

# Our Lessons: AHP III Bangladesh

## Inclusion matters

A disability inclusion journey in the Rohingya crisis response

CBM Global Disability Inclusion with the support of Centre for Disability in Development (CDD), World Vision, CARE, Plan International, Save the Children, Oxfam, and EKOTA (CAN DO).



Man pushing another man in a wheelchair along a rough pathway



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Photo credits: AHP Phase III Communications & Advocacy Working Group.

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# Abbreviations

Acronym	Description
AHP	Australian Humanitarian Partnership
CBM	CBM Global Disability Inclusion
CDD	Centre for Disability in Development
CFRM	Complaints, feedback and response mechanism
CiC	Camp in Charge
CMU	Coordination Management Unit (Hosted by Care)
DIFP	Disability Inclusion Focal Point
DITU	Disability Inclusion Technical Unit
DIWG	Disability Inclusion Working Group
DSCs	Disability Support Committees
DSK	Dushtha Shasthya Kendra
DSS	Department of Social Services
EKOTA	CAN DO EKOTA consortium (Christian Aid, RDRS Bangladesh, Caritas Bangladesh, Green Voice, Dustho Shasthya Kendra (DSK))
FGD	Focus Group Discussion
FIVDB	Friends In Village Development Bangladesh
GBV	Gender-based violence
HI	Humanity & Inclusion (formerly known as Handicap International)
IGAs	Income Generating Activities
NGO	Non-Governmental Organisation
NGOF	NGO Forum for Public Health
OPCA	Organisation for the Poor Community Advancement
PIB	Plan International Bangladesh
RDRS	Rangpur Dinajpur Rural Service (Bangladesh)
SHGs	Self-Help Groups
SRH	Sexual and Reproductive Health
ToT	Training of Trainers
WASH	Water, sanitation and hygiene
WGSS	Women and Girls safe spaces
WV	World Vision
YPSA	Young Power in Social Action

# Executive Summary

## The AHP Phase III program

**The Rohingya crisis is the largest and most complex humanitarian crisis in the Indo-Pacific region, with over 1.5 million people needing humanitarian assistance in Cox’s Bazar, Bangladesh.**

In 2017, the Australian Government directed AU \$6 million of its humanitarian assistance package to the Rohingya crisis through the Australian Humanitarian Partnership (AHP). The initial Phase (AHPI) focused on providing clean water, improved sanitation and hygiene, health, protecting those vulnerable to abuse or not receiving required services, and providing education and basic survival items. The response reached over 280,000 people.

In 2019, Australia provided AU \$9.9 million as part of a second Phase of support to the Rohingya crisis (AHPII). Partners focused on WASH, protecting, and including women, children, people with disabilities and other vulnerable groups; education; adolescent reproductive health and support for host communities.

In 2020, AHP partners came together as a single consortium to further continue Australia’s support to the Rohingya in Bangladesh through a multi-year response until June 2023 (AHP Phase III). This third Phase was supported by the Australian Government with AU \$44 million. AHP Phase III consisted of a three-year humanitarian program contributing to the overarching DFAT Bangladesh Rohingya and Host Community Humanitarian Package (2020–2023). It enabled broader geographic reach, better coordination with key stakeholders, and improved collective response to the needs of Rohingya and host communities under a consortium mechanism. Partners worked towards all DFAT package high-level outcomes: basic needs, self-reliance, resilience and reform amongst refugee and host communities. This four-pillared approach put special consideration on gender, localisation, and disability inclusion. The design of AHP Phase III explicitly emphasised inclusion of people with disabilities so that they are better represented and more actively involved in the program with meaningful and equal access to services.



**Image 2: Man holding ID card and crutches**

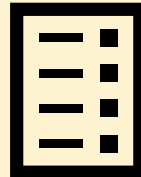
**This lessons learned report documents AHP Phase III achievements per result area and lessons learned both organisationally and programmatically on disability inclusion. It also presents recommendations for future programming to progress disability inclusion further in the Rohingya response and for the humanitarian sector at large.**

## Achievements on disability inclusive humanitarian action



### Collective learning

Joint field visits, providing technical input on disability inclusion to all consortium partners through the DITU. There were 48 trainings conducted over AHP Phase III.



### Integration of the Washington Group Questions

All agencies using the WGQs to identify people with disabilities to ensure they are receiving support services. This practice has also flowed onto other partners and projects.



### Increasing accessibility of services

Disability inclusion assessments conducted by the DITU, not only improved AHP-funded interventions but shaped how agencies include considerations across the sector.



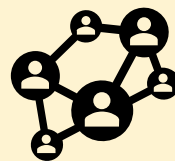
### Effective collaboration

The gender and DI working groups collaborated to develop guidelines to support teachers to deliver gender and disability inclusive education.



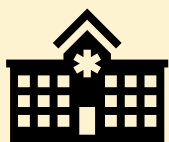
### Voice and participation of people with disabilities

Establishing 13 Self-Help Groups/Disability Support Committees consisting of 159 people with disabilities.



### Consortium network to expand reach and impact

Greater voice of partners, network building, organisational ripple effect, sensitisation of staff and increased understanding.



### Accessible health

Save the Children established an accessible health facility.



### Accessible facilities

CARE improved accessibility of WASH facilities, livelihoods, and health services.



### Learning from doing

EKOTA was the first partner supporting SHGs with support from the DITU. The consortium model allowed four additional consortium partners to visit EKOTA's projects

and take advantage of lessons learned during that process before rolling out that approach themselves.



### Inclusive communities

World Vision established 48 inclusive community groups that include people with and without disabilities.



### Modified latrines and bathrooms

Plan adapted latrines to make them more accessible and include facilities for menstrual hygiene management.



### Inclusive hygiene kits

Oxfam hygiene kits now include additional items for people with disabilities.

## Impact on people with disabilities<sup>1</sup>

Over the first half of 2023, the Disability Inclusion Technical Unit (CBM and CDD) conducted field monitoring activities with the six AHP agencies to assess and further understand access to services and participation of people with disabilities in AHP Phase III. Twelve focus groups were conducted over April and May 2023 to explore achievements and challenges of progressing disability inclusion in AHP Phase III. The twelve focus group discussions involved 119 people with disabilities and their caregivers across different camps and host communities, and explored outcomes across Basic Needs, Self-Reliance, Resilience and Reform including WASH, Education, Health, Protection, and Livelihoods. The data collected from the 119 project beneficiaries (53% Female, 47% Male, nine children and eight caregivers) in 2023 indicated positive levels of change.

### End of program monitoring found:

- 107 people reflected on the **overall situation for people with disabilities**. Just over half (51%) strongly agreed that the situation for people with disabilities has improved over the last year, with an additional 28% agreeing it has improved. However, 18% neither agreed nor disagreed. Highlighting for some people with disabilities their situation is yet to be changed or improved. For 3% there had been no improvement.
- 108 people reflected on **access to water and sanitation**. For 65% of respondents strongly agreed access to water and sanitation facilities has improved significantly. An additional 24% agreed with the statement. Again, there was indication for 11% that their access had not improved or that water and sanitation is still inaccessible.
- Of 29 women from female only FGDs reflected on **safety in the community**. Of these women, 26 agreed or strongly agreed that women with disabilities feel safer in the community. Three women reflected they do not agree or disagree. Of the total of 75 people from mixed focus groups and female only focus groups who reflected on safety, 93% agreed that women with disabilities generally feel safer in the community than they did a year ago.

## Key learning on disability inclusive humanitarian response

Despite the challenges and complex context of AHP Phase III, the impact made in progressing disability inclusion is significant. Substantial progress was seen in the uptake of the Washington Group Questions, the development of Self-Help Groups and the increase in accessible services. The organisational ripple effect and collective learning were also successful elements of AHP Phase III.

What have we learned from AHP Phase III, and what are our recommendations going forward?

1. **Roles and budget:** AHP Phase III partners appreciated dedicated technical assistance on disability inclusion, but it was found more budget and role clarity was

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<sup>1</sup> [AHP Phase II Bangladesh Impact Report: An honest account](#)

needed to drive disability inclusion in a big consortium. A full-fledged twin-track approach needs to be applied in consortium programs like AHP Phase III in which targeted interventions (incl. provision of assistive devices) and mainstreaming disability in humanitarian activities go hand in hand. The budget for disability inclusion should follow the available guidance to earmark 3-7% of the total budget.

2. **Organisational leadership:** Disability inclusion was a key impact area for AHP Phase III. Senior leadership was critical to ensure agencies integrated the Disability Inclusion Action Plan and targets into their overall MEAL plans. Where that occurred, disability inclusion continued to show visible progress and increased momentum and prioritisation.
3. **Collecting and using disability data:** Approximately 4-5% of the total number of beneficiaries reached, were people with disabilities compared to 12% prevalence data ([REACH](#)). Evidently the uptake of the Washington Group Questions was an initial challenge in AHP Phase III. Agencies need to build capacity on using the Washington Group Questions (WGQs) and support partners during initial data collection processes. Furthermore, stronger analyses on equity of access are required to be able to see positive changes on increased equity over time.
4. **Capacity building of staff:** Through the technical unit and disability inclusion focal points progress was made on disability inclusion. It was found that the appointment of dedicated fulltime focal points; training systems that are adaptive; and a focus more on tailored resource development drove better uptake of disability inclusion in the consortium. The collective learning and networking within AHP Phase III was exemplary and learning can be drawn on how it was coordinated and sustained from the start.
5. **Accountability to people with disabilities:** While AHP Phase III made great strides to increase the participation of people with disabilities, more meaningful participation, and empowerment of people with disabilities through SHGs/DSCs is required. Future programming should look to build upon SHGs/DSCs established in AHP Phase III and continue to raise the voice and active participation of people with disabilities. Additionally, start early on in the program with empowerment activities; explore jointly what roles and activities SHGs/DSCs can play; and identify training needs. Humanitarian organisations need to develop a long-term outlook on collaboration with SHGs/DSCs of people with disabilities.

AHP Phase III showed the humanitarian sector what is possible in realising inclusion of people with disabilities within a complex humanitarian environment, and how consortium organisations and their partners collaborated to achieve common goals and progressed learning on disability inclusion. AHP Phase III's approach to disability inclusion has been incredibly powerful in creating organisational and programmatic change. **Delivery, visibility, and continuity of disability inclusion support is critical to build on and maintain momentum developed in AHP Phase III, because inclusion matters!**



# 1 Our Disability Inclusion approach

## 1.1 Introduction

The approach to disability inclusion in AHP Phase III was based on international normative guidance (such as the United Nations Convention on the Rights of Persons with Disabilities (CRPD) and the Inter-Agency Standing Committee (IASC) Guidelines on Inclusion of People with Disabilities in Humanitarian Action), international good practice, emerging learning from earlier phases, and consultation with people with disabilities. **Guiding Principles:**

- **Participation of people with disabilities** - 'nothing about us without us'. Strategies to ensure we were working to improve participation, so people had equal opportunities to actively engage, including working with OPDs (organisations of people with disabilities) and self-help groups.
- **Accessibility and reasonable accommodation** - through fulfilling requirements for people with disabilities to exercise their rights and supporting changes or modifications to remove barriers.
- **Non-discrimination and intersectionality** - addressing multiple barriers that create different and additional modes of discrimination and privilege.
- **Twin track approach** – disability specific and disability inclusive initiatives; that included both targeted programming, and removal of institutional barriers.
- **Localisation** - inclusion in localisation strategies

The **AHP Bangladesh Disability Analysis** was conducted at the start of the program, covering the legal, policy and response context, disability prevalence data among Rohingya refugee and host community population, pre-conditions to inclusion and the baseline situation for people with disabilities aligned to outcome areas (basic needs, self-reliance, resilience, and reform).

Based on the analysis a **Disability Inclusion Action Plan**<sup>2</sup> was developed which sought to advance a systematic and comprehensive approach towards incorporating disability inclusion across the AHP Phase III program through the following key result areas:

1. Building partners' organisational capacity on disability inclusion,
2. Improving representation of people with disabilities in the program
3. Improving people with disabilities' access to services
4. Enhancing collective learning for effective development.

Key interventions included:

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<sup>2</sup> AHP Phase III Disability Inclusion Action Plan

- Supporting disability inclusion awareness, capacity and practice with implementing and local partners and shared consortium strategies.
- Integrating disability inclusion through the whole program cycle, including MEAL and budgeting
- Identification and mitigation of risks related to people with disabilities
- Inclusive complaints and feedback response mechanisms around consortium performance and strategies
- Promoting active participation of people with disabilities and representative organisations (OPD and SHGs) in decision making across the project cycle
- Facilitating collective learning on disability inclusive humanitarian action practice and change processes.
- Guiding disability inclusive data disaggregation through Washington Group Questions (WGQ)

The Disability Inclusion Action Plan set out the specific activities that AHP Phase III partners were to implement in order to achieve disability inclusion in reality. The explanatory [AHP Bangladesh Consortium video on Disability Inclusion shows](#) types of activities taken forward.

## 1.2 Building partners' organisational capacity on disability inclusion

The DITU<sup>3</sup> developed the **Training-of-Trainers (ToT) Modules on Disability Inclusion, which was run** for Disability Inclusion Focal Points (DIFP), who subsequently developed training plans and ran training sessions with their own agency staff. DITU supported the DIFPs to co-facilitate their first training sessions. DITU provided following up training to DIFPs.

The training included three modules:

- Module 1: Introduction to Disability-Inclusive Humanitarian Action,
- Module 2: Minimum standards for Disability-Inclusive Humanitarian Action, and
- Module 3: Putting Disability Inclusion into Action.

The DITU helped to build confidence and capacity of DIFPs within each AHP partner organisations. DIFPs reflected that training increased understanding of the barriers people with disabilities experience, the need to consult and work with people with disabilities, and partnership and mainstreaming approaches to disability inclusion.

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<sup>3</sup> See for a more elaborate capacity building plan, annex C of the Disability Inclusion Action Plan.

Additionally, building the capacity of field level staff was critical. **Practical sector specific coaching and disability inclusion implementation support** was given through Module 3.

Topics included introduction to disability inclusion, protection, health, WASH, accessibility, Self-Help Groups, disability inclusive project cycle management, disability inclusion in Gender-Based Violence programming. Training also covered orientation sessions on Inclusive Complaints Feedback Response Mechanisms and using the Washington Group Questions.

Other capacity building included **Consortium Management Unit Learning Sessions** and **Technical guidance, review**, advice for AHP Implementing Partners. **48 trainings engaging 882 participants** were conducted on disability inclusion (12 trainings to DIFPs; 17 trainings with SHGs/DSCs; and 19 trainings supported by DITU to AHP agencies). As a result, all AHP Phase III agencies used the Washington Group Questions to improve and increase identification of people with disabilities. AHP Phase III disability inclusion knowledge has cascaded to other staff beyond the DIFPs in some organisations, having a ripple effect on other projects, for example, protection teams budgeting for assistive device, strengthened and improved practice and building momentum on disability inclusion internally, training field level staff from different projects based on AHP knowledge, and further increasing accessibility of toilets and latrines in other projects.

The 2023 annual report showed evidence of increased activities and engagement on disability inclusion:

CARE engaged 71 people with disabilities as cash for work labourers and ensured the inclusion of people with disabilities in all groups and committees. CARE programs in DRR, GBV, SRH, and WASH were proactive in adapting inclusive approaches to improve participation of people with disabilities in project activities ranging from awareness-raising activities to income-generation, including in cash for work.

EKOTA engaged 1,988 people with disabilities in various activities across all its sectors. EKOTA ensured that 338 people with disabilities could use accessible latrines and 60 bathing spaces following necessary modifications based on accessibility audits which were conducted by engaging 132 people with disabilities.

Oxfam engaged around 100 people with disabilities in their livestock rearing interventions.

PLAN renovated 6 multi-purpose centres and 17 childhood development centres for improved accessibility.

World Vision ensured 53% representation of people with disabilities on various committees and improved the accessibility of many of its facilities through the engagement of people with disabilities.

Despite these achievements there have been challenges cascading skills and knowledge from the Training-of-Trainers methodology for disability inclusion focal points to field level staff. Some agencies have cited **budgetary constraints** for not being able to replicate staff training, for others the reasons for a lack of replication remain unclear. This resulted in **gaps in disability inclusion knowledge, attitudes, and practice** by field level staff. To address this, DITU intensified field level technical input by providing hands-on support for activities, including accessibility audits and inclusion guidance, as well as sharing information, education and communication materials and guidance notes.

Additionally, a key learning for integrating disability inclusion was to ensure the overarching disability inclusion action plan must be **embedded into agencies' MEAL**

**plans.** This ensures prioritisation of disability inclusion and also keeps agencies accountable.

### **Case story: Leveraging Disability Inclusion by building organisational capacity**

Ms. Taslima Ferdushi (World Vision, Project Coordinator, Child Protection and Education) realised that children with disabilities lie at the top of the vulnerability radar, so ensured their inclusion into her project interventions. Without a “technical” background, her position as a Disability Inclusion Focal Point (DIFP) was frowned upon by the “technical” practitioners. She said that ‘While I admit that I came from a general educational background without any knowledge on disability inclusion which was challenging for me, I realised that I could contribute after receiving 2-3 disability inclusion related trainings from DITU.’ Taslima believes that challenges can be overcome with the right attitude.

Taslima’s work around disability inclusion was highlighted during a high-level meeting involving representatives from 30+ agencies from several sub-sectors within the broader humanitarian sector in Cox’s Bazar. Taslima was asked to support other agencies, so they could replicate her work. When prompted about her impressive knowledge on disability inclusion, Taslima noted that she did not have a disability background but took the opportunity of being nominated as a DIFP to better serve the most marginalised, i.e., people with disabilities. Through DITU, Taslima absorbed the disability inclusion related concepts very quickly and applied the same to her work. Taslima also integrated disability data collection tools into regular assessments, ensured service accessibility, inclusive community feedback and response mechanisms, and helped form disability support groups, while engaging the DITU team to support monitoring and quality assurance.

While Taslima modestly accredits the DITU, her supervisor, management, field staff and facilitators for her achievements in disability inclusion in her program, she demonstrated a tremendous commitment to ensure the inclusion and active participation of people with disabilities during all stages of the humanitarian program cycle in World Vision’s interventions under AHP Phase III. **Taslima dismantled the taboo that only specialists with a “technical” background can bring about changes and has proved that passion and commitment for disability inclusion is all that truly matters when the right support is available.**

## **1.3 Improving representation of people with disabilities in the program**

While **more people with disabilities were supported to get involved during AHP Phase III**, disability prevalence surveys found varying levels of representation of people with disabilities in agency activities: EKOTA (6%), Plan (6.14%), Save the Children (5.5%), and World Vision (13%) of total beneficiaries.

A visit to an Organisation of Persons with Disabilities (OPD) in Sitakunda, Chittagong helped AHP Phase III agencies realise the benefits of OPDs, Self-Help Groups and Disability Support Committees, and helped them understand the operations and sustainability approaches of **OPDs, SHGs and DSCs**. As a result, AHP Phase III partners significantly supported and furthered the formation of Self-Help Groups and Disability Support Committees to empower people with disabilities to raise their voice (a total of 13

Self Help Groups with 159 people with disabilities were functional and supported by AHP PHASE III partners).

Inclusive community groups were also established, with people with disabilities recognised in their communities.

Notable is also the role the **Disability Rights Advocate** played as part of the DITU. Being a person with a disability himself, Mr Ahsan had the personal experience, interest, and legitimacy to support the SHGs and DSCs to raise their voice on disability rights issues. He facilitated training on advocacy, rights of people with disabilities under the CRPD and understanding barriers. Additionally, accessibility audit trainings for members of SHGS and DSCs were facilitated, while conducting monthly capacity strengthening sessions for the members. As a result, SHGs and DSCs are now conducting accessibility audits in other interventions. OPD leaders are invited to monthly meetings, while a plan to link these groups with broader OPD networks is underway as an exit strategy.

### **Case story: Advocating for disability inclusive social service programming with the government**

During AHP Phase III DITU and DIFPs empowered SHGs to advocate to the Department of Social Services. The SHG Advocacy program with the Department of Social Services responsible for the implementation of the CRPD-SDGs and Rights Protection Act, 2013, resulted in 43 participants attending the advocacy program from the Department of Social Services of Cox's Bazar, as well as 18 members of SHGs who have a disability and are living in the host community. The session informed the Department of Social Services about the gaps and challenges that people with disabilities faced in this context and discussed how to ensure the empowerment of people with disabilities and access to support from the Department of Social Services. As a result, SHG members have received Golden Citizen Cards<sup>4</sup> issued by the government allowing them to access increased coverage of social security protection schemes.

## **1.4 Improving people with disabilities' access to services**

To improve access to services for people with disabilities, the DITU supported AHP Phase III partners to identify specific requirements of people with disabilities in project sites and sectors; conduct barrier assessments; and monitor participation data (target was 10% of participants across all sectors and agencies are people with disabilities).

AHP Phase III partners improved and increased accessibility to WASH facilities, education and learning centres, livelihoods, protection services, health services. The training to SHG/DSC members to increase their capacity to conduct accessibility audits proved very helpful in having people with disabilities directly involved in addressing their accessibility concerns. AHP Phase III partners also made strides to ensure that people with disabilities and other intersectional identities would get equal access to services. Some agencies

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<sup>4</sup> [AHP Phase II Bangladesh Impact Report: An honest account](#)

however, faced construction restrictions and financial constraints to modify some structures constructed during previous AHP Phases.

Additionally, several AHP Phase III partners provided assistive device for people with disabilities including children with disabilities or referred to other services providers in the camps and host communities for assistive devices.

From 2023 annual reporting some achievements included renovated health post (CARE and Save); modified a multi-purpose centre and two children's learning centres (PLAN); new accessible WASH and shelters. Constructed (OXFAM); 261 WASH facilities modified (EKOTA); and 249 different types of assistive devices provided (World Vision). Save the Children accommodated the needs of students with disabilities by changing seating arrangements – a simple but effective measure to increase participation.

Disability inclusion assessments conducted by the DITU team, not only improved AHP Phase III-funded interventions but shaped how partners started to apply lessons in other sectors/programs, e.g., on accessible WASH facilities in other projects.

### **Case story: Making WASH services accessible**

Teknaf is one of the biggest Upazilas in Cox's Bazar district. NGO Forum (Oxfam's implementing partner) provided WASH services at the host community area of the Whykong and Nila unions in Teknaf under AHP Phase III. These two unions are nearby Camp-22. In this area, there was a severe shortage of drinking water, people used to defecate in the open and were not conscious of hygiene and sanitation. To get sufficient drinking water, hygiene, and sanitation services, people with disabilities were often excluded.

NGOF DIFP Mr. Dr. Shadly Benzadid Arefin, a public health promotion officer, received training from DITU on how to ensure disability inclusion within their activities. *'I learned about disability inclusion practically from the training and field visit to understand how to identify people with disabilities, how to include people with disabilities as project beneficiaries, how to ensure accessibility within WASH facilities, and how to make inclusive budgeting and monitoring, etc. I also replicated TOT modules 1 and 2 with the Oxfam and NGOF staff and volunteers to build their capacity on disability inclusion.'* Said Shadly.

As a result, NGOF gave high priority to including people with disabilities during social mapping and site selection. NGOF provided accessible WASH facilities (including installation of rainwater harvesting near the homes of people with disabilities, the installation of ponds and filter facilities accessible to people with disabilities, as well as accessible latrines). During the awareness sessions and meetings, people with disabilities were included.

Before incorporating disability inclusion into the WASH activities, they identified people with disabilities only by observing their physical appearance. After DITU training, *'we used the Washington group questions (short set) to identify people with disabilities. We found 400 people with disabilities who directly benefited from our WASH activities. We provided a total of 4 rainwater harvesting systems within our working area, 3 were based at the homes of people with disabilities.'*

At the infrastructure design stage, NGOF followed the social architect approach, where staff consult with people with disabilities. This approach helped them ensure

accessibility. They also received on-site technical support from the DITU. The DITU conducted several field visits with NGO and provided recommendations on how to ensure accessibility. *‘People with disabilities come forward and raise[d] their voice, expressing their requirements and rights and dealing with foreign delegates. This helped other people with disabilities to come forward and share their expectations. In our working environment, now people with disabilities also showed leadership and ownership’*, said Shadly.

Finally, Shadly noted *‘Inclusive budgeting is very important for incorporating disability inclusion. I learned from the training that to meet the physical accessibility requirements and other reasonable accommodations for people with disabilities, between 2 percent to 7 percent should be added to budgets. We had an opportunity to review the budget. We keep our budget inclusive for incorporating disability inclusion into every activity, which helps us to meet the requirements of people with disabilities and ensure their meaningful participation.’*

## 1.5 Enhancing collective learning for effective humanitarian action

The collective learning activities consisted of organizing learning events, developing case studies, reports, and advocacy pieces. The DIFPs from each consortium partner attended the monthly Disability Inclusion Working Group meetings and quarterly joint field visits organized by the DITU. Both activities served as an effective cross-learning platform for agencies to exchange different ways of working towards the same objectives and learn from each other’s best practices. DIFPs learned about disability inclusion in other areas that were not within the primary sector focus of their own organisation, expanding their breadth of knowledge. Through the disability working group three AHP Phase III partners working on education (Save the Children, Plan and World Vision) developed guidelines to support teachers deliver gender and disability inclusive education, which were rolled out in 2023.

Apart from this lessons learned report, the [AHP Phase III Bangladesh Impact Report: an honest account](#) was published in 2023 and reflects the lived experiences of people with disabilities in the Rohingya AHP Phase III response, their stories and feedback on what has changed for them and the continued barriers they face.

In terms of outcomes for people with disabilities, Focus Group Discussions conducted in April and May 2023 found:

- **85 of 107 (79%) people with disabilities and caregivers agreed or strongly agreed that the situation has improved for people with disabilities over the last year.**
- **90 of 108 (89%) people with disabilities and caregivers agreed or strongly agreed access to water and sanitation facilities has improved significantly.**
- **26 of 29 (90%) women from female-only focus group discussions agreed or strongly agreed that women with disabilities generally feel safer in the community.**

- **Significant changes identified by people with disabilities included accessibility, a shift in mindsets and attitudes, and an increase in participation and voice.**
- **AHP Phase III partners also improved and increased their internal and external communications about their own disability inclusive practices and how that impacted the lives of people with disabilities.**

The roll out of the Disability Inclusion Action Plan through the four result areas led to significant changes and has proven to be an effective strategy. The AHP Phase III program also brought various key lessons which will be unpacked in the following chapters, on budget and roles, organisational leadership, collection and use of disability data, capacity building of staff, accountability to people with disabilities and contextualising disability inclusion.



## 2 Lessons from AHP Phase III

### 2.1 Technical capacity and Roles

To roll out the Disability Inclusion Action Plan effectively the **technical capacity** on disability inclusion to provide guidance and **clarity of roles and responsibilities** was vital.

#### 2.1.1 DITU: Technical assistance on disability inclusion

The dedicated Disability Inclusion Technical Unit (DITU) providing disability inclusion guidance was critical due to lack of dedicated in-house expertise within AHP Phase III partners. DITU provided the oversight and ensured coherence in approaches across the consortium, promoted accountability and learning on disability inclusion, and had technical staff to design and facilitate Training of Trainers modules, monitor disability inclusion practices in the field, collect case stories and report achievements.

Lessons learned:

- Finding the right skill set in the program location, proved impossible, thereby requiring the appointment of an international advisor. Getting a work permit for a long-term **international disability inclusion advisor proved difficult. However, having a strong** team in Cox's Bazar and an international advisor as remote support, despite some limitations, still worked when communication lines were strong. In this way the program benefitted from compliance with international standards and normative guidance, at the same time being clear about the need to contextualise it within the Rohingya crisis response and organisational realities.
- The DITU was composed of staff from both CBM and CDD, who worked as a team. The advisor brought technical knowledge, the coordinator ensured integration into the wider consortium program, the disability rights advocate brought lived experience and expertise, and the inclusion officers provided practical guidance at field level. Working in one unit but with staff from two different organisations requires that visibility of both organisations at field and partnership levels needs to be ensured, **decision making about resource planning is coordinated and follows a single work plan.**

#### 2.1.2 Coordination, roles, and responsibilities

Due to the number of AHP Phase III partners, the program governance was complex, and it took a significant amount of implementation time for the program to get up and running. This also indicated a lot of time was needed for coordination with different stakeholders, as well as getting the attention of staff on disability inclusion while they were already busy with other activities. Besides the 20 AHP Phase III partners there was a need to coordinate with Camp-in-Charge, local government authorities, and the UN Cluster system.

**Lessons learned and recommendations:**

- Providing technical assistance on disability inclusion does not only mean that capacity needs to be available on demand, but also that active coordination with

partners is required to determine what technical assistance is needed, when and how it can be delivered. A hierarchical, multilayered approval structure emphasised the **coordination and partnership management** value of DITU functions.

- It was very useful to have DITU participate in **strategic decision making with the CMU**. This enabled DITU to be aware of challenging situations in the consortium to which it could adapt its work plan, but also ensured that CMU was continuously aware of the disability inclusion agenda and commitments of the AHP Phase III program.
- DITU's role was to catalyse disability inclusion within the consortium and provide training and capacity building, but DITU was seen at the beginning, as the one-stop-shop 'taking care of everything related to disability' including delivering assistive devices and rehabilitation services. The role of the technical advisory support on disability inclusion needs to be clarified, and **implications taken into account in the proposal and budget design**.

### **Recommendation: Represent technical assistance at senior management level**

The uptake of disability inclusion is higher when technical assistance is represented at senior management level. It will ensure a more pro-active stand of the technical assistance team and higher chances of contextualising disability inclusion within the organisational reality of the consortium. Coordination and partnership management need to be integral part of the role of a technical assistance team on disability inclusion.

### **Recommendation: Translate implications of different roles on disability inclusion into the budget design**

During program design all consortium members need to understand the implications of the technical assistance role on disability inclusion:

- What is part of the responsibility of the technical partners?
- What is part of their budget responsibility?
- Are there critical areas on disability inclusion that are not covered by either the technical assistance or implementation partners (both in terms of responsibilities and budgets)?

This avoids key areas of disability inclusion being under-resourced. Retrofitting disability inclusion into a program is extremely difficult. If budgets and resources are not considered from the start, it is challenging to get uptake during implementation and confusion about role clarity will remain.

## **2.2 Budget availability and flexibility**

There were budget gaps in AHP Phase III for inclusion of people with disabilities. As mentioned above, rehabilitation services and assistive devices were not sufficiently budgeted for within DITU's budget nor with consortium members. Throughout AHP Phase III **budget** to ensure inclusion of people with disabilities in all the activities needed to be negotiated each time. Fortunately, there was a certain **degree of flexibility** among consortium members and also at the level of the CMU to reallocate budget. The CMU held

the budget for the learning component and funded, for example, the OPD exposure visit and SHG/DSC training. A considerate senior management team was pivotal to make this work.

It is worth noting that the budget for the technical partners on disability inclusion was AUD700,000 out of AUD44 million for three years. Separate budget provisions per consortium partner on disability inclusion are unknown. Based on UNICEF guidance<sup>5</sup>, the **overall budget for disability inclusion should have been 3-7%** in total which would equate to AUD1.3-3.1 million, including provisions for assistive devices and rehabilitation services.

### **Recommendation: Earmark 3-7% of the budget for disability inclusion and promote flexibility**

The guidance of 3-7% of budget for disability inclusion provides a realistic budget outlook. A budget analysis should be done before submission of designs, to ensure the following:

- Mainstream activities (e.g., ensuring that in all activities barrier analyses can be done, disability data is collected, people with disabilities participate and are empowered)
- Targeted activities (e.g., assistive devices, rehabilitation services, reasonable accommodation, specific activities for people with disabilities as the SHG/DSC activities)

In terms of cost categories, analyse:

- Technical expertise, i.e., disability inclusion advisors/officer, disability inclusion focal people, resource people
- Supplies, i.e., assistive devices, training materials, construction materials, workplace adaptations, publications
- Services, i.e., rehabilitation services, communication, arrangements with partnerships with OPDs
- Logistics, i.e., training venue, transport, meals, and accommodation
- Reasonable accommodation, i.e., sign language interpreters, information in accessible formats, personal assistants.
- Contingencies, as the number of people with disabilities may vary during the program or new developments may occur.

**Do not submit a design that is not supported by a realistic budget.**

## **2.2.1 Access to assistive devices and rehabilitation services**

In the context of the Rohingya humanitarian crisis the demand for assistive devices and rehabilitation services was immense, coupled with very few avenues for obtaining assistive devices or services through the humanitarian agencies. A **twin-track approach** needs to be applied in which targeted interventions (incl. provision of assistive devices and rehabilitative services) and mainstreaming disability in humanitarian activities go hand in hand. The Disability Inclusion Working Group found there was insufficient budget to meet the needs, and AHP Phase III partners had made insufficient budget provisions for appropriately fitted assistive devices. In some camps there are service providers for

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<sup>5</sup> [Budgeting and mobilizing resources for disability inclusion in humanitarian actions \(unicef.org\)](https://www.unicef.org/emergencies/files/49467main.pdf).

assistive devices and rehabilitation services but not in all<sup>6</sup>. Where there are services providers, referral pathways can be designed which require agreements between agencies to ensure that sufficient services can be provided and of good quality.

### **Recommendation: Conduct a service mapping exercise during situational analysis and list budget implications**

Consider a **service mapping exercise during the situational analysis at the design phase** of a program. Ensure service mapping includes:

- What assistive devices and rehabilitation services are provided,
- What the requirements are for people with disabilities to access these services and
- What type of agreement is needed between agencies to ensure sufficient services can be provided of good quality.

Include the result of the analysis in designing the budget for the humanitarian crisis response.

## **2.3 Organisational leadership**

Disability inclusion was defined as 'a main agenda item', and as a key impact area for AHP Phase III, it was part of the standard reporting template. For agencies that integrated the Disability Inclusion Action Plan into their overall MEAL plans, disability inclusion progressed well as activities were measured against targets. Organisations needed to own disability inclusion and make it their own priority, and senior leaders played a key role to make that happen.

### **2.3.1 Support of senior leaders**

In each organisation a Disability Inclusion Focal Point drove the agenda on disability inclusion uptake into AHP Phase III. Cascading of knowledge and expertise was needed as one person could not integrate disability inclusion throughout the entire AHP Phase III activities of the organisation, in what was an already stretched role. There was a disjoint in the level of **understanding on disability inclusion between senior and field levels**. The reality in the field was not always reflected at management level, and at the field level the impact was not sufficiently tracked for the management level to understand the progress on disability inclusion. Therefore, DIFPs needed program managers and senior managers to understand and be accountable for incorporating inclusion. Lack of **senior management buy-in** made it challenging for some partners to progress or get the support needed for disability inclusion. At times key disability inclusion activities needed to be negotiated through the CMU. This engagement from CMU was extremely influential, and the support of senior leaders enabled disability inclusion to remain a priority throughout the program. For example, the CMU played a crucial role in advocating for the use of the Washington Group Questions.

### **Recommendation: Engage senior leaders on disability inclusion directly**

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<sup>6</sup> See service mapping in the situational analysis.

When senior leaders convey the importance of disability inclusion and mandate it as a priority, awareness and uptake increases through the entire program. Whenever there are challenges on progressing disability inclusion that require concerted effort across different teams and hierarchies, senior management involvement can support finding a solution. In case there is a coordinating body in a broader consortium, the buy in of that senior management team needs to be secured.

## 2.3.2 Visible progress

Through the capacity approach taken, partners and staff were trained on disability inclusion. Their increased knowledge, understanding and skill was visible when they took up the exercises and surveys to collect disability data using the Washington Group Questions and also when they started to engage with Self-Help Groups and Disability Support Committees. **Tangible and visible progress** such as links to/provision of accessible services and assistive devices support, were activities that created positive momentum on disability inclusion.

This was not the case at the start of the program. Slow uptake and traction in the beginning, as well as the implications of COVID-19 meant disability inclusion activities were delayed and there was not the commitment and buy-in initially needed. Strategic planning based on a **change management approach**, was lacking at times. Some activities or trainings were launched rather late in AHP Phase III but could have given more visibility to the impact of disability inclusion if they were done earlier. As technical partners, the support provided by CBM and CDD could have been more impactful if AHP Phase II partners adopted a change management approach in the way they made that support available to their teams.

### **Recommendation: Apply a change management lens in sequencing of disability inclusion support**

Influencing on disability inclusion requires a deliberate change management lens, both when providing technical assistance on disability inclusion as an advisor or as a focal person within an organisation. Matching change management approaches with disability inclusion training modules equips focal people to strategically consider what change process is needed to advance disability inclusion in the program.

## 2.4 Collecting and using disability data

What is measured gets done. The goal that 10% of the beneficiaries of AHP Phase III would be people with disabilities was a major driver to make progress on disability inclusion. Hence, the identification of people with disabilities was a key activity in AHP Phase III. A number of lessons can be drawn from the collection and use of disability data.

### 2.4.1 Disability inclusion targets into MEAL plans

The goal that **10% of the beneficiaries** of AHP Phase III would be people with disabilities was a major driver to make progress on disability inclusion. AHP Phase III's Disability Inclusion Action Plan, a comprehensive and holistic in the approach to disability inclusion, was used as a guide to follow and as an **accountability mechanism**. It was well received and built a foundation for disability inclusion amongst the six AHP

consortium partners. It was comprehensive in addressing the levels of change and defined the engagement needed to progress disability inclusion across a consortium model. It was anticipated that the AHP partners would put **disability inclusion indicators into their own MEAL plans** and would track progress on the indicators, however this was a challenging element. For example, if SHGs were not integrated into organisation action/MEAL plans, some organisations missed reporting on them, or the progress was limited as it was not prioritised. Positive momentum was built in AHP Phase III when targets were being met.

**Recommendation: Translate disability inclusion targets and indicators in organisation-specific MEAL plans**

Especially in a high paced environment with relatively short program cycles, disability inclusion indicators should be integrated into MEAL plans to foster accountability and ownership of disability inclusion. If disability inclusion indicators are not present, it is challenging for focal points to push disability inclusion forward.

## 2.4.2 Purpose of disability data

Through the collection of disability disaggregated data, prevalence figures could be established to assess:

- how far the program is **reaching out to all people in an equal way** e.g., not unintentionally excluding people, and
- how far the **access to and use of services** within the AHP Phase III program is equal.

Additionally, disability inclusion assessments were done to identify barriers that hindered people with disabilities from participating in and benefiting from activities. These types of assessments are more qualitative in nature and help to remove barriers.

**Recommendation: Collect and analyse both prevalence figures and data on barriers**

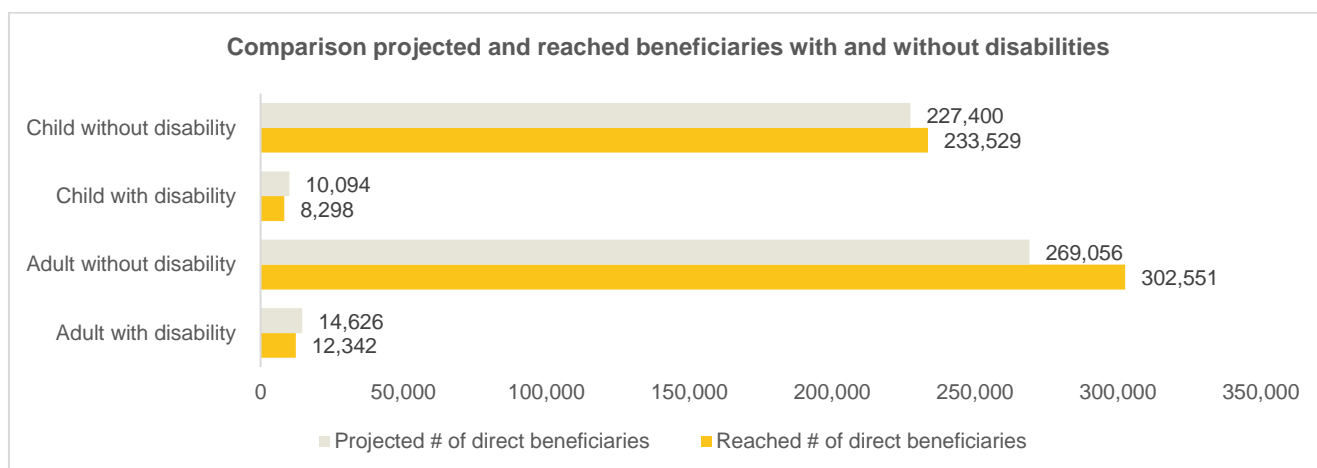
Collecting prevalence data is important but does not explain why there is unequal access. On the other hand, only conducting barrier analyses, lacks the insight in the proportionality of the group of people that may be marginalised, and which intersectional patterns are dominant. Both complementary methods are needed for a sound insight in the situation of people with disabilities and need to be part of the toolkit of monitoring, evaluation and learning staff to establish baselines, track progress and communicate impact.

## 2.4.3 Using prevalence data during intervention design

Shortly after the start of AHP Phase III, a comprehensive survey conducted by REACH found an average prevalence rate of 12% of people with disabilities in the Rohingya camps. REACH used the Washington Group Short Set Enhanced Questions (WG-SS Enhanced) with adults. The WG-SS Enhanced is comprised of 12 questions in eight domains of functioning, it includes the six Washington Group Short Set questions and asks

additional questions about upper body functioning, anxiety, and depression. For children, REACH applied the Washington Group UNICEF Child Functioning Module (CFM).<sup>7</sup>

During implementation, consortium partners conducted **prevalence surveys** in their program areas (camps and host communities) recording rates of prevalence of between 6% and 13%. Projected targets were unfortunately not based on the prevalence data. Beneficiary rates of people with disabilities was recorded at 4-5%. **Both projected and reached numbers were significantly less than the prevalence rates.** Only 30-50% of all people with disabilities living in the program areas were able to benefit from AHP Phase III activities. More work needs to be done to create a situation of equal access for people with disabilities.



### **Recommendation: Set targets and projections of people with disabilities, based on WGQ-prevalence studies**

It is recommended for humanitarian organisations to utilise the widely tested and validated Washington Group Short Set – Enhanced Questions and the WG/UNICEF Child Functioning Module (CFM) for under 18 years old and use the results to define targets in their humanitarian programming to keep focus on equal access. Not in all humanitarian settings prevalence data will be readily available. Humanitarian organisations should make the collection of disability prevalence data part of their baseline.

## **2.4.4 Building capacity on identification of people with disabilities**

In 2021, Disability Inclusion Focal Points (DIFPs) were trained in Module 2 (Minimum Standards for Disability Inclusion in Humanitarian Action) which also covered sessions on disability data collection tools. However, face-to-face trainings were not possible till the end of 2021 due to COVID-19 which delayed uptake. As progress on identification of people with disabilities in AHP Phase III lagged, a **dedicated one-day training on the use of WG-SS Enhanced** was organised by DITU with a broader group of AHP PHASE III partner staff in 2022, including MEAL and technical staff. Representatives of self-help groups joined in as well and were able to provide additional context information.

<sup>7</sup> In 2023 CBM Global and Nossal Institute for Global Health developed a useful [learning brief](#) on the use of the Washington Group Questions .

The disadvantage of identifying people with disabilities mid-way through program implementation is that some activities may have been **already at full capacity**, and even if identified, the program did not have the budget to include more people. For example, the learning centres for children were at maximum capacity, so children with disabilities, if identified late, could not always get access to learning centres.

After training there were **challenges, at field levels, identifying people with disabilities** due to different levels of knowledge and use of local languages by the enumerator, which could lead to inconsistencies.

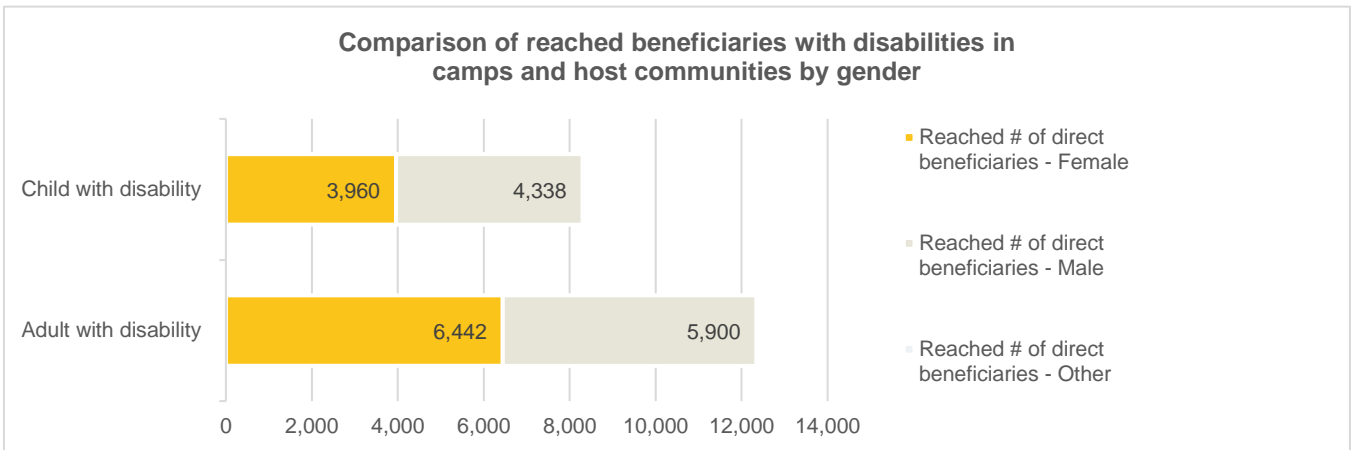
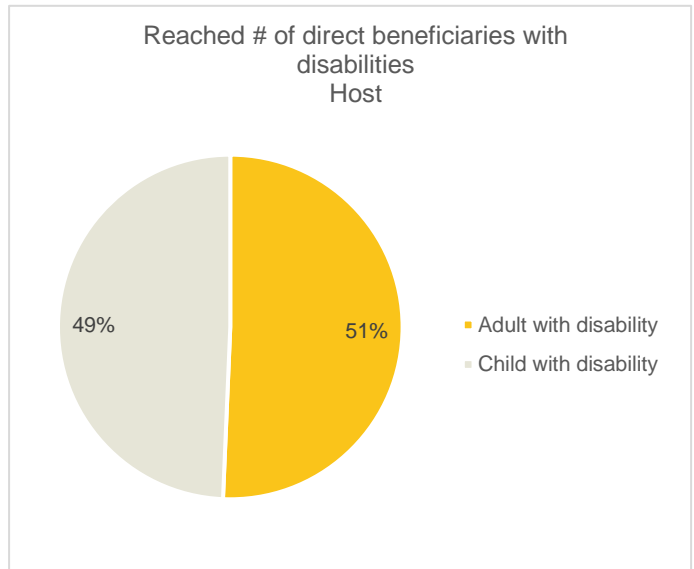
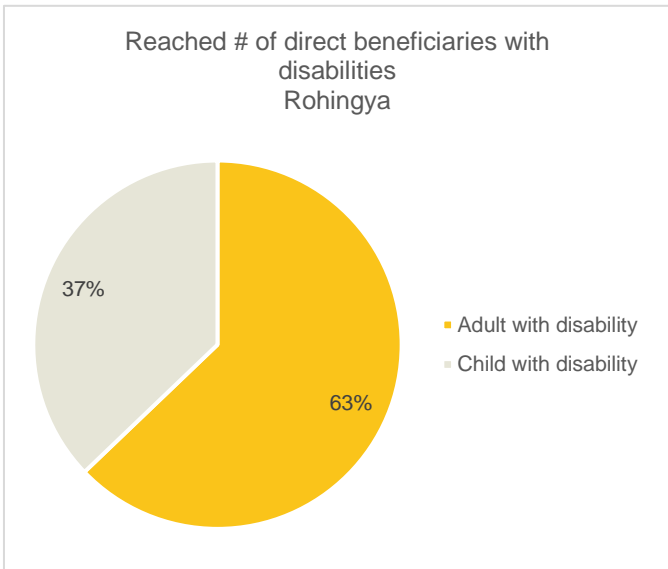
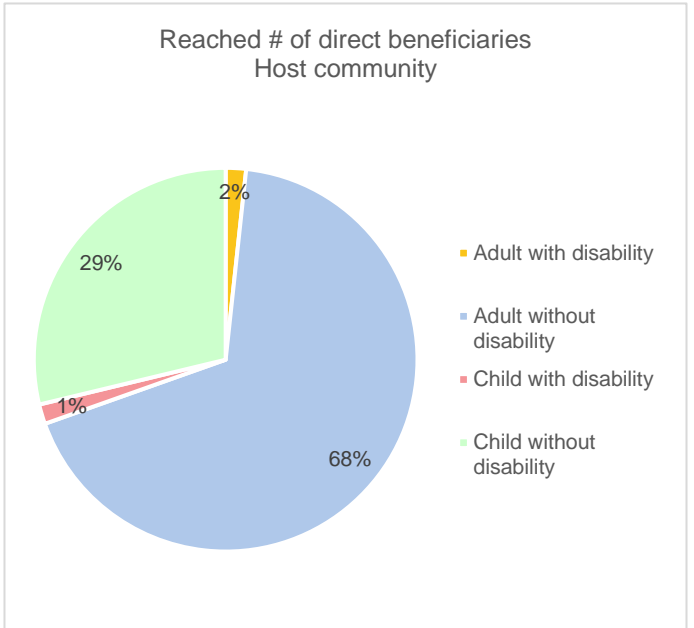
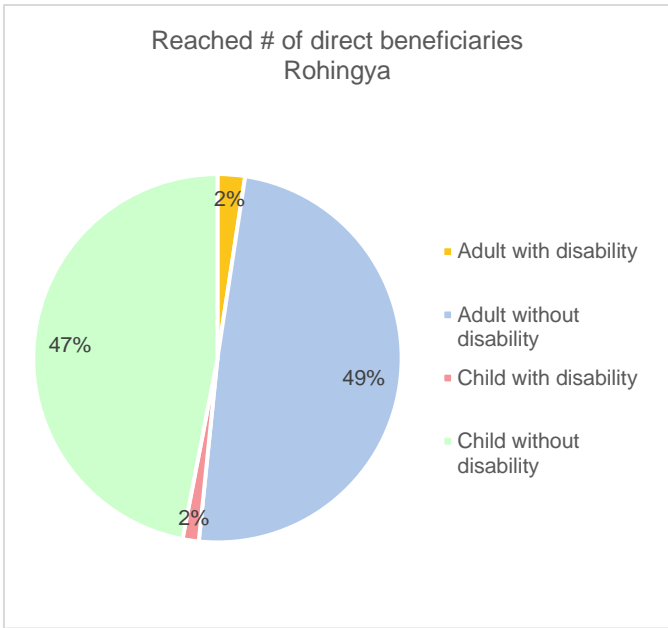
**Recommendation: Train and accompany front line, technical and MEAL staff directly on the collection of disability data through WGQ, early on in the program**

There is a need for the early application of the Washington Group Questions and disaggregation of data in a new Phase to avoid exclusion of newly identified people with disabilities (who cannot be accommodated in activities that have already commenced due to capacity limits). It is recommended that the training and accompaniment on the collection and use of WGQ is done directly by the technical partners on disability inclusion and co-facilitated by DIFP. Further training all field level staff is necessary to ensure that they are confident to collect and analyse data. Consider supporting partners during initial processes to ensure it is being conducted as accurately as possible and inconsistencies are reduced.

## 2.4.5 Tracking and analysing data on people with disabilities

AHP Phase III partners made great strides to increase their reach to people with disabilities. Evidence when available through disability inclusion assessments and use of the Washington Group Questions allowed the consortium to reach out to people with disabilities within their intervention areas that were not previously accessing or engaging with AHP Phase III activities. Data is instrumental to understanding and identifying the varying needs that exist and barriers that need to be addressed. Especially in the second half of 2022 the WGQ were rolled out in AHP Phase III. There was little time left till the end of the program to track disaggregated data over a longer period of time and **conduct in-depth analysis** on the data in terms of differences between people with and without disabilities per activity, per sector, per AHP Phase III partner – as well as analyse intersectional differences based on age, gender, and ethnicity. The data presented on numbers of people with disabilities reached show that although in the host communities AHP Phase III partners worked mostly with adults (70%), among people with disabilities as many adults as children were supported. This is the other way around in the Rohingya camps. Among children with disabilities more boys were assisted, among adults with disabilities relatively more women benefited from AHP Phase III. In order to be able to draw conclusions from these observations, there is need to **collect additional qualitative data to enhance sensemaking**. In case of access differences to certain activities additional barrier analyses and disability inclusion assessments could add important information.





### **Recommendation: Include analysis on access to services in official program reports**

Collecting disaggregated data alone will not explain the reason for differences. Specific analysis would need to be done with additional data inquiries. It is recommended that "access to services" is a reporting requirement in official program reports as it may otherwise be overlooked as it requires an extra effort. Only by understanding the reason for differences in access to services, can appropriate measures be taken to increase and track progress towards equal access.

## **2.5 Capacity building of staff**

Disability inclusion was for many AHP Phase III partners an area of work that was relatively new and on which there was little in-house capacity. Technical expertise was essential to build capacity and confidence in the AHP consortium. The technical partnership of CBM and CDD, which served AHP Phase III partners through DITU, contributed to supporting partners make their humanitarian interventions more disability inclusive. During Phase III valuable lessons were drawn, some of which confirmed the assumptions made during the design Phase while others would need to be reconsidered.

### **2.5.1 Creating disability inclusion champions**

Disability Inclusion Focal Points (DIFPs) were appointed in each of the AHP Phase III partners to drive disability inclusion within their own organisation, together with local partners and as part of their AHP Phase III program. DIFPs were the ideal cadre of staff as they were known by their colleagues, aware of their unique organisational culture and often respected as thematic leads.

The following lessons emerged:

- The DIFPs were significantly stretched, with many DIFPs having significant portfolios of work and wearing many hats in their organisation. This made the role challenging.
- Most of the DIFPs demonstrated a huge passion for and personal interest in disability inclusion. This meant that they tried to go the extra mile to make things work.
- Even the DIFPs who had no considerable background in disability inclusion were able to become champions on disability inclusion in a short time span.
- Having peers in other AHP Phase III organisations in a similar role created a good basis for cross learning, sharing and exchange within the Disability Inclusion Working Group.

### **Recommendation: Appoint full dedicated Disability Inclusion Focal Points (DIFPs) per organisation and retain them as disability inclusion champions**

DIFPs should be a fully dedicated position, with a clear job description, so that disability inclusion can be implemented comprehensively by the consortium partners, and so the DIFP can focus on disability inclusion only (rather than be stretched cross

a number of sectors). In AHP Phase III, significant changes in capacity and staff turnover limited the potential of creating a bigger impact. One person cannot make disability inclusion happen overnight, but it is a lot easier to progress when dedicated resources are made available. Disability inclusion should not be an add on to existing roles in a sizable humanitarian program. Finally, the longer a DIFP stays in the role, the more the organisation can benefit from the capacity building the person has received.

## 2.5.2 Adaptive training system

It was assumed that training DIFPs in a Training of Trainer modality would allow for quick cascading of knowledge and skills. What the training system set up did not foresee was:

Lack of face-to-face opportunities for training at the start of AHP Phase III due to COVID-19 (training to increase awareness, in particular, is often much more effective in a face-to-face environment). This had to be done instead in an online environment with additional technical challenges.

Changes in staff within the AHP Phase III partners as well as at DITU. The high turnover of staff in both consortium Partner agencies and DITU was a barrier for progressing disability inclusion. DIFP roles had significant turnover with a total of 13 changes to six roles across the consortium over the 3-years. This meant that there were delays or gaps, and the initial Training of Trainers approach was limited in the impact it could have.

### **Recommended: From a hierarchical, cascading to an adaptive, networked training system**

Instead of considering the above-mentioned factors as unforeseen changes, the **training system should be adapted in such a way that it mitigates the risks** that come with these factors. **An adaptive training system** would need to cater for:

- More **continuous delivery** of short training sessions, with multiple opportunities for staff to enrol.
- Staff from DITU and DIFPs should form a **team of core trainers** and in each training session trainers should pair up with each other. New DIFPs who join during the program period could then receive coaching and gradually increase their skill set and knowledge.
- Identified people with disabilities from OPDs, SHGs or DSCs could be asked to become resource people or co-facilitators with the core team. Apart from bringing in incredibly valuable lived experience, they can bring a personal interest and commitment.
- Promote the use of training opportunities and training modules on disability inclusion through **online learning platforms** (e.g. [introduction to disability inclusive humanitarian action](#) from the Disability Reference Group, [Collecting data for the inclusion of people with disabilities in humanitarian action](#) on Kaya Connect, [UNICEF training package on strengthening protection of people with disabilities in forced displacement](#)). Although it may not be realistic for many humanitarian staff to enrol in online training given their busy work schedules,

the online modules could also serve as a resource to adapt own training materials.

### 2.5.3 Tailored resource development

Given the complexity of the AHP Phase III consortium and the huge number of staff working in the various organisations, reaching out to the majority of staff with disability inclusion training was already ambitious. DITU dedicated a lot of time to make that happen, particularly in 2022 training on the application of the WGQ and how to work with SHGs/DSCs.

There are extreme barriers to inclusion in humanitarian settings. It is crucial for partners to recognise challenges and look for innovative solutions. What can you do with building restrictions, limited classroom size and full capacity? Collaborating with experts in certain fields such as engineers to find solutions in restricted space should be considered. Disability inclusion is still being thought of largely in terms of ramps and assistive devices, but there is need for more inclusive materials for schools, for health, for livelihoods, and for disaster risk reduction. Due to the complexity of humanitarian environments, there is a real need for contextualised materials, which in the case of AHP Phase III included: translation into Rohingya and Chittagonian verbally; Burmese and Bangla in writing, ensuring culturally acceptable material and use of variety of written guidance, posters with drawings, and drama/theatre. Contextual tools that are translated in terms of language but also from high level technical advice to a field level understanding, was a critical need of AHP Phase III and the ToT approach.

#### **Recommendation: Tailor disability inclusion resources with a user-centred approach**

Involve people with disabilities and the AHP Phase III partner staff to co-create disability inclusion materials that are tailored to the context. Also consider finding solutions and alternatives that are appropriate for the context engaging technical experts and people with disabilities to remove barriers and improve accessibility to services and the environment. Examples include:

- Resources oriented to expand skill and capacity to **engage all types of people with disabilities**, related to deaf and blind people, and people with intellectual, psychosocial, and cognitive disabilities.
- Materials on disability inclusion in a **language** that would be understood by the Rohingya communities, e.g. Bengali, Burmese, Rohingya and Chittagonian.
- **Produce creative materials such as games, prototypes, demonstration materials, stories** on accessibility, attitude, communication that would be designed to the context of the Rohingya refugee population and the host communities.
- **Protocols with 'how to' guidance** that is easy to follow, pictorial and culturally sensitive with an emphasis on different technical sectors such as WASH, Disaster Risk Reduction, Gender-Based Violence, Health and Sexual Reproductive Health.

- Communication materials that are needed by other stakeholders such as government authorities and faith leaders in the camps and host community. To address attitudinal barriers based on social norms in Rohingya communities, and to break down stigma, would need to involve senior decision makers in the camps, such as the Camp-in-Charge, site management and local government, as well as faith leaders. They are all very influential in the normative behaviour of the people living in their area or professing a common faith.

## 2.5.4 Collective learning and networking

The fourth result area of the Disability Inclusion Action Plan was the learning component on disability inclusion. It was composed of joint learning visits, monitoring visits and capturing of practices and lessons learned. The Disability Inclusion Working was instrumental to promote collective learning, the sharing of expertise and best practice, create space for collaboration, and promote accountability. Learning in the context of AHP Phase III was essential, especially as all organisations in camps and host communities had their own resources, processes, and systems. Collective learning was triggered as DIFPs would visit an intervention area of one organisation and would discover both similarities and differences. This was discussed and every joint learning visit included a feedback session; action points were shared, and a learning report was produced. Not once were the monthly meetings of the Disability Inclusion Working Group skipped, indicating the interest by its members and the useful coordination role that DITU played. Having an overarching Disability Inclusion Action Plan ensured that there were common objectives and targets to achieve.

### **Recommendation: Collective learning requires an enabling structure**

In a complex set-up, with multiple layers of governance, DIFPs need peers to learn from and to keep each other accountable to navigate the complexity of the consortium together. Important ingredients of an enabling structure of collective learning and networking are:

- An overarching plan and objective
- Regular meetings and field visits
- Deliberately using techniques to solicit opinions and provide respectful feedback.
- Balance between “giving” (providing comments and feedback) and “taking” (receiving feedback)
- A coordinator or team to keep track of commitments made and create time for personal networking.

## 2.6 Accountability to people with disabilities

In any humanitarian response, people with disabilities are merely seen as beneficiaries of aid rather than potential change agents. In compliance with the IASC guidelines on

inclusion of people with disabilities in humanitarian action, the AHP Phase III program was designed with a specific focus on improving participation and strengthening the voices of people with disabilities in the humanitarian coordination process, with the aim to assert more control over their own development. This is where representative groups of people with disabilities such as Self-Help Groups (SHGs) in host communities and Disability Support Committees (DSCs) in the camps were seen as good avenues for empowerment of and accountability to people with disabilities.

### 2.6.1 Taking a two-pronged service delivery and empowerment approach

In AHP Phase III active engagement of people with disabilities and their empowerment through the establishment of SHGs and DSCs did not take place until 2022. There are several reasons:

- The humanitarian needs in the Rohingya crisis are immense, continuous and growing with an increasing influx of people. Besides, AHP Phase III was faced with the compounded impact of COVID-19 and various cyclones and also fires within the Rohingya camps. **Prioritising service delivery** on WASH, livelihood, and many other sectors to ensure that people have immediate access to basic services is obvious and vital.
- Setting up structures of interest groups was not always welcomed by the authorities, hence the concept of **self-help groups not being acceptable** within the context of the camps. Through negotiation disability support committees were possible instead.
- **Empowerment through organisational structures is perceived as a long-term process**, whereas the humanitarian response plans operate within short cycles. The humanitarian system does not incentivise institutional capacity building, and if skill building and training of beneficiaries takes place it is moreover focused on individuals or smaller groups, not formalised structures.

It was reflected that the OPD visit outside the camps, was successful, and resulted in AHP Phase III partners being more engaged to actively link with existing or help create SHGs and DSCs, in lieu of creating OPDs.

#### **Recommendation: Create pilot initiatives on empowerment early on in the program**

Promoting the voice, active participation, and representation of people with disabilities is non-negotiable. Deliberate actions need to be taken early on in the program to create momentum through learning visits, engagement of a disability rights activist, and small pilots to develop SHGs/DSCs. This has the following advantages:

- Humanitarian staff develop confidence in working with people with disabilities as agents of change through the process.
- Potential challenges can be addressed, and a locally acceptable model can be developed.

- Building a relationship of trust between people, and especially with people who have been marginalised for long periods, takes time. The role the Disability Rights Advocate played in AHP Phase III cannot be underestimated in the process of working with SHGs/DSCs, as a trusted person being able to articulate the importance of representation and sharing from a perspective of lived experience.
- Early pilots can help to develop a phased approach, rather than focusing on SHGs/DSCs at once while the implementation Phase has already progressed.

## 2.6.2 Roles and activities of representative groups of people with disabilities

AHP Phase III partners were linked to existing SHGs and DSCs and created new groups and committees. The members of SHGs/DSCs were taken through a series of training sessions by the disability rights advocate. The disability rights advocate trained the SHG members on key topics such as basic concepts of disability, the rights of people with disabilities, the structure and activities of a SHG/DSC, understanding the concept of advocacy and human rights, objectives of advocacy, type of advocacy, elements of advocacy and its effectiveness, tools of advocacy, how to do advocacy for people with disabilities and its challenges. The leaders of the SHGs were also inducted into barrier identification methods and accessibility, including a field visit and practical session. Also, training was provided on how to provide leadership within a SHG/DSC.

Among the roles the SHG/DSC's the following are noteworthy:

- conducting **accessibility audits** of health centres and other basic services provided by AHP Phase III partners. This was a practical way to influence the identification of accessibility barriers and making recommendations on what could be done to eliminate those.



**Image 3: Woman with hearing aid looking in a mirror**

- **raised their concerns and advocate** towards authorities, which resulted in the provision of **Golden Citizenship Cards**.
- shared **peer support** about information on services, and experiences of other people with disabilities.
- organised focus group discussions, dialogue, and opportunities to listen to the perspectives of people with disabilities.

- **community sensitisation and awareness.**

**Recommendation: Consult SHGs/DSCs of people with disabilities on the roles and activities that they want to play in a humanitarian program**

There are multiple roles that SHGs/DSCs can play in a humanitarian context and the list above is not exhaustive. It may also emerge over time, based on needs and interest. It is important that the humanitarian organisations do not assume to know what SHGs/DSCs have to do but that the process of establishing SHGs/DSCs and their role, demonstrates an empowerment approach in itself.

### 2.6.3 Sustaining SHGs and DSCs

Nearly all AHP Phase III partners linked to or established active groups of people with disabilities. A point of concern was how these groups would be able to sustain themselves after AHP Phase III ended. As an exit strategy a plan was developed to link the SHGs/DSCs with broader OPD networks.

**Recommendation: Develop a long-term outlook on collaboration with SHGs/DSCs**

It would have been helpful if there would have been a longer period of time to accompany the SHGs/DSCs. Explore if young people with disabilities could act as **change agents to support the provision of disability inclusion advice in the camps and host communities**. That would increase localisation of disability inclusion advice by working directly with people with disabilities in the camps and host communities as agents of change rather than only as beneficiaries. It would also increase efficiency of drawing in technical assistance on disability inclusion.

## 3 Final word

AHP Phase III showed the sector what is possible in realising inclusion of people with disabilities within a complex humanitarian environment, and how consortium organisations and their partners collaborated to achieve common goals and progressed learning on disability inclusion.

AHP Phase III's approach to disability inclusion has been incredibly powerful in creating organisational and programmatic change. **In a restricted and complex setting, AHP Phase III set a foundation for disability inclusion and also showed mainstream organisations how to make meaningful impact** and have meaningful engagement with people with disabilities in their interventions.

AHP Phase III sensitised humanitarian actors on disability inclusion and the critical needs of communities for accessible services and participation in interventions. The increase in awareness is visible among key stakeholders, and as seen with the ripple effect to other projects and partners.

AHP Phase III built momentum in the response. DFAT's continued advocacy has been crucial in keeping agencies accountable to disability inclusion and keeping it on the agenda with the aim to leave no one behind.



**Delivery, visibility, and continuity of disability inclusion support is critical to build on and maintain momentum developed in AHP Phase III, because inclusion matters!**



**Image 4: Man with disability collecting water**