MINISTRY OF GENDER, COMMUNITY DEVELOPMENT, AND SOCIAL WELFARE

Training Manual for Capacity Building in Disability and Elderly Programming in Malawi

2024

International Labour Organization

Irish Aid
Rialtas na hÉireann
Government of Ireland
with financial support from IrishAid.

Contents

Acknowledgements

Acknowledgement is made of information used from various sources which include the international and national documentary analysis. The Department of Disabilities and Elderly Affairs would like to thank the following members of the technical team who contributed to the development of this manual; Mrs Loveness Silungwe, Deputy Director for Elderly Affairs, Mrs. Jessie Chiyamwaka, Chief Disability Rehabilitation Officer, Mr. Steve Vinkhumbo, Chief Elderly Affairs Officer, Mr. Joshua Mkwehiwa, Chief Disability Affairs Officer, Mr. Charles Blaimu, Principal Disability Affairs Officer and Mrs. Mayeso Kanyowile-Malembo, Principal Disability Affairs Officer. The Department also wishes to thank the International Labour Organisation (ILO) for its financial, technical support and input to the manual.

Introduction

The development of this manual is part of the Department of Disability and Elderly Affairs efforts to accelerate inclusion of persons with disabilities and the elderly in national development endeavors. The manual will be a useful tool and source of valuable information for capacity building of key stakeholders in disability and elderly mainstreaming. These include programme officers and policy makers in government ministries, departments and agencies, Non-Governmental organizations, Organisations of Persons with Disabilities (OPDs), Civil Society Organizations both at national and district levels as well as the Community at large.

The development of this manual follows the findings from the consultations that the Department of Disability and Elderly Affairs conducted in all the district councils in Malawi. Through the consultations, it was established that there is limited awareness about disability and elderly policies, laws, and programmes among district council personnel. Plans and programmes at council level have also not fully mainstreamed disability and elderly issues. It was also revealed that officers at council level have little or no technical capacity to handle elderly and disability issues.

This manual will serve as a key reference tool for capacity building of various stakeholders at national, district council and community level. The manual has provided detailed technical information in the handout section of each unit. It challenges both rights holders and duty bearers to be proactive in championing disability and elderly mainstreaming as an integral component of inclusive social protection agenda.

Unit 1

UNDERSTANDING AGEING AND THE SITUATION OF OLDER PERSONS IN MALAWI

Training Materials:

- Flip charts
- Markers
- Powerpoint presentation
- Pens
- Writing pads
- Laptop
- LCD projector
- Printed handouts

UNIT 1
UNDERSTANDING AGEING AND THE SITUATION OF OLDER PERSONS IN MALAWI

1.0 Introduction

The concept of ageing is a pattern of life changes that occurs as one grows older. There are different types of ageing such as biological age, psychological age, social age, legal age and functional age. This Unit introduces the concept of ageing, population ageing, successful ageing, healthy ageing and the demographics of ageing and their implications on policy and programming.

1.1 The General Outcome

The participants should be able to explain the concept of ageing, population ageing, the difference between successful ageing and healthy ageing. They should also be able to understand the demography of ageing and its challenges and implications.

1.2 Specific Outcomes

At the end of the unit the participants will be able to:

- Explain the concept of Ageing and Population Ageing
- Differentiate between successful ageing and healthy ageing;
- Explain the demographics of ageing at global, regional and national levels;
- Discuss the challenges and implications of population ageing

1.3 Training Materials:

Training materials include:

- Flip charts
- Markers
- Powerpoint presentation
- Pens
- Writing pads
- Laptop
- LCD projector
- Printed handouts

ACTIVITY 1

Group / Plenary / Pair Work

10 Minutes

1.4 Session 1: Concepts of Ageing

1. Tell the participants to be in the groups of five or six people to discuss the following questions:
   a. What is ageing?
   b. What is population ageing?
   c. What is the difference between Gerontology and Geriatrics?
   d. Define an older person.

2. Each group should present their ideas in the plenary session.
3. Consolidate the groups responses with reference to the facilitators' notes provided (Handout 1).

Summary

It is important to understand the definition of ageing and population ageing and their related concepts as they form a critical basis for appreciating the social, economic, cultural and psychological aspects of the older population.

ACTIVITY 2

Group / Plenary / Pair Work

15 Minutes

1.5 Session 2: Demographics of Ageing

1. Instruct the participants to be in pairs:
   a. Each member should identify 15 married friends and calculate the average number of children per family.
   b. Each member should list down 15 friends that he has known between 2000 and 2010 and indicate how have died so far.

2. The participants should present their work in the plenary session.
3. Consolidate the groups responses with reference to the facilitators' notes provided (Handout 2).

Summary

Population ageing is one of the most important demographic megatrends of the 21st century. It has important and far-reaching implications for all aspects of society. Population ageing is occurring because of declining fertility rates, lower infant mortality and increasing survival at older ages. It is important to understand this demographic phenomenon in order to come up with policies, strategies and programmes that can effectively address the challenges associated with population ageing.

REVIEW QUESTIONS

- In your own words how do you understand the concept of ageing and population ageing?
- Why is population ageing on the increase?
- Explain the difference between successful ageing and healthy ageing.
- What is the definition of an older person?

HANDOUT 1 | Concept of Ageing and Population Ageing

Ageing or aging is the process of becoming older. The term refers mainly to humans, many other animals, and fungi. Aging is a pattern of life changes that occurs as one grows older. It is a process that goes on over the entire adult life span of any living thing. It is associated with changes in dynamic biological, physiological, environmental, psychological, behavioral, and social processes. Some age-related changes are benign, such as graying hair. Others result in declines in function of the senses and activities of daily life and increased susceptibility to and frequency of disease, frailty, or disability. In fact, advancing age is the major risk factor for a number of chronic diseases in humans.

Successful Ageing

Successful ageing has become an important concept to describe the quality of ageing. It is a multidimensional concept, and the main focus is how to expand functional years in a later life span. The concept has developed from a biomedical approach to a wider understanding of social and psychological adaptation processes in later life. A standard definition of successful ageing, however, remains unclear and various operational definitions of concept have been used. Rowe and Kahn stated that successful aging involved three main factors: being free of disability or disease, having high cognitive and physical abilities, and interacting with others in meaningful ways.

The phenomenon of successful ageing can be viewed from a population or an individual perspective. At the population level, definition includes determinants of health and participation for the purpose of promoting policies, whereas at the individual level it is defined by outcomes of health, physical, and cognitive function, and life involvement. Successful ageing is a multidimensional concept encompassing domains of physical, functional, social, and psychological health and all of these dimensions should be taken into account, both with objective and subjective conditions when studying the phenomenon.

Healthy Ageing

Healthy ageing (HA) has been defined using multiple approaches. The WHO defines HA as the process of developing and maintaining the functional ability that enables wellbeing in older age. Functional ability is about having the capabilities that enable all people to be and do what they have reason to value. This includes a person's ability to:

- Meet their basic needs;
- Learn, grow and make decisions;
- Be mobile;
- Build and maintain relationships; and
- Contribute to society.

Functional ability consists of the intrinsic capacity of the individual, relevant environmental characteristics and the interaction between them.

Intrinsic capacity comprises all the mental and physical capacities that a person can draw on and includes their ability to walk, think, see, hear and remember. The level of intrinsic capacity is influenced by several factors such as the presence of diseases, injuries and age-related changes.

Environments include the home, community and broader society, and all the factors within them such as the built environment, people and their relationships, attitudes and values, health and social policies, the systems that support them and the services that they implement. Being able to live in environments that support and maintain one's intrinsic capacity and functional ability is key to healthy ageing.

Population Ageing

Population ageing is an increasing median age in a population because of declining fertility rates and rising life expectancy. Most countries have rising life expectancy and an ageing population, trends that emerged first in developed countries but are now seen in virtually all developing countries. The ageing of the world population is progressive and rapid. It is an unprecedented phenomenon that is affecting nearly all countries of the world . The United Nations uses 60 years to refer to older people. This line, which divides younger and older cohorts of a population, is also used by demographers and policy makers.

The terms "Longevity" and "life expectancy" are often used interchangeably, though their meaning is not strictly the same. Life expectancy refers to the average number of years that a population or a sub-population with certain characteristics is expected to live, usually under the assumption that age-specific death rates will continue the same in the future. Longevity usually refers to individual survival. It is also used to refer to some other characteristics of survival in populations, such as the maximum lifespan.

HANDOUT 2

Demography of Ageing-Challenges And Implications

Population ageing is a major global trend that is transforming economies and societies around the world. In 1950, there were 205 million persons aged 60 or over in the world.1 By 2012, the number of older persons had increased to almost 810 million. It is projected to more than double by 2050, reaching 2 billion. The population of persons aged 60 or over is growing at a faster rate than the total population in almost all regions of the world. Globally, the population aged 80 years or over is growing faster than any younger age group within the older population. The population of centenarians, those aged 100 years or over, is also growing fastest.

Global Ageing Indicators	2011/12	2050 projection
Life expectancy		
Life expectancy at birth by sex (men/women)	67.1/71.6	73.2/78.0
Life expectancy at 60 by sex (men/women)	18.5/21.6	20.9/24.2
Life expectancy at 80 by sex (men/women)	7.1/8.5	8.3/9.8
Population		
Number of people aged 60+	809,742,889	2,031,337,100
Number of people aged 80+	114,479,616	402,467,303
Number of people aged 100+	316,600	3,224,400
Percentage of people aged 60+	11.5	21.8
Percentage of people aged 80+	1.6	4.3
Sex ratio: Number of men aged 60+per 100 women aged 60+	83.7	86.4

Source: UNDESA, Population Division (2012). Prepared by the Population and Development Section on the basis of data from UNDESA, World Population Prospects: The 2010 Revision (New York, 2011), and UNDESA, World Population Ageing and Development 2012, Wall Chart (2012; forthcoming) www.unpopulation.org, and UNDESA, Population Division, World Population Ageing: Profiles of Ageing 2011 (New York, 2011), CD-ROM

Global population ageing

In 1985, there were 427 million persons aged 60 and over, 8.8 percent of the world's total population. By 2025, that number is projected to rise to 1,171 million, or 14.3 percent of the world's population. By 2050 there will be 2 billion persons aged 60 and over, or 21.2 percent of the world's population. Currently there are 15 countries with more than 10 million older persons, seven of these being developing countries. By 2050, 33 countries are expected to have 10 million people aged 60 or over, including five countries with more than 50 million older people. Out of these 33 countries, 22 are currently classified as developing countries.

Total Population and Those Aged 60 and Older by World Region: 2020 and Projected 2050

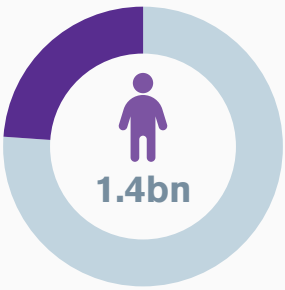
(Numbers in millions)

Region	Total Population		Population aged 60 and older			
			2020		2050	
	2020	2050	Number	Percent	Number	Percent
World	**7,684.3**	**9,665.3**	**1,045.4**	**13.6**	**2,092.2**	**21.6**
Africa	1,339.5	2,533.6	74.4	5.6	235.1	9.3
Asia	4,539.6	5,188.0	603.2	13.3	1,292.2	24.9
Europe	749.3	716.4	191.1	25.5	246.7	34.4
Latin America and the Caribbean	644.3	742.6	82.6	12.8	183.4	24.7
Northern America	370.5	432.1	86.8	23.4	122.2	28.3
Oceania	41.1	52.6	7.3	17.9	12.6	24.0

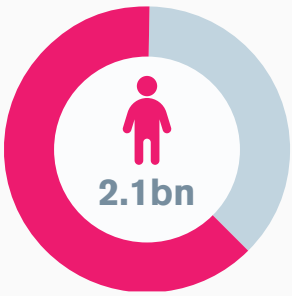
Source: U.S. Census Bureau, International Database, 2019.
https://www.census.gov/content/dam/Census/library/stories/2022/04/why-study-aging-in-africa-region-with-worlds-youngest-population-figure-2.jpg

Population ageing is occurring because of declining fertility rates, lower infant mortality and increasing survival at older ages. Total fertility dropped by half from five children per woman in 1950-1955 to 2.5 children in 2010-2015, and it is expected to continue to decline. Life expectancy at birth has risen substantially across the world; it is not just a developed world phenomenon. In 2010-2015, life expectancy is 78 years in developed countries and 68 years in developing regions. By 2045-2050, newborns can expect to live to 83 years in developed regions and 74 years in developing regions.

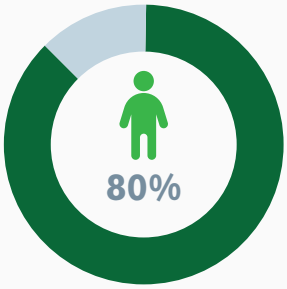
Demographics of an Ageing World



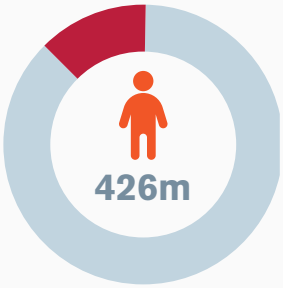
1.4bn People will be aged 60 years or over by 2030



Older people will make up more than one-fifth of the total population by 2050



80% of older people will live in low- and middle-income countries by 2050



the number of people aged ≥ 80 years by 2050

Sub-Saharan Africa

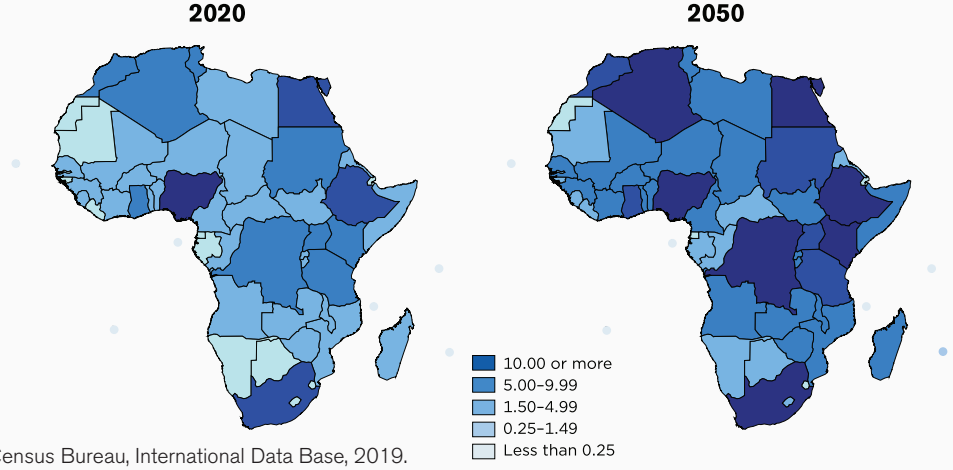
Africa's population is exceptionally young compared to other world regions that have been aging at a fast rate: only 5.6% of Africa's population was age 60 or older in 2020 compared to 23.4% in North America and double-digit percentages in every other world region. Even by 2050, Africa's older population is projected to remain in single digits, less than 1 in 10 (9.3%). That will still be lower than the current rates for other regions.

Despite the fact that the older population makes up a small proportion of the population in most sub-Saharan African countries, the number of older people is growing. In 2005, there were 34 million people age 60 and over in sub-Saharan Africa, and this number is projected to increase to over 67 million by 2030. In fact, the number of older people is growing more rapidly in sub-Saharan Africa than in the developed world. This increase in the number of older people will occur despite the excess mortality due to pandemics such as HIV/AIDS, Covid-19 that many countries are currently experiencing.

In 2020, 18 African countries each had more than 1 million people ages 60 and older. In 30 years, the number of African countries with more than a million older adults is projected to rise to 36 and seven of them will each have at least 10 million older adults.

Population Aged 60 and Older for African Countries: 2020 and Projected 2050

(Numbers in millions)



Source: U.S. Census Bureau, International Data Base, 2019.

MALAWI

Malawi's older population has been on the increase. In 1987, Malawi enumerated a total population of 473,898 older persons representing 6.0 percent of the total population. In 1998 PHC the population of older persons was 547, 542 (5.5 percent), an increase of 15.5 percent from 1987. By 2008, the population of older persons had reached 684,083 representing 5.2 percent of the total population. The number of older persons had increased to 891,805 in 2018, constituting 5.1 percent of the total population. The population of older persons is projected to increase to 2,873,639 by the year 2050, representing 8.5 percent of the total expected population. From 1987 to 2018, the population 60 years and over has been increasing by an annual average growth rate of 2.0 percent, lower than the growth rate of the general population of 2.5 percent.

Distribution of Older Persons by Region

The percentage distribution of older persons in Malawi was similar to the distribution of the total population. Southern region had the highest percentage of older persons (46.3 percent) followed by the Central region (40.4 percent) then the Northern region (13.4 percent). Of the total older population in Malawi, the majority lived in rural areas (91.6 percent). Among districts, the highest percentage of older persons was in Lilongwe district (9.3 percent) followed by Mangochi district (6.5 percent), Lilongwe city (5.6 percent) and Mzimba (5.4 percent).

Percentage Distribution of Older Population

The challenges and Implications of population ageing

Population ageing has significant social and economic implications at the individual, family, and societal levels. It also has important consequences and opportunities for a country's development. Although the percentage of older persons is currently much higher in developed countries, the pace of population ageing is much more rapid in developing countries and their transition from a young to an old age structure will occur over a shorter period.

Aging populations impact productivity, labor markets, health, social security systems, social cohesion, and societal development.

- Financial security is one of the major concerns as people age. It is an issue for both older persons and a growing challenge for families and societies. Ensuring a secure income in old age is seen as a major challenge for governments facing fiscal problems and competing priorities.
- Population ageing is also raising concerns about the ability of countries to provide adequate social protection and social security for the growing numbers of older persons.
- Health is another major concern for older persons. The demographic transition to an ageing population, accompanied by an epidemiological transition from the predominance of infectious diseases to non-communicable diseases, is associated with an increasing demand for health care and long-term care.
- Ensuring enabling and supportive environments as people grow older is another significant challenge, so that older persons can age actively and participate in the political, social, economic and cultural life of society.
- Older people are often the victims of neglect, violence and abuse because of increasing dependence

Situation of Older Persons In Malawi

While the definition of an older person may have different meanings in different societies, in Malawi, an older person is an individual aged 60 years and over regardless of his or her status (Malawi National Policy for Older Persons, 2016).

Older people constitute the fastest growing population segment worldwide. This is for several reasons, among them increase in life-expectancy and reduced fertility levels. Although Malawi's population structure is more youthful than most other countries (especially developed countries), statistical projections show that Malawi, just like other African nations, will soon follow suit.

Challenges Faced by Older Persons

In Malawi, old age is often characterized by extreme poverty, poor housing conditions, loss of dignity, becoming a victim of difficult circumstances including providing care and support to vulnerable and orphaned children among other challenges (National Policy for Older Persons, 2016). At these ages, people become more vulnerable to socio-economic shocks and have limited capacity to sustain their lives. There is evidence that most older Malawians live in poverty, have poor health and nutritional statuses, have no home or shelter and are often abused.

1. Economic and Food Security

- Low/no income
- Limited capacity to generate income
- Limited access to social protection programmes
- Labour constraints
- Lack of farm inputs/fertilisers
- Lack of savings
- Property grabbing
- Lack or no support from children
- Lack of tailor-made social protection programmes/support
- Limited information about commodity markets
- More vulnerable to external shocks

2. Health and Nutrition

- Lack of safe water (esp. in rural)
- Disease vulnerability due to poor housing, sanitation, access, nutrition
- Limited visual aids
- Loneliness impacting on health
- Gender inequality impacting health and nutrition
- Limited access to nutritious food
- Limited access to health care services
- Lack of specialised care services and facilities
- Lack of health insurance
- Limited knowledge of dietary diversification
- Lack of health education

3. Social Participation And Access To Services

- Stigma and discrimination (not invited to participate in social activities)
- Lack of access to justice/legal aid
- Poor housing conditions
- Abuse and exploitation (disrespect of elderly)
- Limited access to basic necessities (clothing, blankets, etc)
- Isolation due to prejudice
- Not given preferential treatment (health services, water points, ADMARC, etc.)
- Lack of involvement by service providers
- Psychological torture
- Name calling
- Accusations of practicing witchcraft
- Physical torture and beatings

Policy and Legal Frameworks Supporting Elderly Programme

- The Malawi Agenda 2063
- The National Policy for Older persons
- The National Social Support Policy
- The Malawi National Social Support Programme II
- The Witchcraft Act 1911
- The Sustainable Development Goals
- Older Persons Act, 2024

Unit 2

UNDERSTANDING DISABILITY

Materials Required:

- Charts,
- Pental markers,
- Presentation and
- Handouts

UNIT 2
UNDERSTANDING DISABILITY

2.0 Introduction

Disability is a normal occurrence in the sense that it exists in all societies, affecting probable and identifiable proportions of each population. There are several categories of disabilities that the participants should be aware of. However, when you look closely at persons with disabilities, it is sometimes difficult to categorise some of them according to the forms of disabilities.

This Unit introduces the concept of disability and the common models of disability that have influenced the understanding of disability and the implications to policy and practice. It is worth pointing out that attitudes, assumptions and the perception of disability are generally grouped into models. These are Traditional, Charity, Medical, Social and the Human Rights Models. The unit also identifies the challenges faced by persons with disabilities and the suggested strategies that can be adopted to address such challenges so that they can fully be mainstreamed in all sectors.

2.1 Expected outcome

Participants should have an overview of disability, its models as well as issues surrounding the matter.

2.2 Objectives of the course

- Explain the meaning of disability.
- Describe the types and causes of disability
- Brainstorm issues surrounding disability and children
- Explain each model of disability.
- Explain the link between each model and implications on service delivery.

2.3 Materials Required:

- Charts,
- Pental markers,
- Presentation and
- Handouts

2.4. Methodology

Explain: The subject of disability has undergone a profound change over the past few years, in society as a whole and in terms of national and international development. The greater role of persons with disabilities in forging this change has been profound and continues to this day. This session looks at the changing face of disability and its link to human rights.

In groups let them discuss the following questions for 30 minutes and let them report
1. How do you understand by the word disability, its types and causes?
2. What are issues effecting children with disabilities?

Plenary should take 40 minutes including discussion

Explain that every persons with disability has an impairment which with interaction with the environment results in the limitation of participation. A presentation on the ICF definition should be presented here

Part 2

40 Minutes

Give a chance to participants to role play the models of disability. Give them a chance to read the models for 10 minutes and let then prepare a role play for 5-8minutes to role play. The participants be divided in five groups

Discuss the models after each presentation. This should take about 40 minutes

Definitions of Disability

Explain: United Nations Convention on the Rights of Persons with Disabilities (UN CRPD) does not exclusively define disability but states that disability is an evolving concept resulting from an interaction between persons with physical, mental, intellectual or sensory impairments and various barriers that may hinder their full and effective participation in society on an equal basis with others.

African Disability Protocol equally, does not exclusively define disability but states that it is a result of an interaction between persons with physical, mental, psychosocial, intellectual, neurological, developmental or other sensory impairments and various barriers that may hinder their full and effective participation in society on an equal basis with others.

Explain: The UN CRPD and the African Disability Protocol are the most important international documents relating to persons with disabilities. We discuss them in detail later in this session.

Persons with Disabilities Act (2024) defines disability in line with the African Disability Protocol as a long term physical, mental, psychosocial, intellectual, neurological, developmental or other sensory impairments and various barriers that may hinder a person's full and effective participation in society on an equal basis with others.

Using a presentation present issues of disability in children for 20minutes. Allow questions and give an allowance of another 20minutes for discussion on this topic.

Partcipants Notes

The understanding of disability has undergone a profound change over the past decades, in society as a whole and in terms of national and international development initiatives. Persons with disabilities have played, and continue to play, a major role in forging this change.

What is Disability?

The current conception of disability defined by the International Classification of Functioning, Disability and Health (ICF) and the United Nations (UN) is as follows:

a. ICF 2001: The outcome of an interaction between health conditions and impairments and the physical, human-built, attitudinal, and social environment.
b. United Nations Human Rights Council Resolution 7/9, "Human rights of persons with disabilities", 2008 states "...disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinder their full and effective participation in society on an equal basis with others.
c. The UN CRPD, African Disability Protocol and the Persons with Disabilities Act 2024 have all adopted a social model of disability, and define disability as including those who have long-term physical, mental, psychosocial, intellectual, neurological, developmental or other sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.

Disability is diverse and might affect one or more of the following aspects of a person:

- Vision
- Movement
- Thinking
- Remembering
- Learning
- Communicating
- Hearing
- Mental capabilities
- Social relationships

Types of Disabilities in Malawi

Disability covers a wide range of conditions: for example: a child born with albinism; a soldier who loses his sight as a result of a gunshot; a young woman with chronic depression; or an older man with an intellectual disability, provide an example of the diversity. Disability can be visible or invisible; static, episodic, or degenerating; painful or inconsequential. It may be cognitive, developmental, intellectual, mental, physical, sensory (affecting sight or sense of hearing) or a combination of these that affects a person's daily life activities.

Disability can be congenital – a disability that a person is born with such as albinism.

It can also be acquired – a disability that comes after birth as a result of a sickness, unknown factors or injury. Globally, the most common causes of disability include:

- Chronic diseases (e.g. diabetes, cardiovascular disease and cancer)
- Other diseases (e.g. malaria, measles, meningitis)
- Injuries (e.g. from road traffic accidents, falls, war and violence)
- Mental health problems
- Birth defects
- Malnutrition
- HIV/AIDS.

It is not the intention of this training manual to cover all disabilities in detail but to look at how all persons with disabilities can be included in society. However, it has been identified that in Malawi there is a lack of awareness on some areas of disability. Therefore, more detailed information is provided on the categories below to raise awareness of their particular characteristics and needs:

- Mental health disabilities
- Intellectual disabilities
- Hearing impairments
- Deafblind
- Epilepsy
- Hydrocephalus
- Spina Bifida

The International Classification of Functioning, Disability and Health (ICF)

The International Classification of Functioning, Disability and Health (ICF) is the World Health Organization's (WHO's) framework for health and disability. It is the conceptual basis for the definition, measurement and policy formulations for health and disability. The ICF was introduced by WHO to replace the 1980 International Classification of Impairments, Disabilities and Handicaps.

ICF conversely is concerned with the health experience of any individual who has had an impairment or health disorder. ICF classifies health and wellbeing, describing the situation of each person within the range of health and health related areas as well as within the context of environmental and personal factors. The ICF looks at how an individual function in three areas, namely:

- Body functions and structures
- Activities (tasks or actions carried out by an individual)
- Participation (involvement of the individual in society, or in daily living).

Activities and participation describe what a person with a health disorder does do or can do. This does not depend on the individual alone but also on the social, physical and attitudinal environment in which the individual lives.

As a result of a health disorder, changes may occur in the body functions and structures, or in activities and participation. The following terms are used to describe any changes that may occur.

Impairments: are problems in body function or structure such as a change or a loss.
Activity limitations: are difficulties an individual may have in carrying out activities.
Participation restrictions: are problems an individual may experience in participating in family or society.

Two other terms are used in the ICF to describe the state of health and wellbeing: functioning and disability.

- Functioning is an umbrella term encompassing all body functions and structures, activities and participation.
- Disability is an umbrella term for impairments, activity limitations or participation restrictions.

The 1980 International Classification of Impairments, Disabilities and Handicaps was The 1980 International Classification of Impairments, Disabilities and Handicaps was changed because it did not take into account the role played by the social environment in disabling people. The ICF promotes the viewpoint that disability is part of the diversity of the human race and identifies the components of health - functioning, activity, and participation and their status – whether impaired, limited or restricted.

Scale and diversity of disability

The World Health Organization/World bank (2011) estimates that persons with disabilities represent approximately 15% of any population. In Malawi, persons with disabilities form a significant proportion of the country's population. According to 2018 Population and Housing Census, 11.6% of the country's population aged 5 years and older has some form of a disability. This percentage includes those with albinism and epilepsy from birth. Disability prevalence is higher in rural areas at 12.3% as compared to 7.5% in urban areas while among sexes, disability is more prevalent among females at 12.1% compared to 11% among males. Among persons with disabilities, about half (49%) have difficulties seeing, 24% have difficulties hearing, 27% have difficulties walking, 9% difficulties speaking, 16% difficulties learning or remembering things, 9% difficulties with self-care while 18% have other difficulties. The prevalence of albinism is at 0.8% while that of epilepsy is at 1.4%. Disability is more prevalent in the Northern Region at 12.6% followed by the Central Region at 10.6% with the Southern Region at 9.4%. However, it is important to know the following about disability data:

- Disability is under-reported in most countries, including Malawi. Factors include:
- Family members with disabilities may be hidden inside the home and not counted in a census.
- Information on family members with disabilities may not be presented during a census.
- People do not admit to their disability on a census form.
- How disability is defined in census forms limits the scope of data that is captured.

Unlike surveys, census tend to focus on collecting data that would reflect changes in overall population trends from one period to the other as opposed to collecting detailed information on specific variables such as on persons with disability. Ideally, countries should conduct specific disability surveys to more accurately establish the percentage of the population with disabilities and the types of disabilities.

Nearly half the WHO 15% figure is composed of people over 60 years and those with long-term and chronic diseases, such as cancer and heart disease. The World Report on Disability found that lower-income countries have a higher prevalence of disability and that disability is more common among older people and households that are poor.

Children and disability

The Convention on the Rights of the Child (CRC) of 1989 which Malawi ratified in 1991 applies to all children in the world, including children with disabilities. It spells out the basic human rights of children everywhere: the right to survival; to develop to the fullest; to protection from harmful influences, abuse and exploitation; and to participate fully in family, cultural and social life. However, children with disabilities are frequently marginalized and excluded from society. They are less likely to attend school, access medical services, or have their voices heard. They are also at a higher risk of physical abuse, and often excluded from receiving proper nutrition or humanitarian assistance in emergencies.

Facing daily discrimination in the form of negative attitudes, and a lack of adequate policies and legislation, children with disabilities are prevented from realizing their rights. Frequently children with disabilities are either neglected or over-protected. They are often hidden because their parents are ashamed. Malawi has domesticated the CRC through the Republican Constitution, 1995, the Child Care, Protection and Justice Act, 2010 and the Disability Act, 2012, among other pieces of legislation.

Gaps in service provision for children with disabilities in Malawi

Healthcare: Challenges for children's access to healthcare include transport and discrimination in line with those faced by adults. Children may have the additional challenge of negligent parents who do not seek healthcare for their children. In some cases, parents go to traditional healers rather than health centers. Access to sanitation is also often challenging. In spite of a policy to provide assistive devices to all who need them, in practice their availability is limited.

Education: In spite of positive initiatives in Malawi to promote inclusion of children with disabilities in education (discussed elsewhere in this package), most children with disabilities are not in school, particularly girls. Schools are generally not physically accessible and specialist teachers are scarce. In addition, the curricula, teaching methodologies, learning materials, and examination systems do not usually take into account the needs of children with disabilities. A WHO/World Bank Study in Malawi showed that 39% of children with a disability of 5 years or older had never attended school, compared to up to 19% without a disability who had never attended.

Importance of early identification and referral

Early childhood is defined as the period from prenatal development to eight years of age. For children with disabilities, it represents a critical time to ensure their access to interventions that can help them reach their full potential. Early childhood development (ECD) is a generic term that refers to a child's cognitive, social, emotional and physical development. Child development is a process through which children progress from dependency on caregivers in all areas of functioning during infancy, towards growing independence at primary school age, through adolescence and into adulthood. Skills develop in different areas through what are called milestones which involve mastering certain simple skills before moving onto more complex ones.

When children do not attain the milestones in the usual way for their age, they are said to have developmental delay. Developmental delays are measured using assessment methods and may be mild, moderate or severe.

Developmental delays can be caused by different factors including poor health habits during pregnancy, poor birthing methods, inadequate stimulation, malnutrition, or chronic ill health. Developmental delay may not be permanent, but when it is identified it can provide a basis to identify children who may experience a disability.

For this reason, early identification through CBR initiatives is important so that children can be referred to specialists who can plan interventions in collaboration with family members aimed at addressing delays and creating the best environment for the child's development. Examples of interventions might include specialized medical or rehabilitation services (e.g. therapy and assistive devices); family support (e.g. training and counselling); or social and psychological support. On an economic level, children with disabilities who receive good care and developmental opportunities during early childhood are more likely to become healthy and contributing adults.

Models of disability

The way that disability has been viewed has changed over time through various perspectives - often called 'models'. The word models here refer to different interpretations of what disability means and what it means to have a disability.

a. The Traditional model

In the Traditional model, disability is perceived as a result of a curse – a natural consequence of an evil that the person with a disability or one of the family members might have done. Persons with disabilities were perceived not to be part of the human race. In this model, persons with disabilities are treated with pity, fear and patronising attitudes. The impairment is focused on, rather than the needs of the person, who is seen as a tragic victim.

Dependence on the part of the persons with disability is emphasised. There are certain remote areas of the rural communities even today who still hold this view in Malawi.

b. The Charity model

In the Charity model disability is seen as a defect in the anatomical structure and function such as the loss or malfunction of a limb or part thereof. This makes them unable to participate in society and to fend for themselves. Persons with disabilities are seen as tragic. They are pitied and treated as objects of charity and welfare to be cared for by others, unable to help themselves or be independent. Their needs are seen in terms of being 'special'.

A focus is on providing special services, special schools etc because they are different from 'normal' people. Within the Charity model some persons with disabilities commonly perceive themselves as powerless, useless, non-contributing individuals. In the Malawi context, the model largely manifested itself from/during the period prior to the introduction of Christianity in the late 18th century leading to the introduction of special needs education by missionaries in the 1950s. This model is still widely embraced by many including local NGOs, some religious institutions and part of the general public

c. The Medical model

As science and medicine developed, disability was commonly viewed in biological or medical terms. The Medical model looks at disability as a deviation from the normal, caused by an underlying disease or other health condition. The Medical model focuses on the impairment that requires fixing by a medical professional for the individual to be a 'normal' member of society.

Disability is viewed as a 'problem' that belongs to the disabled individual and should be borne wholly by them: the person with a disability should ensure that they do not inconvenience anyone else. In practical terms, the Medical model would see an issue of a wheelchair user accessing public transport as an issue to do with the compatibility of the wheelchair to access the transport and not the issue of the way the transport system was organized.

In Malawi, application of the Medical model is exemplified in the passage of the Handicapped Person Act of 1971, which gives powers solely to medical practitioners to assess persons with disability prior to registration and receiving care. In addition, it is reflected in the prioritization of support services for persons with physical disabilities through establishment of a leper colony at Malamulo Mission in Makwasa in the mid-1940s, and the Department of Physiotherapy at QECH to address rehabilitation issues in the late 1960s to treat and correct disability as well as in other initiatives that have established institutions to look into the welfare and care of persons with disabilities. Traits of this model are still rampant in Malawi.

d. The Social model

In the 1960s and 1970s the movement of persons with disabilities grew in strength and the movement argued that disability is not "located" in an individual body at all, but is created by the way society is organized in relation to individual difference – firstly through stigma and discrimination, and secondly through indifference to the accommodations that persons with disabilities may need to participate fully in society.

In the example above, the Social model of disability would see the design of transport as the disabling barrier for the wheelchair user – not the wheelchair.

In Malawi, the Social model gained ground in the 1990s with the establishment of a number of organisations of persons with disabilities focusing on advocacy. These included the formation of: the Malawi National Association of the Deaf, the Malawi Union of the Blind, the Association of Persons with Albinism in Malawi, Disabled Women in Development, and Disabled Persons Association in Malawi (DIPAM) as well as the Federation of Disability Organizations in Malawi (FEDOMA). Other disability organizations were to be established from early 2000. Another factor influencing the Social model to gaining ground in Malawi was the adoption of Community Based Rehabilitation (CBR) for persons with disabilities as an integral component of the Government of Malawi's development policy for 1987-1996, From 1988, CBR became the country's main strategy for addressing barriers that restrict persons with disabilities from actively participating in mainstream development.

The Social model considers that it is society that disables people, by designing everything to meet the needs of the majority of people who are not disabled. There is a recognition within the Social model that there is a great deal that society can do to reduce and remove disabling barriers, and that this is the responsibility of society, rather than of the person with a disability. The Social model is more inclusive in approach. Pro-active thought is given to how persons with disabilities can participate in activities on an equal footing with non-disabled people. Certain adjustments are made, even where this involves time or money, to ensure that disabled people are not excluded.

e) The Rights-based model

This model is closely related to the Social Model. The Rights-based model takes universal human rights as a starting point. Persons with disabilities are seen to have a right to access all aspects of life within their society on an equal basis with others. Consequently, society has the responsibility to change to ensure that all people have equal possibilities for participation. Persons with disabilities are often denied their basic human rights such as the right to health, education, participation in social and political processes, and to employment.

Laws and policies therefore need to ensure that these society-created barriers are removed. The two main elements of the Rights-based approach are empowerment (the participation of persons with disabilities as active stakeholders) and accountability (the duty of public institutions and structures to implement these rights and to justify the quality and quantity of their implementation).

In the Malawi context, examples of how the Rights-based model manifests itself can be seen in the following:

- The revision of the Republican Constitution in 1994 to provide for the bill of rights and specific rights for persons with disabilities
- Adoption of a rights and development oriented National Policy on Equalization of Opportunities for Persons with Disabilities in 2006
- Signing and ratification of the UN CRPD in 2007 and 2009 respectively
- Passage of the Disability Act of 2012
- The Directorate of Disability and Elderly Rights at the Malawi Human Rights Commission
- Ongoing efforts to repeal the Handicapped Persons Act of 1971.

It should be noted that the above models do not manifest in a continuum – with one model succeeding or replacing another. There are elements of all models of disability in Malawi notwithstanding significant progress made to embrace the Social and Rights-based models.

Some examples of how different situations would be viewed by the models are shown below. This has been adapted from 'Making PRSP Inclusive'.

Disability and Human Rights

The protection guaranteed in human rights treaties, and grounded in the Universal Declaration of Human Rights, should apply to all. Persons with disabilities have, however, remained largely 'invisible', often sidelined in the rights debate and unable to enjoy the full range of human rights.

Human Rights provide legal guarantees of protection. They apply to every individual globally regardless of their race, sex, ethnic or social origin, religion, language, nationality, age, sexual orientation, disability or any other status. They are a natural part of what a human being is. They cannot be taken away or given up.

However, persons with disabilities face discrimination and barriers that restrict them from participating in society on an equal basis with others every day. They are denied their rights to be included in the general school system, to be employed, to live independently in the community, to move freely, to vote, to participate in sport and cultural activities, to enjoy social protection, to access justice, to choose medical treatment and to enter freely into legal commitments such as buying and selling property. Human Rights enable human beings to aspire to live a life of dignity, free from want and oppression, and with the hope of fulfillment. Some examples of rights and freedoms generally considered as human rights include:

- Civil and political rights, such as the right to life and liberty, freedom of expression, and equality before the law.
- Social, cultural and economic rights, including the right to participate in culture, the right to food, the right to work, and the right to education, health and housing.

Governments have the primary and legal responsibility for making sure that the human rights of its citizens are promoted and protected. People are often unable to enjoy their human rights because of factors such as who they are, and where they live. Discrimination is common in every society, limiting, for example, persons with disabilities' opportunities to participate in public forums (or household decision-making), or from receiving appropriate education. Discrimination is an abuse preventing people from enjoying their basic human rights, and thus undermining the very concept of a universal right.

Realizing human rights for persons with disabilities

The Convention on the Rights of Persons with Disabilities (UN CRPD) was the first human rights treaty of this millennium. The Convention has served as the major catalyst in the shift from viewing persons with disabilities as objects of charity, medical treatment and social protection towards viewing them as full and equal members of society, with human rights. Malawi signed the Convention on 27 September 2007 and ratified it on 27 August 2009. It is a comprehensive convention covering a broad range of areas. Articles include:

- Article 5: Equality and non-discrimination
- Article 6: Women with disabilities
- Article 7: Children with disabilities
- Article 8: Awareness-raising
- Article 9: Accessibility
- Article 10: Right to life
- Article 11: Situations of risk and humanitarian emergencies
- Article 12: Equal recognition before the law
- Article 13: Access to justice
- Article 14: Liberty and security of the person
- Article 15: Freedom from torture or cruel, inhuman or degrading treatment or punishment
- Article 16: Freedom from exploitation, violence and abuse
- Article 17: Protecting the integrity of the person
- Article 18: Liberty of movement and nationality
- Article 19: Living independently and being included in the community
- Article 20: Personal mobility
- Article 21: Freedom of expression and opinion, and access to information
- Article 22: Respect for privacy
- Article 23: Respect for home and the family
- Article 24: Education
- Article 25: Health
- Article 26: Habilitation and rehabilitation
- Article 27: Work and employment
- Article 28: Adequate standard of living and social protection
- Article 29: Participation in political and public life
- Article 30: Participation in cultural life, recreation, leisure and sport
- Article 31: Statistics and data collection
- Article 32: International cooperation

The UN CRPD offers protection for the civil, cultural, economic, political and social rights of persons with disabilities on the basis of inclusion, equality and non-discrimination. It makes clear that persons with disabilities are entitled to live independently in their communities, to make their own choices and to play an active role in society.

The Convention's Optional Protocol gives the Committee of experts' additional capacities. The Committee can receive and review complaints filed by individuals, and where there is evidence of grave and systemic violations of human rights, it can launch inquiries. The adoption of the Convention and Optional Protocol is seen as evidence of a real commitment to an inclusive and universal human rights framework. Malawi has not at this time signed or ratified the Optional Protocol.

The Washington Group on Disability Statistics

The Washington Group on Disability Statistics is a UN city group established under the United Nations Statistical Commission. It was constituted to address the need for cross-nationally comparable population based measures of disability. It is not possible to collect all information on persons with disabilities in a census. However, important information on selected aspects can be obtained.

The Washington Group (WG) determined that measurement of disability is associated with a variety of purposes which relate to different dimensions of disability or different conceptual components of disability models. A fundamental agreement of the WG was the need for a clear link between the purpose of measurement and the operationalization of indicators of disability. Equalization of opportunities was agreed upon and selected as the purpose for the development of an internationally comparable general disability measure. One reason this purpose was chosen was because it was feasible to collect the proposed information using a small set of six census-like questions.

The questions identify the population with functional limitations that have the potential to limit independent participation in society. The intended use of this data would compare levels of participation in employment, education, or family life for those with disability versus those without disability to see if persons with disability have achieved social inclusion. In addition, the data could be used to monitor prevalence trends for persons with limitations in the particular basic activity domains. The recommended 'short set' of questions developed by the Washington Group are below.

Proposed Washington Group Short Measurement Set on Disability

Introductory phrase: The next questions ask about difficulties you may have doing certain activities because of a HEALTH PROBLEM.

CORE QUESTIONS

1. Do you have difficulty seeing, even if wearing glasses?
a. No-no difficulty **b.** Yes–some difficulty
c. Yes – a lot of difficulty **d.** Cannot do at all

2. Do you have difficulty hearing, even if using a hearing aid?
a. No-no difficulty **b.** Yes–some difficulty
c. Yes – a lot of difficulty **d.** Cannot do at all

3. Do you have difficulty walking or climbing steps?
a. No-no difficulty **b.** Yes–some difficulty
c. Yes – a lot of difficulty **d.** Cannot do at all

4. Do you have difficulty remembering or concentrating?
a. No-no difficulty **b.** Yes–some difficulty
c. Yes – a lot of difficulty **d.** Cannot do at all

Additional Questions:

5. Do you have difficulty (with self-care such as) washing all over or dressing?
a. No-no difficulty **b.** Yes–some difficulty
c. Yes – a lot of difficulty **d.** Cannot do at all

6. Because of a physical, mental or emotional health condition, do you have difficulty communicating, (for example understanding others or others understanding you)?
a. No-no difficulty **b.** Yes–some difficulty
c. Yes – a lot of difficulty **d.** Cannot do at all

Actions I can take to help change attitudes towards persons with disabilities

National

- Develop policies and laws which promote the full inclusion of persons with disabilities.
- Ensure enforcement of laws which protect the rights of persons with disabilities to facilitate their greater inclusion and visibility.
- Use and promote appropriate terminology when referring to or addressing persons with disabilities.
- Plan and run disability awareness and inclusion training for staff from public and private sectors.
- Promote positive images and case studies of persons with disabilities.
- Avoid using negative images of persons with disabilities in materials such as depicting them as weak or pitiful.
- Recruit persons with disabilities in all sectors.
- Promote the appointment of persons with disabilities to decision making roles.
- Promote and support the full integration of persons with disabilities in all sectors.

District

- Recruit persons with disabilities in all sectors, including district committees and other decision making bodies.
- Advocate for policies, and bye laws which promote the full inclusion of persons with disabilities.
- Lobby for enforcement of laws which protect the rights of persons with disabilities to facilitate their greater inclusion and visibility.
- Promote and support the full integration of persons with disabilities in all sectors.
- Use and promote appropriate terminology when referring to or addressing persons with disabilities.
- Plan and run disability awareness and inclusion training.
- Promote positive images and stories of persons with disabilities.
- Mainstream disability issues in district development plans.

Community

- Empower persons with disabilities to be role models and present positive images of disability to educate and raise awareness of their challenges and capabilities.
- Identify persons with disabilities in the community and promote their inclusion in all aspects of community life.
- Use and promote appropriate terminology when referring to or addressing persons with disabilities.
- Identify and remove the barriers that prevent persons with disabilities visibility and inclusion in community life.
- Promote positive images and stories of persons with disabilities.
- Recruit persons with disabilities to village and community committees and other decision making bodies.

Sources

World Health Organization, 2010, CBR Guidelines, Geneva
Padmani Mendis, 2012, Understanding Disability: Background Note Zambia
Padmani Mendis, 2012, Human Rights and Human Needs -an introduction to the CRPD: Background Note, Zambia
CBM International, 2014, The Future is Inclusive, How to Make International Development Disability-Inclusive, Series on Disability-Inclusive (www.cbm.org/didseries1_The_Future_is_Inclusive_pdf)
http://www2.le.ac.uk/offices/accessability/staff/accessabilitytutors/information-for-accessability-tutors/the-social-and-medical-model-of-disability
https://www.disabilityinfo.org/mnip/db/fsl/FactSheet.aspx?id=77
http://sudcc.syr.edu/LanguageGuide/index.html
http://www.feministe.us/blog/archives/2010/06/18/disability-terminology-a-starter-kit-for-nondisabled-people-and-the-media/
http://www.ohchr.org/EN/Issues/Disability/Pages/DisabilityIndex.aspx
https://www.add.org.uk/why-disability/facts-about-disability/dangerous-myths-about-disability
WHO/UNICEF, Early Childhood Development and Disability: A discussion paper
http://www.asksource.info/topics/social-inclusion/gender-and-disability
http://blog.handicap-international.org/influenceandethics/wp-content/uploads/sites/4/2015/12/BP_gender_WEB.pdf
National Youth Leadership Network factsheet
http://www.continuetolearn.uiowa.edu/nas1/07c187/Module%201/module_1_p6.html
http://www.scope.org.uk/Scope/media/Images/Publication%20Directory/Current-attitudes-towards-disabled-people.pdf
http://www.washingtongroup-disability.com/wp-content/uploads/2016/01/Rationale_WG_Short-1.pdf
http://apps.who.int/iris/bitstream/10665/41003/1/9241541261_eng.pdf

Unit 3

DISABILITY FRIENDLY LANGUAGE

Resources/ Materials:

- Pictures
- Flip charts
- Markers

UNIT 3
DISABILITY FRIENDLY LANGUAGE (including vernacular)

3.0 Introduction

The section will focus on terms, language and expressions which are mostly used to describe persons with disabilities that are either positive or negative. Emphasis is placed on the need to be language sensitive, to utilize positive terms, languages and expressions that would rather build confidence, self-esteem and self-actualization in others and encourage person-first address. Negative or discriminatory terms and expressions reinforces the charity model and are thus prohibited. This is expected to be covered 90 Minutes.

3.1 Main Objective

Participants should be able to use appropriate terms and expressions to refer to persons with disabilities.

3.2 Specific Objectives

- Distinguish terms and expressions that are negative and explain why
- Describe the implication of negative terms and expressions
- Discuss appropriate terms and expressions to be used to describe persons with disabilities
- Discuss why appropriate terms and expressions should be used

3.3 Resources/ Materials:

Training materials include:

- PIctures
- Flip charts
- Markers

Summary

HANDOUT | **Handout for disability friendly language**

Language is the ability to acquire and use complex systems of communication, particularly the human ability to do so, and a language is any specific example of such a system.

Humans acquire language through social interaction in early childhood, and children generally speak fluently when they are approximately three years old. The use of language is deeply entrenched in human culture. People use language and expressions to describe each other and in the same vain they use discriminatory language and expressions to describe persons with disabilities and their facilities. The discriminatory language and expressions bring prejudice and thereby discriminate against persons with disabilities.

These discriminatory language and expressions are stereotyping, depersonalizing and derogatory in nature. Stereotypes are discriminatory because they categorically generalize persons without considering individual differences. Common stereotype perceptions that people have about persons with disabilities include tragedy – "victim" or "sufferer"; worthy of sympathy and charity as well as burden on society, among others. While depersonalization takes away a person's individuality by way of replacing a person with a characteristic such as a disability hence there is need to always remember that they are people first. Derogatory terms, language or expressions, on the other hand, portray persons with disabilities as helpless, mindless, suffering beings deserving the sympathy and attention. Such language, terms and expressions lead to discrimination of persons with disabilities. It is therefore important to portray persons with disabilities in a positive manner because they are people just like everyone else and need to be respected. They experience the same range of emotions, needs, interests and ambitions. It is therefore important that we should use appropriate language and expressions to describe them.

Table 1 below illustrates this and Table 2 further below presents the descriptions of the facilities for persons with disabilities.

Table 1

Terms and their Descriptions	Discriminatory Terms and Expressions	Appropriate terms and Expressions
Disability (ulumali): a person can have no legs/ cannot walk because of polio, no hands or with just one leg or one hand	Disabled, handicapped, crippled/ physically challenged person (kupunduka, kupuwala)	Person with disabilities (munthu waulumali)
Visual impairment: kusaona kapena kuona pang'ono	Blind person or persons (munthu or anthu osaona kapena ongoona pang,ono basi)	Visual impairment Person or persons with visual impairment
Hearing impairment: kusamveratu kapena kumva movutikila	Deaf person (osamva) Deaf and dumb person (osamva ndi osalankhula) Hard of hearing person (ovutika kumva, kusamvetsa)	Person with hearing impairment Person with hearing and speech impairment Person with hearing impairment
Spasm: kumangogwedezeka osatha kuziletsa: (very tight muscles occurring in one or more muscle groups that result in stiff, uncoordinated movements) he damaged nerve fibres cause the muscles to spasm, hence the jerky movements	Spastic person (munthu wa zinjenje)	Person with spasm
Cerebral Palsy: Ulumali wa bongo The condition of cerebral palsy is usually caused by birth trauma, either during or shortly after birth.	Cerebral palsy person (munthu olumala bongo)	Person with cerebral palsy
Epilepsy: matenda akugwa	Epileptic person (munthu wachifufu)	Person suffering from epilepsy

Table 1 (Continued)

Terms and their Descriptions	Discriminatory Terms and Expressions	Appropriate terms and Expressions
Intellectual disability: ulumali wa bongo	Mentally handicapped/retarded /Slow learner/subnormal, lunatic abnormal, Slow, subnormal, lunatic abnormal: ozelezeka	Person with an intellectual disability Mental disability Cognitive disability
Down syndrome: ulumali wa bongo	Downs person, mongal: ozelezeka	Person with down syndrome
Wheelchair user: kuyedela njinga ya anthu olumala	Confined to a wheelchair or Wheelchair bound	Wheel chair user
	Suffers from or a victim of disability	Say the condition or impairment

Table 2: Descriptions of the facilities for persons with disabilities

Discriminatory description of the facilities	Appropriate description on the facilities	Description of the terms
Disabled toilets (zimbuzi Za anthu opunduka)	Accessible toilets (Zimbuzi zoti anthu aulumali atha ku gwiritsa ntchito popanda chovuta)	The toilets with features that make them accessible to persons with disabilities Zimbuzi zomwe anthu a ulumali amagwiritsa ntchito. All accessible toilets must meet the requirements of the universal designs
Disabled parking (poimika ma galimoto a anthu opunduka)	Accessible parking (poimika ma galimoto pamene anthu a ulumali athanso kuimika ma galimoto ao popanda chovuta)	Accessible car parking offers persons with disabilities close proximity to an entrance and space to transfer in and out of their vehicle and wheelchair. Accessible parking needs to comply with the requirements of the universal designs

Unit 4

SOCIAL PROTECTION IN MALAWI

Training Materials:

- **Flip charts**
- **Markers**
- **Power point presentation**
- **Pens**
- **Writing pads**
- **Laptop**
- **LCD projector**
- **Printed handouts.**

UNIT 4
SOCIAL PROTECTION IN MALAWI

4.0 Introduction

We are living in times characterized by shocks and vulnerabilities, which have the potential to slow down, or even reverse, achievements in human development. It is evident that global economic downturns have had had some noticeable negative effects on human development. In response, many countries have renewed their interest in social protection policies to help households cope with these negative effects of economic downturns. Many countries are implementing social protection programmes to support their poor households with income as a way of investing in human capital development by improving access to education, health, and other essential social services.

This topic aims to provide an understanding of the social protection in Malawi. It describes key timelines, policy and legal framework, and forms of social protection programmes in Malawi.

4.1 Main Objective

To describe national social protection programmes adopted and implemented in Malawi.

4.2 Specific Objectives

At the end of the unit the participants will be able to:

- Describe the concept of social protection.
- Explain forms of social protection programmes in Malawi.
- Explain key timelines for social protection in the country.

4.3 Training Materials:

Training materials include:

- Flip charts
- Markers
- Power point presentation
- Pens
- Writing pads
- Laptop
- LCD projector
- Printed handouts.

Social Protection in Malawi

Social protection is defined as the set of policies and programmes designed to reduce poverty and vulnerability by promoting efficient labour markets, diminishing people's exposure to risks, and enhancing their capacity to protect themselves against hazards and interruption/loss of income. It has also been defined as a broad range of measures designed and implemented by the state and its partners in development to reduce poverty and strengthen the resilience of the population to shocks.

The policies and procedures included in social protection involve five major kinds of activities namely, labour market policies and programmes, social insurance programmes, social assistance, micro and area-based schemes, and child protection. Social safety net and social security are sometimes used as alternative terms to social protection.

Social Protection in Malawi is guided by the National Social Support Policy (NSSP) and implemented thru the Malawi National Social Support Programme (MNSSP). The MNSSP has five prioritized interventions but organized around thematic priority pillars thus providing enhanced strategic guidance on promoting linkages, strengthening systems. The priority pillars are;

Pillar 1:
Consumption Support: Strategic objective is to provide consumption support through timely, predictable and adequate cash and/or in-kind transfers to poor and vulnerable households throughout the lifecycle. This support should enable households to meet their everyday basic needs.

Pillar 2:
Resilient Livelihoods: This pillars seeks to address the causes of poverty and not simply symptoms. Therefore, the focus lies on how programmes can specifically build resilient livelihoods, based on Individual, Household, and Community needs via Graduation pathways, Inter-programme linkages and by facilitating access to and utilization of basic services beyond MNSSP.

Pillar 3:
Shock-Sensitive Social Protection: The objective is to develop a Shock-sensitive Social Protection System. This pillar focuses on empowering people to respond to shocks and crises and aims to protect the gains made under pillars 1 and 2 by offering additional assistance when a shock occurs. The focus is on reorienting activities beyond day-to-day survival towards investment for future but building on existing systems and enables expansion in cases of humanitarian responses. It also aims to create clear and institutionalized linkages between social support committees and humanitarian structures at both national and district level in order to enhance coordination and information sharing. It ensures prioritization of vulnerable and hazard-prone districts in the development of shock-sensitive system.

Pillar 4:
Strengthen Linkages Between the MNSSP and other Programmes: MNSSP recognizes that poverty is multi-dimensional therefore cash alone is not enough. As such programmes should not be implemented in isolation but provide a comprehensive and complementary package that is responsive to diverse and changing needs of beneficiaries by

- Linking MNSSP beneficiaries, in particular Social Cash Transfer Programme and Public Works Programme beneficiaries, to Savings and Loans Groups and Micro Finance Institutions services to improve access to savings, insurance, and credit.
- Linking MNSSP beneficiaries, in particular SCTP and PWP beneficiaries, to programmes and services that provide productivity and livelihood support, such as training on local livelihood strategies, relevant income generating activities, business and financial literacy skills.
- Facilitate access to and utilization of nutritional intervention, basic healthcare services s for relevant sub-groups of MNSSP beneficiaries.

Pillar 5:
Strengthening Systems: Focuses on strengthening systems and leadership to ensure effective and efficient programme implementation.

Social Assistance Programmes

Social Cash Transfer Programme (SCTP) is one of the flagships and anchor social protection programs in Malawi. It is an unconditional, means-tested cash transfer, aimed at targeting rural ultra-poor and labor-constrained households to reduce poverty and hunger while improving human development. The SCTP was designed to cover the following social protection functions: old age, disability, sickness (in cash), children, access to education, healthcare, food and nutrition and social assistance targeted at poverty. The Ministry of Gender, Community Development and Social Welfare is the agency in charge of implementing the SCTP with policy oversight and guidance is provided by the Ministry of Finance and Economic Affairs specifically the poverty reduction and Social Protection Division.

Affordable Input Programme main objective is to reduce poverty by enhancing the country's food security through fostering increased agricultural productivity. Under this scheme, beneficiary households receive coupons that are used to buy subsidized farm inputs i.e., fertilizers, maize, and legume seed vouchers. The programme has been extended to livestock in selected districts.

Savings and Loans Groups programs aim at covering financial gaps of Malawian households through associations in which people pool savings to access loans in the future. Microfinance has been included in the MNSSP for its potentially significant role in poverty reduction by increasing access to finance.

Food Assistance for Assets and School Feeding Programmes

The food-based social protection initiatives in Malawi are the Food Assistance for Assets administered and financed by the World Food Programme (WFP) and four individual school feeding initiatives under the Ministry of Education, the WFP, Mary's Meals Malawi, and Nascent Solutions Inc. WFP's Food Assistance for Assets programme aims to "support restoration of livelihoods and improve household and community resilience through the creation of productive assets. The programmes also aim to reduce the "disaster risks and enhance resilience of households vulnerable to lean season shortages" (WFP Malawi Country Office, 2021: 4-5). In terms of outcomes, the programme focuses on adequate food consumption, access to livelihood assets and reduced risks from disasters.

Social Insurance Schemes

Contributory social protection schemes in Malawi are limited in coverage and restricted to the formal sector. contributory social security schemes include pensions for the small formal sector. The contributory social security programmes include, The Civil Servants contributory pension scheme, the civil servants non-contributory pension scheme

The Public Service Pension Trust Fund is administered by the Ministry of Finance covering the old age social protection function. The country has a compulsory private pension scheme that currently faces the challenges of inadequate coverage. In addition, there is one private health insurance programme called the Civil Servants Medical Scheme, a voluntary-based scheme covering the public employees.

The country also has an employer liability workers compensation scheme, whose coverage extends to all workers in accordance with the workers compensation Act.

The National Social Support Policy expired in 2016, the Government is currently reviewing the policy and its operational plan the MNSSP III to make it more comprehensive to address different social protection needs across the life cycle, Being the guiding policy framework that provide strategic direction for the effective design, implementation and management of social protection and support programs in Malawi the new policy framework provides an opportunity to expands social protection beyond social assistance by promoting social security in the informal economy.

Unit 5

SOCIAL PROTECTION LEGAL AND POLICY FRAMEWORK

Training Materials:

- **None**

UNIT 5

SOCIAL PROTECTION LEGAL AND POLICY FRAMEWORK

5.0 Introduction

This section describes the international, regional and national legal and policy instruments which guide extension of social protection to all. Th e section also aims to enhance understanding of the gaps within social protection programmes and strengthen capacity to promote age and disability inclusion.

5.1 Objective

1. Describe the purposes fulfilled by a legal social protection framework including social assistance
2. Understand why international and regional standards play a prominent role in determining the scope and content of social assistance;
3. Describe how to make social protection programmes age- and disability-inclusive

Social Protection Legal Framework

A strong legal framework is a vehicle to uphold human rights principles in governance, administration and social protection service delivery. A human rights-based approach to social security identifies rights holders and their entitlements and corresponding duty bearers and their obligations, and works towards strengthening the capacities of rights holders to make their claims and of duty bearers to meet their obligations. One important aspect of a rights based approach is the respect for the inherent dignity of all. Respecting the dignity of those who receive State social security benefits implies that all actors within the social security system must avoid stigmatization and prejudice.

International Instruments and Standards

The Universal Declaration of Human Rights (Articles 22 and 25) and the International Covenant on Economic, Social and Cultural Rights (Articles 9 and 11), set out the right to social security as human right. Social security is an economic and social necessity for development and progress. Efforts towards realizing this right have potential to prevent and reduce poverty, social exclusion and social insecurity among various segments of society. However, indications by the ILO show that in 2022, only 46.9 per cent of the global population were effectively covered by at least one social protection benefit, while the remaining 53.1 per cent – as many as 4.1 billion people were left wholly unprotected.[1] By implication, the unprotected group was living in a situation where their right to social security was being violated. Malawi is a member state of the United Nations and Party to the Universal Declaration of Human Rights thereby should commit to etend social protection to all peope, as indicated in the background over 50% of the population in Malawi lives in poverty and access to social security is yet to be realized by majority of the population.

The Social Security (Minimum Standards) Convention, 1952 (No. 102) establishes worldwide-agreed minimum standards for all nine branches of social security. These branches include medical care; sickness benefit; unemployment benefit; old-age benefit; employment injury benefit; family benefit; maternity benefit; invalidity benefit; and survivors' benefit. The principles anchored in Convention No. 102 are: guarantee of defined benefits; participation of employers and workers in the administration of the schemes and general responsibility of the state for the due provision of the benefits and the proper administration of the institutions. Convention No. 102 is considered as a key tool for the extension of social security coverage. Malawi has not ratified Convention No. 102 development of the current social protection system is needed to for governmnet to have capacity to implment provisions of convetion 102.

The Social Protection Floors Recommendation, 2012 (No. 202) provides that member States should formulate and implement social security extension strategies, based on national consultations through effective social dialogue and social participation. For this purpose, Members should progressively build and maintain comprehensive and adequate social security systems in coherence with national policy objectives, and seek to coordinate social security policies with other public policies. Social security extension strategies should support the growth of formal employment and the reduction of informality.

The Transition from the Informal to the Formal Economy Recommendation, 2015 (No. 204) recognizes that decent work deficits – including inadequate social protection – are most pronounced in the informal economy. It contains guidance for improving the protection of workers in the informal economy and facilitating their transitions to the formal economy. Paragraph 20 proposes that Members should progressively extend, through the transition to the formal economy, the coverage of social insurance to those in the informal economy and, if necessary, adapt administrative procedures, benefits and contributions, considering their contributory capacity (para. 20)

Despite the adoption of the UN Convention on the Rights of Persons with Disabilities (UN CRPD) and the Agenda 2030's pledge to leave no one behind, there is a persistent gap in disability inclusion, especially in low and middle-income countries. Data reveals that persons with disabilities face multiple inequalities in education, health, and poverty levels, with children, older people, rural communities, migrants and women being most affected. Humanitarian crises, climate related disasters and conflicts aggravate these disparities, and persons with disabilities are disproportionately affected.

The impact also extends to households, affecting family members providing care and support, often women and girls. It can lead to dropout from education or employment, creating a vicious cycle of economic insecurity.

Age and Disability Inclusive Social Protection

Inclusive social protection systems can play a crucial role in addressing these gaps and enabling the full participation of persons with disabilities across the life cycle. However, globally only a third of people with significant disabilities receive specific support from social protection systems, and still this support is often inadequate. The current guidance aims to address these issues and establish a framework for developing more inclusive social protection systems. It emphasizes the diversity of disability experiences, the importance of dignity, choice, autonomy, universal support, and the crucial role of consultation with persons with disabilities and the elderly. The guidance is a first step, with updates anticipated as further evidence and practices become available.

What do we mean by inclusive social protection systems

Historically, social protection policies have viewed disability primarily through the lens of inability to work and care for oneself, leading to policies centred on basic income replacement, rehabilitation and institutional care. Reflecting a paradigm shift encouraged by the UN Convention on the Rights of Persons with Disabilities (CRPD), inclusive social protection focuses on enabling socio economic participation, autonomy and community living of persons with disabilities across the life cycle. This holistic approach goes beyond basic income security as well as interventions aimed at addressing the diversity of disability related costs.

Age and Disability-related costs encompass direct costs such as additional spending on regular items like healthcare and transportation, and disability-specific spending on assistive devices or human assistance. Indirect costs include lower income due to discrimination and opportunity costs for family members who provide unpaid support.

Factors influencing age and disability-related costs include the individual's characteristics such as gender, ethnicity, age, the nature and extent of impairment and functional limitations, as well as environmental factors, such as physical and attitudinal barriers, location (urban or rural), and the level of participation desired by the person. These factors should be thoroughly considered, including through adequate individual disability and needs assessment to provide tailored support to persons with disabilities throughout their life course.

A life cycle and gender responsive framework is useful for exploring the specific considerations required by inclusive social protection to provide adequate support to persons with disabilities and the elderly in a diverse range of circumstances;

1. **Children with disabilities** face high levels of social exclusion due to stigma, lack of access to education, separation from family, gaps in healthcare, and difficulties transitioning to independent life. Child poverty and disability are closely linked, with disability-related costs pushing families into deeper poverty. Social protection can mitigate these issues by directly addressing extra costs and compensating for the opportunity costs of those who provide care. It can also facilitate access to services like education. Conditionalities may create barriers to social protection, such as enrolment in inaccessible schools or support in inaccessible locations. Moving away from institutionalization and providing adequate community support services is essential for inclusive social protection.
2. **Working-age persons with disabilities** face significant barriers to independent living and economic empowerment, with lower levels of employment, predominantly in the informal economy, and higher likelihood of poverty. Inclusive social protection must acknowledge the income earning potential of persons with disabilities but also the barriers they face and provide adequate, flexible support to cover disability-related extra costs, including those related to employment, and link to labour market policies promoting economic empowerment. It should avoid 'all-or-nothing' schemes and support risk-taking while ensuring the re-uptake of support in case of loss of work. It should also enable development of community care and support services fostering greater autonomy and enabling community living and the diversity of social roles of adults with disabilities such as parenthood.
3. **In older age** the increased prevalence of disability significantly impacts income security and personal autonomy. Approximately 38-46% of older persons globally live with moderate to severe disability, compared to 15-16% of the general population. Without effective pension systems and in-home based services, older persons often rely on families for support, potentially leading to household poverty, gender inequalities and limiting their autonomy and social participation. Pensions, while providing income security, often do not cover substantial disability-related costs, including care and support needs. As the global population ages, investments in collaborative care models that integrate healthcare and social services are essential.
4. **Women and girls with disabilities** face compounded discrimination due to their gender and disability, resulting in higher rates of exclusion, violence, and poverty. They are less likely to be employed, more likely to be out of school, have unmet health needs, and are often institutionalised. Women with disabilities are three times more likely to be unable to read, have unmet healthcare needs, and twice as less likely to be employed. Moreover, women and girls often shoulder the primary responsibility of care and support for persons with disabilities, reducing their educational and economic opportunities. Applying a gender lens to social protection systems is essential, involving women with and without disabilities in decision-making, addressing their specific needs in scheme designs, and reducing the disproportionate burden of unpaid care on them.

Features of Age and Disability-inclusive social protection systems

1. These systems ensure accessibility and non-discrimination, allowing persons with disabilities to equally access and benefit from social protection programmes and social services by removing physical, communicational, informational, institutional, and attitudinal barriers.
2. They respect dignity, personal autonomy, and privacy, and provide support without contributing to the stigmatisation, marginalisation, or exclusion of persons with disabilities.
3. They foster consultation with representative organisations of persons with disabilities (OPDs) on the design, implementation, and monitoring of social protection, to provide a lived experience perspective, promote ownership, and sustain demand for necessary reforms.
4. They provide both basic income security and covering health and disability-related costs through a flexible combination of inclusive mainstream, and disability specific cash transfer, concessions and services to support socio-economic participation and inclusion,

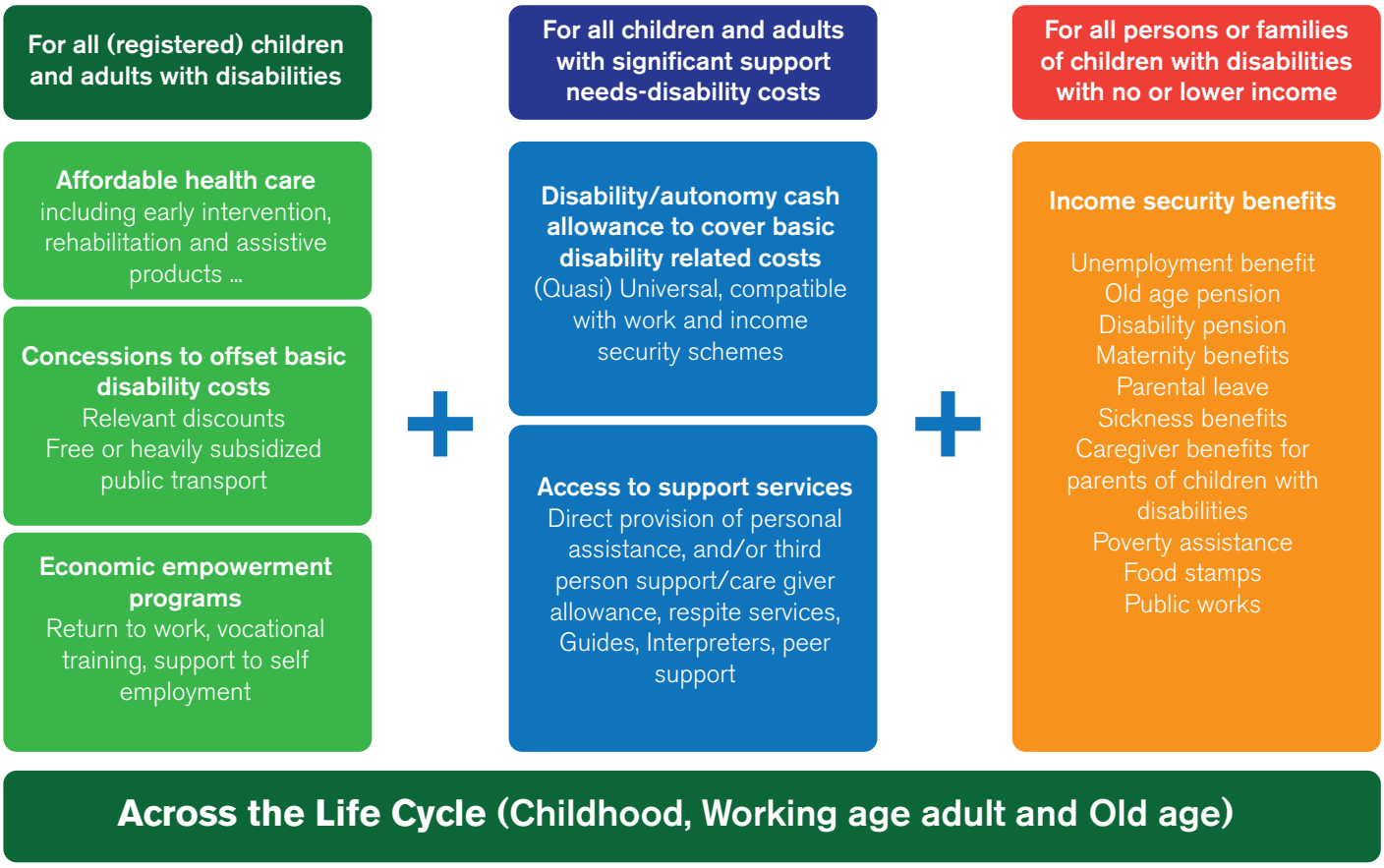
Building universal and inclusive social protection systems requires making the most all instruments available. Cash benefits can replace or supplement income and help offset disability-related costs. Concessions and community services, like support services and subsidies, can reduce out-of-pocket expenses. Social health protection mitigates financial barriers and risk of poverty due to health expenses. Disability and needs assessment and case management mechanisms, and linkages to education and economic empowerment programs are critical for targeted support and inclusion. The mix of these components will vary per country, based on the maturity of the social protection system, availability of goods and services, fiscal space, and institutional capacity.

The table below sets out examples of different social protection schemes in terms of the category of social protection instruments that can be combined, the functions they mostly support, and how they relate to the lifecycle.

<table>
<tr><th rowspan="2">CATEGORIES OF INSTRUMENTS</th><th colspan="3">EXAMPLES OF TYPES SCHEMES ACROSS THE LIFE CYCLE</th><th rowspan="2">MAIN FUNCTION</th></tr>
<tr><th>CHILDHOOD</th><th>WORKING AGE</th><th>OLD AGE</th></tr>
<tr><td rowspan="5">CASH BENEFITS</td><td colspan="3">Poverty assistance cash transfer, cach for work</td><td rowspan="3">INCOME SECURITY</td></tr>
<tr><td>Child grant/family benefits</td><td>Unemployment, maternity, sickness, parental leave benefits</td><td rowspan="2">Old age pensions</td></tr>
<tr><td>Care giver benefits</td><td>Disability related income replacement benefits</td></tr>
<tr><td rowspan="2">Child disability benefits</td><td colspan="2">Disability costs basic allowance/top up schemes</td><td rowspan="3">COVERAGE OF HEALTH-CARE AND DISABILITY RELATED COSTS</td></tr>
<tr><td colspan="2">Third person support / caregiver benefits</td></tr>
<tr><td rowspan="2">IN KIND BENEFITS</td><td colspan="3">Concessions
Health insurarce/cost coverage including early intervention, rehabilitation, assistive technology, tree or discounted public transport, subsidised utilities, tax exemptions, food distribution</td></tr>
<tr><td colspan="3">Services
Health care, case management
Community care and support, social housing, personal assistance, interpreters, counselling, point to point trarsport, respite care</td></tr>
<tr><td>INTERLINKAGE</td><td>Early childhood development child care, education</td><td colspan="2">Economic inclusion/ empowerment programmes, decent work programmes, return to work programmes, women's empowerment, protection services, financial inclusion services</td><td>CONNECTION TO OTHER SERVICES</td></tr>
</table>

Universal and inclusive support doesn't mean every person with disabilities receives all disability related benefits. All individuals with disabilities should have access to affordable healthcare, housing, assistive technology, rehabilitation, meaningful concessions to offset disability-related costs, adequate education, economic inclusion, and necessary human assistance. However, in line with progressive realisation, those most in need should receive further support first. A CRPD-compliant approach requires factoring the extent and type of support needed for independent living and community inclusion. While means testing is often a first option for targeting benefits, its use for disability related support should be carefully considered due to compounded risk of exclusion errors and limited consideration for disability-related costs. A prioritization based on age and level of support needs and disability related costs might be more effective and equitable.

The Figure below proposes an initial distribution of social protection benefits and services according to the level of need of different groups of persons with disabilities. To enable such a distribution, it is critical that disability assessment and determination mechanisms meaningfully take support needs into consideration.



To make the most of all social protection instruments – and identify different starting points and pathways to extending social protection, research is required to identify the diversity of disability-related costs across different socio-demographic groups, genders, and settings to inform the scope of support required and what can be covered by cash transfer and what require subsidies or direct support services.

Contributory and tax-financed cash transfers

Extending cash transfers in low- and middle-income countries to support persons with disabilities requires a flexible approach, recognising their diverse needs. Cash transfers are critical for income security and addressing disability-related costs. However, low coverage and inadequate benefit levels often limit their effectiveness. A shift from a 'one-size-fits-all' approach is necessary, moving from disability being equated to an incapacity to work towards recognising individual needs, abilities and barriers.

Ensuring inclusive access to a broad package of schemes, including disability benefits, child benefits, maternity benefits, sick leave, old-age pensions, employment injury benefits, and unemployment insurance, can ensure universal coverage and adequate benefits.

Contributory schemes should extend beyond public sector workers to include self-employed workers, private sector employees, and leveraged to foster formalization of those in the informal economy. Innovations such as pension credits or contribution catch-up programmes can accommodate career breaks, thereby also addressing gender gaps. Additionally, contributory schemes should be comprehensive, including maternity protection, paternity leave, and family sick leave which can be particularly relevant for parents of children with disabilities among others.

However, given the limited reach of contributory disability benefits, countries should complement efforts to facilitate formalization with non-contributory mainstream and disability-specific benefits addressing income security and disability-related extra costs.

Persons with disabilities and their families should have access to mainstream social assistance programs. Where household poverty targeted schemes are in place, certain design features can be introduced so that schemes better address income security of household members with disabilities. This includes:

- Adjusting eligibility criteria to higher thresholds for persons with disabilities to account for their greater consumption needs,
- Increasing benefit levels for households with persons with disabilities as their capacities to generate additional income is reduced and to compensate for higher expenditures,
- Excluding benefits that address disability related costs benefits when assessing household income status,
- Providing top-ups to incentivize increased investments in education and health services for boys and girls with disabilities, for example by designing soft conditionalities such as labelling and messaging to encourage school enrolment and attendance in particular of girls with disabilities,
- For working adults and older persons with disabilities, make them individual rather than household benefits.

To cover basic disability-related costs, countries should seek to introduce (quasi) universal disability-specific cash benefit which are compatible with work and with other benefits providing income security.

In countries where no mainstream non-contributory income security schemes exist (e.g., household poverty assistance, old age social pension), a starting point can be to introduce a sole hybrid disability benefit which are provided to persons with disabilities regardless of their employment status. For people out of work, it provides basic income security and for those in work it covers part if disability related costs. While not ideal, it is a first step towards flexible support needed to facilitate socio economic inclusion and empowerment.

Non-contributory disability support programmes should be designed to limit exclusion errors by moving away from a narrow poverty-targeting of disability benefits, towards higher-coverage schemes. While shifting to universal benefits is more aligned with the rights-based approach it may not be politically feasibility. An alternative to poverty-targeting in the short term may be focusing schemes on children and those with more severe disabilities, possibly combined with affluence or benefit testing.

Concessions

Concessions and discounts can ease the financial burden of persons with disabilities by reducing or offsetting disability related costs. Most high-income countries, and countries like Nepal, India, Vietnam, Philippines, Georgia, Kenya, and South Africa provide concessions as part of their social protection systems, complementing cash transfers. Concessions can be effective for all but especially for those not eligible for other schemes. These can include tax exemptions, discounts, fee waivers, and subsidies.

However, concessions may disproportionately benefit those with formal employment or higher incomes. Rural and marginalized persons with disabilities often struggle to access concessions, due to limited service availability, informal employment or restrictive social norms. Designing effective concessions requires understanding the diverse needs of persons with disabilities based on their employment status, functional limitations, and residence.

Concessions can take various forms, including:

- Income taxation exemptions or reduced rates, increasing disposable income to cover disability-related costs.
- Sales tax exemptions and import duty exemption on disability-specific items, reducing prices for these goods.
- Discounts and fee waivers on healthcare, transportation, utilities, education, training, livelihoods, and arts and leisure. However, these require the services to be available, accessible, and safe, especially for women, girls, and those living in remote areas.

Some concession while useful for many, might be irrelevant for others such as public transport systems that may not be accessible, or discount on goods provided by providers in the formal economy (due tax related compensation with government) more present in urban setting than rural settings.

Concessions should be progressive, meaningful, and preferably target the first dollar spent or earned. However, few countries have adopted consistent, evidence-based strategies when designing and implementing concessions. Having good insights on the extent and structure of disability related costs can help government design effective concessions.

[1] Poverty targeted schemes can not only be poverty assistance schemes, but also categorical schemes that include means-testing, such as child benefits or old age pensions that target households below a poverty threshold.

Community care and support services

Community care and support services, encompassing various forms such as human assistance, assistive technology, transportation, housing, and more, are essential for persons with disabilities. The requirements for these services are specific to each individual's circumstances and needs. Combined with cash transfers, these services can facilitate independent living in the community, contributing to social participation and dignified living.

The absence of adequate formal and publicly funded community support services, particularly in low and middle-income countries, creates financial strains on households, foregone opportunities, low choice and autonomy of persons with disabilities, overreliance on unpaid assistance from family members which may lead to burn-out of care givers, and even neglect, abuse, abandonment, and institutionalisation. This gap in support services carries significant gender implications, as girls and women most often provide the unpaid support.

Challenges limiting access to community support services include a lack of awareness about their importance, lack of data on diverse needs for support services, low investments in these services, shortages of service providers and trained workforce, and existing services being fragmented, unsustainable, and of low quality. These challenges are particularly acute in rural areas.
While development and expansion of publicly funded community care and support services require cross sectoral coordination, social protection systems and reforms can support by:

- Fostering change in legal and policy framework, integrating community support services in addition to cash in basic benefit packages,
- Supporting awareness-building and collecting comprehensive data on support needs
- Including basic assessment of support needs in Disability identification and determination mechanisms to enable case management
- Mobilising community resources, using social protection regulatory frameworks facilitating public-private-non-profit partnerships and encouraging involvement of disability and community-based organisations and volunteers
- Addressing workforce shortages, especially social services workforce and innovating on the profile and training of available community workers.
- Using public employment/works programmes compensate community care and support work, while considering gender equality and quality of support issues.

Coverage of health care costs

Persons with disabilities and the elderly often face increased healthcare needs and barriers to access health care, leading to greater associated costs. They frequently require access to both general and specialist health services due to underlying conditions and specific impairments.

Access to healthcare is often hindered by physical and informational inaccessibility, discrimination, and lack of specialised care. Women and girls with disabilities face additional prejudices, particularly in seeking sexual and reproductive health care. The quality of care received may be compromised, necessitating travel to major cities or even abroad.

Health care related costs for persons with disabilities and their families include;

- Direct medical costs for general and specialist health services, assistive devices, and long-term care;
- Direct non-medical costs like transportation and personal assistance;
- Indirect costs like loss of income of person themselves and their accompanying family members especially when frequent medical visit are required.

Consequently, they report poorer health status, face increased barriers to care, and are more likely to encounter catastrophic health expenditures. Social protection systems can alleviate these financial barriers, thus enhancing healthcare access.

Given that persons with disabilities often have higher healthcare needs and face barriers such as poverty and limited labour market access, prioritising them in the extension of universal health coverage is essential. This could mean extending subsidized social health insurance to them, and even waiving means test requirements for this group. If coverage is expanded progressively via a tax-financed approach, persons with disabilities should be considered a priority.

For persons with disabilities, the burden of healthcare co-payments should be reduced or eliminated, given their higher usage of health services and the potentially higher cost of these services. Furthermore, addressing direct non-medical costs (like transport or personal assistance) and indirect costs (like lost income while seeking care) is also essential. This could be managed through concessions, community support services, cash benefits, income security measures, and benefits addressing opportunity costs.

In any case, the inclusion of disability-related services, such as assistive devices and rehabilitation, in guaranteed benefit packages is critical. Outreach, simplified application processes, and physical access must be improved. Importantly, persons with disabilities should be actively engaged in the development, implementation, and monitoring of social health protection systems to ensure these are responsive to their needs.

Identification, assessment and certification of persons with disabilities and their needs for social protection purpose

Universal and inclusive social protection systems could theoretically offer tailored support to diverse members of society without labelling them as poor, old, or disabled, by assessing individual vulnerabilities and needs at life stages. Such a system, although ideal, has yet to be developed due to historical policies, technical and financing challenges, and the politics of resource allocation and social protection reforms.

While the Convention on the Rights of Persons with Disabilities (CRPD) doesn't necessitate identifying specifically persons with disabilities for inclusive mainstream services, provision of individual disability related support requires states to develop mechanism to identify those requiring such disability-related assistance.

In all countries that have fairly mature social protection systems, while access to mainstream social protection schemes such as poverty assistance, old age pension, health insurance, public housing might not require identification of persons with disabilities (assuming that they are made accessible), providing disability specific support (cash transfer for income replacement and/or disability related costs, costly assistive devices, personal assistance, among others) require such identification to ensure that programmes reach those for whom they are designed.

Disability assessment and determination mechanisms potentially serve a three-fold purpose:

- Identifying children, working age adults and older persons (and their support need) who may require and want disability-related support to live independently,
- Enabling targeting, prioritization and access to available programs providing such support, and
- Providing data to design, plan, and cost required services to respond to unmet support needs

An important caveat is that disability assessment and determination mechanisms cannot be used to estimate how many people experience disability within the total population. Indeed, many people who may experiencing functional limitation and disability related participation restriction may not self-identify as persons with disabilities in the first place and would not seek disability status. However, Disability registry can provide data contributing to such endeavor, but they will only provide information about people who access the system.

Issues with disability assessment often arise, including lack of accessibility, costs, complexity, or the lack of qualified assessors. Disability assessment often focuses on medical conditions and impairments, rarely considering the diverse support that people need, which can limit access to benefits, especially in low- and middle-income countries.

Reforming or developing disability assessment and determination procedures is a complex task involving multiple stakeholders. Persons with disabilities require clear, accessible and predictable processes, while governments seek cost-effective, legally robust systems with minimal fraud potential. Reform is often seen as a risk by those with disabilities due to possible service limitations.

The CRPD committee recommends a disability determination process based on universal access, focus on support requirements and barriers, and meaningful participation of individuals with disabilities. However, while high-income countries have well-established mechanisms, they may fall short of these standards, and face legal claims or controversy. Low and middle-income countries, while increasing social protection, face resource and administrative capacity challenges.

Therefore, stakeholders are working towards solving an equation combining accessibility, comprehensiveness and reliability in disability assessment and determination procedures:

- Accessibility involves ease, transparency, and minimal burden in application so that the procedure is available, free and accessible to all everywhere in the country
- Comprehensiveness requires inclusion of all disabilities, assessment of individual limitations and support needs, age and gender sensitivity, and respect for privacy
- Reliability entails transparent evaluation procedures, standardized processes, trained staff, grievance mechanisms, fraud minimization, and involvement of organizations of persons with disabilities.

To solve the equation of CRPD compliant disability assessment and determination mechanisms, there is no one-size fits all approach and governments should develop processes, mechanisms and tools that:

- Are tailored to be used and managed effectively by the most relevant staff available at local level across the country so that all persons with disabilities are in position to access the mechanisms,
- Are easily accessible, understandable and manageable by all persons with disabilities and parents of children with disabilities, considering social norms around gender and disability.
- Can capture to the best extent possible evidence of impairment and/or type and level of functional limitations, support requirements, barriers, and level of participation
- Have effective and adapted quality control, fraud prevention and safeguard mechanisms which do not complexify and make the process cumbersome while ensuring consistent outcomes.

Disability assessment information has traditionally been used primarily for determining disability status, but advancements in management information systems in sectors like health, education, and social protection have opened new avenues for its usage. A rising number of nations, such as India, Senegal, Djibouti, or Cambodia, have adopted a national disability registry linked to a disability/equal opportunity card, providing official proof of disability across government services.

These digital registries have started evolving into Disability Management Information Systems (DMIS), offering several benefits:

- Digitization allows community worker to carry out computer assisted assessment more comprehensive than they woud with paper-based tools and provides possibilities for fast verification validation and oversight
- When linked to single-window assessment systems, DMIS can reduce administrative burdens on disabled individuals and their families, preventing repeated assessments and reducing administrative costs.
- They facilitate case management and access to diverse social protection benefits like cash benefits, healthcare, assistive devices, support and concessions. If skills and occupation information is included, they can aid job placements.
- DMIS make social protection systems more shock responsive, supporting expansion of existing disability benefits, and help create new ones during crises, as seen during the COVID-19 pandemic.
- Aggregated data from DMIS can help priorities, plan, and cost service and scheme extensions or development at local and national levels based on assessed needs, especailly when combined with national statistical data.

Several low and middle-income countries have invested in developing such registries and information management systems. Cambodia's DMIS has been used to improve cash transfer targeting and prioritise registered disabled people for COVID-19 vaccines. Senegal used their registry for its equal opportunity card to ensure registered disabled people had access to COVID-19 related relief. India is building a National Database, issuing a Unique Disability Identity Card to facilitate access to various government schemes. Rwanda is piloting a national DMIS based on individual disability assessments capturing support needs. Togo has embarked on a digitization drive to register all persons with disabilities.

Digitization increases accessibility comprehensiveness and reliability. However, data privacy and protection must be considered, given the broad scope of individual information collected.

Data for inclusive social protection

High-quality data is crucial in the design, monitoring, and evaluation of social protection policies and programs, especially for disability-inclusive social protection. Unfortunately, data collection often falls short in supporting disability-inclusive efforts, hindering the development and adjustment of effective schemes for persons with disabilities.

To strengthen the collection of relevant disability data, attention should be paid to national surveys, social protection administrative data, and other pertinent methods to provide data on disability prevalence and demographic patterns, inequalities as per disability status, environmental barriers that foster exclusion, and the extent of met and unmet support needs of disabled individuals and estimate the economic impact of disability-related expenditures. In all those efforts safeguarding the confidentiality of private information, particularly sensitive medical and personal data, is paramount in data collection and processing.

To enhance national censuses and surveys, internationally comparable questions on disability status such as the Washington Group set(s) should be used. While this would allow for disability disaggregation, there is also a need to consider specific modules or even surveys, to collect data on the diversity of disability-related barriers and support needs across the life cycle and for women and girls with disabilities.

Administrative data is also essential for assessing the inclusivity of social protection policies for persons with disabilities. This data typically includes recipient demographics and, for more complex schemes, detailed information about income, assets, and household composition. Such data can be compared with demographic information to estimate coverage and identify issues of accessibility, like low coverage in a certain group or geographical location. When used with survey data, administrative data can provide a comprehensive understanding of the situation and needs of disabled individuals. To strengthen administrative data, it's crucial to collect information on disability status and support needs. For disability-specific schemes, this involves confirming disability status as part of eligibility determination, ideally by using functional limitations questions as a reference. Mainstream schemes should include questions on disability to assess inclusivity and allow inclsuive targeting. In addition, data on support needs should be collected to ensure appropriate support delivery or referral.

National surveys and administrative data can be enhanced with qualitative research, impact evaluations, Knowledge, Attitudes, and Practices (KAP) surveys, and Goods and Services Required (GSR) methods to promote inclusive social. Qualitative research provides insights into attitudinal, institutional, and structural barriers that create exclusion, aiding in policy design. Impact evaluations measure the effect of social protection schemes. KAP surveys shed light on attitudes towards persons with disabilities, influencing policy development. Lastly, GSR methods assess the costs of goods and services required for equal participation or disability-related extra costs, thus informing the design of social protection measures.

Meaningful participation of persons with disabilities

Engaging meaningfully with Organizations of Persons with Disabilities (OPDs) is pivotal for designing, monitoring, and evaluating inclusive social protection policies and programs. Despite historical misunderstandings and unease within the disability movement about social protection, perceived as perpetuating the charity and medical models, shifts in perception are occurring. The impact of the 2008 financial crisis and the COVID-19 pandemic, both of which underscored the critical importance of robust social protection systems, has led to growing awareness about the necessity of such measures for persons with disabilities.

OPDs play three key roles in inclusive social protection systems. First, they offer unique perspectives based on lived experiences, filling data gaps, and providing context. They can highlight the barriers faced by marginalized groups that are often overlooked in national data. Second, they contribute to inclusive design and delivery, raising awareness about disability inclusion among social protection teams in national governments and international agencies. Third, they build ownership, fostering the commitment and advocacy required for sustained and effective reforms. Engagement with OPDs should therefore be extended to the design and implementation phases of social protection policies and programmes.

Mutual capacity building and creating a space for meaningful consultation are equally important. Given that social protection is an emerging field of advocacy for many OPDs, there may be limited understanding of social protection policies. Conversely, social protection professionals might lack understanding of disability rights and inclusion. Therefore, investing in mutual capacity development is necessary to enable meaningful participation in inclusive spaces. The "we want jobs, not charity" motto prevalent within part of the disability movement underscores the need for social protection professionals to adopt a human rights-based, inclusion-focused approach.

To meaningfully engage with OPDs, considerations should be given to accessibility of venues, information, and communication, diversity of persons with disabilities, including women with disabilities and under-represented groups, and the capacity and resources required for engagement.

Different consultation and engagement mechanisms can be used depending on the purpose of engagement, such as advisory or steering committees at the program level, or national disability coordination mechanisms for policy or national reforms. Despite these mechanisms not being perceived as effective by some OPDs, it is essential to leverage them to increase their relevance and capacity.

Accessibility of social protection delivery mechanisms

People with disabilities often face significant barriers in accessing social protection schemes and cash transfer programs. While barriers related to distance to administration and payment points, financial illiteracy or complex administrative processes impact a lot of groups, they are magnified for persons with disabilities.

These barriers stem from a combination of physical, information and communication, and attitudinal factors. For example, they might have to travel long distances or navigate difficult terrains to access enrolment or payment centres, or face difficulties in accessing information in suitable formats. Discriminatory attitudes and lack of engagement from staff involved in the schemes further compound these issues. Additionally, persons with disabilities may face additional costs such as transportation or assistance-related expenses. These obstacles can be present even before enrolment, for instance, as obtaining necessary ID cards may prove challenging.

Accessibility plays a crucial role in the successful implementation of cash transfer schemes and more broadly social protection system. Often, individuals with disabilities are overlooked due to staff unawareness, lack of inclusive regulations and data visibility. To rectify this, accessibility and inclsuive design needs to be integrated into various operational areas of social protection programs including training and data disaggregation, standard setting, administrative processes, and organisational systems and management arrangements.

Awareness training and data disaggregation involve providing disability awareness and gender equality training to staff, thus equipping them with the skills to develop inclusive delivery mechanisms. Additionally, data utilized for design, monitoring, and evaluation should allow for disability disaggregation, helping anticipate potential barriers for those with disabilities.

Minimum standards for operations should be developed with persons with disabilities and their representative organizations. These standards, including accessibility requirements, should be published in accessible formats and incorporated in contracts with private sector contractors. The schemes should also publish annual reports on their compliance with these standards.

Administrative processes involve several steps to ensure accessibility. Communications should be accessible, with staff trained to interact effectively with persons with disabilities. Registration and enrolment processes should be streamlined, considering the mobility and communication limitations of the disabled. Cash withdrawal mechanisms should be electronic and flexible, accounting for the diverse needs of persons with disabilities. Changes in the circumstances of beneficiaries should be easy to report, with options that minimize travel. Conditions and sanctions should be managed sensitively, ensuring accessibility in facilities associated with social protection schemes. Grievances and redress should be available through multiple channels, adapted to accommodate different types of impairments and communication forms.

Organisational systems and management arrangements must include suitable institutional and human resource arrangements, with a specialist disability unit within the implementing ministry or agency. Training on disability inclusion should be provided to all staff, and recruitment processes should be open to employing persons with disabilities. Operations manuals should provide comprehensive guidance on ensuring accessibility. Management Information Systems should allow the identification of persons with disabilities and their accessibility requirements. Payment systems and financial management systems should be adapted to promote access and autonomy and to track spending related to accessibility. Social accountability mechanisms and monitoring and reporting mechanisms should incorporate key indicators on accessibility and disability inclusion.

Evaluations of cash transfer schemes should review the accessibility experiences of persons with disabilities at each mechanism of the cash transfer process. This includes incorporating the Washington Group Short Set of Questions in all quantitative evaluations and national household surveys. Moreover, qualitative surveys should ensure the inclusion of persons with disabilities. Specific evaluations of national disability-specific and old age pension schemes are needed to expand knowledge on the access and impact of such cash transfer schemes.

Financing inclusive social protection

Financing inclusive social protection schemes for persons with disabilities is context-specific, with a strong link to the broader economic, fiscal, and political conditions of a country.

Understanding current spending levels and distribution can inform if allocations are adequate relative to the needs of persons with disabilities. Challenges include identifying what is “disability-related”, discerning what constitutes “social protection”, and distinguishing between different types of schemes.

Internationally-recognised statistical frameworks like the OECD Social Expenditure Database (SOCX), European System of Integrated Social PROtection Statistics (ESSPROS), and the Classification of the Functions of Government (COFOG) can help in classifying disability-related social protection expenditure. They allow the identification of disability-specific expenditure and disaggregation by benefits in cash and kind, and between different benefits. These classification systems have comprehensive documentation and guidance on how benefits should be classified.

However, these classifications don't perfectly correspond to all benefits within inclusive social protection for persons with disabilities. A way to address this would be developing a framework to collect data on a broader range of disability-related expenditures. The System of Health Accounts, developed by the OECD, Eurostat, and the WHO, is another useful framework, as it can identify some key types of disability-related expenditures, such as long-term care.

Data on disability-specific social protection expenditure is generally weak in low- and middle-income countries. Often, the information is not available or hard to find in budget documents and statistical reports. To improve this, national governments should report all disability-related social protection expenditures, and organizations representing persons with disabilities (OPDs) could play a greater role in budget monitoring. Such monitoring provides a platform for OPDs to engage with governments on social protection policy and hold them accountable for their spending commitments.

Costing proposed disability-related social protection schemes is another critical step. Costing requires defining the parameters of different schemes, such as eligibility, benefit level, administrative costs for cash benefits, and complex factors for in-kind benefits, such as price of goods, wages, uptake, etc. These costs can then be tested under different scenarios to understand how adjustments affect total costs. However, existing costing models focus mostly on cash transfers and are limited in scope, necessitating the development of more comprehensive models.

Social protection reforms, particularly disability-related expenditures, can be implemented and financed through various tools and strategies. The process begins with understanding a country's fiscal context, where social protection financing often involves identifying "fiscal space". Fiscal space refers to the budgetary room a government has to allocate resources without harming financial stability or economic growth. This usually involves analyzing revenue sources, debt sustainability, and expenditure allocation in the national budget.

The feasibility of such reforms relies on a comprehensive assessment of the fiscal context using sources like budget documents, IMF consultation documents, Public Expenditure Reviews, and analyses by various institutions. However, the fiscal context also involves predicting changes in revenues, expenditure, and debt in the short, medium, and long term, and how these might affect the potential for social protection investment.

Given that establishing an inclusive social protection system is likely to be a gradual process, it's important to consider long-term investment plans. Gradual expansion may occur organically or be integrated into strategic budgeting plans to create a forward-looking vision. Expansion typically occurs through adjusting scheme parameters, such as eligibility criteria and benefit levels. This might involve initial targeting of specific groups, followed by subsequent expansion, or starting with a lower benefit level and increasing it over time. This gradual, strategic approach allows for manageable, sustainable growth in social protection benefits.

Conclusion

Recent years have seen a growing emphasis on universal social protection, with particular attention on inclusive, shock-responsive systems. This shift is driven by data showing that persons with disabilities face higher risks and barriers which hinder their socio-economic resilience, despite having higher needs for social protection systems. As low- and middle-income nations build or expand their social protection systems, there is an urgent need to prioritize persons with disabilities while ensuring conformity with the Convention on the Rights of Persons with Disabilities.

To develop inclusive social protection, certain key elements are essential. Systems should provide income security and cover healthcare and disability-related costs to improve access to services and promote full participation. These systems should combine cash and in-kind benefits, contributory and non-contributory schemes, and inclusive mainstream and disability-specific schemes.

The guidance note outlines practical steps to make social protection systems more inclusive, including:

1. Collecting and analyzing data on the diverse situations of persons with disabilities.
2. Encouraging meaningful participation of people with disabilities and investing in capacity building.
3. Establishing legal frameworks that foster inclusive social protection system development and cross-sectoral interlinkages.
4. Developing disability registries and inclusive management information systems to inform eligibility, facilitate case management, and enable expansion during shocks.
5. Improving income security by considering persistent barriers and disability-related costs with flexible combination of mainstream and disability benefits
6. Prioritizing people with disabilities in Universal Health coverage policies and develop inclusive package with rehabilitation and AT
7. Mobilizing social protection instruments to progressively provide universal support to address disability-related costs.
8. Increasing accessibility across the delivery chain of social protection schemes.

While the guidance refers to several country examples, there are promising ongoing development across regions that will provide in the coming years more elements on conditions, innovation and steps required to build inclusive social protection programs and systems. It will therefore be a living document with a formal update planned in 2025.

Sources

World Health Organization, 2010, CBR Guidelines, Geneva
Padmani Mendis, 2012, Understanding Disability: Background Note Zambia
Padmani Mendis, 2012, Human Rights and Human Needs -an introduction to the CRPD: Background Note, Zambia
CBM International, 2014, The Future is Inclusive, How to Make International Development Disability-Inclusive, Series on Disability-Inclusive (www.cbm.org/didseries1_The_Future_is_Inclusive_pdf)
http://www2.le.ac.uk/offices/accessability/staff/accessabilitytutors/information-for-accessability-tutors/the-social-and-medical-model-of-disability
https://www.disabilityinfo.org/mnip/db/fsl/FactSheet.aspx?id=77
http://sudcc.syr.edu/LanguageGuide/index.html
http://www.feministe.us/blog/archives/2010/06/18/disability-terminology-a-starter-kit-for-nondisabled-people-and-the-media/
http://www.ohchr.org/EN/Issues/Disability/Pages/DisabilityIndex.aspx
https://www.add.org.uk/why-disability/facts-about-disability/dangerous-myths-about-disability
WHO/UNICEF, Early Childhood Development and Disability: A discussion paper
http://www.asksource.info/topics/social-inclusion/gender-and-disability
http://blog.handicap-international.org/influenceandethics/wp-content/uploads/sites/4/2015/12/BP_gender_WEB.pdf
National Youth Leadership Network factsheet
http://www.continuetolearn.uiowa.edu/nas1/07c187/Module%201/module_1_p6.html
http://www.scope.org.uk/Scope/media/Images/Publication%20Directory/Current-attitudes-towards-disabled-people.pdf
http://www.washingtongroup-disability.com/wp-content/uploads/2016/01/Rationale_WG_Short-1.pdf
http://apps.who.int/iris/bitstream/10665/41003/1/9241541261_eng.pdf
https://www.google.com/

Unit 6

KEY INTERNATIONAL, REGIONAL AND NATIONAL LEGAL-POLICY FRAMEWORK ON DISABILITY

Training Materials:

- **Legal and policy frameworks,**
- **Projector**
- **Charts**

UNIT 6
KEY INTERNATIONAL, REGIONAL AND NATIONAL LEGAL-POLICY FRAMEWORK ON DISABILITY

6.0 Introduction

These are frameworks that influence legal and policy landscape of disability programming in Malawi. As player in global development, Malawi is a member of some these frameworks and some of such have a bearing on disability; some are disability tools and yet some not specifically disability instruments but have an implication on it.

6.1 Main Objective

To equip district personnel with legal and policy instruments that are promoting and protecting rights of Persons with disabilities.

6.2 Specific objective

- Identify key International regional and local human rights instruments applicable to disability;
- Describe the nature of disability rights and obligations provided for under these instruments
- Analyse the implications of these instruments on the human rights approach to disability
- Explain the various disability rights enforcement and monitoring mechanisms provided for under these instruments.

6.3 Resources/ materials:

- Legal and policy frameworks
- Projector
- Charts

HANDOUT NOTES

United Nations Convention on the Rights of Persons with Disabilities (UNCRPD)

It exists to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity. The Convention is the most progressive instruments influencing human rights programming of disability in recent times. Malawi signed and ratified it in 2007 and 2009 respectively hence national instruments are informed by the Convention.

African Charter on Human and Peoples' Rights

The African Charter on Human and Peoples' Rights (ACHPR- 1981). It has a number of rights that generally apply to all persons in Africa, including persons with disabilities. These rights include Family; Education; Culture; Health; Equality and non-discrimination; Religion; Freedom of Opinion, expression and access to information and group rights such as development, self-determination and peace. The African Commission on Human and Peoples' Rights confirmed in ***Purohit and Another v The Gambia*** that persons with disabilities are entitled to enjoy the Charter's rights without discrimination. The Charter also contains a specific provision on the rights of persons with disabilities that guarantees the right to special measures of protection (article 18(4)). In terms of the provision, the special measures of protection taken for persons with disabilities must be designed to respond to their needs (moral and physical).

Protocol to the African Charter on Human and Peoples' Rights on the Rights of Persons with Disabilities in Africa

The Protocol aims to promote and protect the rights of persons with disabilities. It obligates States Parties to put in place measures such as policies, pieces of legislation, and budgets for persons with disabilities to enjoy all human rights on an equal basis with others. The Protocol requires countries to respect the differences and accept disability as part of human diversity and humanity.

The protocol was adopted on 30 January 2018 by the African Union Heads of States as the Disability Protocol to the African Charter on Human and People's Rights (Banjul Charter). Malawi signed the protocol on 6th February 2022 and ratified it on 6th December 2023 in cementing commitment to promote and protect the rights of persons with disabilities in the country.

The protocol details the particular rights of persons with disabilities as follows: life, liberty, security of person, to be free from harmful practices, to protection in situations of risk, to equal recognition before the law, access to justice, to live in the community, accessibility, education, health, rehabilitation and habilitation, work, an adequate standard of living and social protection, participation in political and public life, self-representation, freedom of expression and opinion, participation in recreation and culture, and family (Articles 4-21).

Additionally, the protocol extends rights to family and caregivers of persons with disabilities who might otherwise be subject to discrimination as a result of their association. Besides, the protocol specifically requires States to take necessary steps to promote equality and to provide reasonable accommodations. These affirmative steps and special measures are not to be considered discrimination (Article 5).

The protocol recognizes the specific protection needs of persons with disabilities in periods of armed conflict or other humanitarian situations, as well (Article 12).

It also recognizes the particular vulnerabilities and rights of women and girls, children, youth, and older persons with disabilities (Articles 27-30).

African Women's Protocol

The African Women's Protocol (AWP-2003) is a Protocol to the ACHPR explained above. . The Protocol contains rights that generally apply to all women and girls in Africa, including those with disabilities. These rights include education; employment; equality and non-discrimination; health; religion; sexual and reproductive health; and freedom from harmful practices. The African Women's Protocol further has a specific provision on the rights of girls and women with disabilities (Article 23. The article guarantees women and girls with disabilities the following rights:

i. Right to be treated with dignity;
ii. The right to be provided with specific measures which take into account their physical, economic and social needs), that are aimed at facilitating their access to enjoy substantive rights, services or facilities such as vocational training; and
iii. The right to freedom from disability based discrimination. It is noteworthy that the article expressly recognises disability as a prohibited ground of discrimination

The African Charter on the Rights and Welfare of the Child, 1990

The African Charter on the Rights and Welfare of the Child (ACRWC-1990) provides for the rights of children with disabilities in two aspects: by containing specific provisions on the rights of children with disabilities; and by providing for other rights that generally apply to all children in Africa, including children with disabilities. The Charter makes specific provision for the rights of children with disabilities in article 13 in three separate paragraphs. The provisions make reference to the following:

i. Recognition of the right to inclusion and active participation in society by requiring states to ensure special measures of protection that respond to the physical and moral needs of a child with a disability and under conditions which ensure his or her dignity, promote his self-reliance and active participation in the community;
ii. Obligation to provide assistance to the child and those responsible for his or her care, which must be appropriate to the child's condition and must ensure that the child has effective access to training, preparation for employment and recreation opportunities in a manner conducive to the child achieving the fullest possible social integration, individual development and his cultural and moral;
iii. Obligation to achieving progressively the right to movement and to seek access to public highway buildings and other places.

The implication of this provision is that duty bearers at all levels must ensure that children with disabilities are able to live, participate and be included in the society. In addition, authorities must make provision for specific initiatives that empower children with disabilities have access to services.

African Youth Charter

The African Youth Charter (AYC-2006). It has a specific provision on the rights of youth with disabilities (Article 24), that, amongst others, requires states to do the following:

i. Take special measures aimed at protecting the rights of youth with disabilities;
ii. Ensure that youth with disabilities have equal and effective access to the enjoyment of other rights; and
iii. Eliminate obstacles that prevent the inclusion and participation of youth with disabilities in society.

African Charter on Democracy, Elections and Governance

The African Charter on Democracy, Elections and Governance (ACDEG-2007).
It has an anti-discrimination provision which imposes an obligation on the state to eliminate all forms of discrimination (Article 8). The Charter's articles 8 and 43, among others, require state parties to take measures that guarantee the rights of persons with disabilities and other marginalised and vulnerable groups'.

Convention for the Protection and Assistance of Internally Displaced Persons

The Convention for the Protection and Assistance of Internally Displaced Persons (CPAIDP-2009). It has a provision that obliges states parties to provide special protection for and assistance to internally displaced 'persons with special needs', who include separated and unaccompanied children and persons with disabilities (article 9(2) (c)).

World Programme of Action Concerning Disabled Persons (WPACDP) and Standard Rules

The World Programme of Action Concerning Disabled Persons and the Standard Rules on the Equalisation of Opportunities for Persons with Disabilities have both emphasis on prevention of disability, rehabilitation, and equalisation of opportunities. The two instruments set out various rights of persons with disabilities such as education, employment, and health. However, the Standard Rules further brings in issues that are key in promoting disability rights, which the WPA left out namely accessibility and information and research.

Sustainable Development Goals

The Sustainable Development Goals (SDGs) are officially known as 'transforming our world: The 2030 Agenda for Sustainable Development'. They comprise 17 goals; 169 targets and approximately 241 indicators with a common agenda of "Leaving no one behind". The 17th goal addresses means of implementation such as finance, trade, technology, capacity building, partnerships and data. There are 5 goals that expressly include disability in their indicators and targets by virtue of their wording, focus and conceptualization. Since the SDGs entail that no one must be left behind or excluded, then all the 17 Goals are universal and apply to persons with disabilities. States are therefore called upon to include persons with disabilities as they pursue country specific development agenda.

The Goals that are directly targeting disability are; Goal No. 1 is on eradication of poverty. It calls upon the implementation of appropriate national social protection systems and measures targeting, among other groups, persons with disabilities. It is significant in the disability field since as highlighted above, disability and poverty form a viscous cycle. Secondly, Goal No 4 is on quality education and it speaks into the need to ensure inclusive and equitable quality education and promote lifelong learning opportunities for all. This conceptualisation of inclusive education reflects the human rights approach to disability, as will be highlighted in the next Unit. Thirdly, Goal No 8 is on decent work and economic growth. It is particularly relevant as most persons with disabilities in Malawi do not have access to employment or opportunities to gain a living. The Goal speaks of the need to ensure full and productive employment and decent work for all women and men by the year 20130. It also highlights the need to promote higher levels of productivity and technological innovation in addition to encouraging entrepreneurship and job creation. Fourthly, Goal No 10 is on reducing inequalities. It is significant as discrimination perpetuates inequalities amongst persons with disabilities as compared to persons without disabilities. Lastly, Goal No 16 on Peace, Justice and Strong Institutions since it speaks into issues such as the need to promote peaceful and inclusive societies for sustainable development, and to provide access to justice for all and build effective, accountable and inclusive institutions at all levels. The goal is relevant since, amongst others, access to justice remains a challenge for persons with disabilities, including persons with albinism, who often face various forms of abuse, exploitation and violence. Yet the justice system and accountability institutions often do not provide them with adequate protection.

The SDGs take into account different national realities, capacities and levels of development and respect national policies and priorities. Accordingly, governments are expected to set their own national targets guided by the global level of ambition but taking into account national circumstances. It must be emphasized that the SDGs are also significant as they set the development agenda and as such disability must be mainstreamed.

Persons with Disabilities Act, 2024

An Act to provide for the promotion and protection of the fundamental rights and freedoms of persons with disabilities; obligations of duty bearers in the promotion and protection of rights of persons with disabilities; a simplified and cost-effective mechanism for redress in cases of a breach of the fundamental rights and freedoms of persons with disabilities; the establishment of the Council for Disability Affairs; the establishment of the Disability Trust Fund; the registration of persons with disabilities, institutions, associations and organizations implementing disability programmes; the repeal of the Handicapped Persons Act and the Disability Act

Unit 7

INTERNATIONAL AND NATIONAL POLICY AND LEGAL FRAMEWORKS ON AGEING

Training Materials:

- **Flip charts**
- **Markers**
- **Power point presentation**
- **Pens**
- **Writing pads**
- **Laptop**
- **LCD projector**
- **Printed handouts**

UNIT 7
INTERNATIONAL AND NATIONAL POLICY AND LEGAL FRAMEWORKS ON AGEING

7.0 Introduction

There are a number of legal frameworks protecting the rights of older people in Africa and beyond. In addition to international laws, governments have agreed to the 1991 UN Principles for Older Persons, which address the dignity, self-fulfillment, participation, independence and care of older people and encourage governments to include them in national programmes. This unit presents International and Regional instruments that relate to older persons and their implications for policy and practice.

7.1 The general outcome

By the end of this unit, participants will be able to understand and apply the International and regional Instruments on elderly in responding to and addressing various elderly issues in policy and practice.

7.2 Specific objective

At the end of the unit the participants will be able to:

- Identify the International and Regional human rights instruments that are applicable to the elderly;
- Identify strengths and weaknesses in these instruments in so far as the promotion and protection of elderly rights is concerned;
- Describe the nature of elderly rights and obligations provided for under these instruments;
- Define the concept of Elder Abuse;
- Explain the various forms of Elder Abuse.
- Identify risk factors for Elder Abuse;
- Explain strategies for dealing with Elder Abuse.

7.3 Training Materials:

- Flip charts
- Markers
- Power point presentation
- Pens
- Writing pads
- Laptop
- LCD projector
- Printed handouts.

ACTIVITY 1

Group / Plenary / Pair Work

11 Minutes

7.4 Session 1: International Instruments on Ageing

1. Participants sshould be given copies of the instruments a few days in advance and on the day, they should be asked the following 4 questions in plenary or in groups:
   a. Discuss any major similarities in the various instruments.
   b. Identify any 4 rights of older persons protected by the international Instruments.

Summary

Since 1948 there has been almost 20 declarations, principles, resolutions, plans of action and proclamations issued by the United Nations ("UN") and its instrumentalities relating to aging, and the UN has identified aging as being among the most important global issues of the 21st Century; however, progress has been slow on drafting and adopting a comprehensive universal legal instrument relating specifically to the human rights of older persons. Issues relating to older persons have been integrated into the generic international human rights framework and emerging regional human rights legal systems and it has been recognized that the special circumstances of older persons should be taken into consideration when developing social and economic policies.

INTERNATIONAL LEGAL FRAMEWORKS

Most international legislations and policies continue to address ageing from the perspective of welfare and social programs. They do not take a human rights-based approach that views older persons as equal rights holders and not only as beneficiaries of support and assistance. The elderly are not recognized explicitly under the international human rights laws that legally oblige governments to realise the rights of all people. Although, commitments to the rights of older people exist, such as with the Madrid International Plan of Action on Ageing (MIPAA), they are not legally binding and therefore only impose a moral obligation on governments to implement them.

Only a handful of international human rights mechanisms have devoted attention to older persons, or developed guidance and specific tools for Government and other stakeholders on the promotion and protection of the rights of older persons. Such instruments include; Madrid Plan of Action on Ageing, Universal Declaration of Human Rights, UN Principles on Ageing, International Covenant on Civil and Political Rights, International Covenant on Economic, Social and Cultural Rights, Covenant on the elimination of forms of discrimination against women, ILO Convention no. 102 concerning social security (minimum standards) and the International Convention on the Protection rights of Migrant Workers and the Members of their Families.

The lack of a comprehensive and integrated international legal instrument to promote and protect the rights and dignity of older persons continues to have significant practical implications in this respect.

UNVERSAL DECLARATION OF HUMAN RIGHTS

The Universal Declaration of Human Rights (UDHR) is a milestone document in the history of human rights. Drafted by representatives with different legal and cultural backgrounds from all regions of the world, it set out, for the first time, fundamental human rights to be universally protected. The UDHR in a general sense addresses the human rights of older persons as it promotes the universal respect for and observance of human rights and fundamental freedoms.

THE INTERNATIONAL PLAN OF ACTION ON AGEING

The Vienna International Plan of Action on Ageing is the first international instrument on ageing, guiding thinking and the formulation of policies and programmes on ageing. It was endorsed by the United Nations General Assembly in 1982 (resolution 37/51), having been adopted earlier the same year at the World Assembly on Ageing at Vienna, Austria. The plan of action is a comprehensive blueprint for addressing the opportunities and challenges of population ageing in the 21st century and for promoting the development of a society for all ages.

The plan was aimed at strengthening the capacities of Governments and civil society to deal effectively with the ageing of populations and to addressing the developmental potential and dependency needs of older persons. It promotes regional and international cooperation. It includes 62 recommendations for action addressing research, data collection and analysis, training and education as well as the following sectoral areas:

- Health and nutrition
- Protection of elderly consumers
- Housing and environment
- Family
- Social welfare
- Income security and employment
- Education

The Plan is part of an international framework of standards and strategies developed by the international community in recent decades.

UNITED NATIONS PRNCIPLES FOR OLDER PERSONS

The United Nations Principles for Older Persons were adopted by the UN General Assembly in 1991 and they aim at ensuring that priority attention is given to the situation of older persons. These principles are organized around the following themes: (1) independence, (2) participation, (3) care, (4) self-fulfillment and (5) dignity. These principles reflect the need for striking a balance between integrating older people into society while acknowledging their special needs

1. Independence: Older persons should have access to adequate food, water, shelter, clothing and health care through the provision of income, family and community support and self-help. Older persons should have the opportunity to work or to have access to other income-generating opportunities.
2. Participation: Older persons should remain integrated in society, participate actively in the formulation of policies that directly affect their well-being and share their knowledge and skills with younger generations.
3. Care: Older persons should be able to count on family, community and state support systems to provide the care they need to maintain their well-being and independence. Special attention should be given to those who are most vulnerable.
4. Self-Fulfillment: Older persons should be able to pursue opportunities for the full development of their potential. They should be free to seek ways of expressing their creativity and talents for the benefit of themselves and others.
5. Dignity: Older persons should be treated fairly regardless of age, gender, racial or ethnic background, disability or other status. They should be valued independently of their economic contribution.

THE MADRID INTERNATIONAL PLAN OF ACTION ON AGEING

The Madrid International Plan on Ageing and the Political Declaration was adopted at the second World Assembly on Ageing in April 2002 by UN member states. It offers a comprehensive action plan for handling the issue of ageing in the 21st-century and for building a society for all ages. It focuses on three priority areas: older persons and development; advancing health and well-being into old age; ensuring enabling and supportive environments. It is a resource for policymaking, suggesting ways for Governments, non-governmental organizations, and other actors to reorient the ways in which their societies perceive, interact with and care for their older citizens. It represents the first time Governments agreed to link questions of ageing to other frameworks for social and economic development and human rights, most notably those agreed at the United Nations conferences and summits of the past decade.

The MIPAA has three priority areas which have been designed to guide policy formulation and implementation towards the specific goal of successful adjustment to an ageing world, in which success is measured in terms of social development, the improvement for older persons in quality of life and in the sustainability of the various systems, formal and informal, that underpin the quality of well-being throughout the life course. These three priority directions are: (1) older persons and development; (2) advancing health and wellbeing into old age; and (3) ensuring enabling and supportive environments. The extent to which the lives of older persons are secure is strongly influenced by progress in these three directions.

PROTOCOL TO THE AFRICAN CHARTER ON HUMAN AND PEOPLES' RIGHTS ON THE RIGHTS OF OLDER PERSONS IN AFRICA

This is a strategic framework for delivering on Africa's goal for inclusive and sustainable development and is a concrete manifestation of the Pan-African drive for unity, self-determination, freedom, progress and collective prosperity pursued under Pan-Africanism. Under this protocol the AU member states recognize the fundamental rights of older persons and committed themselves to abolishing all forms of discrimination based on age. The right and obligations contained in the protocol are as follows:

Article 2: Obligations of states parties,
Article 3: Elimination of discrimination against older persons,
Article 4: Access to justice and equal protection before the law
Article 5: Right to make decisions
Article 6: Protection against discrimination in employment
Article 7: Social Protection
Article 8: Protection from abuse and harmful traditional practices
Article 9: Protection of older women
Article 10: Care and support
Article 11: Residential Care
Article 12: Support for older persons taking care of vulnerable children
Article 13: Protection of older persons with disabilities
Article 14: Protection of older persons in disaster and conflict situations
Article 15: Access to health services
Article 16: Access to education
Article 17: Participation in programmes and recreational activities
Article 18: Accessibility
Article 19: Awareness on ageing and preparation for old age
Article 20: duties of older persons

OLDER PERSONS ACT, 2024

An Act to provide for the status, well-being, safety and security of older persons through the promotion and protection of their rights; and to provide for connected and incidental matters

Unit 8

THE HISTORY AND SITUATION OF DISABILITY ISSUES IN MALAWI

Training Materials:

- **Flip charts**
- **Markers**
- **Power point presentation**
- **Pens**
- **Writing pads**
- **Laptop**
- **LCD projector**
- **Printed handouts**

UNIT 8
THE HISTORY AND SITUATION OF DISABILITY ISSUES IN MALAWI

8.0 Introduction

Disability issues in Malawi, as in many other parts of the world, have a long history to reach to where we are now. Conceptualization of disabilities issues have largely been influenced by models of disability covered earlier on. In all these years, the living condition of persons with disabilities has been characterized by social exclusion from mainstream society. Often persons with disabilities are discriminated against, socially marginalized, and have limited or no access to basic social services that they require including disability related services such as education, health care and employment opportunities.

This topic introduces events on disability as happened over the years. It also intends to provide an understanding of the situation of persons with disabilities in the country.

8.1 The Main Objective

To enhance understanding about historical and current information on disability in Malawi

8.2 Specific Objective

At the end of the unit the participants will be able to:

- Explain historical events on disability in Malawi.
- Link historical events with disability models.
- Explain the current situation of disability issues in the country.
- Discuss the challenges encountered by persons with disabilities.
- Explain the solutions to such challenges.

8.3 Training Materials:

- Flip charts,
- Markers,
- Powerpoint presentation,
- Pens
- Writing pads
- Laptop
- LCD projector
- Printed handouts.

ACTIVITY

Pair Work

10 Minutes

Part 1: The history of disability issues in Malawi

1. Participants to be in pairs to identify 6 disability-related events that they know for 3 minutes.
2. Each pair to present their ideas in the plenary session within 2 minutes.
3. The facilitator to consolidate all responses on a flip chart.

Presentation

With reference to the notes provided as Handout 1, the facilitator will take through participants a list of historical events focusing on the key ones.

ACTIVITY

Group discussion/ Plenary

10 Minutes

Part 2: The situation of persons with disabilities in Malawi

1. Facilitator to explain the following information with reference to notes provided as Handout 2:
   a. Disability statistics (population distribution and causes)
   b. Policy, legal, and institutional frameworks/arrangements

   Group discussion/ Plenary – 10 Minutes
   c. Facilitator to instruct the participants to form 5 groups:
   d. Identify and relate challenges facing persons with disabilities in accessing the following services namely health, education, social, livelihoods, and empowerment.
   e. discuss the implications of the challenges to the lives of persons with disabilities.
   f. Suggest solutions to such challenges.
2. Participants should present their group work in the plenary session.
3. Consolidate the groups responses with reference to the facilitators' notes provided (Handout 2).

Presentation:

With reference to the notes provided as Handout 2, the facilitator will take through participants challenges facing persons with disabilities in Malawi in accessing the following services namely health, education, social, livelihoods, and empowerment.

REVIEW QUESTIONS

- Explain historical events of disability issues in Malawi.
- How do they relate to the models of disability?
- Identify the challenges encountered by persons with disabilities in society at all levels or in all sectors and suggest solutions to such challenges. challenges.

HANDOUT 1 The History of Disability Issues in Malawi

The history of disability issues in Malawi dates back to the 1940s. This was the time when the first case of leprosy was registered in the country. A series of key historical events on disability issues could be summarised as presented in Table 1.

Table 1: Timeline on key Disability issues in Malawi

Year	Event
1945	Establishment of a leper colony at Malamulo Mission in Makwasa
1950s	The introduction of special needs education by missionaries
1960	Establishment of Mulanje School for the Blind
Mid 60s	Establishment of the Leprosy Relief Association (LEPRA)
Late 1960s	Involvement of government (Ministries of Education and Labor) in supporting disability issues
1971	The Handicapped Persons act was enacted by parliament to establish and regulate the work of the Malawi Council for the Handicapped
1972	The Malawi Council for the Handicapped became functional
Mid 70s	Establishment of resettlement schemes to offer employment opportunities to the blind
1976	Establishment of Bangwe Weaving Factory (now Bangwe Factory)
1981	Establishment of the Malawi Against Polio (MAP) now known as Malawi Against physical Disabilities
1983	Kamuzu Vocational Rehabilitation and Training Center was established by MACOHA with financial and technical assistance from the United Nations Capital Development Fund, United Nations Development Programme and the International Labor Organization
1983	A Disability Survey was commissioned and conducted by the National Statistics Office
1984	The establishment of Cheshire Homes (Malawi)
Mid 80s	Appointment of the first PWD on the Board of MACOHA
1988	In the same year, DIPAM was formed as an affiliate member of the Southern Africa Federation of the Disabled (SAFOD)
1988	MACOHA launched a Community Based Rehabilitation (CBR) Programme for persons with Disabilities on a pilot basis with financial and technical support from the United Nations Development Programme and the International Labor Organization
1989	Establishment of the Lilongwe Vocational Training for persons with disabilities Center by the Lilongwe Rotary Club. The center was handed over to government to be run by MACOHA the following year
1990	A Baseline Study for the Implementation of the Community Based Rehabilitation Programme for Persons with Disabilities was commissioned by the Malawi Council for the Handicapped and conducted by the Center for Social Research of the University of Malawi
1990	A Guide to Community Resources and Facilities for the Rehabilitation of Disabled People was commissioned by MACOHA and conducted by the University of Malawi
Early 90s	Malawi ratified ILO ratified ILO Convention 159 on vocational rehabilitation
1991	Malawi ratified the Convention on the rights of the Child of 1989
1992	Establishment of Malawi National Association of the Deaf (MANAD) to advocate and lobby for the rights of people with hearing impairments.
1992	The establishment of Kachere Rehabilitation Center
1992	Establishment of the Sue Ryder Foundation in Malawi
1994	The formation of the Malawi Union of the Blind (MUB)
1994	Malawi ratified the International Covenant on Civil and Political Rights of 1966
1995	Association of Albinos in Malawi (TAAM) was formed
1995	A policy developed for special needs education
1996	Formation of Disabled Women in Development (DIWODE)

Year	Event
1996	Establishment of the Physiotherapy Association of Malawi
1996	Sight Savers International supports a CBR programme for the visually impaired
1997	Establishment of a Department for Special Needs education
1997	Sue Ryder starts outreach programs
1997	The introduction of sign language
1997	The President participated the commemoration events of the World Day of the Disabled
1997	'Death' of DIPAM due to internal struggles. Start of discussions to form FEDOMA
1998	Malawi Disability Sports Association (MADISA) was formed
1998	The establishment of the Office of the Minister of State in the Presidents Office Responsible for Persons with Disabilities
1999	Formation of Parents of Disabled Children Association of Malawi (PODCAM)
1999	First Sign language interpreters' training
1999	Formation of a task force on the national disability policy
1999	Norway starts supporting the disability movement in Malawi
1999	Beginning of broadcasts on disability issues
1999	MAP initiated a program for training rehabilitation assistants, the first and only capacity building institution for rehabilitation staff in the country
1999	Disabled Women in development was registered with government under the provisions of the Trustees Incorporation Act
March 1999	Formation of FEDOMA, an umbrella organization for all disability associations in Malawi with financial support from Danish Counsel of Organizations of Disabled People (DSI)
2000	Registration of the Albino Association with government under provisions of the Trustee Incorporation Act
2001	First female person with a disability is appointed minister
2002	The Association of the Physically Disabled in Malawi (APDM) was established to lobby and advocate for the interests and rights of people with physical disabilities.
2002	Government launched the Poverty Reduction Policy/Strategic Paper with a section on support to persons with disabilities
2002	NAD and OPC Disabilities sign a memorandum of understanding
2002	First students in rehabilitation graduate
2002	FEDOMA established a secretariat with support from the Norwegian Association of the Disabled
2003	A Draft Malawi Disability policy was presented to Principal Secretaries
2003	FEDOMA's first general assembly
2004	A study on the living conditions for persons with disabilities conducted by SINTEF and CSR in collaboration with FEDOMA
2006	Cabinet approved and adopted the Disability Policy for implementation
2007	Malawi Government signed the UN Convention on the Rights of Persons with Disabilities
2008	Population and Housing Census included a question on disability
2009	Malawi Government ratified the UN Convention on the Rights of Persons with Disabilities
2011	Memorandum of Understanding with the Norwegian Association of the Disabled (NAD), CBM International, and the Secretariat of the African Decade of Persons with Disabilities (SADPD) in collaboration with the Federation of Disability Organisations in Malawi (FEDOMA)
2011	A study on the situation analysis of persons with disabilities conducted in Malawi to inform the development of the National Disability Mainstreaming Plan for the country with support from CBM International and NAD
2011-2016	Government of Malawi through line ministry of disability implemented a Disability Mainstreaming Project
2012	A study about children with disabilities conducted in Malawi with support from UNICEF
2012	National Assembly enacted a disability specific law, the Disability Act
2013-2018	Malawi registered increased human rights violation (atrocities) of persons with albinism
2014	Government of Malawi in collaboration with Special Olympic hosted an African Leaders Forum on Intellectual Disability

Year	Event
2015-17	Government of Malawi adopted and implemented a response to the abductions, killings, and exhumation of remains of persons with albinism in Malawi
2016	Government of Malawi adopted a Disability Communication Strategy to provide a framework for the creation and dissemination of information on disability as a rights and development issue
2016	Malawi Government developed and submitted its initial and second States Parties report to CRPD Committee
2018	Government of Malawi developed and adopted a National Disability Mainstreaming Strategy to provide a framework for promoting public sector led equity and inclusive development that take cognisance of the rights and needs of persons with disabilities.
2018	Government of Malawi developed and adopted a National Plan of Action on Persons with Albinism to provide comprehensive, multi-sectoral and sustainable means of ensuring equal enjoy of rights and full inclusion of persons with albinism in the development of the society
2019	Persons with Disabilities Bill drafted
2019	Government started funding the Disability Trust Fund (DTF) through National Budget
2019	Government started funding the National Action Plan on Persons with Albinism through the National Budget
2020	Malawi Government through the line ministry of disability affairs established the DTF
2022	Malawi signed the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Persons with Disabilities in Africa
2022	Reviewed the 2006 Disability Policy
2023	Parliament passes Persons with Disabilities Bill
2023	Malawi ratifies the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Persons with Disabilities in Africa
2024	Persons with Disabilities Act became enforceable on 15th April 2024

HANDOUT 2

The Situation of Persons with Disabilities in Malawi

1.1 Disability statistics:

Persons with disabilities in Malawi form a significant proportion of the national population

SINTEF 2004 – 4.18% of national population (480, 000 persons) persons with various forms of disabilities (seeing, hearing, communication, mobility, emotional, mental, and psychological difficulties, multiple disabilities).

PHC 2008 – 3.8% (498,122 persons) person with various types of disabilities: seeing difficulties (26.7%), mobility difficulties (21.9%), hearing difficulties (16.5%), Speech difficulties (Less than 1%), Others (35%) hence not reliable.

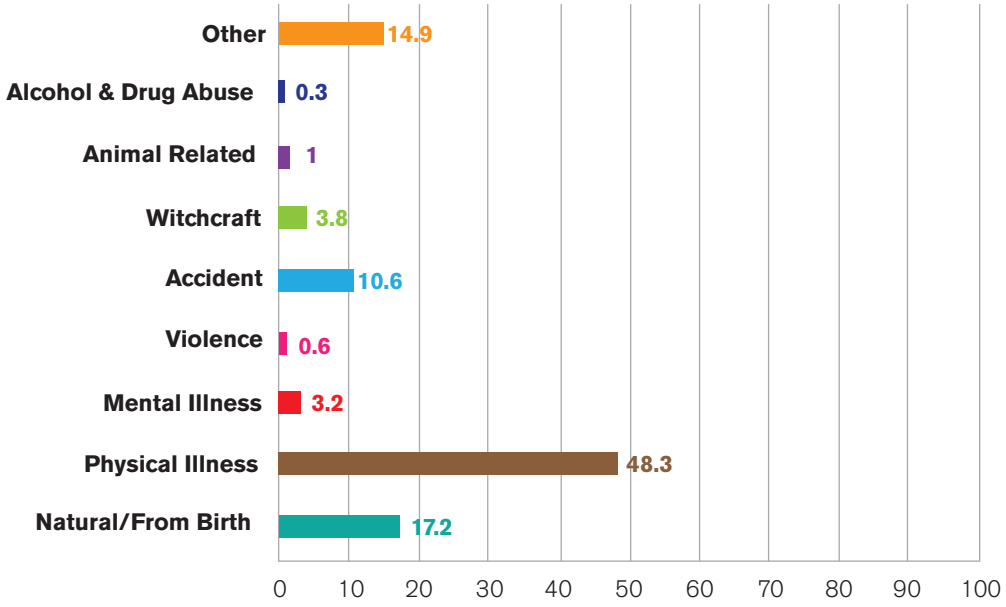
PHC 2018 – 10.4% (1,556,670 persons) persons with various forms of disabilities (aged 5>). 0.8% (134,636 persons) persons with albinism from age 0 and above. 1.4% (237,429 persons) persons with epilepsy from age 0 and above.

However, the global prevalence of disability is estimated at 15% (WHO/World Bank, 2011).

1.2 Causes of disability:

Several studies conducted in Malawi have tried to establish factors/conditions that cause disability.
Findings of the 2003 study on the living conditions of persons with disabilities in Malawi are presented in Figure 1 on the next page.

Figure 1: Conditions that cause disability in Malawi according to 2003 study



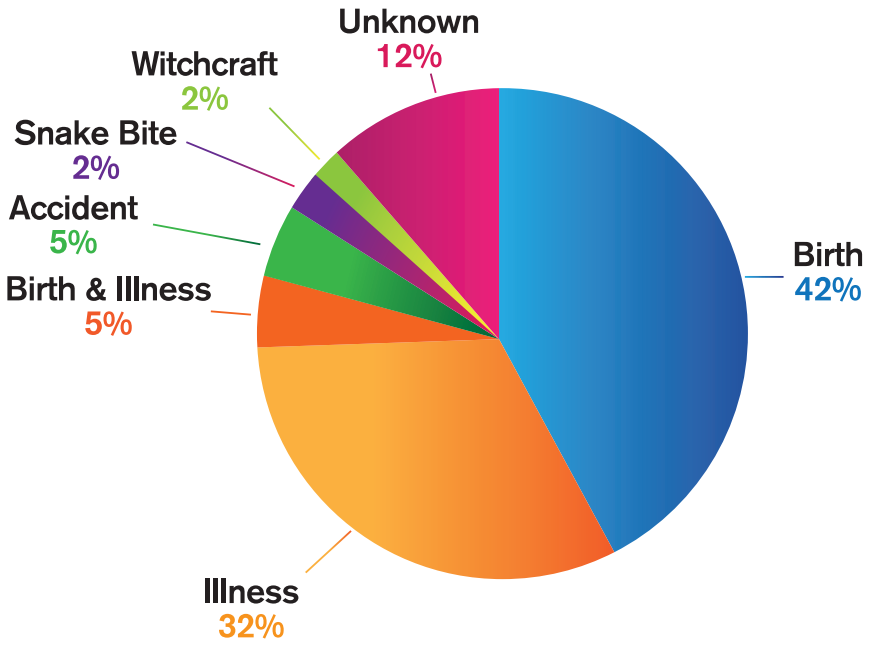
The 2008 Population and Housing Census report shows several conditions that cause disability as presented in Figure 2.

Figure 2: Conditions that cause disability in Malawi according to 2008 PHC

Type of Disability	Total	Congenital		Disease		Injury		Not Known		Other	
		No.	%	No.	%	No.	%	No.	%	No.	%
Total	498122	69,192	13.9	200,754	40.3	34,959	7	91,874	18.5	101,343	20.4
Seeing	133,273	22,679	17	56,697	42.5	6,699	5	25,058	18.8	22,140	16.6
Hearing	82,180	9,690	11.8	52,795	64.2	1,604	2	9,330	11.4	8,760	10.7
Speaking	30,198	11,230	37.2	8,398	27.8	2,225	7.4	4,192	13.9	4,152	13.8
Walking	108,870	12,691	11.7	37,782	34.7	16,269	14.9	30,389	27.9	11,740	10.8
Other	143,601	12,903	9	45,081	31.4	8,162	5.7	22,904	15.9	54,550	38

The 2012 study fundings on the situation of children with disabilities as reported by 43 children interviewed on the conditions that cause disability in Malawi are presented in figure 3.

Figure 3: Conditions that cause disability in Malawi according to 2012 study



1.3 Situation Analysis

Key policy and legal instruments

National instruments that support disability agenda:

1. Malawi Vision 2020
2. Malawi Growth and Development Strategy III, 2017
3. National Policy on Equalisation of Opportunities for Persons with Disabilities (NPEOPD), 2006
4. The National Education Sector Plan (NESP), 2017-2020
5. Republican Constitution, 1996
6. Disability Act, 2012
7. Handicapped Persons Act, 1971
8. Education Act, 2013
9. National Inclusive Education Strategy (NIES), 2017-2021

International instruments that support disability agenda:

1. The 2030 Agenda for Sustainable Development, 2016
2. The UN Convention on the Rights of Persons with Disabilities (UN CRPD) 2006
3. The African Disability Protocol, 2018
4. The Universal Declaration of Human Rights (UDHR) – 1948

Unit 9

APPROACHES TO SERVICE PROVISION AND DISABILITY MAINSTREAMING

Training Materials:

- **Flip charts**
- **Markers**
- **Power point presentation**
- **Pens**
- **Writing pads**
- **Laptop**
- **LCD projector**
- **Printed handouts**

UNIT 9
APPROACHES TO SERVICE PROVISION AND DISABILITY MAINSTREAMING

9.0 Introduction

Access to services is one of the priorities of poverty reduction, however, many groups face challenges accessing services because of their gender, ethnicity, age, sexual orientation, disability, or location. This perpetuates inequality around the world. Persons with disabilities are often among the marginalized in all social undertakings and face barriers in accessing basic social services that they require including disability related services such as rehabilitation. They lack the necessary services to facilitate their independence. Absence of a widely developed system of support services together with a lack of capacity and awareness on rights of persons with disabilities among service providers put persons with disabilities on the extreme end.

This topic provides information on how best we can reach out to persons with disabilities with different social services. It describes recommended approaches to service provision that facilitate access to social services among persons with disabilities.

9.1 Main objective

To describe approaches of service provision that addresses access barriers facing persons with disabilities to ensure equity and equality.

9.2 Specific Objective

At the end of the unit the participants will be able to:

- Explain barriers facing persons with disabilities to access social services.
- Describe disability recommended approaches to service provision.
- Relate the approaches to current practices of service provision.

8.3 Training Materials:

- Flip charts,
- Markers,
- Powerpoint presentation,
- Pens
- Writing pads
- Laptop
- LCD projector
- Printed handouts.

ACTIVITY

Individual Work

10 Minutes

Part 1: Approaches to Service Provision

1. Facilitator to write the four terms (Main-dumping, Integration, Mainstreaming, and Inclusion) and ask participants to explain their understanding of either term that they know for 3 minutes.
2. Selected participants to say their ideas in the plenary session within 2 minutes.
3. The facilitator to consolidate all responses on a flip chart.

Presentation

With reference to the notes provided as Handout 1, the facilitator will take participants through a background to access to services among persons with disabilities focusing on barriers and concepts related to service provision to persons with disabilities.

ACTIVITY

Group discussion/ Plenary

10 Minutes

Part 2: Disability Mainstreaming Process

Presentation:

1. Facilitator to explain the twin-track approach with reference to notes provided as Handout 2:
   a. Mainstreaming disability
   b. Specific actions for persons with disabilities

   Group discussion/ Plenary – 10 Minutes
2. Facilitator to instruct the participants to form 5 groups:
   a. to identify and describe the 3 key actors in disability mainstreaming.
3. Participants should present their group work in the plenary session.
4. Consolidate the groups responses with reference to the facilitators' notes provided (Handout 2).

Presentation

With reference to the notes provided as Handout 2, the facilitator will take through participants the process of disability mainstreaming describing the key actors, approach, and levels of mainstreaming.

REVIEW QUESTIONS

- Explain key concepts that relate to provision of services to persons with disabilities?
- Identify the barriers facing by persons with disabilities in society and suggest solutions to such barriers?
- Describe disability mainstreaming process?

HANDOUT 1 | Approaches to Service Provision

Important terminologies:

Integration: it is about providing certain features and arrangements that will allow a person to access and participate in an environment with limitations. It is a reaction and non-participatory approach which provides a limited degree of independence for a person with a disability. A person (with a disability) is seen as a "problem" and therefore must adjust to societal demands or change to suit the environment.

Main dumping: it is about placing an individual in an environment with no supportive arrangements or features.

Background:

We all face some kind of hardships and difficulties at some point in time. However, for persons with disabilities, these hardships, and difficulties (barriers) are more frequent and have greater impact on their lives. The consensus is that barriers faced by persons with disabilities are more than just physical obstacles. The World Health Organisation (WHO) has defined barriers as ***"factors in a person's environment that, through their absence or presence, limit functioning and create disability."***

Barriers:

There are various barriers facing persons with disabilities, however, the major ones are described below:

Attitudinal barriers are negative mind sets, prejudicial treatment, baseless assumptions towards persons with disabilities. For instance, they are incapable, dependent, of low intelligent and in need of a care or special services and support.

Environmental barriers are the many physical barriers that prevent persons with disabilities from participation. Relate to the built environment, transport system, information, and communication technologies.

Institution barriers relate to institutional policies, procedures or set rules that prevent persons with disabilities from participating in various domains.

Service provision:

Addressing these barriers requires an establishment of service systems that are skewed towards supporting persons with disabilities in reaching and maintaining their optimal level of independence and social participation, considering their personal factors, their environment, and their expectations. Such a system enables persons with disabilities have access to a variety of services that address their specific needs and provide the opportunities to take part in social undertakings.

This enabling system takes a twin-track (involving two simultaneous actions or processes) approach to provision of services. The twin-track approach provides persons with disabilities with access to both all **mainstream services** (disability mainstreaming), and **disability-specific support services**, which enable them to participate on an equal basis with others, for example, a mobility device, Sign Language interpretation, etc.

Making this system a reality involves identifying what functioning gaps exist and undertaking necessary actions in a coordinated and consistent/sustainable manner across all sectors. It is about (1) ensuring that the services not simply exist but are functional and accessible throughout the life cycle of the person in question; and (2) strengthening the capacities of all actors in the system so that the play their rightful roles.

HANDOUT 2 | Disability Mainstreaming

The Concept of Mainstreaming

Mainstreaming means "including into the main stream."

It is a method of addressing specific issues in areas where they would not normally be addressed. Thus, introducing the aspect of, say disability, into the main social functions. The idea is to change special subordinate policies/issues (as a river tributary) to ordinary policies/issues (main river), for all.

It is an ongoing process of including subordinate issues/programmes and services into all our ordinary issues/programmes and services either at international, national, or local level. It is about challenging discrimination and exclusion.

Defining Disability Mainstreaming

Disability mainstreaming is a process of assessing the implications for women, men, boys, and girls with disabilities of any planned action, including legislation, policies and programmes and taking corrective measures to ensure equitable access to services and opportunities in all areas and at all levels.

It is a strategy for making concerns of persons with disabilities and their experiences as an integral dimension of the design, implementation, monitoring and evaluation of policies and programmes. The result is that persons with disabilities equally benefit (disability equity).

It is about ensuring that 'ordinary' or 'generalist' development activities, i.e. not aimed specifically at persons with disabilities, also benefit them.

Why Mainstreaming Disability

We must mainstream disability issues because of several factors including the following outlined below:

1. Disability issues are rights and development issues.
2. Everyone, including persons with disabilities, has the same fundamental rights.
3. Persons with disabilities are usually denied enjoyment of their fundamental rights in their day-to-day life.
4. A tool for achieving equality, equity, and equal recognition before the law.

The Key Actors in Disability Mainstreaming

The main actors in disability mainstreaming are:

GOVERNMENT being the primary duty bearer - central and local governments.

Service providers which include statutory bodies, non-governmental organizations, civil society organizations etc.

Organisations of Persons with Disabilities (OPDs): These are organisations formed by persons with disabilities themselves to advocate for their rights.

It is therefore a requirement that the Public Sector takes a lead in mainstreaming disability if our country is to address issues of persons with disabilities effectively and efficiently.

How to approach Disability Mainstreaming

Disability mainstreaming is an ongoing process of including disability issues into all our routine programmes. As such, it needs a clear plan, with ongoing activities and follow-up, and appropriate time allocation.

It requires wider organizational support and management commitment as it involves taking on board an issue that would not ordinarily be considered as part of the core focus of the institution.

Persons with disabilities need to be involved or consulted from the beginning. They can guide, advise, and support us to successfully mainstream disability. This ensures that our efforts are informed by their perspectives.

Levels of Mainstreaming Disability

There are 4 interconnected levels which assist in putting disability mainstreaming into practice namely, Individual, Workplace, Programme, and Policy levels.

1. Individual Mainstreaming: This is the process of building members of staff's personal engagement with, and commitment to, disability issues. It is about people becoming personally engaged with their organization's commitment to mainstream disability, which is more than raising awareness of disability. It is crucial because mainstreaming starts with each at an organization/workplace – without our individual commitment, there can be no mainstreaming. There must be continuous engagement and management commitment is an important driving factor here. As such, people must be provided with clear guidance on practical actions they can take.

2. Workplace Mainstreaming: It is about creating an inclusive, barrier-free workplace where persons with disabilities can participate or access equally, whether as employees or clients. It is about physical access, accessible communications and work-related information, appropriate policies and procedures and ensuring that all employees treat persons with disabilities equitably, with dignity and respect. Office adaptation is a requirement to realize this. Make steady progress with adjustments and don't expect to change everything at once (it is about progressive realization). Management support is, therefore, key for workplace mainstreaming.

3. Programme Mainstreaming: This is the process of ensuring that our programmes and services are inclusive, equitable and non-discriminatory, and do not reinforce the negative effects of disability. An important step in programme mainstreaming is to include persons with disabilities in our programme planning, implementation, management, and review processes. It is a step in ensuring that persons with disabilities are included in mainstream national development processes. It involves review of how our existing and planned programmes include persons with disabilities and addressing their challenges. It is about challenging and reviewing service models and approaches to include persons with disabilities on an equitable basis.

4. Policy Mainstreaming: In policy mainstreaming, the organization looks at its policies in relation to wider disability and development agendas, rights, and existing legal frameworks, and promote their inclusion. It is a process of addressing wider policy (institutional, attitudinal, and environmental) barriers that exclude persons with disabilities from equally benefiting, participating, or accessing our programmes or services.

   It is about coming up with specific and/or inclusive policy strategies, activities, and indicators on disability in our policies that guide our operations or service delivery. Unless there is policy mainstreaming, disability issues shall remain in our institutions, organizations, or programmes as insignificant, small-scale, ad hoc, local and unsustainable.

Assessment Areas for Disability Mainstreaming

Some areas for consideration to see if we are really mainstreaming disability:

i. Does our organization have disability specific or inclusive policies and programmes?
ii. To what extent are our organization services accessible to persons with disabilities?
iii. Level of accessibility (physical, communications, information) of the organization such that persons with disabilities can participate or access equally, whether as employees or clients.
iv. Are our procedures or standards of work ensuring that all employees treat persons with disabilities equitably, with dignity and respect.
v. Level of disability awareness among members of staff at the organization

Conclusion

For so long persons with disabilities and their issues have been sidelined despite being cross-cutting issues.
Disability mainstreaming aims to address issues of exclusion, inequality, unfairness, and injustice.
Disability mainstreaming is an ongoing process towards inclusion. As such, it needs; (1) wider organizational support and management commitment; (2) a clear plan, with ongoing costed activities and follow-up, and appropriate time allocations; and (3) involvement of persons with disabilities themselves.
Mainstreaming disability could either be at an individual, workplace, programmes, or policy levels. However, policy mainstreaming is key in as far as disability mainstreaming is concern.

Unit 10

ACCESSIBILITY

Training Materials:

- **Markers**
- **Flip charts**
- **Projector**
- **Sampled built facilities**
- **Sampled products**

UNIT 10
ACCESSIBILITY

10.0 Introduction

This section presents accessibility in disability. It will explain the focus areas within which disability ought to access as well as, principles of Universal Design (UD) and reasonable accommodation and how best could barriers be addressed to achieve accessibility. The topic needs two hours.

10.1 Main objective

To inform service designers, construction personnel and policy makers on need for accessible facilities for Persons with disabilities in order for them to function effectively and safely their day to day endeavors in the same spaces as those without disabilities i.e. jobs, school, leisure, sports, goods, services and community participation as everyone else.

10.2 Specific objective

- Define accessibility in relation to PWDs.
- Explain the concept of universal design.
- Discuss reasonable accommodation.
- Explain some of the accessibility principles.
- Discuss strategies that will remove barriers to accessibility.
- Explain how to carry out an accessibility audit.

10.3 Training Materials

- Markers
- Flip charts
- Projector
- Sampled built facilities
- Sampled products

Time	Activity

15mins	Introduction
	
	• Paste the five key focus areas of accessibility onto walls; request four to five members to walk to a key area; then ask them to reflect on the assigned key areas respectively along the following aspects (not exhaustive)
	
	  • Safety/ hazard when in use
	  • Effort need to be utilized, is fatigue minimized or not.
	  • How easy to manipulate regardless of posture or ability.
	
	• Link the reflections to the topic's main concept and connect it to the principles of reasonable accommodation and universal design

90mins	Discussion

10mins	Review
	Review the topic by asking participants to individually address the following 3 questions:
	• Describe the notion of reasonable accommodation
	• Discuss how accessibility could be addressed in the following areas
	
	  • Current news affairs
	  • Lavatories
	  • Public transport or street pavement
	
	Identify any three principles of UD and explain the significance of each respectively

Summary

Disability advocacy calls for equal access to barrier-free social, political, and economic life which includes not only physical access but access to the same tools, services, spaces and facilities as others. Access occurs when persons with disabilities experience a barrier-free environment leading to greater participation and social inclusion. Notice that accessibility is associated with the following:

Reasonable accommodation: Any effort towards necessary and appropriate modification and adjustments, not imposing a disproportionate or undue burden, where needed in a particular case, to ensure to persons with disabilities the enjoyment or exercise on an equal basis with others of all human rights and fundamental freedoms.

Universal Design (UD): Entailing the design of products, environments, programmes and services to be usable by all people, to the greatest extent possible, without the need for adaptation or specialised design. The following are the seven principles of UD:

- Equitable in use
- Flexible to use
- Simplicity
- Perceptible
- Error-torerant
- Requires low effort
- Size and space required for use

HANDOUT / PARTICIPANT NOTES

Accessibility requires that all services, environments, information, facilities, and any infrastructure (available to the public) should be made reachable to all persons with disabilities. Hence, all obstacles and barriers to access should be identified and removed so that there is access for and by persons with disabilities on an equal basis with all others. The role of the state therefore is to put regulatory and monitoring mechanisms in line with universal design to ensure that every new service, facility or infrastructure is accessible.

According to the United Nations Convention on the Rights of Persons with Disabilities (CRPD) "Universal design" means the plan of products, environments, programmes and services to be usable by all people, to the greatest extent possible, without the need for adaptation or specialized design. "Universal design" shall not exclude assistive devices for particular groups of persons with disabilities where this is needed. The regulations must also require already existing infrastructure, service or facilities to be restructured and become accessible. The obligation to ensure accessibility and universal design applies to all entities that offer services to the public. It must be emphasized that in order to ensure accessibility, universal designs and reasonable accommodation must be considered.

There are seven commonly recognized principles of universal design. These were originally developed in 1997 by a working group of architects, product designers, engineers and environmental design researchers in the University of North Carolina, USA. The designs promote access for all and these are:

- Equitable use
- Design that is useful and marketable to persons with diverse abilities.
- Flexibility in use
- Design that accommodates a wide range of individual preferences and abilities.
- Simple and intuitive use
- Design that is easy to understand, regardless of the user's experience, knowledge, language skills, or concentration level.
- Perceptible information
- Design that communicates necessary information effectively to the user, regardless of ambient conditions or the user's sensory abilities.
- Tolerance for error
- Design that minimizes hazards and the adverse consequences of accidental or unintended actions.
- Low physical effort
- Design that can be used efficiently and comfortably and with a minimum of fatigue.
- Size and space for approach and use
- Design that provides appropriate size and space for approach, reach, manipulation, and use regardless of the user's body size, posture or mobility.

Key Areas In Which Accessibility Occurs

Environment: This relates to physical access to buildings, external infrastructure (such as pavements, roads and footpaths). Although often seen only as an issue for persons with physical impairments, good environmental access benefits everyone.

Information & communication: Including sign language interpretation, printed materials, signage, websites and technology. The more accessible and diverse the communication, the more people will be able to use it and benefit from it.

Attitudes and behavior: This is one of the main elements of exclusion. Current practice still too often includes pity, hostility, fear and being patronizing, with negative messages being reinforced by arts and media images and representation.

Systems: For example, the education system, local government, legal system, health, and politics, all of which can control the level of opportunity for persons with disabilities to participate in society.

Economic: Economic accessibility, or affordability relates to people's ability to pay for services without financial hardship. The close relationship of disability and poverty means that persons with disabilities frequently lack economic access to services they require.

Unit 11

INTRODUCTION TO COMMUNITY-BASED INCLUSIVE DEVELOPMENT COMPONENTS

Training Materials:

- **Markers**
- **Flip charts**
- **Projector**
- **Sampled built facilities**
- **Sampled products**

UNIT 11
INTRODUCTION TO COMMUNITY-BASED INCLUSIVE DEVELOPMENT COMPONENTS

11.0 Introduction

This chapter explains comprehensively the five components of the CBR Matrix namely: Health, Education, Livelihood, Social and Empowerment. Each of the five components have five elements totaling to 25 which are intended to holistically provide interventions for persons with disabilities

11.1 The General Outcome

Participants should display the understanding of CBID and its five components comprehensively, explain the 5 elements under each component and discuss the success of CBID

11.2 Specific objective

- Define CBID (CBR) and its role
- Explain the five components of CBR with all the 25 elements
- Discuss the main successes and challenges in implementing the five components of CBR in Malawi and how to address the challenges

11.3 Training Materials:

- Whiteboard or flipchart
- Flipchart paper and markers
- Participants handout
- Masking tape

11.4. Methodology

Divide participants into five groups, each to be allocated one component of the CBR Matrix. To save time, it is suggested to make the group allocations the previous day and request people to pre-read the material in their Handout Manual relating to their component. Let each group define CBID

Note: Participants are allocated one component of the CBR Matrix for the activity in the Introduction to CBR/CBID session and you may want to ensure they focus on a different component of the matrix for this session.

Ask groups to prepare a short presentation/role play representing the component they are focussing on. This should include successes and challenges.

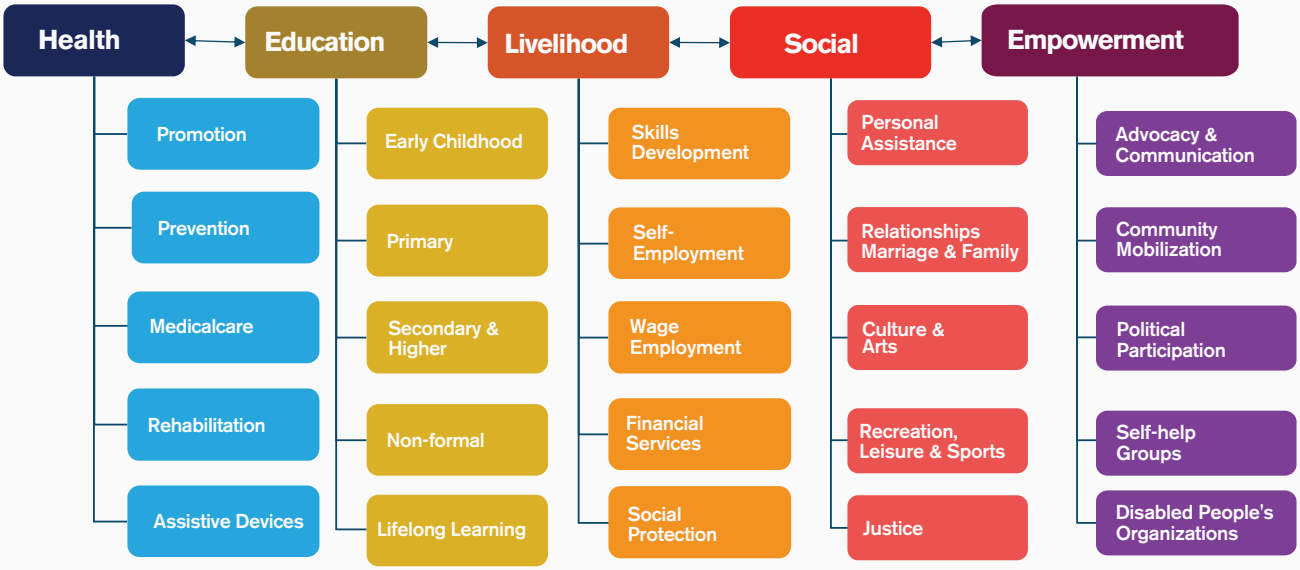
The facilitator should summarize the group discussion of mainstreaming successes and challenges.

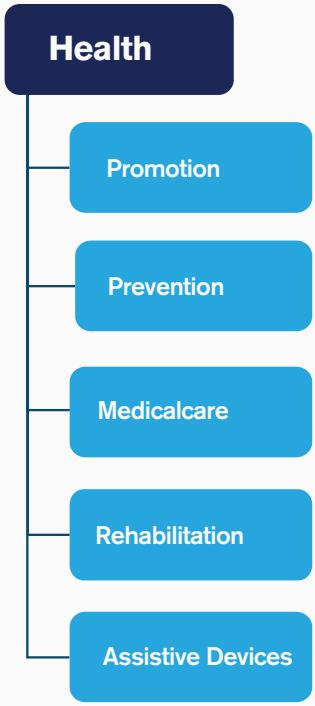
Discuss the role of CBR at the very end in the language best understood by the participants. In groups allow participants to compose songs on CBID

11.5 Assessment questions for participants

1. What is the major role of CBID to persons with disabilities?
2. Why is it important to use the five components in implementation of disability programes
3. Which components do you normally work with
4. How can you incorporate components that you normally work with

PARTICIPANTS HANDOUT





Elements of Health

Evidence shows that persons with disabilities often experience poorer levels of health than the general population. They also face a number of different challenges to the enjoyment of their right to health.

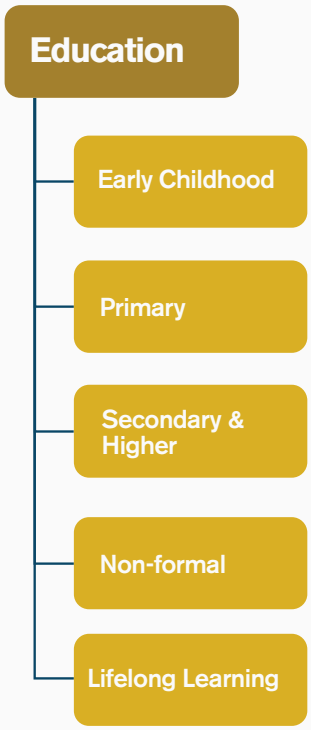
The right to health is not only about access to health services; it is also about access to the underlying determinants of health, such as safe drinking water, adequate sanitation and housing.

CBID can facilitate inclusive health by working with the health sector to:

- Ensure access for all people with disabilities
- Advocate for health services that:
  - Accommodate the rights of people with disabilities
  - Are responsive, community-based and participatory.

The role of CBR is to work with the health sector to ensure that the needs of persons with disabilities and their families are addressed in all aspects of health, across five key areas as outlined below.

	Role of CBID
Promotion	• To identify health promotion activities at local, regional and national level and work with stakeholders to ensure access and inclusion for persons with disabilities and their family members. • To ensure that persons with disabilities and their families know the importance of maintaining good health and encourage them to actively participate in health promoting actions.
Prevention	• To ensure that communities and relevant development sectors focus on prevention activities for persons with disabilities and non-disabled people. • To provide support for persons with disabilities and their families to ensure they can access services that prevent development of negative health conditions or secondary complications.
Medical care	• To work in collaboration with PWDs and their families and medical services to ensure that the former can access services designed to identify prevent, minimize and/or correct health conditions and impairments.
Rehabilitation	• To promote, support and implement rehabilitation activities at the community level and facilitate referrals to access more specialized rehabilitation services.
Assistive devices	• To work with PWDs and their families to determine their needs for assistive devices and facilitate their access and ensure maintenance repair and replacement.



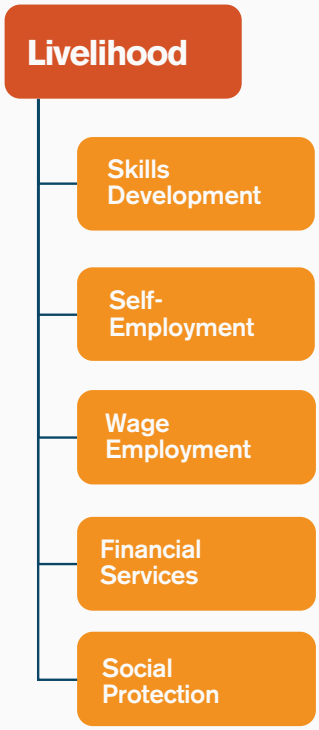
Elements of education

Access to education is critical for achievement of every individual's full potential.

The United Nations Educational, Scientific and Cultural Organization (UNESCO) estimates that more than 90% of children with disabilities in low-income countries do not attend school. For adults with disabilities, the literacy rate is as low as 3%, and even as low as 1% for women with disabilities in some countries. Education can bring changes in all of the key areas that CBR seeks to address, and serve to both empower persons with disabilities and help non-disabled people to understand and include them better. The role of CBID is to work with the education sector to make education inclusive at all levels and to facilitate access to education and lifelong learning for persons with disabilities.

The specific role of CBID for each of the five elements of the education component of the CBR Matrix are below.

	Role of CBID
Early Childhood	• Identify families with children with disabilities. • Interact and work closely with the families and their communities. • Assist in laying the foundations for all activities in the child's life.
Primary	• Collaborate with primary education systems to create inclusive local schools. • Support families and children with disabilities to access primary education in their local community. • Develop and maintain links between the home, community and schools.
Secondary and higher	• Facilitate inclusion with increased access, participation and achievement for students with disabilities. • Work with school authorities to make the environment more accessible and the curriculum more flexible.
Non-formal	• Work with non-formal programmes e.g. adult literacy programmes to ensure that people with disabilities are able to access educational opportunities in inclusive settings. • Help people with disabilities to access educational opportunities that are suited to their own needs and interests.
Lifelong learning	• Provide people with disabilities with continuous learning opportunities to prevent their social exclusion, marginalization and unemployment.



Elements of Livelihood

Persons with disabilities are disproportionately represented among poor people. Disability increases the likelihood of being poor, and being poor increases the likelihood of being disabled.

A primary purpose of CBID is to reduce poverty, therefore livelihoods are central to CBID. By finding and succeeding at work opportunities that are fairly compensated, safe and dignifying, individuals with disabilities can:

- Secure the necessities of life
- Improve their economic and social situations, and
- Increase their self-esteem, personal security and status within their family and community.

CBID needs to provide persons with disabilities with support to secure a livelihood that gives them sufficient resources to lead a dignified life, have access to social protection measures, and contribute to their family and community.

	Role of CBID
Skills development	• To enable people with disabilities to access work opportunities, by actively promoting and facilitating the acquisition of relevant knowledge, skills and attitudes.
Self-employment	• To encourage and support self-employment by assisting people with disabilities and their families, either individually or in groups, to access skills development and financial and material resources.
Wage employment	• To enable persons with disabilities to access and retain wage employment, by working to increase equal access and treatment in the workplace, as well as access to services that lead to wage employment.
Financial services	• To identify, facilitate, and promote access of persons with disabilities to financial services.
Social protection	• To facilitate the access of persons with disabilities to mainstream or specific social benefits. • To promote the provision of, and inclusion of persons with disabilities in, social protection measures.

Elements of Social

Being actively included in the social life of one's family and community is important for personal development. The opportunity to participate in social activities has a strong impact on an individual's identify, self-esteem, quality of life and social status.

Because persons with disabilities face many barriers in society they often have fewer opportunities to participate in social activities. Persons with disabilities need to be able to have meaningful social roles and responsibilities and participate as equals.

The role of CBID is to:

- Work with all relevant stakeholders to ensure the full participation of persons with disabilities in the social life of their families and communities.
- Provide support and assistance to persons with disabilities to enable them to access social opportunities.
- Challenge stigma and discrimination to bring about positive social change.

	Role of CBID
Personal assistance	• To support persons with disabilities to access and actively manage the personal assistance necessary to live with self-determination and dignity.
Relationships, marriage and family	• To support persons with disabilities to have fulfilling relationships with members of their families and communities.
Culture and arts	• To work with relevant stakeholders to enable persons with disabilities to enjoy and participate in cultural and arts activities.
Recreation, leisure and sports	• To promote increased participation of persons with disabilities in recreation, leisure and sports activities. • To provide support to mainstream organizations and programmes to enable them to offer appropriate and accessible recreation, leisure and sports activities.
Justice	• To promote awareness of the rights of persons with disabilities. • To provide support to persons with disabilities and their family members to access justice when they face discrimination and exclusion.

Elements of Empowerment

Empowerment for persons with disabilities means that they can make their own decisions, work with others to improve their communities, and work with community decision-makers to ensure equal opportunities for all. To empower someone may require providing resources, removing obstacles, or strengthening their own resources such as impacting their self-confidence and self-worth.

The role of CBR is to contribute to the empowerment process by promoting, supporting and facilitating the active involvement of persons with disabilities and their families in issues that affect all aspects of their lives.

Persons with disabilities are entitled to rights on an equal basis with others. They have the capacity to speak out for themselves to assert their rights, and are capable of making decisions about their lives.

	Role of CBID
Advocacy and communication	• To support persons with disabilities to develop advocacy and communication skills. • To ensure that the environment provides appropriate opportunities and support to allow persons with disabilities to make decisions, and express their needs and desires effectively.
Community mobilization	• To mobilize the communities to ensure that: • Negative attitudes and behaviors towards persons with disabilities and their families change. • The community is supportive of CBR. • Disability is mainstreamed across all development sectors.
Political participation	• To ensure that persons with disabilities have the information, skills and knowledge to enable them to participate in political processes and have access to opportunities to participate. • To ensure that disability issues are visible so that they are included into processes of political decision-making.
Self-help groups	• To provide support and assistance to persons with disabilities and their families to form new self-help groups and to support the capacity of existing ones to help them achieve greater autonomy and impact. • Where mainstream groups, such as women's groups and microcredit groups already exist, to work with them to promote the inclusion of persons with disabilities and their families in these groups.
Disabled People's Organizations	• Work as a partner with disabled people's organizations where they exist. • Provide assistance as and when appropriate to support the formation of disabled people's organizations where they do not exist.

Unit 12

INTERSECTIONALITY OF GENDER, DISABILITY AND POVERTY

Training Materials:

- **None**

UNIT 12

INTERSECTIONALITY OF GENDER, DISABILITY AND POVERTY

12.0 Introduction

In this unit, participants will explore how gender and poverty dynamics negatively affect persons with disabilities in our communities. It is critical that programmes that seek to promote rights of persons with disabilities should be gender responsive.

12.1 The General Outcome

By the end of this unit, you will identify strategies that assist in reducing the double social burden of gender, poverty and disability on persons with disabilities.

12.2 Specific objective

By the end of the unit, participants will be able to:

1. Explain the terms gender, poverty and disability
2. Explain how to address the intersectionality of poverty, disability, and gender

HANDOUT / PARTICIPANT NOTES

Intersectionality is a concept that recognizes that people experience multiple forms of oppression and discrimination based on their overlapping identities, such as race, class, sexuality, age and disability.

Gender, disability and poverty are three dimensions that intersect to create specific challenges and barriers for persons with disabilities more especially women in low resource settings. These three factors interact in various ways to create disadvantages and inequalities for women with disabilities, especially in low-resource settings. Women with disabilities may face multiple forms of discrimination and exclusion based on their gender, disability, ethnicity, age, location or other factors. They may also have less access to education, health care, employment, social protection, justice and decision-making than men with disabilities or women without disabilities.

Poverty is a condition of lack of resources and opportunities that affects people's well-being and dignity. Poverty can have multiple causes and consequences, such as poor health, low education, violence, social exclusion, and environmental degradation.

Disability is a term that describes the barriers that people face in society due to impairments or differences in their physical, mental, sensory, or cognitive functioning. Disability can be influenced by personal, environmental, and social factors.

Gender is a term that refers to the socially constructed roles, behaviors, expectations, and identities of women, men, and gender-diverse people. Gender can affect how people access rights, resources, opportunities, and power in society. Gender can also be a basis for discrimination and violence. For example, gender can determine the division of labor, income, and assets in households and communities. Gender can also expose people to different forms of abuse, harassment, and exploitation.

Poverty, disability, and gender are interrelated and mutually reinforcing. People who experience poverty are more likely to have disabilities or acquire them due to lack of access to health care, nutrition, sanitation, and safe living conditions.

Persons with disabilities are more likely to live in poverty due to lack of access to education, employment, social protection, and participation.

Gender and disability are both social constructs that shape the experiences and opportunities of individuals in society. Gender norms and stereotypes can affect the expectations, roles and responsibilities of women and men, while disability can be influenced by the physical, social and attitudinal barriers that hinder the full participation of persons with disabilities in society

Women with disabilities are more likely to face multiple forms of discrimination and violence due to their gender and disability status. For example, women with disabilities may face caretaker abuse, forced sterilization, or sexual violence. Women with disabilities may also be excluded from women's movements or disability movements due to their intersectional identity.
How to address the intersectionality of poverty, disability, and gender?

- Adopt a human rights-based approach that recognizes the dignity, diversity, and agency of all people.
- Challenge the stereotypes and stigma that create barriers for people living in poverty, with disabilities, or with non-conforming gender identities.
- Promote inclusive policies and programs that ensure equal access to health care, education, employment, social protection, justice, and decision-making for all people.
- Empower people living in poverty, with disabilities, or with non-conforming gender identities to claim their rights and participate in society
- Conducting participatory and disaggregated data collection and analysis to identify the specific gaps and challenges faced by different groups of people, especially those who are most marginalized and excluded.
- Developing and implementing policies and programs that address the root causes and structural factors of inequality and discrimination, such as gender norms, social stigma, legal barriers, economic exclusion, etc.
- Ensuring that policies and programs are accessible, affordable, appropriate, and responsive to the needs and preferences of different groups of people, especially those who face multiple forms of exclusion and vulnerability.
- Promoting the empowerment and participation of people who belong to multiple marginalized groups in decision-making processes at all levels, from local to national. This includes supporting their leadership, representation, advocacy, and mobilization for their rights and interests.
- Building alliances and partnerships among different stakeholders, such as governments, civil society organizations, private sector actors, donors, etc., to foster collaboration and coordination across sectors and issues.

Unit 13

DISABILITY INCLUSION

Training Materials:

- **None**

UNIT 13
DISABILITY INCLUSION

Aim

This lesson aims to introduce the concept of disability inclusion and why it is important for everyone.

Learning objectives

- To understand what disability is and how it affects people's lives in different ways.
- To recognize the barriers and challenges that persons with disabilities face in their daily lives, such as physical, attitudinal, communication, and institutional barriers.
- To identify ways to promote disability inclusion in workplaces, such as by using inclusive language, providing reasonable accommodations, and supporting advocacy efforts.
- To reflect on our own attitudes and behaviors towards persons with disabilities, and how we can become more inclusive.

Learning outcomes

By the end of this lesson, participants should be able to:

- Define disability and disability inclusion in your own words.
- Give examples of different types of disabilities and how they impact people's abilities and needs.
- Explain why disability inclusion is important for human rights, social justice, and sustainable development.
- Describe some of the actions you can take to make your environment more accessible and inclusive for persons with disabilities

HANDOUT / PARTICIPANT NOTES

Disability Inclusion

Disability inclusion is the practice of ensuring that persons with disabilities have equal access and opportunities to participate in all aspects of society such as education, employment, health care, and social activities. It also means respecting and valuing the diversity and contributions of people with disabilities, and challenging the stereotypes and stigma that often exclude them from society

Disability inclusion is not only a human right, but also a social and economic benefit for everyone. By removing barriers and promoting inclusion, we can create a more diverse, inclusive and innovative world.

Disability inclusion is a vital aspect of creating a more equitable and inclusive society for all. It means ensuring that people with disabilities have the same opportunities and access to participate in every sphere of life as their non-disabled peers. It also means recognizing and valuing the diversity and contributions of people with disabilities in various roles and settings.

Disability inclusion involves making sure that adequate policies and practices are in effect in a community or organization to support the full and effective participation of persons with disabilities. This includes:

- Providing education, health programs, and public resources that are accessible and responsive to the needs and preferences of persons with disabilities.
- Offering flexible work arrangements, providing assistive technology, or ensuring that buildings and facilities are accessible

Benefits/advantages of disability inclusion

It enhances human dignity and respect for diversity. For example, by ensuring that persons with disabilities can access education, health care, culture and sports, we can recognize their inherent worth and dignity as human beings.

- It improves the quality of life and well-being of people with disabilities and their families. For example, by providing assistive devices, personal assistance and social protection, we can enable people with disabilities to live independently and enjoy their rights and freedoms.
- It reduces poverty and inequality by increasing employment and income opportunities for people with disabilities. For example, by promoting inclusive and accessible workplaces, we can increase the productivity and contribution of people with disabilities to the economy and society.
- It fosters social cohesion and solidarity by reducing stigma and discrimination. For example, by raising awareness and changing attitudes towards people with disabilities through education and media, we can create a more inclusive and respectful culture that values diversity and difference.
- It boosts creativity and innovation by tapping into the talents and perspectives of people with disabilities. For example, by involving people with disabilities in research and development, we can generate new ideas and solutions that benefit everyone.

How to achieve disability inclusion?

- Consult and involve persons with disabilities and their representative organizations in all stages of planning, implementation, monitoring, and evaluation of policies and programs.
- Address barriers and challenges that persons with disabilities face, such as: Stigma, discrimination, lack of accessibility, and lack of reasonable accommodation.
- Create a culture of respect, inclusion, and empowerment for persons with disabilities.
- Adopting laws and policies that protect the rights and interests of persons with disabilities. For example, by ratifying and implementing the Convention on the Rights of Persons with Disabilities (CRPD), we can ensure that persons with disabilities have equal protection before the law and access to justice.
- Providing accessible and affordable services and facilities that meet the needs and preferences of persons with disabilities. For example, by applying universal design principles, we can ensure that buildings, transportation, information and communication are accessible to everyone regardless of their abilities or disabilities.
- Raising awareness and changing attitudes towards persons with disabilities through education and media. For example, by using positive and respectful language and images, we can challenge stereotypes and prejudices about persons with disabilities and promote their achievements and contributions.
- Supporting the empowerment and participation of persons with disabilities in decision-making and leadership roles. For example, by providing training, mentoring and networking opportunities, we can enhance the skills and confidence of people with disabilities to advocate for their rights and interests.
- Encouraging collaboration and partnership among different stakeholders, such as governments, civil society, private sector and international organizations. For example, by establishing platforms for dialogue and
- Consultation, we can foster mutual understanding and cooperation among different actors to advance disability inclusion.

Unit 14

CIVIL SOCIETY SPACE IN THE PROMOTION OF DISABILITY AND ELDERLY MAINSTREAMING AND PROTECTION OF THEIR RIGHTS

Training Materials:

- **None**

UNIT 14

CIVIL SOCIETY SPACE IN THE PROMOTION OF DISABILITY AND ELDERLY MAINSTREAMING AND PROTECTION OF THEIR RIGHTS

Introduction

The role of CSOs in disability and elderly programming is crucial for ensuring the inclusion and empowerment of persons with disabilities and the elderly in the development processes. Civil society organizations (CSOs) are groups that act independently of the state and the market to promote collective interests and social change. They can play various roles, such as:

- Holding institutions to account, promoting transparency and accountability
- Raising awareness of societal issues and challenges and advocating for change
- Delivering services to meet societal needs such as education, health, food and security
- Defending human rights and protecting the environment

Overall objective

At the end of this unit, participants will be able to understand the role of civil society organisations in the implementation of disability and elderly policies and programmes.

Specific objectives

At the end of the unit the participants will be able to;

a. Define a Civil Society Organisation
b. Explain the different roles of CSOs in disability and elderly sectors
c. Discuss the roles of disability peoples organisations in disability mainstreaming

HANDOUT / PARTICIPANT NOTES

What is a Civil Society Organisation

A civil society organization (CSO) or non-governmental organization (NGO) is a non-profit, voluntary citizens' group organized on a local, national, or international level. They are task-oriented and driven by people with a common interest, and perform a variety of services and humanitarian functions, such as bringing citizens' concerns to governments, monitoring policies, and encouraging political participation at the community level.

CSOs provide analysis and expertise, serve as early warning mechanisms, and help monitor and implement international agreements, including Agenda 2030 and the Sustainable Development Goals. They are typically organized around specific issues, such as peace and security, human rights, and development. Civil society organizations are not associated with government and play multiple roles, including being an important source of information for both citizens and government, monitoring government policies and actions, holding government accountable, engaging in advocacy, and offering alternative policies for government, the private sector, and other institutions.

CSOs can advocate for the rights and needs of persons with disabilities and the elderly, provide them with services and support, and facilitate their participation and representation in decision-making. CSOs can also monitor and evaluate the implementation and impact of disability and elderly policies and programs, and hold governments and other stakeholders accountable for their commitments.

By working in partnership with persons with disabilities, the elderly and their organizations, CSOs can contribute to the realization of the 2030 Agenda for Sustainable Development and its promise to leave no one behind.
CSOs can raise awareness and challenge stigma, provide services and support, monitor and evaluate policies and programs, collaborate with governments, development partners, and other stakeholders, and empower persons with disabilities and the elderly to participate in decision-making processes and to claim their entitlements.

a. The Role Of CSO's in Disability and Elderly Mainstreaming

CSOs can play an important role in disability and elderly mainstreaming, which is the process of ensuring that disability and elderly perspectives are integrated into all policies, programs and services that affect persons with disabilities and the elderly.

1. Representation and advocacy
   - One of the main roles of CSOs is to represent and advocate for the diverse needs and preferences of persons with disabilities and the elderly at different levels of decision-making.
   - CSOs can provide valuable insights and expertise on the barriers and challenges faced by persons with disabilities and the elderly, as well as the solutions and opportunities for their empowerment and participation.
   - CSOs can also monitor and evaluate the implementation and impact of disability and elderly-inclusive policies and programs, and hold duty-bearers accountable for their obligations and commitments.

2. Awareness and education
   - Another role of CSOs in disability and elderly mainstreaming is to raise awareness and educate various stakeholders about the rights and realities of persons with disabilities and the elderly.
   - CSOs can use different strategies and platforms to communicate and disseminate information on disability and elderly issues, such as media campaigns, social media, publications, events, trainings and workshops.
   - CSOs can also challenge negative stereotypes and attitudes towards persons with disabilities and the elderly, and promote positive images and narratives that celebrate their diversity and contributions.

3. Collaboration and partnership
   - CSOs can build alliances and networks with other civil society organizations, government agencies, international organizations, private sector entities, academic institutions and media outlets.
   - CSOs can also engage in dialogue and consultation with these actors to influence their policies and practices, and to leverage their resources and capacities for disability and elderly mainstreaming.

b. CSOs in the elderly sector

In the elderly sector, CSOs help in various ways such as providing care services, advocacy and awareness campaigns. They aim at making a measurable contribution towards transforming the lives of older men and women in Malawi so that they can lead dignified, secure, active and healthy lives.

Some of the key areas that CSOs in the elderly sector focus on include:

1. Responding to humanitarian crises: they respond to emergencies and crises around the country by providing essential aid and support to older people affected by disasters and displacements.
2. Improving income security: they work to ensure that older people have access to sustainable and adequate income, including through social protection programmes and livelihood support.
3. Supporting healthy ageing: work to improve the health and wellbeing of older people by providing and advocating for healthcare, rehabilitation services, and support for those who are the furthest behind.
4. Creating a society for all ages: support older people to speak out, claim their rights and influence decisions that affect their lives.
5. Acting on climate change: recognise the impact that climate change has on older people and their communities, and the importance of addressing this issue in order to protect and improve their lives.
6. Advancing gender equality: campaign to ensure that older people of all genders enjoy the same rights, responsibilities and opportunities.
7. Protecting the rights of older people: advocate for the rights of older people and work to raise awareness about issues affecting them, such as age discrimination, elder abuse, and neglect.
8. Challenging ageism: challenge ageism so that older people are recognised as individuals and treated fairly and without discrimination

Unit 15

MINIMUM STANDARDS FOR AGE AND DISABILITY INCLUSION IN HUMANITARIAN ACTION

Training Materials:

- **None**

UNIT 15

MINIMUM STANDARDS FOR AGE AND DISABILITY INCLUSION IN HUMANITARIAN ACTION

Introduction

Humanitarian crises affect each person differently depending on their gender, age, disability and other personal characteristics. Older people and people with disabilities are often overlooked in humanitarian relief and response and they may find it harder than others to access the assistance and protection they need. The humanitarian principle of impartiality – providing assistance on the basis of need and without discrimination – requires agencies working in emergencies to reduce barriers so that people with disabilities and older people are not purposefully or inadvertently excluded from the humanitarian response.

Objectives

At the end of this unit, participants will be able to;

a. Describe the structure of the minimum standards
b. Understand the aim of using minimum standards in all humanitarian progrmmes
c. Identify the overarching principles on which minimum standards are based
d. Discuss the key inclusion standards and actions to meet a particular standard
e. Identify the sector specific standards

HANDOUT / PARTICIPANT NOTES

Background

The Minimum Standards for Age and Disability Inclusion in Humanitarian Action have been developed for use by all practitioners involved in humanitarian response, including staff and volunteers of local, national, and international humanitarian agencies, with the expectation that the inclusion of people with disabilities and older people is feasible at every stage of the response and in every sector and context. The Standards are intended to inform the design, implementation, monitoring and evaluation of humanitarian programmes; to strengthen accountability to people with disabilities and older people; and to support advocacy, capacity-building and preparedness measures on age and disability across the humanitarian system. The Standards are drawn from a wide-ranging review of existing guidance and standards developed by humanitarian actors over recent years. This includes material from organisations with a special focus on disability and/or older age, together with key documents, including the Sphere Handbook,1 the Sphere Companion Standards2 and the Core Humanitarian Standard on Quality and Accountability (CHS).3 The Minimum Standards for Age and Disability Inclusion do not create entirely new demands on humanitarian actors; rather, they clarify and reinforce what is already required if broader standards of impartial humanitarian programming and the principles of the Humanitarian Charter are to be upheld.

While generic standards on quality and accountability have helped to improve the overall coverage of humanitarian response, there is still a need for more relevant and systematic approaches to ensure the inclusion of older people and people with disabilities. Both (overlapping) groups are affected by many of the same or very similar barriers to access and participation, and there are simple measures that can be taken by humanitarian organisations to address these barriers by adapting existing programmes.

Structure of the Minimum Standards

The Minimum Standards consist of eight Key Inclusion Standards and accompanying Sector-specific Standards. Each set of Sector-specific Standards relates to a particular theme (eg water, sanitation and hygiene (WASH), nutrition, health). These are intended for use by humanitarian technical teams and coordination mechanisms, including clusters, with reference to the Key Inclusion Standards; they are not designed to be used in isolation.

Supporting principles

The Minimum Standards are based on the following overarching principles:

- **Principled humanitarian action:** ensuring that humanitarian organisations offer services on the basis of the principles of humanity and the humanitarian imperative, recognising the fundamental rights of all people affected by disaster and conflict, including the right to life with dignity, the right to receive humanitarian assistance, and the right to protection and security. These fundamental principles apply to everyone affected by disaster and conflict, including persons with disabilities and older people.
- **Non-discrimination:** ensuring that all of the affected population including older women and men, and women, men, girls and boys with disabilities can access assistance and benefit from humanitarian response on an equal basis with others.
- **Meaningful access:** ensuring that any barriers affecting the access and participation of people with disabilities and older people in humanitarian assistance and protection are addressed.
- **Respect for the inherent dignity of people with disabilities and older people:** ensuring that people with disabilities and older people are respected as having an active role in their families and communities, and in their own lives. An inclusive humanitarian response requires staff to be aware of disability and age and of how to respect and communicate with these groups
- **Active and effective participation and equality of opportunities:** ensuring that people with disabilities and older people participate in all aspects of the humanitarian response on an equal basis with others.
- **Respect for diversity, including equality between women, men, girls and boys of all ages:** ensuring that all persons with disabilities and older people receive the assistance and protection that they need during a humanitarian response.
- **Recognition of the essential role of carers:** ensuring the contribution provided by carers is recognised and their needs are supported, and acknowledging the fact that many people with disabilities, children and older people are themselves carers.

Key Inclusion Standards

Key Inclusion Standard 1: People with disabilities and older people affected by crisis are recognised to ensure they receive assistance that is appropriate and relevant to their needs.

Actions to meet the Standard

1. Systematically include people with disabilities and older people in data collection, registration and all assessments. Use this data to support the design, implementation, monitoring and evaluation of inclusive humanitarian responses. For example:
   - Actively collect sex-, age- and disability disaggregated data (SADDD) throughout the course of programmes.
   - Collect and use the most reliable available data on, or estimates of, disability and older age within the affected population.
   - Where national data is unreliable, plan on the assumption that 15 per cent of the population have some kind of disability and some 12.5+ per cent are aged 60+.7
   - Use selected questions to allow for basic disaggregation of data on disability, activity and participation, as well as the need for services. Train personnel to use these

2. Ensure participatory needs, vulnerability, capacity and all other assessments include direct and meaningful consultation with people with disabilities and older people, and their carers, to identify and address specific risks and barriers that affect them, and their capacity to participate in the response. For example:
   - Use initial assessments to identify and include particularly vulnerable and excluded people with disabilities and older people.
   - Use outreach action to identify groups who are not visible in usual assessments as soon as possible and maintain this process over time.
   - Create protocols for sharing of data and referral processes between agencies, programmes and services, to avoid duplication in assistance and ensure data protection.

Key Inclusion Standard 2: People with disabilities and older people affected by crisis have access to the humanitarian assistance they need.

Actions to meet the Standard

1. Design all sectoral humanitarian responses to maximise accessibility of services and inclusion of people with disabilities and older people. For example:
   - Develop and provide services, infrastructure, communication and information using the principles of universal design.
   - Ensure humanitarian assistance and services meet the sector-specific age and disability minimum standards that follow in this document.
2. Adapt budgets to include costs for accessible services according to the needs of the community. For physical accessibility (buildings and latrines), budget an additional 0.5-1 per cent. To also include specialised non-food items (NFIs) and mobility equipment, budget 3-4 per cent. Include a transport budget for people with mobility challenges and their carers to access services.
3. Routinely identify, monitor and address barriers affecting participation and access to services for people with disabilities and older people. Take consideration of:
   - Gender-specific factors (eg heightened risks of gender-based violence).
   - Obstacles faced in accessing specific services (eg physical barriers affecting people with mobility-related limitations or visual impairments, communication barriers affecting people with hearing or intellectual impairments, or caring responsibilities).
   - Discrimination and other attitudinal barriers (including attitudes of humanitarian service providers and community members) and social stigma affecting particular groups
4. Encourage and support outreach services, community members, groups and organisations representing people with disabilities or older people to identify those who are not accessing services. Identify barriers and potential solutions to discrimination or exclusion, applying a gender analysis.
5. Refer people with disabilities and older people with specific needs to organisations with the relevant technical expertise and mandate, and advocate for those needs to be addressed.

Key Inclusion Standard 3: People with disabilities and older people affected by crisis are not negatively affected and are more prepared, resilient and less at-risk as a result of humanitarian action.

Actions to meet the Standard

1. Create and sustain an inclusive environment for people with disabilities and older people. Ensure that all activities promote and protect the inclusion and safety of these groups.11 For example:
   - Encourage national and local duty bearers to respect the rights, needs and capacities of people with disabilities and older people (including those who are refugees or internally displaced).
   - Support culturally and gender-sensitive community awareness-raising initiatives to address negative attitudes and actions at the local level.
2. Include people with disabilities and older people, and their carers, in mechanisms to assess and reduce risks to vulnerable groups. These should include policies to prevent sexual exploitation, abuse or discrimination, taking into account the heightened risks for these groups. Systematically monitor humanitarian programmes to ensure that people with disabilities and older people are not exposed to additional risks or harm as a consequence of humanitarian action.
3. Ensure that people with disabilities and older people, and their carers, are informed of their relief entitlements, the targeting criteria being used and the mechanisms through which they will receive assistance, to minimise risk of abuse by humanitarian actors or community members. Establish codes of conduct, protection policies, transparent decision making and reporting mechanisms for the delivery of assistance. Put in place measures to protect the dignity and safety of older people and people with disabilities at distribution sites and when using other essential services. Consider specific risks to women, girls, boys and men.
4. Be sensitive to protection risks that could arise from measures to facilitate access to assistance for people with disabilities, older people and other vulnerable groups (eg prioritising them for assistance may increase stigma and the risk of theft or even violence). Consider the impact of such measures, ensuring they do not increase risks for particular individuals or groups (take account of gender roles and social and cultural contexts).

Key Inclusion Standard 4: People with disabilities and older people affected by crisis know their rights and entitlements, have access to information and participate in decisions that affect them on an equal basis with others.

Actions to meet the Standard

1. Ensure people with disabilities and older people can access all important information and accommodate for people with vision, hearing, communication, mobility and literacy limitations and/or difficulties with processing information. For example:
   - Use a variety of communication methods, media and information channels to maximise the reach and coverage of key messages. Train and support staff, partners and volunteers accordingly.
   - Make staff aware that many people with disabilities and older people cannot use or access mainstream communication (eg written messages or mobile phones).
   - Monitor and evaluate the suitability of different communication methods and information channels for different disability and age groups.
   - Ensure that policies and protocols on informed consent take into account people with disabilities and older people, including those with mental and/or intellectual disabilities.
2. Ensure people with disabilities and older people, and their carers, participate directly in needs assessments, consultation and feedback mechanisms to inform programming. For example:
   - Use a range of accessible communication methods in consultation/engagement activities and train staff to support this (eg the use of pictures or photos, audio, large print, visual demonstrations, face-to-face explanations, clear/slower speech and simple language).
   - Consult people with disabilities and older people about their communication needs or preferences. Partner with disabled or older people's organisations if specialist communication is required.
   - Ensure that meeting venues are physically accessible and safe for people with mobility limitations or visual impairments, that communication is as accessible as possible to all, and arrangements support carers.
3. Take measures to include and consult 'hard-to reach' people with disabilities and older people, and their carers, including those who cannot leave their homes or shelters. Use community outreach and/or partner with representative or specialised age and disability organisations.

Key Inclusion Standard 5: People with disabilities and older people affected by crisis have access to safe and responsive mechanisms to handle complaints on an equal basis with others.

Actions to meet the Standard

1. Consult people with disabilities and older people on the design, implementation and monitoring of complaints-handling processes.
2. Ensure processes for making complaints and seeking redress are accessible for people with disabilities and older people.
3. Make sure that people with disabilities and older people have equal access to information about what to expect from agencies, how to make complaints, and what can and can't be addressed through the complaints process (see Key Inclusion Standard 4).
4. Ensure complaints are handled within an organisational culture that listens to and acts on complaints and respects the dignity, rights and capacities of people with disabilities and older people. For example:
   - Include people with disabilities and older people in the organisation's policies relating to duty of care, codes of conduct, and protection of vulnerable people.
   - Make staff aware of the risks that many people with disabilities face, in particular sexual exploitation, abuse and discrimination.
   - Train staff on how to communicate respectfully with people with disabilities and older people.
5. Ensure that people with disabilities and older people who are survivors of abuse are sensitively and appropriately supported and/or referred for assistance or protection.

Key Inclusion Standard 6: People with disabilities and older people affected by crisis receive and participate in coordinated, complementary assistance on an equal basis with others.

Actions to meet the Standard

1. Include the needs of people with disabilities and older people in the agendas of sector/cluster meetings and other coordination mechanisms as a matter of routine. Ensure that disability- and age-sensitive programming is systematically addressed by all sectors and integrated into coordination mechanisms to ensure a holistic approach to inclusion (eg addressing interrelated shelter, water, sanitation and hygiene (WASH), psychosocial and protection needs).
2. Map services and organisations in your area, to identify actors who provide targeted assistance for these people and other vulnerable groups, such as treatment of chronic diseases, or provision of mobility aids/assistive devices and physical rehabilitation. Include this information in service directories and referral systems and keep all relevant actors updated.
3. Develop partnerships between mainstream humanitarian actors and age- and disability-specialised organisations, including disabled people's and older people's organisations. Ensure that disabled people's and older people's organisations participate effectively in the humanitarian response by making appropriate use of their expertise, capacities and resources.
4. Make sure actions focused on the needs of people with disabilities and older people are not delivered in isolation, and are accompanied by appropriate follow up. Ensure older people and people with disabilities benefit from synergies between mainstream and targeted interventions, to increase their impact and effectiveness.

Key Inclusion Standard 7: People with disabilities and older people affected by crisis can expect improved assistance and inclusion as organisations learn from experience and reflection.

Actions to meet the Standard

1. Aim to continuously improve the accessibility and quality of assistance and protection for people with disabilities and older people. This can be achieved by:
   - Learning from experience with routine monitoring.
   - Consulting specialised organisations representing people with disabilities and older people.
   - Consulting directly with individuals and families.
2. Define and use appropriate age- and disability indicators in baseline data, monitoring forms and evaluations (eg percentages of people with disabilities and older people accessing services).
3. Include people with disabilities and older people in monitoring and evaluation. Include groups that may be overlooked in routine monitoring, such as children and adolescents with multiple disabilities (and their carers) and people with mental or intellectual disabilities. Budget for accessibility in evaluations.
4. Ensure people with disabilities and older people participate in monitoring and evaluation alongside other people affected by crisis. Include their experiences in lesson-learning and actions to improve the accountability, accessibility, and safety of humanitarian responses.
5. Share learning, good practice and innovation related to the inclusion of people with disabilities and older people within your organisation and with other stakeholders, such as partners, national organisations and authorities.

Key Inclusion Standard 8: People with disabilities and older people affected by crisis receive the assistance they require from competent and well-managed staff and volunteers who are skilled and equipped to include them in humanitarian responses, and they have equal opportunities for employment and volunteering in humanitarian organisations.

Actions to meet the Standard

1. Train staff at all levels to deliver impartial assistance that recognises gender, age and disability, and to assist in recognising these factors as a source of potential vulnerability or reduced capacity. Make sure that no group or individual is intentionally or unintentionally overlooked or excluded (ie discriminated against) because of their gender and/or age and/or disability. Ensure humanitarian staff are aware that people with disabilities and older people are not homogeneous groups, and that they understand people's individual specific needs, capacities and vulnerabilities.
2. Make all partners and staff aware of the rights of people with disabilities and older people and the importance of including them in humanitarian response. Include disability and age in induction programmes and training to raise awareness of:
   - Disability-, age- and gender-based discrimination.
   - Risks that may particularly affect people with disabilities and older people (eg difficulty accessing services and risks of gender-based violence (GBV) and sexual exploitation and abuse, particularly for women and girls), and the importance of protection standards and policies for these groups.
   - The importance of collecting and using sex-, age- and disability-disaggregated data.
3. Appoint staff at appropriate (including senior) levels within the organisation to support and monitor cross-organisation and partner awareness to deliver age and disability inclusive response, and/or establish inter-agency disability, age and gender focal points for this purpose.
4. Make staff and partners aware of international, national and local agencies focusing on disability and age as well as organisations representing people with disabilities and older people.
5. Make provision within organisations to ensure that people with disabilities and older people have equal opportunities for employment and volunteering; budget for this accordingly.

Sector-Specific Standards

Protection

Standard 1: People with disabilities and older people, and their carers, are fully included in the design, implementation, monitoring and evaluation of protection activities and services, and they participate in relevant protection assessments and monitoring. Humanitarian organisations identify and address specific protection concerns affecting people with disabilities and older people, including exclusion from services and assistance.

Standard 2: Humanitarian actors make all possible efforts to ensure a safe, inclusive and protective environment for older people and people with disabilities affected by crisis, and these groups play a full role in community-level protection action.

Standard 3: People with disabilities and older people, and their carers, have full access to protection services and to all information relevant to their protection.

Standard 4: People with disabilities and older people have full access to registration systems and identification and other documents that are essential for their legal and social protection.

Standard 5: People with disabilities and older people are protected from physical and psychological harm arising from violence and abuse, including gender-based violence (GBV).

Standard 6: People with disabilities and older people living in residential institutions and hospitals are protected.

Standard 7: People with disabilities and older people are protected in situations of displacement and return.

Water, Sanitation and Hygiene (Wash)

Standard 1: People with disabilities and older people, and their carers, are fully included in the design, implementation, monitoring and evaluation of WASH services and facilities, and they participate in relevant needs assessments.

Standard 2: Information on WASH services and facilities is fully accessible and available to people with disabilities and older people, and their carers.

Standard 3: People with disabilities and older people, and their carers, have full access to an adequate supply of water for drinking, cooking and other domestic use.

Standard 4: People with disabilities and older people have full access to latrine facilities that are appropriate for them to use safely and with dignity.

Standard 5: People with disabilities and older people, and their carers, have full access to hygiene services including an adequate and appropriate supply of hygiene items, and to hygiene facilities that are appropriate for them to use safely and with dignity.

Food Security and Livelihoods

Standard 1: People with disabilities and older people are included in food security and livelihoods assessments, and in the design, implementation, monitoring and evaluation of food security programmes.

Standard 2: Information relating to food assistance and food security programmes is fully accessible and available to people with disabilities and older people, and their carers.

Standard 3: Food distributions and cash and voucher transfers use methods that ensure inclusion and access to adequate food for people with disabilities and older people, and that safeguard their dignity.

Standard 4: Food-for-work, cash-for-work and livelihoods programmes are designed and implemented in ways that take account of the capacities of older people, people with disabilities and their carers seek to overcome or compensate for barriers to their participation, and meet their food security and livelihood needs.

Nutrition

Standard 1: The nutritional status of people with disabilities and older people is systematically assessed and monitored. Nutritional assessments are used to trigger and inform emergency nutrition responses that include or target people with disabilities and older people.

Standard 2: People with disabilities and older people, and their carers, participate in the design, implementation, monitoring and evaluation of nutrition-related services and interventions, including nutrition assessments.

Standard 3: Information relating to food and nutrition services and interventions is fully accessible and available to people with disabilities and older people, and their carers.

Standard 4: Moderate acute malnutrition (MAM) and severe acute malnutrition (SAM) among people with disabilities and older people are prevented and treated on the basis of impartiality of humanitarian assistance.

Shelter, Settlement and Non-Food Items

NFIs might be referred to as essential household items, as they should include items that are essential for daily living for many people with disabilities and older people, such as mobility or other assistive devices (eg hearing aids and batteries, spectacles, etc) and items for special WASH, food or health needs (eg commodes, drinking straws, etc).

Standard 1: People with disabilities and older people, and their carers, are included in the design, implementation, monitoring and evaluation of shelter/settlement programmes, and they participate in relevant needs assessments.

Standard 2: Information relating to shelter and settlement assistance and essential NFI distributions is fully available and accessible to people with disabilities and older people.

Standard 3: People with disabilities and older people have safe and equitable access to shelter and settlement facilities that are appropriate, adequate and safe for them to use.

Standard 4: People with disabilities and older people, and their carers, are included in the design, implementation and monitoring and evaluation of NFI programmes, and they participate in relevant needs assessments.

Standard 5: Cash and voucher and NFI distributions are designed, targeted and implemented in ways that ensure dignity and minimise exclusion or marginalisation and other risks for people with disabilities and older people.

Health

Standard 1: People with disabilities and older people, and their carers, affected by crisis are fully included in multisectoral and specific health assessments and in the design, implementation and monitoring of health programmes and services.

Standard 2: Healthcare staff are trained and sensitised on disability and age and associated healthcare needs, and in how to respectfully communicate with people with disabilities and older people.

Standard 3: People with disabilities and older people affected by crisis have access to comprehensive health services and health information.

Standard 4: People affected by crisis, including people with disabilities and older people, have access to trauma/injury care during humanitarian crises to prevent avoidable morbidity, mortality and disability, and people with injuries or disabilities have access to rehabilitation services and assistive aids and devices to help reduce the disabling impacts of injuries or impairments.

Standard 5: People with disabilities and older people have access to essential therapies to reduce morbidity and mortality due to chronic health conditions.

Standard 6: Children with disabilities have full access to child health services.

Standard 7: People with disabilities and older people have full access to sexual and reproductive health services.

Standard 8: People with disabilities and older people have access to preventive, diagnostic and therapeutic health services for communicable diseases on an equal basis with others.

Standard 9: People affected by crisis, including people with disabilities and older people, have access to mental health services that prevent or reduce emergency-related and pre-existing mental health conditions and associated impaired functioning.

Emergency Education

Standard 1: The participation of girls and boys and young people with disabilities in education is systematically assessed and monitored, and barriers to participation are identified to inform inclusive education responses.

Standard 2: Parents and guardians of children and young people with disabilities, and girls and boys with disabilities, participate in needs assessments and in the design, implementation, monitoring and evaluation of education services and interventions. Humanitarian actors actively promote an inclusive community environment that is supportive of including girls and boys with disabilities in education.

Standard 3: Girls and boys with disabilities have full access to quality and relevant education opportunities.

Standard 4: People with disabilities and older people have full access to vocational training, skills training and adult literacy classes.

Appendixes

1. THE ROLE OF DISABILITY AND ELDERLY DESK OFFICERS

Introduction

The District Disability and Elderly desk officer shall be the focal person responsible for disability and elderly matters at district council level. He/she shall be a serving officer from the district social welfare office appointed by the District Commissioner. He/she shall work hand in hand with other relevant officers directly dealing with disability and elderly issues in the district. Furthermore, the desk officer shall be expected to attend District Executive Committee meetings and provide technical advice to the council on all matters concerning persons with disabilities and the elderly.

Disability and elderly desk officers are professionals who work in various sectors and organizations to promote the inclusion and participation of persons with disabilities and the elderly in society. They are responsible for coordinating, implementing and monitoring disability and elderly-related policies, programs and services within their respective domains. Disability and elderly desk officers also act as focal points for disability and elderly issues and liaise with other stakeholders, such as government agencies, civil society organizations, disabled people's organizations, service providers and donors.

Main Functions Of Disability And Elderly Desk Officers

1. To conduct situational analysis and needs assessment of persons with disabilities and the elderly in their sector or organization.
2. To develop and implement disability and elderly mainstreaming strategies and action plans in line with the national disability policy and the Convention on the Rights of Persons with Disabilities.
3. To ensure that persons with disabilities have equal access to opportunities, resources and benefits in their sector or organization.
4. To facilitate the participation and consultation of persons with disabilities, the elderly and their representatives in decision-making processes and policy formulation.
5. To provide technical guidance and support on disability and elderly issues to their colleagues and managers.
6. To monitor and evaluate the impact and outcomes of disability-related interventions and initiatives in their sector or organization.
7. To report on the progress and challenges of disability mainstreaming in their sector or organization.
8. To advocate for the rights and interests of persons with disabilities at various levels and platforms.
9. To build partnerships and networks with other disability desk officers and relevant actors in the field of disability.
10. Conducting research and analysis on ageing trends, challenges, and opportunities
11. Developing and reviewing policies, strategies, and action plans on ageing and intergenerational solidarity
12. Advocating for the rights and interests of older persons and promoting their participation and inclusion in society
13. Providing technical assistance and capacity building to stakeholders on ageing-related matters
14. Monitoring and evaluating the impact and effectiveness of ageing interventions and initiatives
15. Liaising and collaborating with other desk officers, partners, and networks on cross-cutting issues such as health, social protection, gender, disability, and human rights
16. Raising awareness and disseminating information on ageing issues and best practices

Specifically, the responsibilities of the desk officers include;

1. Collect and maintain data on persons with disabilities and the elderly in the district
2. Participates on stakeholders' programs/activities requiring technical and policy contribution from the department of disability and elderly affairs
3. Follow up and report on cases of human rights violations against persons with disabilities and the elderly
4. Provide a quarterly report on disability and elderly for management use
5. Represents the Department of disability and elderly in the district civil protection committee and other relevant committees/structures
6. Facilitate the mainstreaming of disability and elderly issues into the district development and implementation plans
7. Preparation of work plans and budgets for disability and elderly activities within the district council recurrent budget
8. In liaison with relevant institutions or organizations ensure that persons with disabilities and the elderly are provided with appropriate and timely interventions
9. Strengthen the referral system for persons with disabilities and the elderly to access various services in the district
10. Maintain an up to date catalogue of organizations and institutions providing services to persons with disabilities and the elderly
11. Promote awareness of disability and elderly issues at all levels in the district
12. Facilitate the provision of psychosocial support to persons with disabilities and the elderly
13. In consultation with relevant stakeholders at the district council promote compliance of facilities and services to national standards on accessibility
14. Advise the Ministry on the capacity building needs of the councils
15. Conduct capacity building of relevant stakeholders at community level
16. Facilitate the inclusion of persons with disabilities and the elderly in social protection programs
17. Taking part in monitoring and evaluation of various programs and interventions at district council

2. TERMS OF REFERENCE FOR THE DISTRICT DISABILITY AND ELDERLY AFFAIRS TECHNICAL WORKING GROUP (TWG)

Name:
The group shall be called the District Disability and Elderly Affairs Technical Working Group (DDEA-TWG).

Background
The District Disability and Elderly Affairs Technical Working Group terms of reference have been developed in line with National Gender and Social Empowerment Sector Working Group guidelines that were formulated to serve as administrative instructions and standard operating procedures for enhanced coordination of national development programs. The TWG will, therefore, assist district councils in improving the coordination and adoption of disability and elderly inclusive strategies with the aim of realizing the goals and objectives of the national disability and older persons' policies thereby contributing to the achievement of the aspirations of the Malawi 2063.

Aim
The purpose of the DD&EA-TWG is to act as a think tank for the District Gender and Social Empowerment Sector Working Group (DGSE-SWG). As such, the TWG is expected to technically assist the DGSE-SWG in the implementation of its strategies and be able to deliver on its goals and objectives. The main aim of DD&EA-TWG is to ensure that the DGSE-SWG is effective both in terms of its operations and the outputs or services that it delivers to persons with disabilities and the elderly. This will be reflected in the planning, implementation, reporting, monitoring and evaluation of initiatives intended to achieve the national Disability and Elderly Affairs goals and objectives.

The Mandate of the District Disability and Elderly Affairs Technical Working Group

1. Providing a forum for disability and elderly policy dialogue and coordination amongst the key government departments and agencies, implementing partners including the private sector, donors, national and international NGOs, FBOs and CSOs.
2. Promote best practices and document lesson learning for wider sharing in the Disability and elderly Affairs sector;
3. Give recommendation and direction relating to disability and elderly issues at the district.
4. Monitor and report on disability and elderly sectoral progress which among other key areas include government and partners spending, program implementation, donor assistance and progress made in implementing sector priorities
5. Identify areas for harmonization for the Disability and Elderly programmes in terms of impact, outcomes, outputs, and activities or strategies;
6. Mobilize resources for implementation of disability and elderly activities in the district
7. Facilitate mapping of service providers
8. Facilitate implementation of disability and elderly inclusive social protection programmes in the district

Modus Operandi

The DD&EA-TWG shall be chaired by the Director of Planning and development at the District Council on a permanent basis and shall have a co-chair from the Civil Society that shall rotate on an annual basis. The TWG shall have a secretariat from within the District Social Welfare Office. It shall meet the third week of the last month of the quarter unless otherwise determined.

Roles of the Chair

1. Provide leadership for the DD&EA-TWG to ensure that the group is well coordinated and achieves its results.
2. Offer government guidance and authority in the endorsement of crucial decisions and resolutions passed by the DD&EA-TWG meetings.
3. Preside over all DD&EA-TWG meetings
4. Liaise with the TWG secretariat in calling for the TWG meetings and developing their agenda.

Roles of a Co-Chair

1. Preside over all DD&EA-TWG meetings in the absence of the chair
2. Coordinate NGO efforts in implementing Disability and Elderly related activities
3. Offer technical expertise through DD&EA-TWG
4. Liaise with the secretariat in developing agenda for the meetings and calling for meetings in the absence of the Chair

Roles of the Secretariat

1. With the Chair's guidance, developing agenda and call for meetings.
2. Taking minutes during meetings, compile and distribute them to members in time
3. Distribute necessary documentation and information amongst members of the DD&EA-TWG
4. Take care of all operational requirements or the proper running of the group especially during meetings
5. Support the implementation of action points identified during DD&EA-TWG meetings

Frequency of meetings

The TWG will meet quarterly and at such times as it deems necessary and appropriate to fulfill its responsibilities as directed by the DGSE-SWG. The TWG shall establish its own schedule of activities that will be submitted to the DGSE-SWG through the Secretariat.

Reports/Minutes

The TWG is required to document minutes of its meetings and report main issues to the DGSE-SWG meeting at the end of each quarter. The report shall include recommendations for action.

Delegation of Authority
With permission from the DGSE-SWG or the District Executive Committee, the TWG may form or delegate authority to a specialized working group such as Task Force or sub-committees with a view to undertake specific activities within a limited time period. These Task Forces will be dissolved once they deliver on the allocated assignments.

Membership:
Membership is expected to include relevant technical stakeholders as follows:

1. The Directorate of Planning and Development (DPD),

District Gender Office,

2. District Social Welfare Office,
3. District Community Development Office,
4. Malawi Council for the Handicapped (MACOHA)
5. District Youth and Sports Office,
6. District Agricultural Development Office,
7. District Nutrition Office (DNO),
8. District Police Victim Support Unit (PVSU),
9. District Education Management Office (DEMO),
10. Judiciary,

District Information Office,
District ECD Coordinator,

11. District Community Policing Coordinator,
12. Directorate of Public Works,

National Registration Bureau,

13. District Health Office (Ophthalmology, Dermatology, Orthopedics)
14. District Labour Office (DLO),
15. District Disability Forum (DDF)
16. Malawi Network of Older Persons Organisations (MANEPO)

International and Local NGOs
Representatives of CBOs,

17. Representative of Public Service Pensioners Association (PUSEPA)
18. Youth Network,
19. Faith Based Organizations
20. Traditional leaders' representatives.

Membership shall also be extended to individuals and special interest groups based on their expertise and interest in the promotion of Disability and Elderly Affairs in the district as may be deemed necessary by the DD&EA-TWG members.

MINISTRY OF GENDER, COMMUNITY DEVELOPMENT,
AND SOCIAL WELFARE

Training Manual for Disability and Elderly