILITIES

Disability-inclusive nutrition services and programmes, and related activities, can reduce nutrition risks faced by persons with disabilities. They can also act as entry points to address and, in some cases, avoid or prevent disability.

However, the current evidence base on the impact of specific approaches to ensuring people with disabilities are reached through nutrition programming is limited.[57]

This section provides guidance on nutrition programming that is sensitive to, inclusive of, and equally accessible to persons with disabilities based on currently available global guidance, and in alignment with the UN Convention on the Rights of Persons with Disabilities and other relevant policies, conventions and principles.[58]

It is focused on programming components perceived as within WFP's direct control or circle of influence; responsibilities of various stakeholders are proposed.

The actions are not prescriptive; as they need to be adaptive and flexible based on the specific realities of the context in which they are being applied.

The information provides a base to develop regional and country nutrition strategies, action plans, policies and guideline documents that are explicit about disability and nutrition-related links and interactions, and programming, with consideration of the local context and specific needs by impairment type.

The information contained in this document should be considered together with other WFP guidance that is relevant to ensuring appropriate, quality programming for improved nutrition of populations.

A programme design and implementation checklist is provided in Annex 1.

A list of support resources is provided in Annex 5.

KEY PRINCIPLES FOR INCLUSIVE NUTRITION PROGRAMMING

Inclusive nutrition programming should be guided by the following key principles. These are reflected in the UN Convention on the Rights of Persons with Disabilities.[59]

Human rights approach

Respect the value and dignity of persons with disabilities, recognizing that impairment is part of human diversity and humanity, with consideration of the specific contributions, capacities (abilities, skills, resources, knowledge), vulnerabilities and needs of individuals with different types of impairments. This recognizes that a 'one size fits all' approach cannot address the needs of persons with disabilities, given their diversity.

Mainstreaming a human rights-based approach to disability, in combination with targeted measures, will make the concerns and experiences of persons with disabilities an integral dimension of the design, implementation, monitoring and evaluation of policies and programmes in all political, economic and societal spheres so that persons with disabilities benefit equally.

57 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/818123/query-6-disability-and-nutrition.pdf
58 Disability Inclusion | WFPgo
59 United Nations 2019. United National Disability Inclusion Strategy

"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..."

(Universal declaration of Human Rights Article 25, 1948; Un Convention on the Rights of Persons with Disabilities, 2006) [60,61]

The human rights approach to address disability is reflected in the Social Model. The Social Model focuses on barriers facing people with disabilities instead of concentrating on impairments and deficits of the person with a disability. In this model a person's activities are limited not by the impairment or condition but by physical, organizational and attitudinal barriers and these can be changed and eliminated. It states that impairment is, and always will be, present in every society, and therefore society should be planned and organized in a way that includes, rather than excludes, persons with disabilities.

The Social Model not only identifies society as the cause of disability but, equally importantly, it provides a way of explaining *how* society goes about disabling people with impairments.[62,63]

Safe and equal access

Identify and address the multiple and intersecting forms of discrimination faced by persons with disabilities to ensure that persons with physical, sensory, intellectual, mental and/or psychosocial disabilities have safe and equal access to, and opportunities to benefit from, food and nutrition information, services and programmes as those without disabilities, and that services and programmes do not expose them to harm or risk. This requires taking into consideration the intersectionality of factors (such as sex, age, religion, race, ethnicity, class, location, economic, among others) to ensure that the most marginalised groups are not left behind.

Meaningful Participation

Empower and respect persons with disabilities capacities, individual autonomy and control over their own lives. Engage the meaningful consultation and active participation of persons with disabilities (representing diversity of impairments, age, gender and other factors), their families - and organizations for persons with disabilities (OPDs) - in matters affecting them and their lives, throughout all stages of the programme cycle (context and needs analyses, planning, designing, implementing, monitoring and evaluating services and programmes -in line with the principle: "Nothing about us without us". This will serve to promote inclusiveness and appropriateness of the services and programmes for preventing and treating malnutrition.

60 UN. 1989. The United Nations Convention on the Rights of the Child
61 https://www.ohchr.org/EN/HRBodies/CRPD/Pages/CRPDIndex.aspx
62 https://www.inclusionlondon.org.uk/wp-content/uploads/2015/05/FactSheets_TheSocialModel_Easy-Read.pdf
63 https://disabilityinpublichealth.org/1-1/

A TWIN TRACK APPROACH TO NUTRITION PROGRAMMING

Given the multiple factors affecting access (individual, attitudinal, environmental and institutional) for persons with disabilities, a multi-component, twin-track approach to nutrition policies and programming may need to be implemented to enable equality of rights and opportunities for persons with disabilities.

A twin-track approach requires that nutrition services include (i.e. mainstream) disability and also provide disability specific services that target persons with disabilities, and their families or caretakers, where needed. The two tracks -mainstreamed and targeted approaches- reinforce each other.

1) **Mainstream, or consistently and systematically integrate consideration of disability in food and nutrition programmes and services** so they are inclusive , non-discriminatory and fully accessible, to persons with all types of impairments (hearing, visual, physical, cognitive, and intellectual), so they can participate equally with others in activities and services intended for the general public.
Mainstreaming may also serve to promote an overall social culture of respect to disability, which leads to better social integration and participation.
Examples of mainstreaming are nutrition facilities and food/ cash-based transfer distribution modalities fully accessible for persons with disabilities.

2) **Target impairment-specific food and nutrition support** directly to persons with disabilities where needed, to accommodate individual disability-related requirements, such as with respect to outreach services, counselling modalities, dietary needs and assistive devices.

An important avenue for systematically employing a twin-track approach to disability inclusion in nutrition projects and programming is through country strategic plans (CSPs), including second-generation CSPs.

The UN Disability Inclusion Strategy requires WFP to ensure that the rights of persons with disabilities are embedded in all programmes and projects, employing a twin-track approach.

GUIDANCE APPLICABLE TO ALL PROGRAMMING MODALITIES

The information presented in this section is applicable to all programming modalities, to promote inclusion of persons with differing impairments, for consideration by WFP and Cooperating Partners.

DATA COLLECTION AND USE

Collecting data on persons with disabilities is an obligation for States who have ratified the CRPD. Article 31 on Statistics and Data Collection requires states parties to "undertake to collect appropriate information, including statistical and research data." Collecting disaggregated data, as appropriate, ensures persons with disabilities are visible, to identify and address the barriers faced by persons with disabilities and to help assess the implementation of States Parties' obligations under the CRPD.[64]

Identify persons with disabilities so they are visible

- Use standardised criteria for defining 'disability'.

64 Disability Inclusion | WFPgo

- To identify persons suspected to have a disability the following can be considered for population level assessment/ surveys:
    - Washington Group Question Sets[65,66], and other tools, for persons aged 18 years and above
    - WHO Model Disability Survey[67]
    - Washington/UNICEF Child Functioning Questionnaires for children aged 2-17 years[68]
    - WHO Disability assessment Schedule 2.0 (WHODAS 2.0)[69]

  The above question sets identify functional difficulties persons may have with doing certain activities.
- Estimate the prevalence of persons with disabilities. Where reliable data are not available or cannot be collected, use the World Bank/ WHO 15 per cent estimate of global population disability prevalence;[70] noting this needs to be adjusted with consideration that in some humanitarian contexts the number of persons with disabilities will be significantly higher than the global average due to acquired impairments, mental health issues, disruption in services, and the creation of new barriers.

Conduct a Poverty and Vulnerability Assessment

- Conduct a Poverty and Vulnerability Assessment that includes food and nutrition considerations, to identify and understand inequalities, corresponding vulnerabilities affecting persons with disabilities and the broader context they are situated in. Disaggregate the data by type of impairment, economic (income levels), social, identity (such as age, gender and ethnicity) and location.

Integrate disability into routine data collection and analysis, so their vulnerabilities, risks and capacities are identified, and their needs can be responded to.

- Develop targets and prioritized disability-specific indicators to systematically monitor and evaluate coverage, reach and effectiveness of programming for improved nutrition of persons with disabilities.
- Institutionalise the systematic collection, analysis, reporting and use of relevant data on persons in need disaggregated by disability, age and sex, and when appropriate and feasible by other vulnerability and diversity characteristics, to inform needs and monitor programming.
- Consider explicit questions such as "Were persons with disabilities in equitably participating in activities and able to benefit from this programme? How? To what extent? Why? What needs to be done to help facilitate access to and appropriateness services and programmes for improved nutrition outcomes".
- Ensure data collection methodologies and tools are accessible and appropriate for persons with differing impairments, to ensure their active engagement.
- Facilitate the meaningful participation of persons with different types of disabilities and/or their representative organizations in data collection processes. Consult with persons with disabilities, of diverse age groups, genders and types of impairments, their families and other caregivers. Where feasible ensure the population proportion of prevalence of persons with disabilities is represented in the total sample size (or, if unknown, 15% of the total sample size includes persons with disabilities).
- Collaborate with Persons with Disabilities Organizations/networks or other sources to help find persons with

65 http://www.washingtongroup-disability.com/washington-group-question-sets/
66 http://www.washingtongroup-disability.com/washington-group-question-sets/short-set-of-disability-questions/
67 https://www.who.int/disabilities/data/mds/en/
68 https://data.unicef.org/resources/module-child-functioning/
69 https://www.who.int/classifications/icf/WHODAS2.0_36itemsSELF.pdf
70 Interagency Standing Committee (IASC). 2019. Guidelines on the inclusion of persons with disabilities in humanitarian action

- Document and report on analyses of progress, outcomes and impact (disaggregated by disability, sex and age) towards meeting the food security and nutrition needs of persons with disabilities -even if a disability perspective has not been included in a project's assessment, planning and implementation stages. Compare to persons without disabilities. Identify achievements, barriers, unmet needs, enablers and lessons learned and provide recommendations on how disability inclusion can be better applied in subsequent phases of the project or in future projects.
- Provide case studies on inclusion of persons with disabilities in nutrition interventions, as appropriate.
- Share information on the cross-sectoral needs of persons with disabilities in inter-agency coordination mechanisms (especially nutrition, food security, protection), while maintaining data ethics and protection principles.

Conduct research that expands the evidence base on programming for persons with disabilities

- Mobilise resources to encourage research on access to food and nutrition requirements for persons with disabilities (considering different disabilities and capacities, age, sex, contexts, and other applicable factors) to inform policy and programme/ service development.

Data collection challenges

- The prevalence of disability may be underestimated as it is difficult to easily identify who is a person with disabilities because of:
  - Stigma may stop a person being publicly identified as having a disability due to shame.
  - Different understandings of disability and lack of definition clarity or beliefs regarding what is disability or what is 'normal' functioning.
  - Invisible impairments (e.g. hearing or psychosocial impairments) may be overlooked when visual identification is used.

BUILD HUMAN RESOURCE COMPETENCY

Ensure staff have the technical knowledge, understanding, sensitivity and skills to appropriately address disability inclusion. This includes technical staff of food assistance and nutrition programmes at all levels (Country Office, Regional Bureau and Headquarters) and cooperating partners.

- Assess the competency of nutrition and food assistance staff with regards disability inclusion.
- Develop and implement trainings, based on understanding of the competency base and context, to build the technical knowledge, understanding, sensitivity and skills of staff on addressing disability inclusion and the provision of timely and appropriate disability-specific food and nutrition support:

Topics to consider:

- Disability rights and disability inclusion principles and practices;
- Vulnerabilities, risks, barriers and capacities of persons with disabilities;
- Links between disability and nutrition;
- Understanding the specific food, feeding and nutrition requirements of persons with differing impairments;
- Assessing nutrition status and feeding practices of persons with disabilities;
- Integration of disability considerations into food security and nutrition-related preparedness plans;
- Formulating appropriate and principled rights- and needs-based disability-inclusive nutrition responses;
- Communicating effectively with persons with disabilities, respecting their specific impairments, capacities and dignity; (See Annex 1: Communicating with persons with disabilities)
- Providing guidance or counselling on managing dietary and feeding challenges and concerns;
- Using assistive devices, implements and utensils to make eating easier and safer;
- First aid skills on what to do in case of aspiration, air obstruction and choking.

Strengthen the capacity of organizations, governments and national frameworks

Inform relevant staff of organizations representing persons with disabilities, organizations that do not currently recognize or consider disability and of governments and national frameworks, of the links between nutrition and disability, food and nutrition requirements, nutrition-related risks and barriers faced by persons with disabilities, overcoming feeding difficulties, and available support services, programmes and entitlements.

COMMUNICATION

Ensure communication approaches and tools reach and are understood by persons with differing impairments

- Ensure information, education and communication materials and campaigns use approaches, channels and methods, that effectively reach and are clearly understood by persons with physical, intellectual, hearing and visual disabilities, their families and their communities, as appropriate to the populations and context. Accommodate and build on exiting community-based solutions. Work with disability organizations on the development of innovative delivery mechanisms.
    - Formats that are accessible for people with visual disabilities (blind and low vision) include large print, text messages (most smartphones have free voiceover application), Braille, radio and audio announcements.
    - Formats that are accessible for people with hearing disabilities (deaf and low hearing) include print, text messages, captions and sign language interpretation for meetings or television announcements.
    - Formats that are accessible for people with intellectual disabilities include simple plain language and visual signs, such as pictograms, drawings, pictures and photos on printed materials.
    - Signage should be visible, clear, simple, easy to read and understand, have tactile elements and be positioned with good lighting.
    - Include positive images of persons with disabilities in communication materials (e.g., women with disabilities as mothers or pregnant women) to help transform attitudes and reduce stigma and discrimination towards persons with disabilities.

Integrate communication on persons with disabilities into routine programming

- Develop and implement awareness raising strategies and materials to improve public understanding of disability and food and nutrition linkages and needs.
- Inform persons with disabilities and the wider community on nutrition and disability services available. Mitigate stigma, myths or jealousy that may result from disability-targeted interventions (such as transport allowances, assistive devices distributions) through clearly consulting with and informing community members on eligibility criteria and the rationale.

Ensure accountability mechanisms are effectively inclusive and respectful of the rights of persons with differing disabilities

- Ensure mechanisms for communicating entitlements, complaints and feedback, on the delivery of services and programmes that affect their lives, are safe, accessible to and understood by them, and that feedback and complaints are responded to.

  Actively engage persons with differing impairments in providing feedback.[71,72,73]

71 IASC. 2012. Accountability to affected populations: Tools to assist in implementing the IASC AAP Commitments

72 https://corehumanitarianstandard.org/the-standard

73 https://newgo.wfp.org/documents/accountability-to-affected-populations-aap-manual

PHYSICAL ENVIRONMENT

When planning programmes, and identifying locations and facilities, consider the following:

Ensure locations of social services are accessible for persons with different types of impairments

- Reach persons with disabilities through community-based/outreach nutrition activities for active case finding of persons with disabilities to provide nutrition screening and other services to persons with disabilities who are marginalized and isolated, including persons who have psychosocial disabilities, who are not mobile, or who face other barriers -with particular attention to those who are malnourished or having feeding difficulties.
- Provide transport assistance or allowances to enable persons with disabilities to reach nutrition and distribution services.

Ensure shelters are easily accessible for persons with different types of impairments

- Consider accessibility in assessment criteria or standards for social service facilities.
  Ensure that design standards of all WFP permanent and temporary spaces or infrastructures (such as distribution points, nutrition and health care facilities, baby-friendly spaces, support group spaces) are built to enable all persons with any type of disability to reach, enter, circulate and use (RECU principle) in a continuous movement (i.e. without facing barriers). For example:
  - Pathways firm and even, and a minimum width of 900 mm with the ideal being 1800 mm to allow two wheelchair users to pass each other;
  - Ramps a minimum width of 1000 mm with handrails for slopes steeper than 1:20 and stairs;
  - Entrances and door openings a minimum of 800 mm wide;
  - Door handles mounted 800–900 mm above the floor; D-lever handles preferred;
  - Lighting to ensure clear vision;
  - Provide covered seating to enable people to rest while waiting.
- Ensure the workplace promotes an inclusive and accessible environment that supports all WFP nutrition staff, with reasonable accommodation for employees with disabilities where needed.

Note: For detailed technical guidance, refer to the WFP. 2021. 'Technical Guide to plan an Inclusive Accessibility of WFP facilities -Annex 1.'

REFERRAL MECHANISMS

Establish robust coordinated two-way referral mechanisms and refer persons with disabilities to specialized disability, nutrition and healthcare support services as required.

- Establish mechanisms and ensure programme staff, particularly front-line workers, are aware of procedures for referral to:
    - Nutrition and healthcare services.
    - Disability-specific services. (This could be achieved through compiling a directory of referral organizations that are in line with context-appropriate quality standards.)
- Create referral pathways through inter-sectoral connections, to available sectoral programmes, particularly Health, Education, Protection, Social protection -and Food Assistance.
- Follow-up all referrals to confirm that referred beneficiaries have accessed the service and receive appropriate and timely care. Ensure awareness of and access to a two-way complaints and feedback mechanism.

PARTNERSHIPS AND COLLABORATION

Establish and maintain cross-sectoral collaboration and coordination considering the multi-sectoral factors contributing to the nutritional status of persons with disabilities

- Ensure coordination and collaboration between nutrition and disability specialists and/or key representative organizations of persons with disabilities in the prevention and management of malnutrition.
    - Represent the interests of persons with disabilities in coordination structures and mechanisms.
    - Establish, or advocate for, mainstreaming of persons with disabilities in complementary or cross-sectoral interventions, which also impact on nutritional status (e.g. WASH, social protection, Early Child Development).

Collaborate with organisations who work with persons with disabilities and families to expand reach and appropriateness of programmes

- Collaborate with identifying persons with disabilities, data collection, and the dissemination of nutrition guidance and programme information.

Develop private sector partnerships to provide assistive equipment

- Explore and establish partnerships for the development and design of assistive technologies, that enhance nutrition and food security for persons with disabilities.

NUTRITION PROGRAMMES

Nutrition situation assessment

The following information should be considered along with the guidance on data in the section 'Guidance applicable to all programming modalities', above.

WFP and Cooperating Partners

- Include disability-specific questions in WFP assessment/ survey activities and analyses, to increase knowledge and awareness about men, women, boys and girls with disabilities, of a variety of ages and diverse impairment types.
- Persons with disabilities can be identified by a household survey in two ways:
    1) Washington Group Short Set of Questions applied to all adults aged 18 years and over.[74]
    2) Child Functioning Module, developed by Washington Group and UNICEF applied to children aged 2 to 17 years.[75]
- Consider the following information on persons with disabilities in situation assessments:
    - knowledge; practices; capacities; coping mechanisms; contributions; priorities;
    - bottlenecks and barriers affecting equal access to food and nutrition security and services or programmes, including population and front-line workers knowledge, practices, beliefs, and attitudes;
    - appropriateness and acceptability of service and commodity provision;
    - mapping of existing disability-specific information and services (who does what, where, when and for whom) available in the project area(s), and potential collaboration and beneficiary referral for systems.

(See Annex 2: Persons with Disabilities Situation Analysis: Example Key Questions).

- Integrate disability into Fill the Nutrient Gap and Cost of Diet analyses, considering the nutritional quality of foods, types of food required, assistive devices required, and costs to access nutritious food and nutrition/ health support services. Through secondary analyses, understand how persons with disabilities access food in local contexts and what are the barriers and enablers to access.

Nutrition individual assessment

Identification of impairments and disabilities

Key to enabling disability inclusion is being able to identify persons with a disability, so their needs are visible, their eligibility for support identified, and their safe and easy access to the provision of timely and appropriate nutrition support and advice can be provided.

Cooperating partners

- Routinely assess presence of disabilities during key contacts: anthropometric screening, surveys, dietary/ feeding assessments, malnutrition management -as well as post-natal care and other health/ nutrition visits
- Use of the following question sets can be considered, along with visual assessment:
    - Washington/UNICEF Child Functioning Questionnaires for children aged 2-17 years;[76]

74 http://www.washingtongroup-disability.com/washington-group-question-sets/
75 https://data.unicef.org/resources/module-child-functioning/
76 https://data.unicef.org/resources/module-child-functioning/

- Washington Group Question Sets for persons aged 18 years and above;[77]
- WHO WHODAS 2.0;[78]
- The questionnaire should be used in conjunction with other measurement tools to enable disaggregation of other measures by disability status.

Instruments to collect information, such as anthropometric status and feeding/ dietary practices, may need to be adapted, based on the individual's specific impairment.

Anthropometric assessment

Use standard anthropometric assessment procedures where appropriate.

Where required adapt screening and diagnosis of malnutrition so it is accessible and appropriate to persons with disabilities.

A person with a disability who is assessed as having acute malnutrition, should be managed according to the guidance for cases of acute malnutrition with complications.

Cooperating partners

- When assessment of Body Mass Index (BMI), length/height-for-age, weight-for-age, and/or weight/ length for height are not feasible or reliable use which ever measures are possible, such as visual assessment, demi-span, lower leg length measurements.[79]
- Mid-Upper Arm Circumference (MUAC) and skinfold measurement may be used for some people, however, they may be misleading in cases where upper arm muscle has built up through using assistive devices to aid mobility (such as manual wheelchair or crutches).

Assessment and management of feeding/ dietary practices

Assessment of feeding/ dietary practices

Specific impairments can cause difficulties feeding. Identify feeding and dietary difficulties by consulting with the person with the impairment, and/or their caregiver, and by use of visual assessment. Provide onward referral as required if possible.

Symptoms which may suggest difficulties with chewing and swallowing include poor muscle control in the face, mouth and tongue; drooling or poor saliva control; pocketing of food in the sides of the mouth; and coughing associated with eating and drinking.

For infants, difficulties with breastfeeding should be considered when the infant has a cleft palate and cleft lip, apparent muscle weakness or stiffness, or when the infants shows fatigue or distress during feeding.

Guidance

WFP and Cooperating partners

- Use standard tools and indicators for assessing feeding and dietary practices (such as MDD-W[80]; IYCF practices[81]).

77 https://www.washingtongroup-disability.com/
78 https://www.who.int/classifications/icf/WHODAS2.0_36itemsSELF.pdf
79 https://www.cdc.gov/NCHS/data/nhanes/nhanes_07_08/manual_an.pdf
80 FAO; USAID. 2016. Minimum Dietary Diversity for Women
81 WHO. 2010. Indicators for assessing infant and young child feeding practices

- Adapt the communication method as required based on the specific type of impairment.

Management of feeding difficulties

Guidance

Cooperating partners

- Refer persons with difficulties eating or drinking to a trained healthcare facility or outreach worker for guidance on safe and appropriate feeding. Some individuals may need additional or specific nutrients because of medications or health issues associated with their disability. Further referral to rehabilitation services for specific therapeutic activities to improve basic oral motor skills and nutrient intake may be required.[82] Partial or full nutrition via a nasogastric or gastrostomy may be needed if the person is still unable to consume an adequate intake and/or it is unsafe for the person to eat.
- Inform the whole household, including persons with disabilities, on the nutrient content of food and how to follow a balanced, nutrient-rich diet. Explain the importance of sharing food fairly within the family, based on need and not on distribution of power, for example, providing access to food for girls with disabilities on an equal basis with their siblings.
- Collaborate with health actors and disability organizations for the provision of assistive devices and tools to support feeding, such as adapted cutlery and manual food processors; provide information on use and ongoing maintenance.

Healthcare workers guidance: Ways to support safe and adequate feeding

Provide information and demonstrations to persons with disabilities, and their families and carers as relevant, on feeding practices for persons who have difficulties eating and/or swallowing.

- Modify food and fluid types or consistencies/textures to support the level of oral motor control and swallowing function, while ensuring adequate nutrient intake.
- Increase the energy of foods by adding oil and supplemental or fortified foods if a person eats a reduced quantity of food due to feeding difficulties.
- Ensure proper positioning during feeding: sitting in a stable, upright position, with head and neck aligned, for eating and drinking to promote safe swallowing and reduce risk of aspiration. When feeding a person, sit to their side to feed her/him so they don't need to lean forward.
- Support use of assistive devices and adapted implements (such as utensils, cups, plates with high sides, equipment to make soft pureed foods) to help overcome food preparation and feeding limitations.
    - Spoon and forks with a fold and/or thicker handle (e.g., using plastic or rubber) help hold and bring food to the mouth.
    - A plate with steep sides makes eating easier for persons who are blind or have mobility limitations as the edges assist to move the food on to the feeding utensil.
- Encourage mothers of infants with developmental delays and disabilities and mothers with disabilities to breastfeed and support them to do so.

82 https://www.who.int/publications/i/item/9789240018389

Women who cannot use their arms and upper body can breastfeed with help from family members or friends. Support breastfeeding by suggesting different positions and techniques (e.g., sitting in a chair, wheelchair or bed to support her back and arms; using pillows or a rolled-up cloth under the baby; lying on her side with her baby beside her supported by pillows or a rolled-up cloth). For babies with cleft lip, cleft palate and babies with low muscle tone use upright and semi-upright positions.

Community-based support for pregnant and lactating women/ girls and infants and young children

- Provide support groups inclusive of pregnant women, mothers with infants and young children with disabilities, mainstreaming information and support, and providing targeted guidance and discussion as required and appropriate.
- Provide disability-skilled support at Mother-Baby-Friendly Spaces.
- Conduct home visits for mother-infant/ young child dyads with disabilities to provide individualised support when required.

Management of acute malnutrition

Individuals are admitted to acute malnutrition treatment programmes based on whether they meet criteria in the national protocol for the management of acute malnutrition (which normally follow WHO admission criteria) rather than based on disability criteria.

- Alternative screening methods protocols may need to be adapted for persons with physical impairments. *(See section: Nutrition Assessment)*
- Management of individuals with acute malnutrition should consider the individual's specific impairment and adapt management methods accordingly.
- As a rule, any malnourished child presenting with medical complications, including anorexia or feeding difficulties (such as chewing; swallowing) based on an appetite test, feeding history and disability assessment, should initially be referred for inpatient care, even if s/he suffers from moderate, rather than severe, malnutrition (W/H > –3 Z-score).
- Individuals should be counselled on recommended feeding positions *(see box above)*.

Obesity rates for adults and children with disabilities can be significantly higher than for those without disabilities, with differences remaining even when controlling for other factors. Reasons for this include lack of healthy food options for those living in restrictive environments, selective eating patterns, difficulty with chewing or swallowing food, medication use contributing to changes in appetite, physical activity limitations, constant pain, energy imbalance, lack of knowledge, social support and guidance, and economic resource scarcity -among other factors.[83]

(Note: For guidance on overweight and obesity see WFP's guidelines for overweight and obesity prevention. 2020)

83 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4476958/

FOOD ASSISTANCE PROGRAMMES

Understanding social protection

Social protection aims to address the risks and vulnerabilities of individuals through policies and programmes designed to protect people from shocks and crises. 'Social assistance' or 'safety nets, such as food assistance programmes providing in-kind food or cash-based transfers to people in need are types of social protection schemes that WFP implements.

Disability targeting can ensure that persons with disabilities participate in social safety nets, however disability targeting represents fundamental challenges; persons with disabilities form a very heterogeneous group and identification of eligibility is particularly challenging in the case of invisible impairments.

An alternative is to mainstream existing social safety nets to include persons with disabilities in these programmes. This requires that social protection schemes are designed to be sensitive to food and nutrition security protection and support for persons with disabilities and their families, on an equal basis with others, through inclusiveness in terms of coverage and effective access, with targeted actions taken as appropriate.

Guidance

Design social protection policies and programmes to include persons with disabilities, considering the intersectionality of inequalities.[84]

WFP

Consider the following for the design of social protection schemes:

- Identify existing social protection programmes for persons with disabilities (e.g., disability allowances, pensions, free transport passes, special needs education grants, food subsidy coupons, food transfers) and consider building on or modifying them to reach persons with disabilities.[85]
- Collaborate with government departments and/or persons with disabilities organizations to identify women, girls, boys and men with disabilities eligible for social protection programmes.
- Identify and remove barriers and obstacles that persons with disabilities face in accessing and fully benefiting from social protection on an equal basis with others.
- Link social protection schemes with other programmes and services, such as nutrition and health services and disability-specific services, in order to effectively address additional disability-related support needs. Establish safe and clear referral mechanisms to other programmes and services.

WFP and Cooperating Partners

- Ensure disability inclusion is considered in the design, budget, implementation and evaluation of social protection schemes. Consult persons with different disabilities, and of different ages and genders, in the design and throughout implementation to ensure they are appropriate and responsive to their heterogeneity (in terms of types of disabilities, location, age, gender) and diversity of needs, as well as environmental and socio-cultural factors.[86]

84 WFP. 2020. Addressing intersecting inequalities through social protection programming for greater inclusion
85 See: WFP. 2018. Quick WFP Guidance for Planning an Intervention through Government Social Protection systems in preparation or during an Emergency. OSZIS.
86 Mitral S. 2005. Disability and social safety nets in developing countries. Social Protection Unit, World Bank

- Carry out awareness-raising initiatives to disseminate accessible information on social protection schemes available, including on eligibility, application, assessment, delivery of services, and complementarity with other social protection programmes.
- Whenever possible, prioritise persons with disabilities in queues for distribution or, if they prefer and as feasible organise dedicated queues or distribution times. Inform the community of the rationale for the queueing modality. Provide shaded seating at distribution sites.
- Ensure that conditions are in place to ensure that persons with disabilities have access to and appropriately use their entitlements, with specific consideration made of situations when the entitlement is received by a person on behalf of the person with a disability.
- Integrate key messaging on feeding/dietary practices and hygiene for persons with disabilities into in-kind food assistance and cash-based transfer programmes, targeted to the local context and priority nutrition issues and hygiene practices of concern.
- Integrate early nutrition screening and diagnosis, as feasible, linked to the provision of skilled nutrition support.
- Systematically monitor the coverage, appropriateness and acceptability of social protection schemes among people with disabilities. Ensure data is disaggregation by disability, age and gender.

In-kind food assistance

It is important to ensure that in-kind food assistance programmes are inclusive of persons with disabilities, through accessible food distributions, appropriate and acceptable rations, as well as the provision of social support and assistive food preparation and feeding technologies.

Guidance

WFP and Cooperating Partners

Food distributions modalities

Implement universal design standards, and the provision of reasonable accommodation as required, to enable persons with disabilities to access food distribution services.

- Locate food distribution sites and facilities in safely and easily accessible venues. Consider shelter/site design standards.
- Provide registration and information on eligibility, distribution frequency and location in modalities accessible to and able to be understood by persons with differing disabilities.
- Set up simplified, fast track or prioritization processes for registration and collection of food rations.
- Arrange specific support to ensure that persons with disabilities can collect and retain their entitlements, as required, such as options available for collection of rations by a third party, direct delivery or transfers to cover transport costs to/from distribution sites.
- Provide specialist feeding programmes within institutional care facilities (specialist institutions and orphanages) as appropriate and feasible.

WFP

Rations

Choose food and items for preparation and feeding that take account of the requirements of persons with disabilities, considering dietary and nutritional needs and functional and digestive capacities.

- Provide food that is safe, nutritionally adequate and appropriate -for example easy to chew and digest (mashed

or smooth food) for persons with difficulties chewing or swallowing, or with digestive problems. Supplementary food in addition to any general ration may be required. Note: Supplements may be required, for example vitamin D for persons with limited mobility.

- Ensure the size, shape and weight of food ration packages can be easily transported, opened and used by persons with disabilities (e.g. packages with less weight and easy to use handles/lids for persons with limited mobility). Provide frequent, smaller rations as required.
- Provide sufficient quantity of nutrient rich food for families with a member with disabilities, as required based on consideration of poverty and unequal distribution of resources within the household.
- Provide additional safe drinking water to persons with disabilities at heightened risk for dehydration or difficulty swallowing.

Assistive feeding devices

- Support access to assistive equipment (provision or cover the costs) for those with food preparation, cooking, and feeding or drinking difficulties, for example special utensils, straws, plates with high sides.

Cooperating Partners

- Arrange social support for the home preparation of rations, based on identification of need.

Cash-based transfers

Evidence suggests that higher disability is associated with higher poverty, and therefore poverty-reducing social safety nets such as cash-based transfers (CBTs), in the form of cash and vouchers), have a role to play with regards to disability.[87]

They have the potential to provide short-term benefits for improved food security and nutrition outcomes for persons with disabilities, through supporting their economic access to adequate food and nutrition, safe water, social services such as healthcare (including transport, consultation fees and treatment costs, prescriptions, diagnostic tests), assistive devices, and decent shelter. They can also enhance decision-making power, prevent or reduce gender-based violence, improve psychological well-being and have important developmental impacts, such as increased participation in local labour markets, skills and knowledge development, investment in livelihoods productive assets and inputs and access credit.[88]

Cash transfers are in principle unrestricted such that individuals or households can take their own decisions on how best to spend the money. Vouchers are by nature restricted and usually earmarked towards specific or multi-purpose sectoral purchases.[89]

Feasibility of CBT modalities for improved nutrition outcomes requires adequate functioning and capacity of appropriate markets for goods and services, safe and reliable delivery mechanisms to reach targeted recipients, considering both supply and access, and appropriate and effective recipient eligibility targeting.

87 Mitral S. 2005. Disability and social safety nets in developing countries. Social Protection Unit, World Bank
88 Naila K. 2011. MDGs, social justice and the challenge of intersecting inequalities -Policy brief. No.3. Centre for Development Policy and Research
89 Global Nutrition Cluster. 2020. Evidence and guidance note on the use of cash and voucher assistance for nutrition outcomes in emergencies.

Guidance

WFP

- Conduct a baseline evaluation of how disability-inclusive current safety nets are, considering factors such as environmental, social and communication accessibility, eligibility criteria, programme coverage, programme impact on poverty alleviation and inequality.
- Include disability as a nutritional vulnerability criterion for recipient selection in CBT programmes to reach households of persons with disabilities.
- During formative research, consider cash delivery mechanisms (how persons with disabilities access cash, how they prefer to access cash (cash, cash cards, mobile phone credit, etc), financial and technological access and literacy), physical and communication access (e.g. how they access markets, services and information), and which needs they usually meet using markets. Consider the availability of market supply of appropriate food and required assistive devices.
- Ensure the transfer amount addresses the gap in relation to basic needs and broader nutrition support requirements. Consider allowances that compensate for estimated disability-related expenditures (the extra costs of disability and the major sources of these extra costs).
- Note: Restricted cash transfers may reduce access to assistive devices, which are often classified as health-related expenses.
- Link CBT programmes with nutrition, health, food security and livelihoods programmes to promote access to nutrient-rich food and nutrition and to disability-targeted support services, assistive devices, and vocational rehabilitation services.
- Integrate social behaviour change (SBC) activities into CBTs to promote improved nutrition practices, such as allocation of spending on food, healthcare and health-seeking practices.

WFP and Cooperating Partners

- Provide support and training to persons with disabilities to enable them to access cash-based assistance and use cash distribution systems (such as banks), as required.
- Monitor whether persons with disabilities are receiving their full allowance, have equal access to CBTs in their households and are empowered to use them, and that they are not being put at greater risk by receiving cash-based assistance – for example, not at risk of theft or violence, or other forms of abuse.
- Collect evidence and share lessons learned on what worked well and the enablers for the safe, appropriate, and effective inclusion of persons with disabilities in CBT interventions.

Conditional transfers for persons with disabilities

Conditional transfers are a type of social safety net that provides support conditional on certain behaviours. Conditions that apply to persons with disabilities may be entirely different from the ones that apply to persons without disabilities. Holistic assessment of personal and societal factors is required in determining the conditionality to ensure it is doable and does no harm.

SCHOOL-BASED PROGRAMMES

School-based programmes are part of a wider school-health and nutrition approach, primarily supporting the vision that healthy children learn better and have better chances to thrive and fulfil their potential as adults. A systematic review of low- and middle-income countries found that school feeding programmes are one of the few education interventions that show positive impact in both school participation and learning.[90] Evidence also suggests that a well-designed school feeding programmes can promote macronutrient and micronutrient adequacy in diets of school-age children leading to enhanced nutrition and health, decreased morbidity, and increased learning capacities.[91] These education, health and nutrition outcomes impact school-age children including those with disabilities.

However, boys and girls with disabilities can be marginalized due to stigma and discrimination, which may lead to their exclusion from attending school, and the nutritional needs of children with disabilities are rarely considered in the design of school feeding programmes.[92]

Children with disabilities may be more likely to benefit from social-based platforms if those programmes are accessible and appropriate for the specific disability, while also providing vital nutrition that is necessary for their continued optimal development. School-based programming initiatives that are tailored to incorporate and address the needs of girls and boys with and without disabilities contribute to upholding the rights of all children.

Barriers to children benefitting from school-based programmes exist, which include: discrimination and marginalization, which leads to their exclusion from school-based activities; gaps in policy regarding inclusive education; lack of resources; insufficient number of teachers trained on disability inclusion; inappropriate teaching methods; lack of adaptive learning materials and tools; lack of or inappropriate food provision,; inaccessibility to and within the school environment.[93,94]

Guidance

WFP and Cooperating Partners

Disability-inclusive approaches under the school health and nutrition umbrella should be promoted, in alignment with international conventions and commitments.[95] Give special attention to girls with disabilities considering the compounded effects of gender and disability which can exacerbate existing barriers to access.

- Disaggregate data by disability (and age, sex) in order to understand the special needs of children related to the provision of school health and nutrition services and take them into account in the planning and implementation of school-based programmes.
- In the design of school feeding programmes consider the appropriateness of food rations and distribution modalities for the feeding capacities of children/ adolescents with differing impairments
- Identify and implement measures to support school children with disabilities during feeding times.

90 Snilstveit et al. (2015) Interventions for Improving Learning Outcomes and Access to Education in Low- and Middle-Income Countries: A Systematic Review. Systematic Review 24, International Initiative for Impact Evaluation (3ie), in Bashir et al. (2018) Facing Forward: Schooling for Learning in Africa. Washington, DC: World Bank.
91 Jomaa et al. (2011) School feeding programs in developing countries: impacts on children's health and educational outcomes. Nutrition reviews, 69(2), 83-98
92 Are School Feeding Programs Prepared to Be Inclusive of Children with Disabilities? (core.ac.uk)
93 https://www.un.org/development/desa/disabilities/resources/women-with-disabilities-fact-sheet.html
94 Are School Feeding Programs Prepared to Be Inclusive of Children with Disabilities? (core.ac.uk)
95 UN. 2006. UN Convention on the Rights of Persons with Disabilities

- Give ample consideration on the capacity of children with disabilities to receive school meal/ration when the transfer modality is changed/adjusted. For example, when a take home ration is to be provided, establish communications to the parents/carers of children with disabilities the schedule of distribution to ensure that assistance/help will be conferred.
- When the school assessment indicated children with disabilities, include in the programme plan the additional manpower needed for food preparation or for feeding support to children with disabilities. This may include access to assistive feeding utensils and/or equipment, as required for specific functional impairments.
- Give priority to children with disabilities during service delivery schedules. For example, children with disabilities to be among the first in line to receive meals or hygiene kits. If necessary, provide a special schedule for vaccination, deworming and other services that may pose difficulty in administering to children with disabilities. This would ensure that those children are protected from possible insults or embarrassment among other school children.
- Conduct awareness sessions to parents, teachers and community members on the needs and vulnerabilities of children with disabilities attending regular/special schools. This may be done before meal/ration distributions or as part of parent-teacher-community meetings.

Additional school-based considerations[96]

- Analyze disability, along with age, gender and other identity factors, when mapping protection risks faced by children.
- Coordinate with child protection actors, social workers, or dedicated government stakeholders with an expertise in child protection and safeguarding to help ensure the physical and mental well-being of school children with disabilities, including safe and reasonable access to community feedback mechanisms.
- Provide policy/strategy support to ensure that the rights and needs of children with disabilities are considered and addressed in school health and nutrition programmes through education sector plans.
- Invest in training teachers and other workers on inclusive education, including ways to support children/adolescents with learning and feeding difficulties.
- Ensure access to health and nutrition programmes and facilities through addressing issues of physical access and delivery of services and information in a way that is adapted to their impairments and capacities.
- Provide teaching methodologies and learning material formats suitable for the needs of persons with different types of disabilities.

School-based programmes can contribute to ensuring that girls and boys with and without disabilities learn and feel safe while in school. Child protection measures should be taken to promote the child's physical and mental wellbeing, fulfil children's right to be free from abuse and exploitation, provide them equal access to basic services, and ensure that they have a positive experience while coming into contact with programmes in which WFP has a responsibility.

96 https://www.unicef.org/media/56196/file/Equitable%20access%20to%20quality%20education%20for%20internally%20displaced%20children.pdf

LIVELIHOODS PROGRAMMES

Facilitate access to livelihoods programmes for persons with disabilities and members of households with a person with a disability, when feasible directed at mitigating some of the associations between disability, poverty and food and nutrition insecurity.

Guidance

WFP and Cooperating Partners

- Provide skills-based trainings inclusive of persons with disabilities to support income-generation activities, such as small-scale food production. Integrate key guidance on nutrition for persons with disabilities into trainings.
- Make available micro-finance programmes, subsidies, natural or productive resources for persons with disabilities, to engage in sustainable food production, particularly women, youth and older persons.
- Provide awareness on subsidies, grants and exemptions available.
- Provide awareness and access to available technologies to facilitate persons with disabilities work and improve their productivity.

ANNEX

Annex 1

Programme design and implementation checklist

Key recommendations to make interventions inclusive and accessible, so persons with differing disabilities have appropriate, safe and adequate food and effective nutritional support.

- ☐ Routinely collect, analyse and use data disaggregated by disability, age, sex -and other applicable factors in assessments/ surveys and programme monitoring and evaluations, so that persons with disabilities are visible, and their needs can be identified and appropriately responded to in the planning and implementation of programmes. Identify the vulnerabilities, risks, capacities, coping mechanisms, needs, and priorities -with specific attention to accessibility and on-discrimination- related to food and nutrition security and assistance programmes for persons with differing disabilities (and their caregivers as applicable), to gain an understanding of factors that contribute to food insecurity and malnutrition and vice versa, and how WFP's interventions can help close these gaps.
- ☐ Systematically consult and actively involve persons with differing disabilities on all issues that involve their lives, throughout the programme cycle.
- ☐ Ensure availability of disability-informed, skilled and sensitive personnel for identifying and working with persons with disabilities. Integrate disability-inclusion into nutrition trainings and orientations.
- ☐ Consider the mainstreaming of persons with disabilities when developing and reviewing proposals, strategies and plans.
- ☐ Ensure disability is reflected in the programme logical framework or theory of change, integrating specific objectives, outcomes or targets, based on mainstreamed and targeted approaches, for a minimum level of programming that effectively promotes disability inclusion. *(See box below: 'A twin-track approach to nutrition programming')*
- ☐ Consider persons with disabilities, and their diversity (age, gender, type of impairment and other factors), and their vulnerabilities, capacities, coping mechanisms and needs, when setting beneficiary selection criteria.
- ☐ Consider accessibility criteria and standards in the procurement or design or goods, services and facilities.
- ☐ Use information and communications (including capacity-building) approaches, methodologies and tools, are inclusive, accessible and able to be understood by persons with differing impairments, or their caregivers.
- ☐ Establish and clearly define coordinated two-way referral mechanisms and refer persons with disabilities to specialized disability and nutrition services, as required
- ☐ Ensure persons with disabilities have access to safe and responsive feedback and complaints mechanisms
- ☐ When developing proposals, incorporate costs of disability inclusion and disability-specific activities as specific project budget items. Examples may include constructing or modifying nutrition facilities for accessibility, transport costs, assistive devices, conducting awareness campaigns, developing accessible communication modalities and tools/materials, and mobilizing outreach teams.
- ☐ Track funding and projects dedicated to responding to the nutritional needs of persons with disabilities

Annex 2

Communicating with persons with disabilities[97]

Appropriate language and terminology

- When referring to persons with disabilities, use person-first language and choose words that reflect dignity and respect. For example, use the terminology 'a person with a disability' or the plural "persons with disabilities". When referring to persons with disabilities in writing, write this phrase in full (do not use acronyms).
- Use appropriate terminology for different types of disabilities: physical, visual/vision, hearing, intellectual and mental/psychosocial impairments

Behaviours

- **Ask before you help**. Don't assume that a person with disability always needs to be helped.
- **Speak to and try to get information directly from the person with a disability**, even if a person is using an interpreter or a personal assistant
- **Be conscious of physical contact**. Avoid leaning on a person's wheelchair, crutches or cane as these devices are part of his/her personal space and it is considered similar to leaning or hanging on to a person. If a person with vision impairment needs to be guided, don't grab his/her hand; instead offer your arm indicating where they can hold you.
- If you are meeting a person with vision impairment, **always identify yourself and others who may be with you** and remember to identify the person by name when conversing in a group.
- **To get the attention of a person who is deaf**, tap the person on the shoulder or wave your hand, as appropriate. Look directly at the person and speak clearly and slowly. For those who lip-read, be sensitive to their needs by placing yourself so that you face the light source and keep hands and items away from your mouth when speaking.
- **Listen patiently and attentively** when talking with a person who has difficulty speaking. Avoid correcting or speaking for the person; wait for him/her to finish. If you haven't understood something, don't pretend that you have; instead you could repeat what you have understood and allow the person to respond.
- **Be specific when giving directions** to a person with vision impairment. Say "in front of you", "behind you", "to your left/right", instead of "over there", "here", or using hand or facial gestures to indicate where to go.
- When speaking to someone with intellectual impairment, **use plain language and speak with shorter sentences**. Do not talk down to the person or treat an adult as a child when communicating.
- **Ask the person** when you're unsure of what to do.

Annex 3

Persons with Disabilities Situation Analysis: Example Key Questions

(Adapted from: UNICEF Guidelines for Disability Situation Analyses. UNICEF. 2013) Appropriate language and terminology

Rights-based and equity-focused Situation Analyses highlighting disability should seek to respond to the following questions, either through direct consideration, or through reference to other documents in which these are adequately addressed:

General

1) To what extent are the rights of persons with disabilities and their families articulated in national policies and programmes?
2) How do outcomes and trends differ across sub-groups of persons with disabilities (e.g. by impairment type, age, gender), by geographical areas, in humanitarian and in development contexts? What are the underlying causes of inequalities among the disability community? Which are the most deprived groups of persons with disabilities in terms of access and facing negative attitudes? What forms of deprivation and exclusion do they face? What are the determining factors that give rise to and perpetuate their exclusion?

Enabling Environment

3) Has the government signed or ratified the CRPD? Are national legislations and policies compliant with the CRPD, and to what extent is the government taking steps to realize the rights?
4) What existing social, institutional and political factors (e.g. social norms, institutional capacities at all levels of government, accountability and coordination mechanisms, policy and legal frameworks) could potentially support the creation of an enabling environment for the realization of the persons with disabilities?
5) What are the immediate, underlying and structural barriers and bottlenecks to the well-being of persons with disabilities and to accessing and utilizing basic social services and other critical resources?

Supply

6) What capacities (financial, technical and institutional) exist at national, sub-national and community levels to address inclusion of persons with disabilities?
7) To what extent do social protection measures exist and are inclusive of and reach persons with disabilities and their families?
8) To what extent is the physical, communication and information environment accessible for persons with disabilities?

Demand

9) To what extent are persons with disabilities, and their families as relevant, aware of financial programmes and social protection measures available and to what extent do they access them?
10) To what extent are persons with disabilities, and their caregivers as relevant, excluded from participation in society based on social and cultural practices, and beliefs?

11) How are the voices of persons with disabilities and their families or their representative organisations incorporated into the design and planning of national/local and organizations strategies and programmes?

Quality

12) How satisfied are persons with disabilities, and their families as relevant, with the current policies and programmes?

13) To what extent do persons with disabilities have the same level of participation and the opportunity and access to services as their peers without disabilities?

Annex 4

Concepts and Definitions	
Accessibility	Ensuring that persons with disabilities have access, on an equal basis with others, to the physical environment, to transportation, to information and communications, and to other facilities and services open or provided to the public, both in urban and in rural areas (CRPD, article 9). An accessible environment is an environment which allows for the freedom of movement and use in total safety, regardless of age, gender or impairments, of a space or product that can be used by all, with no obstacles, with dignity and with the highest possible level of independence. Accessibility is a pre-condition for inclusion.
Assistive device	An external product (including devices, equipment, instruments, software), specially produced or generally available of which the primary purpose is to maintain or improve an individual's functioning and independence, and thereby promote their participation and well-being. Assistive products are also used to prevent impairments and secondary health conditions.
Barrier	Obstacles that hinder the participation and inclusion of persons with disabilities in society.

Barrier	Obstacles that hinder the participation and inclusion of persons with disabilities in society.
Disabled People's Organization	A DPO is an organisation representing persons with disabilities, rooted, committed to and fully respecting the principles and rights recognized in the CRPD. These organisations should comprise a majority of persons with disabilities and be governed, led and directed by persons with disabilities. In the case of people with significant intellectual or multiple disabilities, they can also be family-based organisations advocating for the human rights of persons with disabilities.[98]
Discrimination on the basis of disability	Any distinction, exclusion or restriction on the basis of disability that has the purpose or effect of impairing or nullifying the recognition, enjoyment or exercise, on an equal basis with others, of all human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field. It includes all forms of discrimination, including denial of reasonable accommodation. (CRPD, article 2)
Inclusive education	A process of addressing and responding to the diversity of needs of all learners through increasing participation in learning, cultures and communities, and reducing exclusion within and from education. It involves changes and modifications in content, approaches, structures and strategies, with a common vision which covers all children of the appropriate age range and a conviction that it is the responsibility of the state to educate all children. (UNESCO. 2005)[99]
Intersectionality	An intersectional approach assumes that harms and violations associated with disability, race and ethnicity, gender, or other identities cannot be understood sufficiently by studying them separately. To see clearly how they affect access to resources or create risks for persons with disabilities, it is necessary to see how disability, age, gender and other factors interrelate and to evaluate their overall effect.[100]
Reasonable accommodation	Necessary and appropriate modifications and adjustments not imposing a disproportionate or undue burden, that are reasonable and needed in a particular case, to ensure that persons with disabilities are able to exercise, on an equal basis with others, all human rights and fundamental freedoms. (CRPD, article 2) Examples of reasonable accommodation in WFP services could include: • Adopting alternate service delivery strategies where possible (e.g. providing mobile units or community-based services instead of centre-based services). • Providing sign-language interpretation for meetings and workshops. • Making health information and messages available in alternative formats (e.g. texts in Braille, large print, easy-to-read, audio, etc.). • Taking the needs of persons with disabilities into consideration when designing, building or rehabilitating a shelter, in order to ensure the rooms, kitchen and toilet are safe and easy to access.
Universal design	The design of products, environments, programmes and services to be usable by all people, to the greatest extent possible, without the need for adaptation or specialized design. "Universal design" shall not exclude assistive devices for particular groups of persons with disabilities where this is needed (CRPD, article 2).

98 https://www.un.org/disabilities/documents/iasg/undg_guidance_note_final.pdf
99 UNESCO. 2005. Guidelines for Inclusion: ensuring access to education for all
100 IASC Guidelines, Inclusion of Persons with Disabilities in Humanitarian Action, 2019 | IASC (interagencystandingcommittee.org)

Annex 5

Reference Resources

WFP Reference Resources

Disability Inclusion
https://newgo.wfp.org/collection/disability-inclusion

Targeting and Prioritization Operational Guidance Note Version 1.0. WFP. 2020
https://docs.wfp.org/api/documents/WFP-0000122035/download/

Protection and Accountability Policy. WFP. 2020
https://docs.wfp.org/api/documents/WFP-0000119393/download/

Food and Nutrition Handbook. WFP. 2018
https://docs.wfp.org/api/documents/WFP-0000102101/download/

Addressing intersecting inequalities through social protection programming for greater inclusion. WFP. 2020
Social Protection and Nutrition at a Glance. WFP. 2020
https://newgo.wfp.org/documents/social-protection-and-nutrition-at-a-glance

Cash-Based Transfers Manual. WFP. 2016 (updated 2020)
https://newgo.wfp.org/documents/cash-based-transfers-manual-0

Food Assistance for Assets Guidance Manual. WFP. 2016
https://newgo.wfp.org/topics/food-assistance-for-assets-ffa

Standard Operating Procedures for Ration Substitution. WFP. 2017
https://newgo.wfp.org/documents/standard-operating-procedure-for-ration-substitutions

The Complete School Feeding Handbook. WFP. 2020
https://newgo.wfp.org/documents/school-feeding-handbook

A chance for every school child: Partnering to scale up School Health and Nutrition for Human Capital, WFP School Feeding Strategy 2020 – 2030. WFP. 2020
https://www.wfp.org/publications/chance-every-schoolchild-wfp-school-feeding-strategy-2020-2030

Social and Behaviour Change Communication: Guidance Manual for WFP Nutrition (v2) WFP. 2019.
NEW | SBCC Guidance Manual for WFP Nutrition | WFPgo

Additional Reference Resources

United Nations Disability Inclusion Strategy
https://www.un.org/en/content/disabilitystrategy/assets/documentation/UN_Disability_Inclusion_Strategy_english.pdf

SDG-CRPD resource Package
https://www.ohchr.org/EN/Issues/Disability/Pages/SDG-CRPD-Resource.aspx

Humanitarian inclusion standards for older people and people with disabilities. Humanitarian Standards Partnership. 2018
https://www.helpage.org/newsroom/latest-news/new-humanitarian-guidelines-launched-for-ageing-and-disability-inclusion/

Nutrition and health in a developing world. Chapter 24. Duncan B, Andrews J, Pottinger H, Meaney F. 2017
UNICEF resources on children with disabilities
https://www.unicef.org/disabilities/index_65943.html

Including children with disabilities in humanitarian action: Nutrition. UNICEF. 2018
https://sites.unicef.org/disability/emergencies/downloads/UNICEF_Nutrition_English.pdf

Background note for the global partnership on children with disabilities: Inclusive nutrition for children and mothers with disabilities. UNICEF
https://sites.unicef.org/disabilities/files/Nutrition_Background_Note-GPcwd.pdf

Interagency Social Protection Assessment (ISPA) tool on Food Security and Nutrition. FAO, World Bank. 2020
https://ispatools.org/food-security-and-nutrition/

CODI Core Diagnostic Instrument. Interagency Social Protection Assessment (ISPA)
https://ispatools.org/core-diagnostic-instrument/

Inclusive social protection systems for children with disabilities in Europe and Central Asia. UNICEF
https://www.unicef.org/eca/media/8421/file/inclusive-social-systems-brief.pdf

Inclusive education. Global Partnership for Education. GPE
https://www.globalpartnership.org/what-we-do/inclusive-education

Policy markers for nutrition in the Creditor Reporting System (CRS). OECD-DAC. 2018
http://www.oecd.org/officialdocuments/publicdisplaydocumentpdf/?cote=DCD/DAC/STAT(2018)38/REV1&docLanguage=En

Sample population level disability assessment reports:

Model Disability Survey of Afghanistan 2019
https://reliefweb.int/report/afghanistan/model-disability-survey-afghanistan-2019

Disability assessment among Syrian refugees in Jordan and Lebanon. Humanity Inclusion, IMMAP. 2018
https://reliefweb.int/sites/reliefweb.int/files/resources/65892.pdf

Photo Credits

Cover Photo : WFP/Giulio d'Adamo

Photo page 3: WFP/Hugh Rutherford

Photo page 17: WFP/Hugh Rutherford

World Food Programme
Via Cesare Giulio Viola 68/70,
00148 Rome, Italy - T +39 06 65131
wfp.org