

INCLUSIVE SCHOOL HEALTH AND NUTRITION PROGRAMMES

A roadmap for mainstreaming
disability into the FRESH
Agenda



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Purpose of this document

Integrating disability in the post 2015 development agenda is part of a broader strategy for achieving equity. Inclusive approaches to education and health are required to ensure equal rights and opportunities, personal autonomy and dignity to all children, regardless of their social status, gender, age, physical or mental condition, race, religion or sexual orientation.

The purpose of this document is to support the implementation of comprehensive school health and nutrition programmes (SHNP) that are inclusive of children with disabilities. It provides background information and practical examples of how to address the needs of children and adolescents with various disabilities within SHN strategies and activities.

The paper was developed by reflecting on the initiatives carried out in recent years and the principles of the inclusive health and education policy. It represents a further contribution to FRESH¹ efforts to promote more equitable health and nutrition strategies for all children in countries and regions around the world. It is aimed at SHN planners and implementers, and to community and civil society organizations that work with or would like to promote greater involvement of children and adolescents with disabilities in their programmes. Other audiences who will benefit from this source book include but are not limited to:

- **Education and health policy makers, particularly those involved in planning, implementing and evaluating school health and nutrition programmes**
- **Implementers of broader health or education projects which have a school health component**
- **International disability organizations**
- **International agencies and donors interested in effective SHN programmes**
- **Disabled people's organizations (DPOs), particularly those interested in working with children in inclusive education and rehabilitation programmes.**

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Chapter 1

CHILDREN WITH DISABILITIES: A BRIEF GLOBAL SNAPSHOT

Demographics

According to the 2011 World Report on Disability, produced by the World Health Organization and the World Bank (2011), approximately 15% of the world's population lives with some form of disability (roughly one billion persons). The vast majority (80%) of these people live in developing countries with two-thirds in the Asia-Pacific region². These figures are rapidly increasing, as a result of population growth and ageing (with a consequent rise in chronic diseases) but also violence, war, malnutrition, poor living conditions and improvements in measurement techniques. Between 2.5 and 3.5 million of the world's 35 million displaced persons also live with disabilities. The relative numbers of persons with disabilities living in poverty is likely to be much higher, given the injuries caused by violent conflict or natural disasters that cause people to become refugees.³

Children and adolescents with disabilities constitute a significant proportion of the population, especially in low-income countries. By one widely used estimate, some 93 million children – 1 in 20 children aged 14 or younger – live with a moderate or severe disability of some kind.⁴ Citing the Global Burden of Disease study (2004) the World Report further estimates that among those aged 0-14 years, roughly 5.1% of all children live with a “moderate or severe” disability and 0.7%, or 13 million children, live with severe difficulties.⁵ An estimation of school-age children with disabilities can be made on the basis of these figures; resulting in 80 to 110 million children aged 5 to 14 living with disabilities worldwide. Eighty per cent of these children are in the poorest countries of the world (UNDP, 2006). Those children have the least access to education, suffer from severe social stigma that leads to their ostracism and exclusion, and are among the most vulnerable to violence and sexual abuse (UNICEF, 2005).

Becoming visible: The need for data

Millions of children with disabilities are left out of health and education sector plans due to poor data and a lack of knowledge on how to include them. Their “invisibility” is evident in the lack of demographic and social information regarding their numbers, characteristics and needs. Few countries have reliable information on how many children with disabilities are in the population, what disabilities they have or how these disabilities affect their lives.

A key step towards equality and inclusion is to start collecting and disaggregating data on children with disabilities. This can be implemented by introducing basic disability-related questions in rapid assessments, health and nutrition surveys and situation analysis:

- Are there children with disabilities in school?
- Have there been children with disabilities in the recent years that have dropped out?
- Have schools located and contacted all children with disabilities in the area?
- Is the school compound accessible?
- Are health activities accessible? Have adaptations been made to respond to needs of children with disabilities?
- Are school meals accessible?

For a complete check list on children with disabilities, see www.schoolsandhealth.org/Pages/documents.aspx

A recent study found that the likelihood of children with disabilities not attending school is often over 10 times greater – with disabled boys and girls in Kenya for instance the least likely to go to school (UNICEF, 2013). From the analysis of data gathered amongst 1,4 million sponsored children worldwide, it appears that children are being excluded as a result of their disability, rather than lack of access to education in general. This is particularly prevalent in Egypt, where 80% of children with disabilities cited their disability status as a reason for not attending school. The research also found that when children with disabilities do attend school, their level of schooling is below that of their peers and that a child with a disability is also much more likely to have had a serious illness in the last 12 months, including malaria and malnutrition. (Plan International, 2013).

How is it possible that such a large proportion of children and adolescents are not reached by the international, longstanding efforts to provide education and health to all children?

The answer to this question lies primarily with the social, economic and political exclusion that these children and adolescents face. A long chain of barriers combined with the persistent poverty and exclusion affects the large majority of persons with disabilities and their families. These limitations deprive them of access to inclusive education and to essential health services. Prevention campaigns and educational programmes are often not accessible to them, making them even more vulnerable to many diseases and “secondary” disabilities that often results from not having access to rehabilitation services.

In Indonesia, for instance, the attendance rate in primary school is almost 60 percentage points lower among children with disabilities compared to nondisabled children.

D. Filmer, 2008

Education

Disability is a factor commonly found among children who are out of education.⁶ However, “disability” is not the reason for being out of school. The reasons are social and environmental barriers that children with disabilities face.

Stigma and ignorance often lead parents to keep a child with impairment at home. Also, if household resources are scarce, parents may educate non-disabled children only, based on the belief that they will be better able to support their siblings with disabilities.⁷

The education system and infrastructure can also exacerbate marginalization. Physical access to school premises is often inadequate, curriculum and pedagogy might not be appropriate, attitudinal barriers and prejudice are common. Teachers are often untrained to meet the support needs of students with impairments, or have low expectations about their possibilities. Some children with disabilities may find schools threatening. A non-inclusive educational environment would not address and may even increase the barriers that children with impairments face, thereby accentuating their marginalization.

As a consequence, children with disabilities tend to receive relatively little education and therefore face enormous obstacles to reach their potential.⁸ UNESCO estimates that one-third of the 75 million children worldwide who are not in school have impairments.⁹ A child with a disability aged 6 to 11 is on average half as likely to be in school as a child without a disability of the same age.¹⁰

“Disability” is not the reason for being out of school. The reasons are environmental barriers that children with disabilities face:

- **Negative attitudes and low expectations**
- **Inaccessible infrastructure and transportation**
- **Lack of access to assistive devices**
- **Schools’ lack of capacity for delivering education for all.**



Only half of the children with disabilities who start school actually complete their primary education, with many leaving soon after enrolment because they are gaining little from the experience.¹¹ UNESCO estimates that only 5% of all children with disabilities worldwide have completed primary school.¹² In countries such as Malawi and Tanzania, for example, having a disability doubles the probability of children not attending school.¹³

This difference in school attendance between children with and without disabilities varies widely from country to country. According to the *World report on disability* (2011), only 33% of girls and 46% of boys with disabilities have completed primary school, compared with 42% of girls and 56% of boys without disabilities. In India for example, the difference at primary school level is 10% while in Indonesia it stands at 60%. In rural areas and poor urban neighbourhoods children with disabilities are particularly at risk of not receiving an education,¹⁴ with subgroups such as orphans and displaced children with disabilities facing a double jeopardy.¹⁵

The social environment firmly determines the scope of disability. Children with the same impairment experience very different types and degrees of functional limitations, depending on the physical and social conditions in which they live.

WHO, 2011

Poverty

Although disability is not isolated in one social or economic group, a strong, bi-directional link between poverty and disability has been proved.^{16,17} The Millennium Development Goals such as eradicating, or reducing by half, extreme poverty and hunger cannot be achieved without taking into consideration a group of people (women and children in particular), who are largely over-represented among the world's poorer people.

Raising a child with a disability also places an increased economic burden on the family. Estimates of additional costs associated with disability range from 9% of income in Viet Nam to 11-69% in the United Kingdom. In addition to medical, rehabilitation and other direct expenses, families also face

opportunity costs, as parents and family members are often forced to sacrifice or limit their employment in order to care for children with disabilities.¹⁸

The inaccessibility of health services to children with disabilities is entirely avoidable and the cost of such exclusion will always be much higher than the cost of inclusion.

Investing in inclusion will improve services and interventions not only for children with disabilities but for all children. (UNICEF, 2013)

Together, poverty and disability create a vicious circle. There are two main correlations to consider in this cycle:

- **Poverty may cause disability** through malnutrition and poor health care, Poverty leads to secondary disabilities for those individuals who are already disabled, as a result of their poor living conditions, malnutrition, and poor access to health care and educational opportunities. Case studies in developing countries show that higher disability rates are associated with higher rates of illiteracy, poor nutritional status, lower immunization coverage, lower birth weight, higher rates of unemployment and underemployment, and lower occupational mobility.
- **Disability often causes poverty** by preventing the full participation of persons with disabilities in the economic and social life of their communities, especially if the appropriate equipment, support and accommodations are not available.

Health

In accordance with the Convention on the Rights of the Child and the Convention on the Rights of Persons with Disabilities, promoting the right to “the highest attainable standard of health” for all children means providing children with disabilities with equal access to the full spectrum of care:

- Immunization
- Nutrition
- Treatment for childhood ailments and injuries (e.g. deworming)
- Access to health and hygiene education and infrastructure (WASH)
- HIV and sexual and reproductive health information.

Despite this obligation, children with disabilities are often invisible to programme administrators, which lead to health plans that fail to take barriers to inclusion into consideration, and to health services that are inaccessible.

In addition, and because health is affected not only by access to services, programming and logistics but also by social attitudes, nutrition and a safe living environment. And because indicators in these basic conditions are very poor for children with disabilities, they are likely to face a higher incidence of poor health. This is the reason for inequalities that are not directly connected to their disabilities; for instance, mortality for children with disabilities is as high as 80% in countries where under-five mortality overall has dropped below 20%.¹⁹

Health promotion and prevention, early identification and assessment and early intervention are key health interventions for children with disabilities. A particularly important role that schools can play is to help in identifying those children with the less obvious or “minor” functional limitations (which represent the largest group of children) and propose the –often subtle– adaptations necessary to make learning accessible to them. The most common examples of such adaptations are those that can be made for children with minor visual or hearing disabilities. In these cases, accessibility can be resolved by placing the children nearer to the teacher and the blackboard so they are able to fully participate in lessons.

Children with minor intellectual disabilities will also be able to keep up with lessons if provided with a bit of extra support from the teachers, peers or special education teachers.

Only in the case of more severe disabilities, the role of schools and teachers becomes essential in effective detection of impairments and referral of children with disabilities to specialists for further assessment and support (including medical treatment).

Nutrition

The intersection between nutrition and disability has been largely overlooked. Malnutrition can be a cause of disability, but it can also be a consequence. Both conditions can severely limit life opportunities; both are global development priorities; and progress in both is dependent on addressing underlying poverty, equity and human rights issues.

While improved nutrition of pregnant women to prevent prenatal disability or disability in childhood has received increased attention, the nutritional needs of children with disabilities are rarely included in school feeding programmes.

In addition to physical factors, attitudes may also play an adverse role. Deliberate omission also occurs; for example, children with disabilities may be fed less, denied food or provided with less nutritious food than siblings without disabilities. They may also be hidden away from community feeding initiatives and other nutritional safety net efforts; all

based on the belief that preserving the life of a child with a disability is of lower priority than preserving the life of someone who is non-disabled.

For school feeding programmes, reaching children with disabilities is both a challenge and an opportunity. On one hand, children with disabilities who do not attend school miss out on school feeding programmes. On the other hand, when accommodations are provided (i.e. the school is accessible, transportation is aided, the school environment is inclusive) and efforts are made to reach out to these children, school feeding can work as a tangible incentive for families to also send their children with disabilities to school.

Social barriers

Children with disabilities encounter different forms of exclusion, and social norms are a negative factor influencing their situation. In many countries, there are adverse perceptions concerning people with disability, resulting in stigma and discrimination. Children with disabilities are often regarded as inferior and perceived as a curse to their family and community, which puts them in a position of increased vulnerability.²⁰ These attitudes can lead to structural barriers to access to education and health services.

Gender further exacerbates disability status: girls with disabilities are less likely to get an education, receive vocational training or find employment than are boys with disabilities or girls without disabilities.



Chapter 2

NEW PERSPECTIVES ON DISABILITY

How to define disability today

The many definitions of disability used in different countries contribute to the current lack of information regarding children and adolescents with disabilities. These differences influence the results and make it difficult to collect comparable data in order to develop systems that foster and guide inclusive programming.

The most common definition of disability today is based on the International Classification of Functioning, Disability and Health (ICF), which focuses on the implied possibilities and limitations of a particular physical condition with regard to the individual's mobility, social participation, and relationship to his or her living environment.²¹

In line with this, the Convention on the Rights of Persons with Disabilities (CPRD) defines people with disabilities as those who have “long-term physical, mental, intellectual, or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others” (CPRD, Article 1). This definition emphasizes the social and environmental aspects of disability, refuting the historical view of people with disabilities almost solely as “charity cases”.

Disability is not the same as illness: This distinction has become increasingly salient in recent years; a traditional, medical-centred view has frequently led to treating people with disabilities as if they need health care, instead of adjusting the environment where they live, learn and grow up to their functional needs. By differentiating between disease, functional diminution and disability, the ICF encourages a non-stigmatizing interpretation of disability. A social interpretation of disability allows highlighting the environmental factors that impact a person's ability to function in society and the modifications needed to foster the participation of children and adults with disabilities.

Over the past decades, disability has increasingly been conceptualised and addressed as a human rights issue.

Children with disabilities are entitled to all rights guaranteed to children under the Convention on the Rights of the Child and the Convention on the Rights of Persons with Disabilities.

Gathering data on the basis of a correct definition of disability: The way disability is defined has enormous consequences in terms of the information that is gathered on this group. Common limitations in collecting data that are related to the definitions of disability include the following:

- The term “disability” is still not widely recognized and understanding of the terminology varies considerably across cultures and educational levels.
- Having a disability carries negative social and personal connotations. For example, the child feels ashamed or afraid of being bullied or stigmatized.
- The term “disability” can be interpreted as a severe condition. For example, the parents of a child who is able to walk within their house, but is unable to walk to school, may perceive their condition as a mild one and thus fail to recognize it as a “disability”.²²

Gathering data on disabilities

Anyone at any time can acquire an impairment of any kind and can become permanently or temporarily disabled.

Different kinds of impairments may generate different kinds and levels of functioning limitations but, if we eliminate barriers, these limitations may not necessarily become a disability.

Consequently, the question “*Does someone in the family have a disability?*” (frequently used in surveys) is actually a good example of an extremely ineffective way to ask about disabilities, eliciting an affirmative response rate between 1% and 2%. Asking children specific questions that focus on how they function in their daily lives decreases ambiguity, and increases the reliability and accuracy of the data.

Types of disabilities

Disabilities are grouped in four main types:

- Physical disabilities
- Sensory disabilities
 - Vision impairment
 - Hearing impairment
- Intellectual disabilities
- Mental health, emotional and developmental disabilities.

Although disabilities vary a great deal, they can be compared to each other as mild, moderate and severe. Moderate disabilities account for the larger number of children with disabilities (UNICEF, 2013).

In Chapter 3, we will provide some specific recommendations on what is important in addressing the specific needs of each type of disability, in order to effectively include children and adolescents with these disabilities in SHNP.

Types of disabilities

Moderate disabilities account for the larger number of children with disabilities. In Cambodia, some children who screened positive for hearing impairment were found to have ear infections or a build-up of ear wax. Once identified, these conditions were easily treated and more serious secondary infections and longer-term impairments prevented.



Chapter 3

INCLUSIVE SCHOOL HEALTH AND NUTRITION PROGRAMMES:

FROM A VISION TO IMPLEMENTATION AND FROM EVIDENCE TO ACTION

What is “inclusive”?²³

Over the years, the term “inclusive education” has been translated into “including children with disabilities,” such as children who have difficulties seeing or hearing, limited mobility, or experience difficulty learning in “regular” classrooms for children without disabilities.

We use “inclusive” within the FRESH framework of including ALL children who are left out or excluded from school. This means, for example, children who don’t speak the language of the classroom or belong to a different religion or caste, and children who may be at risk of dropping out because they are sick, hungry, or not excelling academically. The term can also include girls who are pregnant; children affected by HIV/AIDS. The term also extends to all girls and boys who should be in school but are not, especially those who work at home, in the fields, or elsewhere (migrants), to help their families survive.

Even when all children are enrolled in school, some may still be excluded from participating and learning in the classroom. For instance, there may be children:

- who are never asked or never offer to contribute;
- who can’t see the blackboard or a textbook or can’t hear the teacher;
- who experience difficulty learning and no solution is offered.
- for whom a lesson or textbook is not written in their first language;

These children are likely to be sitting at the back of the classroom and many will soon stop attending classes. As teachers, we are responsible for creating a learning environment where ALL children can learn, ALL children want to learn, and ALL children feel included in classrooms and schools.

Why is inclusion important?

Because children and adolescents with disabilities constitute a significant proportion of the population (especially in low-income countries), the goals of development and education for all cannot be achieved without the full and effective inclusion of the most vulnerable children, and children with disabilities definitely count among them.

There are different (and complementary) arguments to explain the need for inclusion in school health and nutrition programmes²⁴:

- **There is an educational justification;** the requirement for schools to educate all children places the inclusion of children with disabilities as an opportunity for schools and teachers to develop ways of teaching that respond to all individual differences and thus benefit all children.
- **There is a social justification;** inclusive schools are able to change attitudes to difference and diversity by educating all children together and form the basis for a just and non-discriminatory society.
- **There is an economic justification;** it is likely to be less costly to establish and maintain schools which educate all children together than to set up a complex system of different types of schools specializing in different groups of children. If such inclusive schools can offer an effective education to all of their students, then they are also a more cost-effective means of delivering Education for All.

While research and experience have largely proved the relationships among health, cognition, school participation and academic achievement (FRESH, 2006),²⁵ children with disabilities remain largely invisible to SHN programming. Inclusive School Health and Nutrition programmes propose to significantly help children with disabilities by promoting their educational access, retention, and learning outcomes.

From *segregated interventions to universal design and inclusive development*

There is often disagreement over whether children and adolescents with disabilities are more effectively reached through “special” campaigns (often targeted exclusively to specific types of disability) or by using the same resources to make interventions addressed to the population as a whole more accessible. In most cases, this debate is misleading, because both strategies are valid, necessary and can easily be combined. As a general rule, it is always better to take the principles of accessibility into account when designing programmes and services for the general population. A growing body of evidence is also showing that inclusive schools are more cost-effective, and academically and socially effective, than “special” schools (Steinfeld, 2005).

Inclusive policies are based on concepts such as “inclusive development” and “universal design”.

Inclusive development is a strategy for achieving equity. It “emphasizes the inclusion, personal autonomy and dignity of all people, regardless of their social status, gender, age, physical or mental condition, race, religion or sexual orientation” (Berman Bieler, 2005). In practical terms, inclusive development means designing actions, spaces, structures, services and products that all people can use regardless of their age, ability or situation – to the greatest extent possible, without the need for adaptations or specialized design.

The idea of designing for all help us to envision school health programmes that are free of physical or communication barriers, nutrition services that are accessible and geared to the full range of abilities and the need – in some cases – of taking specific measures into account by making adaptations or providing assistance and support to children.

One of the basic tenets of inclusive development, backed by broad international consensus, is the avoidance (whenever possible) of creating parallel or “special” (segregated) programmes for people with disabilities (or other sectors of the population). Instead, every effort should be made to mainstream the principles of inclusion in all initiatives in health care, education and other areas (WHO, 2003).

In cases where mainstreaming has not been achieved, consideration should be given to modifying and adapting programmes that are already in place and functioning.

However, it will be necessary in some cases to provide *specific* services and solutions to respond to the particular needs of children with disabilities. This combination of disability “mainstreaming” in all projects and disability-specific projects or project components is called the “twin track” approach (Inclusive Development, 2008).

The Seven Principles of Universal Design

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



Applying inclusion to FRESH pillars²⁶

The concepts of *inclusive development* and *universal design* help us to envision SHN programmes and services that are aligned with the FRESH pillars while free of physical or communication barriers and inclusive of children with disabilities throughout all of their components.

FRESH pillar	Key concepts for inclusion	Practical implications
Equitable school health policies	<ul style="list-style-type: none"> • Inclusive development • Universal design 	<ul style="list-style-type: none"> • Gathering and disaggregating data on children with disabilities • Adequate and sustainable funding • Policy makers aware and trained
A safe learning environment	<ul style="list-style-type: none"> • Physical access • Stigma-free environment 	<ul style="list-style-type: none"> • Follow accessibility standards • Promote human rights, equity and diversity to remove attitudinal barriers
Skills-based health education	<ul style="list-style-type: none"> • Curriculum adaptations • Information, education and communication materials in accessible formats (braille, sign language, easy reading, etc.) 	<ul style="list-style-type: none"> • Adapt methodologies and contents to the learning needs of all children • Accessible learning materials
School-based health and nutrition services	<ul style="list-style-type: none"> • Inclusive delivery of health and nutrition services • Cross-sectorial collaboration • Integrated approaches to programming 	<ul style="list-style-type: none"> • Train teachers and health workers in inclusive SHN • Health screening and appropriate assistive devices • High quality context analysis • Inclusive HGSP programmes • Inclusive WASH • Engage families and disable people organizations to support outreach and delivery of services



Principles for inclusive SHNP

There are three key aspects that need to be addressed and carefully monitored when it comes to the implementation of inclusive SHN programmes:

PRINCIPLE 1: Make children and adolescents with disabilities visible.

Improved health, education and disability data will increase the likelihood that programmes are targeting the areas of greatest need. It is crucial to combat the invisibility of children and adolescents with disabilities, beginning with the collection of basic information and statistics in order to better understand their needs and take them into account in the planning and implementation of programmes.

PRINCIPLE 2: Ensure access to the programmes.

Ensuring access to health and nutrition programmes for children with disabilities implies addressing issues of physical access as well as the delivery of services and information in a way that is adapted to their needs and functional styles:

- **The accessibility of the physical environment**, meaning access to the school premises and to health and nutrition services and spaces where activities take place, including health care centres, and community centres where prevention or education programmes are offered.
- **The accessibility of information**, which means ensuring that all information, education and communication materials and campaigns are designed in such a way as to effectively reach children with different types of disability, taking into account the diversity of their functional characteristics. The accessibility of information applies to printed materials, media-based campaigns, and information offered over the internet (digital accessibility).
- **The accessibility of communication**, which entails training for health and nutrition staff to ensure that they can communicate effectively with children and adolescents with disabilities, so as to provide them with the best possible treatment and care.

Here we will take a closer look at each of these aspects and offer some practical recommendations and concrete strategies for addressing them.

Accessibility of the physical environment

An accessible school environment is a key prerequisite for the full inclusion of children and adolescents with disabilities in SHNP. Complying with accessibility standards and removing architectural barriers in all spaces where activities take place is the first step in enabling the equitable participation of all. Universal Design is also cost-effective. Research has

demonstrated that the cost of accessibility is generally less than 1% of total construction costs; however, the cost of making adaptations after a building is completed is far greater (Steinfeld, 2005). Physical accessibility standards and guidelines are widely available and can serve as a reference for ensuring the physical accessibility of all SHN-related activities and services²⁷. The following basic criteria can guide us through inclusive SHNP:

In new constructions: When a new school, health centre or community facility is being constructed, architectural standards for accessibility must be fulfilled. In these cases, the challenge for SHN programmes lies in taking advantage of the new conditions of accessibility by engaging social organizations that work with children and adolescents with disabilities, so that they can join in on these programmes and activities, thereby increasing their coverage and enabling broader participation.

In previously constructed buildings: Very often, SHN activities take place in facilities that were built without taking accessibility standards into account. In this case, some changes and adaptations may be needed to improve the conditions for access and participation by children and adolescents with disabilities. Quite often, these improvements can be made with relative ease and at low cost, by removing obstacles from routes of access or expanding the size of spaces so that they can accommodate those who use wheelchairs. These modifications could improve safety and comfort for everyone, and not only those with disabilities.

Assistive devices

Personal assistive devices can often resolve or minimize communication difficulties. These are devices designed or adapted to help a person with a disability to successfully carry out a particular task. Many children and adolescents with disabilities depend on assistive devices to communicate as well as to carry out their daily activities and to participate actively and productively, in the life of their community.

WHO, 2011



Accessibility to health and nutrition information

Providing access to health and nutrition information for children with disabilities is crucial to decrease their risk of infections and improve their health and nutrition-related decisions. Here are some recommendations to ensure that information is accessible for and inclusive of all children:

- Make sure that all information, education and communication materials on the subject, as well as the activities, events and media through which these materials are disseminated, fulfil the requirements of universal/inclusive design. This can be achieved through the use of alternative means of communication such as:
 - **Braille, large print and audio recordings** to make printed materials accessible for children and adolescents with visual disabilities.
 - **Sign language** to make spoken/audio information accessible to children and adolescents with hearing disabilities.
 - **Plain language, pictures and symbols** to make information more accessible for children and adolescents with intellectual disabilities. This would also benefit those with other types of disabilities who may have limited comprehension skills.
 - **Subtitles** in video material for language barriers.
- Include children, adolescents and young adults with disabilities in all graphic materials and campaigns (integrated as part of the general population, to avoid the reinforcement of stigmatisation through the images used), so that they see themselves reflected as part of the target audience of the message.

Accessibility of communication

Some disabilities affect the way that children and adolescents communicate. It can be difficult to understand them, and difficult for them to understand others, which can also lead to misunderstandings that further impede comprehension.

Communication between teachers and health professionals and children with disabilities therefore represents a challenge which, if not resolved, can become a serious barrier that excludes them from access to important information, as well as making them less eager to continue their education in general.

Children and adolescents with disabilities present different characteristics depending on the nature of their impairment (intellectual, sensory, physical, motor), and this takes on great significance when it comes to communication. A child with an intellectual disability, who may need some subjects explained in a simpler manner than other children of the same age, is not the same as a child with a physical disability that will compromise his or her physical functioning and mobility in intimate relationships as well.

Sometimes communication strategies need to be adapted for children and adolescents with a minor functional limitation or slight cognitive impairment; at other times, they will need to be tailored to children and adolescents whose comprehension skills and behaviour are much more severely affected. It is important to know the main characteristics of each group you work with and take these variables into account in order to respond more effectively to their needs through the most appropriate style of communication and personal interaction in each case. Not only is every disability different, every person is different too.

Preconceptions and prejudices also get in the way of good communication. Teachers and health staff need to deal with their own prejudices around children and adolescents with disabilities, in order to relate to them on a basis of mutual trust and affection and – equally important – without pity or paternalism. Communicating with a child with a disability and his/her family requires a flexible approach, sensitive to the needs, possibilities and ways of communicating of each individual. Disability is just one more aspect of human diversity.

It is important to ensure that children and adolescents with disabilities are provided with opportunities for asking health and nutrition-related issues. They need these opportunities to ask and participate in the activities. It is very important that they are encouraged to interact with other children: to be respected, to feel valued, to develop emotional bonds, and to fulfil their need for affection.

Recommendations for Good Communication

Be positive and encouraging. Show enthusiasm and emphasize possibilities.	Avoid discouraging or defeatist messages.
When speaking with children or adolescents with disabilities, look them in the eye.	Avoid looking at or directing your comments to family members or caregivers, as if the child or adolescent is incapable of understanding.
When speaking with a person with a disability, be sensitive to his or her particular needs.	Do not refer to him or her in the third person.
Show that you are interested and ready and willing to listen and understand.	Avoid complicated words and explain technical terms. Do not be afraid of using colloquial language.
Explore alternative ways of communicating and interacting.	Do not be condescending, and maintain high expectations for communication.

PRINCIPLE 3: Promote family awareness and community-based responses.

It is very important to liaise with families and with community organizations that work with children with disabilities – such as disabled people’s organizations, churches, special education centres and rehabilitation programmes – to promote their involvement in SHN activities. Engaging these organizations and families in the dissemination of health and nutrition information and raising awareness of risks are critical for sustained inclusive programming.

Collaboration between school health and nutrition experts and disability organizations also represents an important point of crossover between two worthy approaches. On the one hand, school health and nutrition programmes and networks have a long history of reaching out to historically excluded groups and fighting against poverty and exclusion. On the other hand, organizations involved in the movement of people with disabilities have extensive experience in overcoming the barriers of exclusion, as well as valuable knowledge in various technical areas.

Be aware that many of the available resources to include children with disabilities in health and education activities are outside the formal sector. Building alliances to reach out to children with disabilities and sustain their inclusion in SHN activities depends on the ability to mobilize these resources through partnerships and collaboration while mainstreaming disabilities into public policies for all. Building bridges with these institutions and empowering children and adolescents with disabilities also responds to a historical premise of the movement of people with disabilities: “Nothing about us without us.”

Participatory and community-based approaches

Because of a lack of experience with persons with disabilities, many teachers as well as health staff involved in SHN programmes are unaware of the codes of interaction that are needed to work effectively and comfortably with children and adolescents with disabilities. Fostering inclusion will always require overcoming barriers created by prejudice and confronting longstanding taboos.

At the same time, most people, specialists and organizations working with children and adolescents with disabilities might have little information and knowledge about SHN-related issues or opportunities. Consulting with disability groups is the best way to overcome these barriers and implement successful programmes.

Participatory methods also promote the engagement and empowerment of children and adolescents, increasing their self-reliance skills. These personal development aspects are especially valuable in the case of children and adolescents with disabilities.

The direct participation of disability specialists and organizations in selecting, testing and adapting health education materials increases the potential impact in the following ways:

- It makes it possible to choose the formats that are most sensitive to the different needs and levels of functionality.
- It provides greater understanding on the causes and contexts that determine the decisions and particular behaviours of each group.
- It entails the identification and mobilization of available social assets leading to greater community involvement in the protection of their health.

Youth with disabilities often face limited possibilities for participation in their everyday lives and a low sense of self-esteem. The development of personal skills to deal with the feelings, behaviours and decisions associated with their health should be fostered in a way that allows each individual to find the way of protecting themselves best suited to their way of existing in the world. (Meresman, 2009).

Opportunities and entry points for outreach and alliances:

While strategies and opportunities for implementing effective, inclusive SHN activities should be identified locally, there are a number of networks and resources that can be used as entry points for possible interventions.

- Several international and local disabled people’s organizations (DPOs) have a long history within the disability community around the world and offer a good entry point for developing partnerships and promoting the participation of adolescents and youth with disabilities.
- Parents’ organizations are often the ones that have the most capacity for implementation. They know how to deal with children with disabilities, understand their needs and are ideally placed to communicate to the community how to get involved in school health and nutrition programmes.
- International and regional disability networks have a longstanding reputation as key references and resources for local disability-related interventions. Examples are:
 - The International Disability Alliance (<http://www.internationaldisabilityalliance.org>)



promotes the effective and full implementation of the UN Convention on the Rights of Persons with Disabilities (CRPD) worldwide in partnership with organizations led by persons with disabilities from around the world.

- *The International Disability and Development Consortium* (www.iddcconsortium.net) brings together NGOs and service providers which work in the area of inclusive development in developing countries and have been involved in various health and disability programmes.
- The *Secretariat of the African Decade of Persons with Disabilities (SADPD)* works with governments and DPOs to promote inclusive development and human rights for people with disabilities.
- *The Latin American Network of Non-Governmental Organizations of Persons with Disabilities and their Families (RIADIS)* is an excellent resource formed by DPOs from 19 countries in Latin America and the Caribbean.
- The *Asian People's Disability Alliance and Bradnet* (formerly the *Asian Disability Network*) are two of the many organizations working in Asia with the goal of empowering and enabling disabled people to access services and policies.

Addressing the needs of each type of disability²⁸

Depending on each type of impairment and the degree of functional limitations, there are a range of specific measures to be taken into account to ensure outreach, accessibility and inclusion of children with disabilities in school health and nutrition programmes. In this section we will look at some of the most frequent challenges (e.g. the most common difficulties in communicating with children) along with a few recommendations in each case.

These are all general rules that must be approached flexibly, depending on the needs, possibilities, characters and ways of communicating and interacting of each person, as the need for assistance and support may vary, depending on the individual.

It is especially important to take into account and be sensitive to the character and way of communicating of each group and each child or adolescent. Effective interventions are guided by sensitivity and adaptability to the different needs of each type of impairment, and of each individual. In the case of children and adolescents with disabilities, learning these lessons may be more challenging or take more time but it is still possible.

VISUAL IMPAIRMENTS

Around the world, an estimated 19 million children are visually impaired. Of these, 12 million children are visually impaired due to refractive errors, which is a condition that could be easily diagnosed and corrected. Overall, approximately 90% of visually impaired people live in developing countries (WHO, 2012). Primary school-age children may be affected by allergic eye disease, red sticky eyes, and eye injuries, in addition to refractive errors. School programmes can play a role in prevention, detection and/or referral for treatment for these

conditions. In addition, school-going children can play a role in the community and in their families by taking health messages and ideas back home about conditions that may affect preschool-age children's eye health, such as vitamin A deficiency and trachoma (IAPD, 2011).²⁹

What schools can do: School eye health programmes need to be integrated within school health initiatives, monitored and evaluated, and cost effective. Components of comprehensive school eye health programmes include: education about eye conditions and eye health; primary eye care for children, including identifying children with significant refractive errors and supplying them with spectacles; eye care for teachers; a health-promoting school environment; a child-to-child approach; and links to control programmes for local endemic diseases (Gilbert, n.d.).

Children who are blind or low-vision might have difficulty finding their way around the school premises or inside health centres. Ensure that all locations are marked with signs in Braille or tactile markings. When such features are not available, other children or school personnel may take a few minutes to orient them.

How to include a child with a visual impairment in learning: Removing obstacles, tactile flooring and having key schools places marked brightly are important factors to contribute to children with visual impairments to feel comfortable and safe in schools. When communicating health information, tactile materials and audio messages (which are easy to produce and disseminate through the radio, internet and other media) are examples of low-cost accessible materials that are effective not only for people with visual impairment but the majority of the population. Be aware that children may see contours and contrasts but may not read text or see images clearly.

Training needs:

- **Teachers are required to be aware of the need for using printed materials with large print and high contrast. Accompany images with brief explanations.**
- **Teachers need to know that it is very important that they refer to children by their name, not their disability!**

INTELLECTUAL DISABILITIES

The category of "intellectual" or "developmental" disabilities encompasses a wide range of highly diverse conditions, very often including children who are slow to understand, speak or learn. Children with *mild and moderate intellectual disabilities* can participate in regular schools when teaching methodologies and curriculum are adapted to their biological and cognitive development age.

What schools can do: A significant number of children with intellectual disabilities can be included in regular classrooms. If provided with the required support, they will learn and develop to their maximum potential, the same as the other children.

How to include a child with an intellectual disability in learning: Children with intellectual disabilities may need more time than others to understand issues related to their bodies and health. Strategies for teaching and learning need to be designed and customized according to the child's needs. Always remember that although their bodies and physical needs develop, their intellectual ability may not follow the same rhythm. In most cases, it is enough to simply respect the time it takes for them to process things, to listen to them and give them basic guidance using simple and straightforward language.

Visual resources, clear step-by-step instructions, and short messages (breaking information down into manageable portions) are good strategies for good communication. To learn, they benefit from creative and dynamic methodologies (e.g. theatre, videos, group activities, colourful and visually attractive materials).

The family (parents, siblings and other close relatives), caregivers and educators represent a network of influence that determines both their degree of autonomy and their exposure to health risks. For this reason, it is essential to include this network as partners in health education activities.

Stigma and discrimination reinforce the social exclusion of girls and adolescents with intellectual disabilities, increasing their vulnerability to sexual abuse. They may be naïve and have limited knowledge about themselves and their bodies, and may often have difficulty distinguishing between what is and what is not appropriate, which makes them vulnerable.

Training needs:

- Children with intellectual disabilities are “infantilised” or treated like younger children. Teachers need to avoid patronizing children and stimulate parents to not overprotect them. It is important to communicate with them in a way that is appropriate for their physical age as well as their level of cognitive development.
- Low expectations on the part of people who interact with them hinder children's development potential. Teachers should avoid prejudice and give children the opportunity to make their own decisions.

Training needs:

- Teachers have to be aware that for children that use a wheelchair it is part of their body and personal space. Hence, it is important to treat it accordingly and teach other children to:
 - Avoid resting on their wheelchair, or touch or move it without asking them first. When you hold onto or lean on a wheelchair, the person using it may feel like you are doing this to them.
 - Never move a person's wheelchair while they are in it unless you have been asked to; this can be very dangerous, as people with a fine sense of balance can very easily fall out of their wheelchair if not warned before being moved.
 - Speak from a position that is comfortable for everyone.

PHYSICAL AND MOTOR IMPAIRMENTS

Physical, motor or mobility impairments are highly diverse and behaviours will vary, depending on the type of disability and on the individual. However, we can safely say that the vast majority of these impairments do not impede education in regular classrooms if accessibility is ensured.

What schools can do: The main challenge facing children with physical disabilities is the lack of access to school buildings and to delivery points of SHN activities. To ensure their involvement and participation, physical accessibility standards should be met, through the elimination or reduction of architectural barriers to the greatest degree possible.

Some children with more severe physical limitations will have difficulty using their hands and can find it difficult to wash their hands, keep their clothes clean or feed themselves. Help them find strategies for better dexterity, or encourage them to ask for help.

How to include a child with a physical limitation in learning: Children with cerebral palsy often have difficulty speaking, which means you need to listen carefully and be patient. Sometimes they emit unintelligible or overly loud sounds in their efforts to communicate. If you do not understand what they are saying, calmly let them know so they can try again or use another way to communicate. If necessary, communication can be facilitated with flash cards, keyboards, etc.



HEARING IMPAIRMENTS

Recent WHO estimates reveal that 32 million children across the world live with disabling hearing loss. Spoken language development is often delayed in children with hearing impairment. Hearing loss and ear diseases such as otitis (middle ear infection) can have a significantly adverse effect on the academic performance of children.³⁰

What schools can do: Half of all cases of hearing loss and deafness are avoidable through primary prevention, and many can be treated through early diagnosis and suitable management (WHO, 2012). Prevention strategies which could be screened for or offered through schools include immunizing children against childhood diseases such as measles, meningitis, rubella and mumps, and immunizing adolescent girls against rubella (WHO, 2012).

In addition, screening young children for early detection of ear diseases and hearing loss should be conducted on school entry as part of the school health screening programme. Children who screen positively can be targeted for simple classroom measures to improve their progress in school and to raise the level of awareness in the school and community (WHO, 2006).

How to include a child with a hearing impairment in learning:

The main characteristic of children, adolescents and youth with hearing loss is that their language and communication possibilities are limited, often resulting in decreased interaction with others. To communicate, some deaf people use sign language (also known as signed language). There are many different sign languages, usually specific to a certain country (or sometimes a region). Through this language based on hand gestures, facial expressions, and orientation and movement of the hands, arms or body, persons who are deaf can communicate with others who know the same language. Sign languages have their own syntax and are not a mere “translation” of spoken language. Any information provided verbally and then interpreted through sign language needs to take this into consideration – use as few words as possible and no slang.

Deaf persons learn about the world through their visual sense. When it comes to health information, they may be limited not only by their hearing impairment but also by the fact of having fewer opportunities for dialogue and interaction with those around them. Because of this, they often lack basic information about health, or the information they have is unclear, incorrect, partial or biased. Evidence has proved that deaf people are very vulnerable to HIV, for instance, as a result of serious barriers to accessing HIV/AIDS information as well as testing and treatment. As a consequence of this, studies indicate that they are as likely, if not twice as likely, to be infected with HIV as people without a hearing impairment (UNAIDS, 2009).

Training needs:

- **Children who are deaf may have difficulty communicating with health professionals, which is why they often do not consult with them. Staff should be aware that a sign language interpreter is required to be present at their appointments when possible. When interpreters are not available, printed materials with simple language and images can be useful.**
- **People who are deaf can have difficulties negotiating safe sexual relations with their partners, especially when they have hearing partners. It is necessary to offer them information and help them to develop negotiating and self-protection skills. Teachers and health staff can use printed materials and graphics to explain the way HIV is transmitted and introduce key preventive measures.**

Making SHN Inclusive

FRESH pillar	Be aware	What you can do
Health services	<ul style="list-style-type: none"> • While more children than ever are being reached by health screenings, children with disabilities are still not benefiting from increased coverage. Universal coverage cannot be reached if children with disabilities remain excluded (UNICEF, 2013). • While health screenings can pre-empt some diseases that lead to disabilities, it is no less important to provide screening and health checks to children who are already disabled. Denied the full range of health screenings, children with disabilities are at risk of developmental delays, avoidable secondary conditions and preventable death. 	<ul style="list-style-type: none"> • Include children with disabilities alongside others in posters and other promotional materials. • Contact local organizations of people with disabilities and conduct awareness campaigns in collaboration with them. • Start producing accessible information materials by considering universal design principles.
Nutrition	<ul style="list-style-type: none"> • Those who do not attend school miss out on school feeding. • When food is scarce, disabled children may be fed less, denied food or provided with less nutritious food than siblings without disabilities in the belief that preserving the life of a child with a disability is of lower priority than preserving the life of someone who is non-disabled. • Physical barriers may hinder children with disabilities from accessing school lunch. • Social barriers impede or discourage inclusion: children with disabilities often face discrimination when using household and public facilities (e.g. children with disability are forced to use separate facilities). • Children with some types of physical or intellectual disabilities may have difficulty feeding themselves – e.g. conditions such as cleft palate or cerebral palsy may interfere with the mechanics of consuming food. • Some children with disabilities may need special diets or increased calorie intake to maintain a healthy weight (UNICEF, 2013). 	<ul style="list-style-type: none"> • Identify out-of-school children. It is important to ensure that all local girls and boys with disabilities are tracked, admitted to school, and helped to continue in school if difficulties occur.³¹ Often, children with disabilities are hidden in their homes and kept away from education. Start by encouraging children in schools to inform you about their siblings, cousins and neighbours with disabilities that are out of school. Find out from itinerant teachers about those that can be included in mainstreaming schools. • Reach out to parents and disabled people's organizations to engage them and promote school feeding through their institutions and networks. • Make nutrition information and education materials accessible to the different types of disabilities so all children can learn about healthy nutrition.
Hygiene and sanitation	<ul style="list-style-type: none"> • Some children might face particular difficulties in accessing safe drinking water and basic sanitation – e.g. facilities are physically inaccessible. • Children may not attend school if there is not an accessible toilet. Some children report lowering food/water consumption to cut down the number of visits to the toilet. 	<ul style="list-style-type: none"> • Conduct accessibility evaluations in schools. • Promote changes to remove barriers and work with schools and the community to support and implement these changes. • Ask children with disabilities about their toilet needs and find out how schools can respond to that accordingly.

Making SHN Inclusive

FRESH pillar	Be aware	What you can do
Health education and promotion	<ul style="list-style-type: none"> • Children with disabilities do not receive information or are given the opportunities to learn on basic health and hygiene concepts. They are therefore at greater risk of infections, exposed to health hazards and unaware of common risk behaviours. • Children and adolescents with disabilities are often overlooked in sexual and HIV/AIDS education, because they are incorrectly believed to be sexually inactive. According to research they actually face a greater risks than their peers without disabilities. (UNICEF, 2013). • Research has demonstrated that adolescents with disabilities are just as likely to be sexually active as their peers without disabilities. In addition, girls and female adolescents with disabilities are often the victims of sexual abuse and thus face a greater risk of HIV infection. 	<ul style="list-style-type: none"> • Ensure that all children and adolescents with disabilities have access to health education programmes and that these programmes take their needs into account. • Distribute health information in simplified language (for children with intellectual disabilities), Braille and large print (for the visually impaired), symbol-based language (for the deaf), and other accessible formats. • It is essential to eradicate the myth that people with disabilities are asexual, and to offer them the information they need to protect themselves. On the other hand, some medical treatments related to disabilities involve frequent contact with syringes, transfusions, etc. • Make sure that the needs of adolescents with disabilities are taken into account when promoting effective use of condoms (for example, the expiration is not legible if not printed in Braille). • Sensitize families as well as organizations that work with children with disabilities to help them to detect situations of potential risks and offer support to help prevent them. • In the case of children and adolescents with disabilities, learning about health-related behaviour is possible but may be challenging or take more time, and require frequent breaks or smaller groups.
General recommendations	<ul style="list-style-type: none"> • Always start by fighting discrimination and dismantling barriers to inclusion. • Provide training to health personnel on how to deal with a child with a disability. • Depending on each type of impairment, there are a range of specific measures to be taken into account to ensure outreach, accessibility and inclusion of young people with disabilities. Remember: Not only is every disability different, every person is different too. • In order for children with disabilities to have access to health services, health care workers must be trained to treat them. Screening and tests and the communication of results and advice must be carried out in an appropriate way (for example, with a sign language interpreter if the individual is deaf). • The need for assistance and support may vary, depending on the individual. Effective communication is guided by sensitivity and adaptability to the different needs of each type of impairment, and of each individual. • Develop partnerships with organizations of people with disabilities who can offer invaluable help both in training teachers and health personnel and in providing personal assistants, interpreters, etc. 	

Chapter 4

EXAMPLES FROM THE GROUND

Everybody's School (Brazil)

Since 2006, the Inter-American Institute on Disability and Inclusive Development (iiDi) in collaboration with the Center for Health Promotion of Brazil and the Partnership for Child Development (UK) has been successfully implementing “Everybody’s School”, an initiative aimed at integrating school health and inclusion in primary schools in Uruguay and Brazil. The implementation framework is based on providing guidance to schools and the community to improve the delivery of health and education services, making them more equitable and inclusive of children with disabilities. Some of the resources provided include a teacher’s manual and regular training, a classroom toolkit on inclusion, and online advice and exchange.

A participatory approach to health and sex education in sign language (Uruguay)

According to the 2011 National Census, there are 30,000 people in Uruguay, a country of three million people, who have severe hearing limitations or total deafness. Of this total, 2,500 are children and young people under 30.

A lack of appropriate materials in their own language, social taboos, and numerous barriers to information and communication put young people with hearing impairments at a higher risk of sexually transmitted diseases and HIV. A new set of sexual and reproductive health and HIV education resources has been prepared by the Inter-American Institute on

Disability and Inclusive Development (iiDi) in collaboration with UNFPA, UNICEF, the Partnership for Child Development (PCD) and the deaf community in Uruguay.

The approach for producing these materials was highly participatory, and all the activities were designed to train participants (deaf adolescents) as health promoters in the Uruguayan Sign Language. Engaging local Deaf organizations was key to distributing these materials through Deaf institutions and networks. The materials include posters, postcards and QR Code messages – a modern digital media format which has been increasingly used in inclusive projects aimed at Deaf people. These materials can be accessed and shared from the materials from www.facebook.com/iidienred

Learning with Glasses (Cambodia and Malawi)

Children with visual and hearing impairments start school at a big disadvantage. The prevalence of these disabilities is often unknown, partly because most of these children are not in school. At the same time, basic training does not give teachers skills to identify and help children with disabilities. Consequently, these children are at risk of falling behind and dropping out.

Nevertheless, screening children for vision and hearing problems is relatively simple and can be done easily by teachers at the start of the school year. Schools can resolve mild impairments immediately and refer more severe problems to health facilities.



Between 2010 and 2012, the Global Partnership for Education (GPE), funded a data collection project on out-of-school children and disability in Cambodia. The project was implemented by the Cambodian Ministry of Education, Youth and Sports as part of the country's Education Sector Plan. The main goal of the project was to understand the needs of marginalized and disabled children who are excluded from education.

Who are these children? How many are they? Why are they excluded? Collecting data and understanding the needs of children with disabilities enabled the Cambodian education ministry to set goals, monitor progress and, ultimately, include these children in the education system. This GPE-funded project helped to make children with disabilities visible. They became a focus group and moved on top of the education ministry's agenda.

One of the key findings of the project indicated that many children who dropped out of school or never enrolled suffered from health issues, most often vision and hearing problems. The Global Partnership for Education collaborated with partner organizations such as *Sightsavers*, *Partnership for Child Development*, *the World Bank*, *the Center for Eye Research Australia* and *Fred Hollows Foundation*, and supported a subsequent vision screening project in elementary schools.

About 13,000 children in 56 schools in Siem Reap province were part of the school-based vision screening. Many children received eye glasses; a few were referred for eye surgery or for other treatments related to vision problems. For most children, it was their first vision screening and their first pair of glasses. The results of the project provided valuable input for strategic planning discussions with the ministry of education and led to increased support for excluded children.

- **The story of Chung Lang:** Chung Lang, a 13-year-old 5th grader lost vision in her right eye due to vitamin D deficiency. Poor vision in her left eye made it very difficult for her to see the teachers' writing on the blackboard. She persevered in school mostly relying on her hearing. But eventually, she dropped out of school. Now, with a pair of new eye glasses, Chung Lang says, "I really enjoy reading." A \$2 pair of glasses determined whether or not this young girl goes to school and receives an education. Thanks to GPE's support, Cambodia is now planning to make vision screening part of the national school-based health program. Other GPE developing country partners heard about the programme and requested support to establish similar projects in their countries. GPE is eager to help them.

- **Successes and lessons learned from the Mangochi District (Malawi):** In Malawi, the prevalence of these disabilities is unknown, partly because most of these children are not in school. In places where hearing and visual aids are expensive parents are unlikely to be able to afford them without contributions from external donors. Even if the cost of corrective aids is out of reach, the identification of children with vision and hearing problems is essential as it allows teachers to take appropriate action instead of assuming the child is intellectually delayed. Save the Children introduced vision screening in the country within the context of a comprehensive School Health and Nutrition (SHN) programme initially reaching 101 schools in Mangochi and 70 schools in the Balaka district. Children reported that before screening they could not see the board well and often failed exams because they could not grasp the material. After the programme was introduced, most of these pupils said teachers positioned them at an appropriate distance from the board and that they could now follow classes and progress with their peers.

Expanded Niger food programme means disabled children won't be left out³²

In Niger, where most families struggle through chronic food shortages, some children are even more vulnerable to hunger. The Counterpart International's Food Aid for Disabled Children Project (FAIR) aims to ensure deaf and blind children receive just as much support as their neighbours. Through this USAID initiative, 167 blind children and 141 children with physical disabilities receive hot meals through two school canteens that specialize in children with special needs. The goals go beyond feeding children with disabilities: using schools as platforms for better nutrition is an effort to jointly increase their attendance rates and improve their overall social conditions. *"Because of the daily hot meals that are cooked at the schools, more handicapped children are attending school rather than begging on the streets of Niamey"*, says Country Director Marie Aughenbaugh.

In Niger as in many other countries children with disabilities are sometimes neglected or even hidden away, their condition viewed as a punishment from God. Public awareness of their rights and needs even among teachers and parents of children with disabilities, is growing but according to UNICEF remains low. Discrimination is expressed through poor access to education, making school-based feeding programme a particularly valuable way to support them.

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Endnotes

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- 30 WHO Global estimates on Prevalence of Hearing Loss, WHO, 2012 <http://www.who.int/pbd/deafness/estimates/en/index.html>
- 31 UNESCO has developed guidelines on reaching out-of-school children. Although these do not provide specifics on children with disabilities, they can be helpful for general guidance. http://www.uis.unesco.org/template/pdf/educgeneral/OOSC_EN_WEB_FINAL.pdf
- 32 Adapted from <http://www.counterpart.org/blog/expanded-niger-food-program-means-disabled-children-wont-be-left-out>



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