



Inclusive Community Preparedness for Sexual and Reproductive Health in Nepal

Report

April 2022



Acknowledgments

This report was authored by Lily Jacobi, Julianne Deitch, and Erin Worden, all of WRC. This report was reviewed by Sandra Krause and Diana Quick, and designed by Erin Worden, all of WRC.

Project Team

- Family Planning Association of Nepal: Bibek Risal and Mala Chalise
- Nepal Disabled Women Association: Niruja Sherchan
- Senior Citizen Care Society: Kumar KC and Sarala KC
- Women's Refugee Commission: Lily Jacobi, Julianne Deitch, and Erin Worden

This project was funded and supported by Elrha's Humanitarian Innovation Fund (HIF), a programme which improves outcomes for people affected by humanitarian crises by identifying, nurturing and sharing more effective and scalable solutions. Elrha's HIF is funded by the UK Foreign, Commonwealth and Development Office (FCDO). Elrha is a global charity that finds solutions to complex humanitarian problems through research and innovation. Visit www.elrha.org to find out more.

Contact

For more information or to share comments about this report, please contact Lily Jacobi (advisor, sexual and reproductive health, WRC) at LilyJ@wrcommission.org.

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Women's Refugee Commission
15 West 37th Street
9th Floor
New York, NY 10018
(212) 551 3115
info@wrcommission.org
womensrefugeecommission.org



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Partners

Nepal Disabled Women Association

Nepal Disabled Women Association (NDWA) was established in 1998 adopting the values of the fundamental rights and responsibilities provided by the constitution of Nepal in order to support Women with Disabilities (WWDs) to pursue their rights, and provide them protection and livelihood support. It aims to organize, empower and advocate for the provision and utilization of the rights of girls/ women with disabilities for their increased inclusion in all spheres of the society.



Family Planning Association of Nepal

Family Planning Association of Nepal (FPAN) was established in 1959 as a first national sexual and reproductive health service delivery and advocacy organization. FPAN works across 37 districts to provide live saving health services to poor, marginalized, socially excluded, and underserved (PMSEU) communities. It visions to ensure universal access to comprehensive sexual and reproductive health for all.



Senior Citizen Care Society

Senior Citizen Care Society (SCCS) was established in 2010 with the aim to provide support and care to senior citizen. SCCS works to provide different services to older populations like care giver services, health check-up, distribution of relief materials during disaster and advocacy for rights of senior citizens.



Women's Refugee Commission

The Women's Refugee Commission (WRC) improves the lives and protects the rights of women, children, and youth displaced by conflict and crisis. We research their needs, identify solutions, and advocate for programs and policies to strengthen their resilience and drive change in humanitarian practice.



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*No one should
be left behind.
Everyone should
work together for
the benefit of all.*

Older man, focus group discussion participant



Introduction and project overview

Nepal is highly vulnerable to diverse cyclical natural hazards and disasters, including flooding, landslides, earthquakes, drought, and wildfires.¹ In 2015, massive earthquakes struck Nepal, causing catastrophic damage and thousands of fatalities. In 2019, flooding and landslides caused more than 100 fatalities and destroyed or damaged more than 60,000 homes.² In recent months, Nepal has suffered multiple disaster events, including flooding and landslides, against the backdrop of the global COVID-19 pandemic.³

More broadly, Nepal is at extremely high risk for climate-related hazards and disasters – which will only increase as climate change continues to disproportionately impact developing countries.⁴ It is well documented that emergencies have a disproportionate effect on the poorest and most vulnerable and elevate communities' sexual and reproductive health (SRH) needs and risks, including for people with disabilities and older people. Risks of sexual violence, exploitation, and abuse increase across the board. Women and girls are at elevated risk of gender-based violence, unwanted pregnancy, unsafe abortion, and sexually transmitted infections, including HIV, due to the collapse of social and structural support systems, and consistently face higher mortality rates during crises.

Communities can prepare for crises by assessing disaster risks, identifying communities' needs and capacities, and taking action to address gaps in health systems and services. Emergency preparedness and disaster risk management can strengthen humanitarian health response, including for SRH, mitigate negative health consequences, and support community resilience.

Due to the cyclical nature of crises in Nepal and the ever-growing threat of climate change and extreme weather events, preparedness is essential. Although the Nepalese government has identified emergency preparedness and disaster risk management as priorities, a 2020 scoping exercise conducted by the Family Planning Association of Nepal (FPAN) and the Women's Refugee Commission (WRC) identified critical gaps in preparedness and disaster risk management at the local level, including particular barriers and exclusion of people with disabilities and other historically excluded groups.

Effective emergency preparedness depends on inclusion of community members in all their diversity, regardless of their gender, age, disability status, race or ethnicity, sexual orientation, gender identity or expression, or religion. Older people and people with disabilities are consistently left out of assessments and preparedness planning, including the development of disaster risk reduction and disaster risk management policies and meetings. This not only leaves their specific needs and priorities unaddressed, but it also deprives the community of their unique knowledge, expertise, and leadership.

1 Center for Excellence in Disaster Management and Humanitarian Assistance, [Nepal Disaster Management Reference Handbook](#), August 2017.

2 Mercy Corps, [July 2019 Nepal Floods Needs Assessment](#), 23 August 2019.

3 ReliefWeb, [Nepal: Floods and Landslides - Jul 2020](#), accessed 13 September 2020.

4 German Watch, [Global Climate Risk Index 2021](#), 21 January 2021.

In this project, FPAN, the Nepal Disabled Women Association (NDWA), the Senior Citizen Care Society (SCCS), and WRC worked together to conduct participatory research in partnership with older people and people with disabilities to learn more about their priorities for disaster preparedness and SRH care. Research questions included:

- What are the SRH needs and priorities of older people and people with disabilities in Nepal, including in the aftermath of emergencies?
- What barriers hinder inclusion and participation of older people and people with disabilities in emergency preparedness at the community level?
- How can older people and people with disabilities lead community-level gender and SRH preparedness, response, and recovery to ensure more inclusive humanitarian action?

This report details the project's key findings, and corresponding recommendations and guidance to ensure that emergency preparedness activities at the community level are inclusive and accessible for people with disabilities and older people, and responsive to their needs and priorities.

Partners also drew on these key findings and recommendations to strengthen an existing toolkit for community-level SRH preparedness: the [Facilitator's Kit: Community Preparedness for Sexual and Reproductive Health and Gender](#), including the [Capacity and Needs Assessment Tools to Build Community Resilience](#). These tools were developed by WRC in 2014, and updated in 2020 in partnership with FPAN, to support communities to work together to identify their SRH and gender needs and resources, and to develop action plans to undertake emergency preparedness activities. Partners also used the key findings and recommendations to develop a Quick Start Guide to provide step by step guidance for organizations and program staff to use these tools to plan and organize assessments and workshops that are inclusive of and accessible to older people, people with disabilities, older people's associations (OPAs), and organizations of people with disabilities (OPDs).

Methods and limitations

The overall goal of the project's research was to understand the SRH needs and priorities of older people and people with disabilities living in Nepal to ensure that the Facilitator's Kit: Community Preparedness for Sexual and Reproductive Health and Gender, including the Capacity and Needs Assessment Tools to Build Community Resilience, are inclusive of these historically excluded populations. The study utilized a qualitative, participatory research design in the form of workbook activities, focus group discussions, and co-analysis sessions. Ethical approval for the research was obtained by Health Media Labs.

Tool development

Research tools included workbooks and focus group discussion guides. WRC, FPAN, NDWA, and SCCS collaborated to develop an action learning research plan and participatory research tools. The process began with several sessions to jointly articulate research aims, objectives and research questions. Considering the ultimate goals of inclusive research with older people and people with disabilities, partners then brainstormed possible modes of data collection and associated research activities. Activities were developed in a workbook format, with multiple rounds of feedback from

partner organizations. Particular attention was given to the feasibility and inclusivity of the research activities and the extent to which they would provide information to answer the co-developed research questions. Workbooks were adjusted for both participant groups (older persons and persons with disabilities). Table 1 summarizes the workbook activities.

Table 1: Summary of workbook activities

<i>Activity Name</i>	<i>Activity Objective(s)</i>	<i>Activity Description</i>
What does your community look like?	To understand where individuals receive information and support for emergency preparedness and response.	Community mapping: Participants asked to draw a map of their communities and indicate places where they receive support and places that are difficult to access after an emergency
What happens in your community?	To understand experiences participating in community activities, accessing SRH services, and emergency response	Photo elicitation: Participants asked to describe several photos (of people at a health facility, a community experiencing a flood, etc.) and explain if they have had similar experiences
Your story	To understand experiences in an acute emergency	Storytelling: Participants asked to write a story about their experience during a disaster in the past, including where they received information and services
A note of support	To identify individual and community-level resources, skills, and assets that can be helpful in the immediate aftermath of an emergency	Narrative: Participants asked to write a letter to an older person or person with a disability describing how they can help them during an emergency
What do you need to be prepared?	To identify perceptions of what an individual needs to be prepared for a natural disaster	Drawing: Participants asked to draw an older person or person with a disability who is prepared for a natural disaster
A timeline of COVID-19	To understand experiences, challenges, and resources available throughout the COVID-19 pandemic	Timeline: Participants asked to fill in a timeline of key events from January 2020 to the present, including challenges they experienced and how they felt.
Ranking sexual and reproductive health needs	To identify the top SRH needs and priorities of older people and people with disabilities before, during, and immediately after an emergency	Ranking: Participants asked to select the three most important SRH needs or services for older people or people with disabilities, both in times when there is not an emergency and in the aftermath of an emergency.

In addition to the workbook activities, focus group discussion guides were co-developed to elicit more information from participants who completed the workbook activities and key informant interview guides were developed to answer implementation and process-related research questions.

Participant recruitment and data collection

Participants were selected using purposive sampling to ensure saturation, with the criteria that they had the ability to complete written activities either alone or with the support of a friend, family member, or representative from NDWA or SCCS. NDWA and SCCS identified a total of 35 eligible participants and contacted them to assess their interest in participating. A total of 26 individuals agreed to participate, at which point NDWA or SCCS delivered a workbook and administered verbal

informed consent. Participants had ten days to complete the workbook activities, during which time NDWA and SCCS were available to answer any questions regarding the activities. Some participants had support in completing the activities if they were unable to do so by themselves. After completing the workbook activities, participants were invited to a focus group discussion. Four focus group discussions were held: Two with persons with disabilities, one with older women, and one with older men. Discussions were conducted in Nepali by a trained facilitator from FPAN.

Table 2: Research participants demographics

<i>Information by Category</i>	<i>Number of Participants</i>
AGE	
18-29	2
30-59	11
60-74	10
75 or older	3
GENDER	
Male	6
Female	20
REPORTED DISABILITY	
Difficulty seeing	4
Difficulty hearing	2
Difficulty walking or moving	10

Analysis

A series of co-analysis activities took place with key stakeholders, including representatives from NDWA and SCCS, as well as experts working in the field of emergency preparedness and inclusion. A total of 21 participants attended three separate co-analysis sessions (three participants, nine participants, and nine participants, respectively). Activities were co-led by WRC and FPAN and included review and discussions of select workbooks and focus group discussion transcripts. Participants in the co-analysis activities followed a series of discussion prompts to identify emerging themes from the data and provide recommendations for revisions to the Facilitator’s Kit: Community Preparedness for Sexual and Reproductive Health and Gender and the Capacity and Needs Assessment Tools to Build Community Resilience.

Following the co-analysis activities, a codebook was developed based on the identified themes. Three coders independently coded a set of the data, compared coding, and made adjustments to the codebook. Coder consensus was agreed upon using the revised codebook and all workbooks, focus group discussions, and co-analysis activities were coded using Dedoose. Key findings were identified collaboratively among the three coders.



Key findings

Experiences of crises

Participants were asked to reflect on their experiences of disasters and humanitarian response. Many respondents discussed their experiences in the aftermath of the 2015 earthquake and the COVID-19 pandemic.

When discussing the earthquake, participants overwhelmingly reported gaps in emergency preparedness, and in humanitarian response in the aftermath of the crisis, including for SRH. Participants highlighted that older people and people with disabilities were not prioritized in the humanitarian response. Participants reported that where services were available, they were not accessible to older people and people with disabilities, or responsive to their needs. Participants with disabilities noted that there was a lack of programming and services focused on people with disabilities.

Both older people and people with disabilities highlighted challenges during and in the immediate aftermath of the earthquake related to mobility. Participants reported being unable to flee buildings to reach safety due to mobility issues or vision impairments and having significant challenges navigating rubble and damaged or destroyed roads and sidewalks. Many homes and buildings were destroyed, and people were not able to stay in standing homes and buildings for an extended period of time. Tents were not immediately available, and people were sleeping on the ground and out in the open – which posed particular challenges for older people and people with disabilities.

Participants reported that they did not have access to basic supplies, including food, medicines, sanitary supplies, clothing, and blankets, and that distribution of humanitarian aid excluded older people and people with disabilities. Many participants reported that there was an acute lack of information available about the disaster, and the humanitarian response, including available services. The earthquake caused extensive damage to telecommunications systems, which further obstructed emergency communications efforts. Participants reported that where information was available, it was not in accessible formats for people with visual and hearing impairments.

Participants also reported that when safe shelters became available, they were not accessible for people with different impairments. Similarly, they reported a lack of accessible latrine facilities. Participants also reported that older women, and women and girls with disabilities, faced high risks of sexual violence, abuse, and exploitation in the shelters.

Some participants with disabilities also reported experiencing discrimination in the aftermath of the earthquake from their family members, including isolation and ill-treatment, as families viewed people with disabilities as burdens if they were not able to contribute to supporting the family. One participant noted that many girls and women with disabilities were not able to participate in education and livelihoods prior to the earthquake, which further exacerbated barriers to their participation in the recovery.

Experiences during the COVID-19 pandemic

Many participants shared experiences and reflections from the COVID-19 pandemic in the workbooks and FGDs. As in many countries around the world, the pandemic, and its attendant lockdowns, restrictions, and disruptions, had a profound impact in Nepal. Many participants reported

experiencing negative economic impacts, with people being unable to work, incurring debt, and experiencing concerns about being able to obtain food and medicines.

Many participants reflected that their experience of the COVID-19 pandemic was marked by isolation and loneliness, especially for older people, and fear and anxiety. Participants reported extremely high levels of fear for their health and safety, and the health and safety of their families and loved ones. Many participants reported experiencing grief, and loss of friends and family. The pandemic thus had a significant, negative impact on the mental health and psychosocial wellbeing of older people and people with disabilities.

Many participants noted that there was an acute shortage of hospital beds, and that many people who needed to be hospitalized were not able to receive care. Participants also reported that in many cases, people were not able to afford care – not all hospitals and medical services were free of charge.

Notably, older participants reported that lockdowns, and being unable to access routine health services, resulted in more or more severe chronic health problems, including hypertension and diabetes. Many participants reported that, at critical periods during the pandemic, masks and medicines were not available, or if they were available, they were prohibitively expensive.

As with prior crises, participants expressed that they had not received enough information from the authorities about the coronavirus, the COVID-19 pandemic, and public health measures. Several participants described periods of fear, confusion, and uncertainty in the earlier months of the pandemic, when information on the virus was still very limited, and myths and misinformation were rampant. However, participants reported that information sharing did improve, and compared favorably to prior crises. Participants reported receiving information about the pandemic and public health measures through the internet, social media, FM radio, and television.

Despite their increased risk of morbidity and mortality from COVID-19, multiple participants reported that there were delays in receiving the vaccine. Participants also reported that people with disabilities were not prioritized for vaccination. When vaccines were available, several participants reported that there were long lines, which was particularly challenging for older people and people with disabilities.

Participants with disabilities reported experiencing heightened barriers to accessing health services during the pandemic and being excluded from COVID-19 response measures. Participants expressed that this was consistent with their general experience with the health system, and with disaster response. Notably, one participant said:

“Especially during COVID, service providers were found to be more scared and uncomfortable to treat us. This may be due to the extra effort they needed to serve us, as compared with people without disabilities.”

However, participants’ experiences during COVID-19 also underscored the capacity of older people and people with disabilities to play leading roles in delivering humanitarian aid and supporting their community. Many participants undertook COVID-19 response activities in their communities, including distributing masks and gloves, food, hygiene kits, menstrual health supplies, prenatal kits, and sharing information about the COVID-19 pandemic. As one woman with a disability said:



“During COVID, I supported through social media by sharing useful information which was published by different stakeholders and governments. We mobilized women with disabilities to prepare masks by capacity building, through skill development training, and sell those products at a reasonable price when there was a shortage of masks and gloves.”

Others described providing counseling and organizing support groups and yoga classes over Zoom to support their communities’ mental health, and provide psychosocial support and connection.

Emergency preparedness for older people and people with disabilities

Broadly, there was consensus among participants that emergency preparedness for older people and people with disabilities should be undertaken to prioritize access to safe, accessible shelter, food and water supplies, and clothing and warm blankets. On an individual basis, participants expressed that an older person or a person with a disability should have a cell phone, and know how to use it, medicines, and important papers to be prepared. Participants recommended that older people and people with disabilities should have an emergency kit in their homes, to ensure some essential supplies were available in the event of a disaster. Participants with disabilities also noted that they may have specific items they need to manage their health and hygiene (for example, assisted mobility devices, or toileting supplies), and that these should be included in individuals’ emergency supplies.

Many participants emphasized that family members play a critical role in preparedness and response for people with disabilities and older people, particularly for individuals with impairments that affect their mobility and their ability to operate (e.g., to move or travel, to obtain supplies, etc.) independently. Participants agreed that people with disabilities and older people who are isolated, or do not live with family members or caretakers, are particularly vulnerable. Access to financial resources was also cited as an important factor in individual preparedness.

Participants also noted that it is important for people to know what to do – to have individual and household plans with their families – in the event of an emergency. Notably, several participants reflected that they had received information about what to do in case of an earthquake prior to the 2015 earthquake, but that they were too distressed and panicked to take action accordingly during the 2015 earthquake.

Many participants emphasized the importance of having access to accurate information in the immediate aftermath of a crisis, and over the course of the humanitarian response. As noted above, participants’ reported that during emergencies in the past, older people and people with disabilities were often unaware of available services and programs, or where and how to access assistance. Accordingly, an essential component of individual emergency preparedness for older people and people with disabilities is identifying accessible sources of information. Of those participants who shared different sources of information, most expressed that in their experience, radio broadcasts on FM stations provided the most real-time and valuable information during and in the aftermath of a crisis. During the COVID-19 pandemic, radio broadcasts shared information about the spread of COVID-19 in Nepal, best practices for masking and hand hygiene, and available services for medical care, mental health counselling, vaccines, and SRH services, such as contraceptive services.

Older participants and participants with disabilities cited many of the same barriers and challenges to individual emergency preparedness. A large majority of respondents described mobility as a

key challenge they face in emergency preparedness and response, explaining that if an individual faced limitations to navigating their community independently pre-crisis (for example, a person with a visual impairment), or relied on an assisted mobility device, it was incredibly challenging to move around during and after disasters. Accessibility was also a concern during evacuation efforts: some participants shared that in their experience, not all vehicles were equipped with ramps, lifts, and other accessible functionalities to support the evacuation of older people and people with disabilities.

Participants also reflected on intersectionality, noting that women and girls with disabilities, and people with multiple disabilities, face particularly heightened challenges. People residing in rural or isolated areas were also cited as being particularly at risk. As noted above, older participants reported that isolated older people are especially vulnerable during crises, but are more likely to be excluded from preparedness and response. Some older participants reflected that it is becoming increasingly common for grown children to live apart from their parents, or far away – this poses many challenges for older people, who have traditionally resided with their children in multigenerational households for care and support.

Inclusion of older people and people with disabilities in community-level emergency preparedness

At the community level, both older participants and participants with disabilities reported that their needs were not prioritized in emergency preparedness and response. “In times of disaster, everyone looks out for their own safety,” one older person remarked, adding that “we are not prioritized, and therefore we fall behind.” Another older person responded that, “In crises, senior citizens [are] in [the] shadow[s] even though they are in dire need of help.”

Participants across the board reported that community-level preparedness actions did not address their specific needs and priorities. One major theme that emerged among both older participants and participants with disabilities was a lack of accessible information about emergency preparedness measures, including for early warning systems.

Participants also noted that older people and people with disabilities are often excluded from or overlooked in community assessments and data collection conducted prior to disasters – assessments that are later used to inform humanitarian response and service delivery.

Participants identified numerous barriers to participation in community-level emergency preparedness action. First and foremost, participants stressed that people with disabilities and older people cannot participate in activities if they are not aware of them, and it is therefore very important that information be made available in advance of activities, in accessible formats. One older woman said: “We don’t have any information about participating in any program, so we are not even called during planning activities.” Participants also reported that family members and caretakers may hesitate to facilitate participation if they do not have adequate information about the activity and its purpose, safety measures, and available accommodations.

Several respondents reported having participated in community-level activities before, but that they did not generally focus specifically on emergency preparedness. One older woman said, “I have participated in the issue of senior citizen’s rights, but I’ve never been called for planning.” Another reported, “No one invites us...we are invited when there are programs for senior citizens.



But we are not involved in disaster preparedness activities.” Similarly, in one focus group discussion, a participant with a disability noted that, where people with disabilities are included in planning activities, it is usually for activities that specifically focus on people with disabilities – but that they are not included in general planning activities.

Older participants also reflected that gender impacted their participation, and expressed that older women were less likely to be included or consulted in community-level activities, as compared to older men. An older woman remarked that “women are not allowed to participate in such activities. Only men participate in them. We stay at our homes.” Another woman reported that “There may be some programs, but we women are not much involved. So, we are completely unaware of these planning activities and programs.”

Participants also reported mixed experiences during activities. One woman with a disability reported a positive response from authorities, which she attributed to NDWA’s ongoing advocacy:

“In my municipality, I find a positive response. It may be due to our advocacy on inclusion in meetings and in different programs. I think they are supportive in comparison with other municipalities.”

Conversely, multiple participants reported that their contributions were not consistently addressed, with one participant with a disability reporting that when people with disabilities do participate in activities, they are not empowered to make decisions. One older woman shared that “our voices are ignored even when we participate in such activities.”

Inclusive, responsive community-level emergency preparedness

During focus group discussions and co-analysis activities, participants reflected on facilitators to support older people and people with disabilities to fully participate in community-level emergency preparedness activities, and to ensure their needs are prioritized.

Participants noted that the accessibility of activities often depends on the availability of funding to arrange for the appropriate accommodations, and underscored the importance of safe and accessible transportation, accessible venues, and arranging for sign interpreters, large print and braille materials, easy to read materials, audio recordings, among other accommodations.

Both older people and people with disabilities emphasized the importance of non-governmental and community-based organizations, including OPAs and OPDs, for emergency preparedness and response, given low prioritization in government programs. Participants largely agreed that older persons who were involved in OPAs or other programming focused on older people were more likely to participate in and benefit from preparedness programming.

When asked how community-level emergency preparedness should be organized to support the inclusion of people with disabilities, participants emphasized the importance of understanding and leveraging the network of services and programming offered by local associations and organizations in service of people with disabilities. These groups offer a range of services and support, including financial assistance, mental health and psychosocial support, and counselling and peer networks.

Participants with disabilities also expressed that communities and networks of people with disabilities play an essential role in supporting people with disabilities and facilitating their participation in

preparedness action. Both older participants and participants with disabilities expressed that older people and people with disabilities actively engaged in community-based organizations had greater access to available information, resources, and services.

When asked how community-level emergency preparedness should be organized to support the inclusion of people with disabilities, participants emphasized the importance of understanding and leveraging the network of services and programming offered by local associations and organizations in service of people with disabilities. These groups offer a range of services and support, including financial assistance and mental health and psychosocial support, including counselling and peer networks.

Notably, despite being excluded from or marginalized in community-wide preparedness action, both older participants and participants with disabilities expressed a desire to be actively involved in emergency preparedness, including for SRH. Participants that had participated in preparedness programming in the past felt it provided useful information and helped community members learn more about what to do in the event of an emergency. One participant reported that community preparedness activities provided opportunities for women to “learn new subject matter” and, as a result, “feel more enthusiastic and empowered” about their roles in their community.

Participants also described their personal experiences organizing and participating in disaster response activities. In the aftermath of the 2015 earthquake, NDWA partnered with different organizations to distribute tents, rice, dry food, and essential supplies throughout the community. NDWA members also conducted advocacy to government and NGO monitoring teams to prioritize people with disabilities and ensure they were considered in the planning and delivery of the response. During the COVID-19 pandemic, NDWA members prepared and distributed dignity kits and personal protective equipment (PPE) and organized peer support activities, including over zoom, to provide mental health and psychosocial support to their members.

Participants expressed that older people and people with disabilities are best positioned to provide information and support to their peers. As stated by one woman with a disability:

“Employees working in government bodies and are not well trained to serve people with disabilities. It would have been better if the person with the disability remained a position to serve other people with disabilities...because he or she can better assist and understand the severity of the disaster, and serve accordingly.”

Participants further emphasized that older people and people with disabilities have unique skills and capacities that benefit the community as a whole. For example, one respondent said, “Senior citizens themselves have a lot of life skills to deal with such disasters as the 1990 earthquake, the [2015] earthquake, the flood, and so on.”

Sexual and reproductive health needs and priorities

Participants' SRH needs and priorities varied according to their age and gender and, to a certain extent, by phase of emergency – that is, during stable times, as compared to during or after a crisis.

Among older participants, participants consistently identified screening for reproductive cancers, care for uterine prolapse, and treatment for reproductive cancers as priority SRH needs and services for older people, both during and outside of crises. Screening and treatment for reproductive cancers applied to both men and women (e.g., prostate cancer, ovarian cancer, etc.).

Among participants with disabilities, participants identified counseling and education on SRH and sexual well-being, screening for reproductive cancers, and obstetric, maternal, and newborn care as priority SRH needs and services for people with disabilities outside of crises. During and after crises, participants identified counseling and education on SRH and sexual well-being, care for people who have experienced sexual and gender-based violence, and obstetric, maternal, and newborn care.

Table 3: SRH needs and priorities

<i>People with Disabilities</i>		<i>Older People</i>	
Non-crisis	Crisis	Non-crisis	Crisis
1. Counseling and education on SRH and sexual well-being	1. Counseling and education on SRH and sexual well-being	1. Screening for reproductive cancers	1. Screening for reproductive cancers
2. Screening for reproductive cancers	2. Care for people who have experienced SGBV	2. Care for uterine prolapse	2. Care for uterine prolapse
3. Obstetric, maternal and newborn care	3. Obstetric, maternal, and newborn care	3. Treatment for reproductive cancers	3. Treatment for reproductive cancers

Notably, both older participants and participants with disabilities reported that older people and people with disabilities, particularly women, girls, and people with cognitive or intellectual impairments, faced very high risks of sexual violence, exploitation, and abuse, and gender-based violence (GBV) more broadly, in the aftermath of crises, but that services for survivors were not available or accessible.

People with disabilities

All participants with disabilities identified as women, and accordingly included reflections on both gender and disability when discussing SRH needs and priorities among people with disabilities in their communities.

Participants consistently expressed that SRH information and services are essential for girls and women with disabilities, and that SRH needs increase during and in the aftermath of emergencies.

There was consensus among participants SRH services are essential for girls and women with disabilities in the aftermath of emergencies. Many participants noted that girls and women were at particular risk for sexual violence, exploitation, and abuse, and GBV, both before and during crises.

Participants also discussed the importance of obstetric, maternal, and newborn health services.

However, participants reported that girls and women with disabilities face numerous barriers to accessing SRH services, during stable times, and during crises. Participants consistently reported that facilities and services are not accessible for people with different types of disabilities. Participants expressed the need for service delivery models that address accessibility, and barriers to facility-based care. Several participants noted that SRH camps—that is, mobile service delivery—have the potential to support access for people with disabilities. Participants also noted that, in many cases, services are not free of charge, and people with disabilities may have more limited financial resources.

Participants also noted that girls and women with disabilities are often excluded from programming where SRH information is shared, and do not have accurate information about their bodies and SRH. One woman shared:

“People with disabilities can also have children and get married...there should be a change in the way society looks at [these] things. We need education so that we will be able to seek the services, and [benefit from them]. Although we speak out on this issue, sometimes we feel like...they will make a joke of it. So, we are not able to speak confidently on such issues. This is why education is important.”

Multiple participants reported experiencing discrimination and poor treatment from health providers when accessing SRH services. One woman said, “[There] is a tendency to make fun of us if we use these services. Like other people, people with disabilities have sexual desires and this must be understood by all.” Another participant reflected:

“Inequalities and discrimination exist everywhere for us. Whenever we utilize maternal health services, providers ask why you are pregnant. They tell us we will be at risk. Service centers are not disability friendly. But everyone should understand that we also want children and families.”

Many participants expressed that health providers should be systematically trained on disability inclusion, and that it is important that providers, and communities more broadly, recognize that people with disabilities are sexually active, and have the right to healthy, safe, and pleasurable relationships.

Notably, participants explicitly attributed their own awareness of and comfort with sexual and reproductive health and rights (SRHR) issues to their participation in NDWA, and NDWA’s partnership with FPAN. Several participants shared that their participation in these activities empowered them to lead awareness-raising activities with their peers, and advocate for disability inclusion and access to SRH information and services. One woman said: “If I did not [get] involved in FPAN, I would not have this knowledge and confidence to openly discuss and share SRHR messages.” This reinforces the important role that OPDs play in facilitating access to services for people with disabilities, and their leadership in their communities.



Older people

When queried about older people's SRH needs and priorities, many older participants expressed that SRH is generally not a priority issue for them. Among older men participants, multiple participants stated that SRH did not concern them, and that they do not participate in activities. Older women participants confirmed that men in their communities frequently did not attend SRH-related programming, as they consider SRH to be specific to girls and women.

Although numerous older participants reported that sexual violence, exploitation, and abuse and GBV is of high concern for older people, especially older women, during and after emergencies, participants reported that access to SRH information and services is not their priority for humanitarian health response. The priority SRH needs and services identified by older participants during crises – screening and treatment for reproductive cancers, and care for uterine prolapse—are not part of the Minimum Initial Services Package (MISP) for SRH, which is comprised of essential services that prevent morbidity and mortality that must be available in the immediate aftermath of an emergency. However, these services should be made available as situations stabilize, and SRH service delivery is expanded and scaled up to include comprehensive SRH services.

Outside of crises, participants did report experiencing barriers to accessing SRH services, particularly related to costs. Participants noted that services are not always free of cost and shared that older people may not be able to use SRH services. Participants reported instances of older people not being able to afford screenings for reproductive cancers, or not being able to afford cancer treatment after their diagnosis. Older people who do not live with their families were reported to be especially impacted by financial barriers.

More broadly, older participants did express that it is important that SRH information and services are important for communities, and noted that many older people have limited knowledge and awareness related to SRH. Participants expressed support for SRH education and counselling, and that people should feel confident to discuss SRH issues with their health providers. Older participants also cited SRH camps as being a helpful service delivery model for reaching older people and people with disabilities with SRH information and services and noted that these camps should be planned and delivered in partnership with OPDs and OPAs. Several participants expressed that older people can serve as resources for their families and communities and share information about SRHR and the importance of accessing services.

Recommendations

Community-level emergency preparedness policy and planning

District disaster management and health authorities and diverse service delivery organizations must:

- **Strengthen the capacity of key community leaders and stakeholders to promote inclusive community preparedness, including for SRH.** Train and support authorities and officials, health personnel, and other relevant stakeholders on principles for inclusion, and conduct values

clarification and attitudes transformation on age, disability, and SRHR to raise awareness of the unique SRHR needs and priorities of older people and people with disabilities.

- **Strengthen the participation of OPAs and OPDs in national, provincial, and district level disaster risk management and emergency preparedness bodies and mechanisms.**
- **Collect population data that is disaggregated by age, gender, and disability status** to inform policy and planning, including for emergency preparedness and response. District and community mapping must identify older people and people with disabilities.
- **Regularly budget for disaster risk management and emergency preparedness, including for health, at the district level.** Allocate funding to support the development, implementation, and monitoring of emergency preparedness policies, plans, and activities. Allocate funding to provide accommodations to ensure that activities are accessible for people with diverse disabilities.
- **Ensure that emergency preparedness activities are fully accessible for people with diverse disabilities.** This includes ensuring safe and accessible venues and transportation options, and providing sign interpretation, materials in braille, large print, and easy-to-read materials, materials in audio formats, closed captioning, and support persons.
- **Ensure that community-level emergency preparedness plans address accessible transportation** and evacuation for people with mobility impairments.
- **Ensure that information shared as part of emergency preparedness planning and activities, including early warning systems, is available in accessible formats to ensure it is accessible to people with a range of disabilities.** This includes sign interpretation, braille, large print, easy-to-read, audio formats.
- **Leverage existing networks and communications platforms** (e.g., WhatsApp, Viber, social media, radio, television) among older people and people with disabilities to ensure information on emergency preparedness and response, including early warning systems, is accessible to older people and people with disabilities.
- **Include family members and support persons of older people and people with disabilities when sharing information about and planning emergency preparedness activities** that engage older people and people with disabilities. Ensure that family members and support persons have information about the purpose of the activity, where the activity will be held and if it will be fully accessible, what kinds of accommodations will be available, and if it will be safe.
- **Support older age homes in the community to support vulnerable or isolated older people.** Provide funding to maintain existing older age homes and the services they provide and build new older age homes to meet the needs of older people in the community.

During humanitarian response:

Stakeholders delivering humanitarian response, including governments, UN agencies, international NGOs, and local NGOs must:

- **Ensure that information throughout the disaster and the humanitarian response is made available in a range of accessible formats** to ensure that people with diverse disabilities,



including hearing and visual impairments, can access critical information. Information and communications materials should reflect affected communities in all their diversity, including older people and people with disabilities.

- **Leverage existing networks and communications platforms** (e.g., WhatsApp, Viber, social media, radio, television) among older people and people with disabilities to share information. Partner with OPAs and OPDs to identify these networks and platforms, and to share out information.
- **Ensure that humanitarian facilities, including safe shelter and latrines, are accessible and address protection risks for older people and people with disabilities.** Stakeholders across sectors – not only health and protection – must be sensitized to the protection risks facing older people and people with disabilities, and equipped to organize and deliver humanitarian services to address these risks. Ensure that older people and people with disabilities are aware of available shelter and protection services, and how to access them. Prioritize older people and people with disabilities when placing vulnerable individuals in safe shelter.
- **Provide targeted protection services for older people and people with disabilities that address their high risk of sexual violence, exploitation, and abuse, and GBV more broadly.** Older people and people with disabilities face heightened barriers to accessing protection services. Protection services must be organized to be accessible, and responsive to their unique needs, risks, and priorities. Partner with services and organizations that provide services for older people and people with disabilities, including OPAs and OPDs, to plan and organize protection programming, and to reach older people, people with disabilities, and their networks with information about available services.
- **Ensure that distribution points for humanitarian aid and service delivery points for health and protection services are fully accessible for older people and people with diverse disabilities.** Ensure that older people and people with disabilities are able to receive assistance (e.g., food supplies, non-food items, water) without having to stand in lines, carry heavy loads, etc.
- **Ensure the availability of supplies to meet the specific needs of older people and people with disabilities,** including in dignity kits, such as toileting supplies, menstrual management supplies, and mobility aids. Ensure older people and people with disabilities are systematically included in the prepositioning and distribution of SRH supplies by partnering with OPAs, OPDs, and service delivery organizations serving older people and people with disabilities.
- **Ensure condom distribution points are accessible to older people and people with disabilities,** and conduct condom distribution in partnership with services and organizations that provide services for older people and people with disabilities, including OPAs and OPDs.
- **Organize targeted health camps and community-based health and protection programming to reach older people and people with disabilities** as part of ongoing humanitarian response, particularly those who face barriers to accessing facility-based services. Partner with services and organizations that provide services for older people and people with disabilities, including OPAs and OPDs, to plan and implement community-based service delivery.
- **Organize targeted mental health and psychosocial support programming with older people and people with disabilities.** Community groups and peer-networks can support the health and wellbeing of older people and people with disabilities. Ensure that older people and people with disabilities have access to programming in their preferred formats. Partner with OPAs to organize social and leisure activities (for example, “day camps”) with older people to support social connection and an active lifestyle.

Sexual and reproductive health

Sexual and reproductive health service providers and district health policy makers must:

- **Ensure that health facilities and SRH service delivery points are fully accessible for older people and people with disabilities**, including people with visual impairments, and people with mobility impairments.
- **Conduct trainings on older age and disability inclusion and values clarification and attitudes transformation (VCAT) activities with diverse health providers** to strengthen capacity to provide respectful, inclusive care for older people and people with disabilities.
- **Address financial barriers to service uptake among older people and people with disabilities**, for example, by providing vouchers, stipends, or refunds for transportation and services, and providing free screenings for reproductive cancers.
- **Organize community-based service delivery, including targeted health camps, in partnership with OPAs and OPDs**, to reach older people and people with disabilities who face particular barriers to accessing facility-based care with SRH information and services.
- **Engage older people and people with disabilities in community-based SRH information and service delivery**. Train and support older people and people with disabilities to serve as community health resource persons for their peers and communities.
- **Conduct targeted outreach and tailored community awareness raising activities for SRHR**, in partnership with OPAs and OPDs, with older people, people with disabilities, and their families, support persons, and networks to increase knowledge of SRHR and available services, and address their specific, self-identified needs and priorities. These activities should also address sexual violence. Ensure that older men and boys and men with disabilities are included in these activities.
- **Engage older people and people with disabilities in community-based SRHR information and service delivery**. Train and support older people and people with disabilities to serve as community health resource persons for their peers and communities.
- **Address low knowledge of risks of sexual violence and available services for survivors, including one-stop crisis management centers, among people with disabilities, older people, and their support persons** through targeted outreach and community awareness raising activities. Build awareness among service providers that older people and people with disabilities, particularly older women, girls and women with disabilities, and people with cognitive or intellectual impairments are at very high risk of sexual violence, exploitation, and abuse.
- **Ensure that IEC materials reflect community members in all their diversity**, including older people and people with disabilities.



Conclusion

Emergency preparedness is essential to mitigate the effects of conflict, natural disasters, and epidemics and pandemics, and their disparate impact on historically excluded populations—including girls and women, people with disabilities, and older people. This includes emergency preparedness for SRH: access to good quality SRH services supports women's and girls' participation in livelihoods and education, fosters resilience, and empowers women and girls to lead preparedness and recovery efforts. SRH services are lifesaving, and a recognized component of minimum humanitarian health response. In humanitarian emergencies, women and girls face elevated rates of maternal death, GBV, unintended pregnancy, and sexually transmitted infections (STIs), including HIV. This includes girls and women with disabilities, and older women. In fact, girls and women with disabilities and older women face very high risks of sexual violence and GBV more broadly, but face heightened barriers to accessing essential health and protection services.

Despite this compelling need, there are persistent gaps in emergency preparedness and response for SRH. More broadly, emergency preparedness planning at every level consistently fails to address the specific needs and vulnerabilities of diverse populations. It is essential that stakeholders,—including governments, development, and humanitarian actors, work directly with diverse populations, including older people and people with disabilities, to design and implement emergency preparedness and ensure that humanitarian response is accessible, inclusive, and addresses their specific needs and priorities.

Moreover, older people and people with disabilities have unique experiences, networks, resources, and expertise. Partnering with and investing in the participation and leadership of older people, OPAs, people with disabilities, and OPDs at every stage of the emergency response cycle will strengthen preparedness, response, and recovery across the board.

