
Protection

*Issues for People with
Disabilities and Injuries*

**HANDICAP
INTERNATIONAL**

a INTRODUCTION

PROTECTION – ISSUES FOR PEOPLE WITH DISABILITIES AND INJURIES

People with disabilities and injuries are especially vulnerable to physical, mental, sexual and emotional abuse. They may require additional protection considerations.

General guidelines, guidelines for especially vulnerable groups of people with disabilities and some guidelines for support are detailed in of this booklet.



TABLE OF CONTENTS

a) Introduction	i
b) Table of Contents	ii
1) Handicap International Experience	3
Hambali: today is not like tomorrow	3
2) General Guidelines	7
3) Especially Vulnerable Groups of People with Disabilities and some Guidelines for Support	9
People with learning, language, speaking and reading difficulties	9
People with very low mobility, people with physical disabilities that cannot move on their own...	9
People with intellectual impairments, learning and cognition challenges, brain injury or damage	10
People with mental health issues and disorders (depression, bi-polar disorder, etc)	11
Children with disabilities and injuries	12
Women with disabilities	13
4) Cross Cutting Issues for the Most Vulnerable Groups	15
c) References...	xvi

1 HANDICAP INTERNATIONAL EXPERIENCE

Handicap International has been working with and for people with disabilities and injuries in several post – disaster situations in Indonesia since January 2005.

Below is an illustration of one of these experiences.

HAMBALI: TODAY IS NOT LIKE TOMORROW

Hambali¹, a quiet 39-year old man, lives in a small, peaceful, rural village near the city of Meulaboh in the Province of Aceh. He has been battling a serious mental illness, without any kind of medical intervention for almost half of his life.

Hambali's six sisters, who all live in the same house with him recount that since 1990 he progressively grew sadder and quieter, slowly withdrawing from his family and community; often, he was seen speaking to himself. Despite his deepening depression, Hambali managed to keep his job as a carpenter for the first 10 years of his illness. In 2001 a minor motorcycle accident, which did not result in any physical injury, accelerated Hambali's deteriorating mental health. Suddenly Hambali refused to get out of bed, go to work or leave the house.

When Handicap International staff met Hambali in mid-2005 he had not gotten out of bed on his own initiative for four years, having lost interest in all the activities of daily life. Hambali's sisters washed him, cared for

1 Handicap International is authorized by the subject to publish photographs, but name has been changed for protection of identity.

him, fed him and cleared his bed-pan. After years of lying in bed Hambali had developed contractures of the knees which prevented him from straightening his legs, and walking.

The Handicap International team provided Hambali with a wheelchair, and although initially he was too weak to push himself around, the wheelchair assisted Hambali's sisters so that they would not have to carry him around the house. The second goal was to wheel Hambali out of the house, which he had not left for 4 years.



On his first excursion into the neighbourhood Hambali seemed happy that he was being taken outside, but was also anxious about all the attention he was receiving.

By the team's fourth visit it was clear that Hambali was spending more time outside the house. His family was taking him for visits to the mosque and fields in the neighbouring community. Hambali was starting to talk more and interact with people, but he was still very weak, unable to move himself around and still completely dependant on his sisters for support.

The next step for the Handicap International team was to assess Hambali's physical condition and help design a rehabilitation program in order to improve Hambali's strength and get him back on his feet. However, Hambali absolutely refused to have an assessment; he would not get out of bed and would not allow the physiotherapists to touch him. Hambali's sisters explained that he found it difficult to interact with women and even they found his behaviour hard to cope with at times. The team decided to

consult a mental-health NGO who was working in the area.

During the mental health assessment conducted by the NGO's doctor, Hambali's emotions went from high to low and back up again, he would become sad and then suddenly start laughing out of context, much of the conversation was nonsensical. The doctor identified that Hambali was schizophrenic and depressive, however due to his low body weight and state of malnourishment he could not be put on medication. The doctor prescribed nutritional supplements and agreed to continue monitoring Hambali's situation.



During the team's next visit they tried again to motivate Hambali to do some exercise, however this time he got extremely aggressive and he threatened to kill the physiotherapists. He said that a traditional doctor had put a lock on his knees to stop him from leaving the house; only the key from the doctor would straighten his legs again. During a discussion with the mental health doctor concerning Hambali's motivation to improve his strength, he became distressed and said that he did not want the physiotherapists to torture him anymore. Because Hambali's health had improved from the last visit the team decided to put him on anti-psychotic medication. The mental health doctor would continue to monitor Hambali and recommend physical rehabilitation once his mental health had improved.

After several weeks on medication, the mental health doctor reported that Hambali's condition had improved and recommended another attempt to engage him in physical rehabilitation. Upon arrival the team found Hambali was still in bed, but with some encouragement he decided to go outside. The team noted that he could sit up on his own, transfer himself to the wheelchair with the assistance of just one of his sisters and propel himself around. His family reported that over the past couple of weeks Hambali had been spending more and more time outside, mostly sitting outside the mosque on his own, but would also on occasion help his sisters in their family-run shop. Hambali still flatly refused to participate in physiotherapy.

Although Hambali is now strong enough to take more responsibility for his feeding and washing his motivation to get out of bed varies from day to day. His sisters report that since being on anti-psychotic medication Hambali has become more active and 'mischievous'. Despite having to look after his physical needs less, they now need to monitor his behaviour more; as one day he tried to burn his mattress with a cigarette.

What is clear is that Hambali is a man living with a long term mental illness. It is apparent that although Hambali's family love and care for him, they are unsure of how to look after him during this rocky period of recovery. For families of recovering mental-health patients it is often easier to look after a person who is bed-ridden rather than someone who is in recovery one day, and in decline the next. Although there are definite signs of improvement in both Hambali's mental and physical condition, he remains unwilling to cooperate in a rehabilitation plan and still spends most of time sitting alone outside the community mosque or in bed. The road to recovery is not easy for Hambali and his family and for them, good or bad, each day is different.



2 GENERAL GUIDELINES

People with disabilities and injuries are especially vulnerable to physical, mental, sexual and emotional abuse. They may require additional protection considerations.

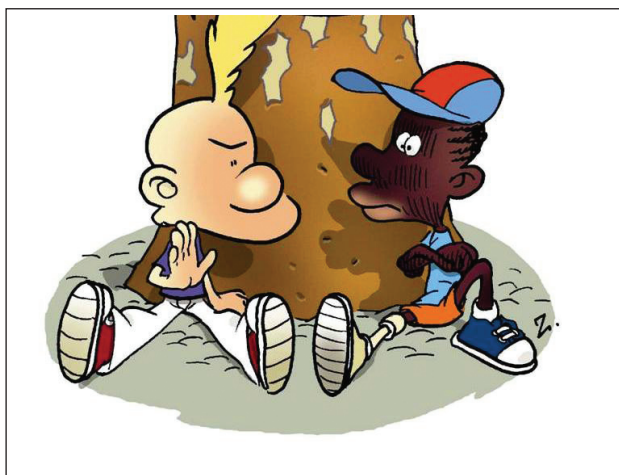
- Include people with all types of disabilities (including men, women and children with disabilities) and people with injuries in all your vulnerability assessments and support activities.
- Find out where they are living from village leaders, elders and other community members and go to their homes to conduct the assessments and provide messages about your support services and activities.
- Ensure that assessments are conducted by field – workers that are the same gender as the person you are assessing.
- Prepare to conduct assessments with alternative communication means (using drawings, symbols, body language or simple language)



- Ensure that all your messages on protection issues (where you are holding assessments, where you are establishing safe areas, self-help groups, hotlines etc) are communicated using multiple formats. For example if you only put up posters and hand out leaflets people with

visual impairments, low literacy or learning difficulties will not have access to this information. Use several means of communication including posters, leaflets, radio / loudspeaker announcements, simple language and drawing / symbols.

- Ensure that the services you are providing are accessible for all (Physical Accessibility, Proximity of the Service and your ways of communicating and conducting activities. You should consider the physical accessibility of the spaces you are establishing (are they accessible for wheel-chair users and people with low mobility?) Will people with low mobility or no means of transportation be able to come? Is the space you have established close enough for them to come, if not are you providing transportation? You should also consider the non-physical barriers that people may face, for example if you are establishing a safe – space / psychosocial support centre, do you have counsellors that can speak sign language in order to support people who use sign as a means of communication?
- If you are providing psycho-social support or creating peer support systems for people with disabilities and injuries, ensure that the counsellor is a person with a disability. Having gone through the same experiences as the person you are supporting they will be able to understand problems, needs and give support much better than a non-disabled person.



3

VULNERABLE GROUPS AND GUIDELINES FOR SUPPORT

PEOPLE WITH LEARNING, LANGUAGE, SPEAKING AND READING DIFFICULTIES

- **Why are they more vulnerable?**
 - 1) Because they are unable to communicate through conventional channels and using regular language.
- **What can you do?**
 - 1) Use pictures; act out your message (use body language).
 - 2) Take a lot of time.
 - 3) Ensure a safe and calm environment during the interaction.

PEOPLE WITH VERY LOW MOBILITY, PEOPLE WITH PHYSICAL DISABILITIES THAT CANNOT MOVE ON THEIR OWN, FOR EXAMPLE PARAPLEGICS AND TETRAPLEGICS

- **Why are they more vulnerable?**
 - 1) Because they are unable to remove themselves from an unsafe environment.
 - 2) They are unable to physically resist unwanted physical contact.
 - 3) They may not be able to reach safe areas or help

- **What can you do?**

- 1) Work towards increasing their personal security; give them an alert system (like a bell or a whistle).
- 2) Establish a support network for the person with disability which may include trusted friends, neighbours and family members
- 3) Support the family by volunteering extra assistance, or encouraging and supporting the person with disability to attend safe spaces. This gives the family some time to rest, or work on other priorities.

PEOPLE WITH INTELLECTUAL IMPAIRMENTS, LEARNING AND COGNITION CHALLENGES, BRAIN INJURY OR DAMAGE

- **Why are they more vulnerable?**

- 1) Because they may not understand the concept of abuse or recognize that they are being abused or exploited.
- 2) They may not know where to get help or may not comprehend services and support available to them.

- **What can you do?**

- 1) Use multiple and simple forms of conveying your messages.
- 2) Be patient and take lots of time.
- 3) Primary carers of the individual may have an effective communication system and you can use them to help you convey your message

PEOPLE WITH MENTAL HEALTH ISSUES AND DISORDERS (DEPRESSION, BI-POLAR DISORDER, ETC)

- **Why are they more vulnerable?**
 - 1) They may resist your offers of support
 - 2) They may not recognize they have mental health issues
 - 3) They may have other complications such as malnutrition, weakness etc.
 - 4) Even if they comprehend your messages and services available they may not be willing to leave their homes or interact.

- **What can you do?**
 - 1) Wherever possible encourage the family to seek professional medical attention.
 - 2) Make a referral to an appropriate mental health service provider.
 - 3) Follow up with the family to ensure that they are seeking and continuing treatment.

CHILDREN WITH DISABILITIES AND INJURIES

- **Why are they more vulnerable?**

- 1) Because they are young and will be less likely to have established a support system for themselves.
- 2) They may be dependant for their basic needs on family members.
- 3) They may not have developed communication mechanisms with non – family members.
- 4) They may be forced to contribute to family income by using their disability (begging etc)



- **What can you do?**

- 1) Ensure that children with disabilities and their families are aware of and are encouraged to attend safe spaces and participate in play groups (whether they are established by organizations or are informal play groups organized by the children themselves).
- 2) Monitor the behaviour of children by observing the type of play they engage in, the pictures and drawings they create and information they may share with other children but not with adults.

WOMEN WITH DISABILITIES

- **Why are the more vulnerable?**

- 1) They may have low – self esteem, or have been overprotected by their families.
- 2) They may have many responsibilities and lack the time to participate in vulnerability assessments, visit crisis / support centres or participate in self – help groups.
- 3) Since women are generally the primary – caregivers in the family their own physical and mental health may be less of a priority for them than that of their family members.
- 4) Women and especially women with disabilities are more vulnerable to sexual abuse
- 5) Women with disabilities are less likely to have husbands or be divorced due to perceptions of attractiveness, usefulness etc. Therefore besides being a women with a disability she may also be a single – head of household



- **What can you do?**

- 1) Find women with disabilities. Even if they do not attend community events, they exist. Ask community leaders, elders or go door to door.
- 2) Ensure that you do your assessments with the person or ask for personal information from them, in private and away from their family members. (If family members are also perpetrators of abuse you are much more likely to get this information by talking to the WWD in private)
- 3) Encourage the inclusion of WWDs in community – level self – help groups
- 4) Respect their time and work load (you may not be their priority)
- 5) Include them in all women’s empowerment activities, such as discussion groups, lending schemes, leadership training etc.
- 6) Remember that women with disabilities are women. They have the same needs to hygiene kits, sanitary care products, reproductive health information and birth control as all other women. They also have the same needs for privacy when bathing, toileting, sleeping, praying etc. Ensure / advocate for them so that they have access to private spaces

4

CROSS CUTTING ISSUES FOR THE MOST VULNERABLE GROUPS

- In most cases the primary care-giver for the person with disability will be able to understand and communicate much better than you. This is good because, using them as a translator and interpreter will make your assessments much easier to carry out. This is also dangerous since the primary care-giver may be the abuser.
- Communication Tools must be as simple and clear as possible. Ensure you are prepared to ask questions in different ways, and provide your messages in multiple formats, (using body language to demonstrate, writing the message down on a note pad, using drawing etc). Take lots of time
- Ensure you are complying with the wishes of the person even if your assessments suggest otherwise



REFERENCES

Available technical guide booklets from Handicap International:

- **Disability Checklist for Emergency Response** – General protection and inclusion principles of people with disabilities and injuries
- **Shelter, Public Infrastructure, Water and Sanitation** – A guide for including people with disabilities and injuries
- **Livelihoods** – Facilitating early recovery for people with disabilities and injuries

