Independent review of the role of CERF's Disability Inclusion Envelope

Final Report: September 24th, 2023

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Executive Summary

Almost exclusively, interviewees for this review were supportive of the *intent* of the envelope. They recognised that direct funding for disability inclusion is an absolute requirement if the system is to live up to the commitments which had been made. It is hard to attribute immediate, concrete improvements to coordination structures or funding allocations systems at country level and significant challenges in the inclusion of OPDs and specialist agencies in decision making. Ongoing or planned advances in disability inclusion, although incremental, are reported in Afghanistan, Nigeria and South Sudan subsequent to the allocation. Overall, there was an undeniable sense of positivity around this allocation and a sense that it contributed to forward momentum for disability inclusion.

Given the specific intent of this envelope, to support direct action for disability inclusion , the level of engagement with OPDs and/ or specialist agencies fell significantly short of what was expected under the guidance provided by CERF in consultation with global experts. As such, it also fell short of requirements under the 'must-do' actions in the IASC Guidelines on Inclusion of Persons with Disabilities in Humanitarian Action and the principle which underpins a rights-based approach: 'nothing about us without us'. In simple terms and overall, people with disabilities, and their representative organisations were not meaningfully involved in upstream country level allocation decisions and did not bring forward their needs or expectations.

Representatives of Disability Inclusion Working Groups (DIWGs) *did* tend to be engaged in technical checks (essentially a technical quality assurance role) after key allocation and project design decisions had been made i.e., 'downstream' engagement. Typically, the agencies consulted were active participants in each country's respective Disability and Inclusion Working Groups.

Across the six case study countries, at the time of the allocation, a number of challenges clearly worked against an adequate level of engagement.

- None of the countries had a detailed inter-agency plan on disability inclusion which articulated shared priorities identified in consultation with OPDs and based on sector-specific data on disability-related risks and barriers to access. This would have reduced the time required for consultation during the allocation process.
- Across the group of countries, DIWGs were typically in relatively formative states, or experiencing a lull in activity due to a resource gap, at the time of this allocation.
- Typically, at this point in time, the formal mechanisms for the *consistent* engagement of OPDs with humanitarian coordination structures were in a nascent state or weak (and furthered weakened by the ongoing pandemic).
- Allocations were run in a way which emphasised the need for efficiency, requiring the limitation of consultation as a tactic to ensure that the processes were relatively quick

and could meet short deadlines. The fact this was a relatively small allocation exaggerated this thinking.

- Disability inclusion is relevant to all clusters and themes. The use of standard, cluster-based allocation processes in this case, limited the potential reach of the allocation.
- Competition for CERF funding among agencies was a factor in the allocation in most countries, notably in Mozambique. The notion that all of the agencies are entitled to 'a piece' of the funding was raised unprompted in every country. There was a disconnect between the DI envelope and the larger UFE envelope in Mozambique and South Sudan.

Overall, it is fair to say that the disability inclusion envelope was subject to the norms of each country's respective allocation processes, exaggerated by the small scale of the envelope and its disconnect, in some cases, from the larger UFE envelope. In some of the focus countries, it was also subject to the prevailing medical approach to disability, despite being designed according to a rights-based approach. These factors worked against the intent of the envelope, 'Success' in this respect would have required longer allocation processes and a higher than typical level of external consultation and collective working. A higher level of inclusion in decision making would arguably have led to a greater chance of funding being passed through to OPDs or other local groups, for whom this funding would have been extremely significant.

It is impossible to say that data collection and targeting of the needs of people with disabilities have been strengthened overall. Section 1 details several structural issues that presented challenges for DI in humanitarian action at the time of the allocation: data from HNOs was weak and/or inconsistent, with many countries relying on global averages.

Findings from the two in-person country visits align clearly with the findings above. In South Sudan, at the time of the allocation, there was no interface between the standing group of national OPDs and humanitarian coordination. This group was aligned to a development ministry and had been dormant during the COVID-19 Pandemic. The South Sudan team were faced with an unusually short widow for decision making, even by the normal standards of humanitarian action, ruling out the possibility of any meaningful consultation for this envelope. In Mozambique, CERF allocation norms saw the envelope assigned to the protection cluster, arguably improving the speed of decision making while reducing the possibility of broader consultation. OCHA and partners in Pemba were not included in decision making, in part at least to minimise further competition for funding, and compounding the sense of narrow consultation.

The allocation of the whole envelope to IOM in South Sudan, while having only limited, bilateral consultations, was positive in terms of outcomes, as it built on IOMs solid track record in DI. In Mozambique, in the absence of further consultation with the DIWG in the

protection cluster in Pemba, the envelope was divided into four very small grants, limiting the possibilities of results at scale and exacerbating design challenges.

1 Introduction and aims of the review

1.1 Background

The United Nations Central Emergency Response Fund (CERF) provides rapid funding for humanitarian crises globally. Since its establishment by the UN General Assembly in 2005 under Resolution A/RES/60/124, the CERF works to achieve the following objectives:

- Promoting early action and response to reduce loss of life
- Enhancing response to time-critical requirements
- Strengthening core elements of humanitarian response in underfunded crises[1]

These objectives are primarily achieved through two instruments, the Rapid Response (RR) and Under-funded Emergencies (UFE) Windows. Over the past 17 years, CERF has contributed to large-scale humanitarian responses across the globe in an effort to save lives and reduce the negative impacts of humanitarian crises on the most vulnerable segments of the population.

Every year, the Emergency Relief Coordinator (ERC) allocates funding from CERF's Underfunded Emergencies (UFE) Window to address core emergency humanitarian needs in chronically underfunded emergencies. In 2021, the ERC allocated US$125 million to 12 countries. To better address the needs of persons with disabilities, the ERC allocated a further $10 million (hereafter referred to as the "disability inclusion envelope") to seven of these 12 countries.

All UFE allocations encourage agencies to promote an inclusive response that takes into consideration the specific access requirements of people with disability. The IASC's guidelines[2] identify 'must-do' actions on the inclusion of persons with disabilities in humanitarian action (2019), including:

- The promotion of meaningful participation of persons with disabilities in all processes regarding humanitarian programmes.
- The removal of barriers to ensure persons with disabilities aren't prevented from accessing services.

[1] Please see the CERF website.

[2] The IASC guidelines on Inclusion of Persons with Disabilities in Humanitarian Action are the first and only framework that provides a rights-based approach the inclusion of persons with disabilities in humanitarian contexts. As such, it is important in that it sets out actions that humanitarian actors should take to ensure that all phases of humanitarian action are disability inclusive. While an implementation of the sectorial "must do " actions at programme level is important, the framework goes beyond this. The UFE allocation is the first global CERF allocation that encourages actors to roll out this framework. As such, the review will look at the actions of all participants in the allocation, with a view to understanding how well the spirit of the IASC framework was upheld.

- The disaggregation of data to help monitor the inclusion of persons with disabilities, and
- The empowerment of persons with disabilities, equipping them with the knowledge and skills needed to contribute to and benefit from humanitarian assistance and protection.

Specific funding through the disability inclusion envelope was made available to address foundational issues, to advance programming for persons with disabilities and to generate learning for the system towards better addressing the needs of people with disability in humanitarian responses. As explained in the guidance note prepared for the allocation, the objectives of this additional $10 million of CERF funding for persons with disabilities were to:

- Address the specific requirements of persons with disabilities by providing specific interventions.
- Catalyse lasting improvements by strengthening collective structures and systems to enhance the ability of humanitarian actors to develop and implement quality programmes that are inclusive of persons with disabilities.
- Promote greater accountability in the system, including by increasing and improving the participation of persons with disabilities and organizations of persons with disabilities.

In addition to HCs and/or HCTs being asked to consult disability specialists (including Organizations for Persons with Disabilities (OPDs)) at the strategic stage of the allocation processes (below), UN recipients of CERF funding were also encouraged to form or strengthen partnerships with OPDs. In the event that OPDs did not exist, HCTs and/or recipient agencies were encouraged to seek to create committees that engage persons with disabilities and/or disability experts in governance mechanisms.

1.2 Review purpose, scope, research methods and key review questions

1.2.1 Review purpose and scope

The main objective of the review is to generate learning from the disability inclusion envelope of US $ 10 million for targeted interventions. Since the allocation was the first of its kind, identifying lessons, best practices and potential challenges will help generate learning to advance disability inclusion in humanitarian actions, and specifically the use of earmarked funding for structural improvements and targeted programming.

The intended users of the review are the CERF secretariat, the CERF Advisory Group, donors, and OCHA offices, country teams and Resident and Humanitarian Coordinators, as well as the Disability Reference Group, CERF recipient Agencies and partners, including OPDs,

especially in the six focus countries. The CERF secretariat will use the lessons generated by the review to inform how it promotes disability inclusion in its allocation processes. Other stakeholders will benefit from learning related to disability inclusion more generally, including as it relates to financing. The final report will be published on the CERF website.

1.2.2 Research methods

The review gathered evidence to answer the research questions using mixed methods for data collection and analysis. Most of the data collected was qualitative and was gathered through a document and literature review as well as semi-structured key informant interviews (KIIs). In addition, in focus countries which were the subject of in-country visits. focus group discussions were held with people with disabilities, and caregivers, who were engaged with CERF funded services. All interviews were undertaken on a not-for-attribution basis. Evidence was collected, triangulated and synthesised under the research questions outlined in the research matrix.

Document and literature review

A preliminary review of CERF documents (including internal correspondence, allocation guidance, and proposals) was carried out during the inception stage.

A more detailed review of documents and reports was carried out prior to each country study. A list of sources of documentary evidence is presented in Table 1. For all the focus countries, the review relied on OCHA country offices and those of recipient agencies to provide in-country documents, such as meeting minutes and project level reporting.

Table 1: Sources of documentary evidence

Global level	**Case study countries**	**Non-case study countries**
Prioritization Strategies - Persons with Disabilities Funding Guidance Note on Funding for Persons with Disabilities Correspondence on the selection of persons with disabilities countries CERF Handbook	HRPs, HNOs and OCHA sitreps Country level strategy papers Recipient agency proposals and country chapeau documents Project interim reports and ad hoc reporting i.e. reports from the implementing partners to the recipient agency to the extent that these are made available. (very few in number)	Recipient agency proposals and country chapeau documents

Semi-structured key informant interviews

The review matrix was used to develop a guide for semi-structured interviews (Annex X). Other than in South Sudan and Mozambique, these were conducted as remote interviews via Zoom, Teams, of Skype. Where possible, in-person interviews were held in South Sudan and Mozambique.

To the fullest extent possible, the review undertook key informant interviews (KIIs) with all stakeholders involved in the allocation process in the three focus countries. Country-level debriefs were provided in these three countries to reflect on and validate findings and preliminary analysis. In the other countries, a smaller sample of interviews were carried out for triangulation purposes including with the OCHA offices and country-based fund managers where present.

Additional interviews were carried out at the global level, primarily within the CERF Secretariat and members of the Disability Reference Group.

Focus group discussions (in-person focus countries only)

Focus group discussions (FGDs) were held in South Sudan and Mozambique at a number of levels. These discussions solicited direct feedback from OPDs who participate in national and sub-national level disability inclusion working groups (DIWGs), persons with disabilities, support persons, and OPDs involved at project level. Discussions at national and sub-national levels covered OPD engagement in allocation processes, project design and project implementation. At project level, the FGDs explored the extent to which projects identified and addressed needs of persons with disabilities and whether they had meaningful opportunities to influence decision-making around the design and implementation of the programmes. The FGDs further explored whether the programme equipped OPDs with the knowledge and skills needed to contribute to and benefit from humanitarian assistance and protection, whether they resulted in better participation of OPDs in humanitarian decision-making and coordination, and whether they gave OPDs opportunities to improve their organisational capacity and/ or access additional resource to address additional identified needs.

1.2.3 Data synthesis and analysis

The review utilised Humanitarian Outcomes' (HO) in-house research system (known as 'Praxis'). HO employs this standardised research process and information management system in all its projects. It uses a suite of software tools, which includes the use of a shared online platform (Airtable) that affords transparency and real-time collaboration. The system enables research teams to:

- Centralise and organise tasks, templates and evidence (e.g. interview notes and document sources);
- Allow key data to be easily retrieved, ordered, and visualised, reducing cognitive

biases and facilitating linkages between disparate ideas and information sources; and

- Ensure quality, integrity, and credibility by incorporating principles of rigour and objectivity in the process and creating a thorough archived record of the research.

All project-related materials including interview notes, documents reviewed, and other data sources were entered into the system. The system allowed for multi-level comparative analysis, minimizing common challenges such as recency and availability bias, and provides a documented archive of the research process. The data is kept secure.

1.2.4 Terminology

This report uses a number of terms throughout. It is useful to specify their meaning in advance.

Organisations of Persons with Disabilities (OPDs): An OPD is a representative organization or group of persons with disabilities, where persons with disabilities constitute a majority of the overall staff and volunteers in all levels of the organization. OPDs work locally, nationally, regionally, and globally. Some focus on one type of disability, whilst others are cross-disability. Some represent a specific demographic group (e.g. women with disabilities, youth with disabilities). Many OPDs belong to a local, national, regional or global network (see definition of OPD umbrella organisations).

The primary role of OPDs is to represent the voices and experiences of people with disabilities and advocate on their behalf. This is a unique role i.e. it cannot be undertaken by other actors. Some OPDs may also provide information and advice, support networking; as well as undertake training and technical assistance to promote disability inclusion and empowerment. Consultation with OPDs contributes to accountability (for decision-making) and relevance (of programme design).

OPD umbrella organisations: coalitions of representative organisations of persons with disabilities. A diverse membership consisting of different OPDs allows them to represent the interests of people with disabilities in all their diversity. They are democratic and open in their functioning; they speak only on behalf of their member organisations and solely on matters of mutual interest that are collectively decided upon. The existence of umbrella organisations in a country should not hinder individuals or organisations of persons with disabilities from participating in consultations themselves.

Disability inclusion specialist organisations: For this report, specialist organisations are defined as those who have a technical specialism in disability inclusion (whether or not this is their sole focus). Examples include International and National NGOs[3]. There is a case to

[3] Humanity and Inclusion in multiple countries, CBM Global, Light for the World, and ASB in Indonesia and the Swedish Committee in Afghanistan.

include individual UN agencies here, if and only if they have a significant technical speciality in any given country.

Disability Inclusion Working Groups[4] (DIWGs): A DIWG is an inter-agency and inter-sectoral coordination body established to advance disability inclusion issues in humanitarian contexts. It is intended to bring together a range of actors working in this space including UN agencies, national and international NGOs, civil society organisations, OPDs, private sectors actors to address the full spectrum of factors that impact people living with disabilities. The DIWG collaborates and works closely with all relevant existing technical working groups and clusters to strengthen policy and practice on disability inclusion. Broad areas of work by the group may include:

1. Strengthening disability inclusion in the Humanitarian Response Cycle through active engagement in the HNO and HRP processes and other processes
2. Strengthening disability inclusive programming in both humanitarian and development-oriented actions through capacity building on disability inclusive programme design, implementation, monitoring and evaluation
3. Support the development and use of tools and guidelines to strengthen disability inclusion in humanitarian and development response in line with IASC Guidelines on Disability Inclusion in Humanitarian Response
4. Facilitate active engagement and participation of Person with disabilities and Organisations of Persons with Disabilities (OPDs)

Overview of CERF funded projects by country[5]

Project Code	Project Title	Country	Agency	Emergency Type	Amount Approved
21-UF-OPS-004	Victim Assistance in Hama and Homs governorates	Syrian Arab Republic	UNOPS	Multiple Emergencies	800,000
21-UF-HCR-029	Provision of protection services and upgrade of common facilities for persons with disabilities	Syrian Arab Republic	UNHCR	Multiple Emergencies	1,200,000
21-UF-IOM-031	Improving the well-being of persons with disabilities in camp and camp-like settings	Nigeria	IOM	Displacement	600,000

[4] This report uses the title DIWG as a default. In some countries, however, these groups are referred to as Disability Working Groups (DWG) or Age and Disability Working Groups (ADWG).
[5] As above, the team in DRC did not develop separate 'disability-specific' project proposals/budgets, rather consolidated the funding from the disability inclusion envelope into the regular UF allocation. As such, there are no disability specific projects.

21-UF-CEF-052	Support and inclusion of children with disabilities and caregivers in CP service delivery in North East Nigeria	Nigeria	UNICEF	Displacement	300,000
21-UF-IOM-030	Multisectoral humanitarian assistance for people with disabilities affected by insecurity in Cabo Delgado	Mozambique	IOM	Displacement	125,000
21-UF-CEF-051	Disability Inclusion in Cabo Delgado through Capacity Building and Improvement in Service Delivery in Child Protection and Education	Mozambique	UNICEF	Displacement	200,001
21-UF-HCR-028	Provision of Protection Activities for Persons with Disability in Cabo Delgado, Mozambique	Mozambique	UNHCR	Displacement	100,000
21-UF-FPA-031	Essential GBV response services to women and girls living with disabilities in IDP sites and host communities in Cabo Delgado	Mozambique	UNFPA	Displacement	75,056
21-UF-HCR-027	Protection, Assistance and Durable Solutions for People with Disabilities in North-East Nigeria	Nigeria	UNHCR	Displacement	600,362
21-UF-WHO-028	Strengthen Health Emergency Response by Supporting Post Trauma Physical Rehabilitation and WASH Services to persons with disabilities Living in Conflict Affected Areas	Afghanistan	WHO	Multiple Emergencies	740,000
21-UF-OPS-003	Provision of victim assistance services in Farah, Kunar and Uruzgan provinces	Afghanistan	UNOPS	Multiple Emergencies	759,903
21-UF-FPA-019	Tackling Gender-based violence against women and girls with disabilities affected by the Venezuela humanitarian crisis	Venezuela	UNFPA	Unspecified Emergency	200,000
21-UF-IOM-017	Provision of holistic humanitarian support to persons with disabilities in Aweil South and Tonj South	South Sudan	IOM	Violence/Clashes	1,500,000
21-UF-WFP-023	Emergency school meals programme in special education schools	Venezuela	WFP	Unspecified Emergency	400,000

21-UF-CEF-031	Promoting inclusion for children with disabilities in Venezuela	Venezuela	UNICEF	Unspecified Emergency	400,000

2 Section 2 - Findings

2.1 Global level allocation process

Overarching questions:

- Were the parameters (e.g., in terms of criteria for country selection and prioritization of interventions) used for the allocation the right measures to better meet humanitarian needs?
- How was the disability envelope integrated into the overall UFE allocation process?
- To what extent did the global allocation embody the spirit of the IASC guidelines?
- Was the involvement of disability experts in the preparation and implementation of the allocation process beneficial and appropriate?

Ahead of the allocation, CERF secretariat staff engaged the 'disability contact group'. This group had been assembled[6] to provide advise on how to improve disability inclusion in CERF/CBPF allocations and processes. Engagement with the group was in the form of 10-12 meetings around various topics over more than 18 months. The group's initial engagement was around disability inclusion in CERF allocations more broadly. Overall, the work of the group was valued by CERF secretariat staff, both in terms of its 'refreshingly technical approach' (i.e., engagement without inter-agency politics) and their ability to provide clear steers to the process.

The group engaged in specific support to the DI allocation, albeit in varying degrees based on availability, in the second quarter of 2021. The experts themselves described their engagement during the period around the allocation in terms of two, loosely defined phases. The first 'phase' encompassed the production of the specific guidance for countries. The component of the guidance most often cited as important and directly attributable to the group's engagement was the insistence on the need to engage OPDs in decision-making processes and strategy design. The group were consistently appreciative of this phase of engagement, describing it as 'collegiate' and very open ('everything out on the table').

The second phase of the allocation included remote engagement in country level decision making, including the review of projects submitted. This 'phase' was described as having a different dynamic, characterized by a rushed pace and a decrease in the level of consultation with the non-UN members of the group. In the latter stages, as the group was engaged in

[6] in parallel with a similar gender group

reviewing proposals, the process was described as 'competitive' and 'confusing'. One commonality, noted in other pooled funding reviews, was the tension inherent in the dual-hatted role of the UN representatives in the contact group i.e., while they played the quality control and technical advisory function required by OCHA, they were, in some instances, engaged by their own agency representatives at field level.

Overall, there was a great deal of praise for the early stages of the engagement and disappointment for the latter. This sense of disappointment was exacerbated by a lack of feedback about how, whether or to what extent the group's inputs had been used.

2.2 Country level allocation processes

2.2.1 How were the "specific requirements" of disabled people defined? (Was reference made to priorities identified in HRPs/HNOs, appropriately for each context and through consultations with OPDs and others in disability movement.)

Of the countries included in this review, only Syria and Afghanistan provided data on persons with disabilities in their 2021 HRPs / HNOs. The others used the global estimate of 15% as the basis for any estimate of needs. Documentation on Afghanistan stated that 79% of the population have a disability of one sort another. This figure reportedly came from research by the 'Asia Foundation'. The 79% figure covered a broad a range of issues, broken down in the report into a number of categories. Subsequently, the 'reference' figure for targeting persons with disabilities was reportedly changed to 8.5%. One interviewee stated that both figures were counterproductive, one unrealistically high and the other unrealistically low.

Syria and Afghanistan were the only countries to refer specifically to the IASC guidelines as a reference for disability inclusion. Most HRPs did include high-level analysis of specific underlying factors, including barriers or structural inequalities that prohibit the inclusion of persons with disabilities into humanitarian responses. In very brief summary, HRPs are inconsistent in their treatment of DI. Overall, the rapid consultations which timely CERF processes require would need a much more detailed level of sub-national data. Albeit an estimate, the DIWG in Pemba in Mozambique stated that they would need three months to put together a meaningful strategy for prioritising the allocation in Cabo Delgado.

2.2.2 Did the allocation ensure the promotion of meaningful participation of persons with disabilities?

The definitions outlined in the introduction can be mapped directly onto CERF's guidance note for this envelope and equally onto the IASC guidance and its 'must do' actions. The note states that *"HCTs/UNCTs should ensure consultations with* **disability experts** *at the country level (***including appropriate working groups and Organizations of Persons with Disabilities***) as part of defining their approach/vision to the envelope for people with disabilities."* The review team interprets this as requiring *a* **direct** *role for OPDs*, at national level, ideally represented by a national umbrella organisation representing a diverse range of disability types and groups. This would be in addition to specialist organisations and disability focal points from UN bodies and international INGOs, typically those involved in DIWGs. The review team also interprets the guidance as referring to 'up-stream' consultation i.e., during the development of strategy for the envelope *and* at the time of the development of project design.

In South Sudan, OCHA stated that no OPDs were involved in the *allocation* process and that no such groups were accessible for consultation at the time of the allocation. A focus group discussion with several South Sudanese OPDs revealed a more nuanced picture. OPDs have been in existence in South Sudan for several years and have been part of a coordinated group under the Ministry of Gender. This group had been relatively dormant during the COVID-19 lockdown and was, in the recollection of participants, inactive at the time of the allocation. By virtue of its origin and its linkage to this specific Ministry, the group is characterised as a development oriented. There has been no consistent interface between the group and humanitarian coordination structures. This characterization notwithstanding, *some members* of the group displayed expert knowledge of humanitarian coordination systems, norms and practices including the IASC guidance on disability inclusion and offered suggestions for their potential involvement.

The focus group discussion also highlighted one trait that was evident consistently across the review, a tendency for them to be consulted after the project design phase i.e., to be offered the role of quality assurance and/or technical engagement on projects, only once the key design work had already been done and key budgetary decisions made.

In discussions specifically regarding CERF allocation rounds, the OPDs were clear that while they had not been asked to participate, there were also limits to their capacity to assist in these relatively high/national level processes. The group in Juba has been active only intermittently, the organisations are not uniformly strong and are not necessarily representative of all, or even most, areas outside of Juba. Nor are they equally representative of all types of disability types or groups. They also described themselves as lacking the capacity to assist in consolidating a picture of the needs of people with disabilities country wide. They were explicit about their capacity constraints; in administrative terms as well as in terms of their ability to communicate with colleagues or

peers outside of Juba and/funding for transportation and other basics[7]. While they recognised limitations in their capacity to assist in a country-level allocation processes, they saw their future inclusion and the opportunity to build a link with humanitarian coordination as essential. The group also highlighted the unequal attention on certain cross-cutting issues i.e., greater emphasis on formal structures for gender, such as gender markers and GenCap advisers, for which there are no equivalents for disability inclusion.

Similarly, in Mozambique, there was no 'up-stream' consultation with OPDs at the time of the allocation. DIWGs exist in both Maputo and in Pemba[8] (for the Cabo Delgado response), both had been formed at the time of the allocation but were in a relatively nascent state. Both groups sit within the protection cluster, the significance of which is discussed below. FAMOD[9], the umbrella organisation for OPDs is active in both. Members of both working groups detailed the challenges of communication between Cabo Delgado and Maputo, including between the two FAMOD offices[10]. In meetings with the DIWG's in Pemba and Maputo, concerns very similar to those in South Sudan were raised, specifically about a chronic lack of capacity in OPDs and a lack of access to resources and support. The lack of capacity was noted as especially acute beyond Pemba in Cabo Delgado[11]. As was the case in South Sudan, FAMOD (on behalf of OPDs in Cabo Delgado) expressed frustration with the lack of meaningful engagement with humanitarian actors above implementation level.

In Afghanistan, at the time of the allocation, DIWGs reportedly existed in a relatively formative state, having been created in 2020. It included UN bodies, INGOs (including specialist agencies) and national NGOs and community groups including OPD[12]s. As was the case in South Sudan and Mozambique, there was no 'upstream' consultation with the group. The members of the DIWG *steering group* at the time were invited to review the proposals. This mirrors technical consultation described by OPDs in South Sudan and Mozambique. In addition, the steering group at that time was reportedly made up of international agencies only[13]. The steering committee for the DIWG continues to play the same role (technical consultation at project level) for allocations of the Afghanistan Humanitarian Fund, but not for CERF allocations. As detailed below, the position of one DIWG in the health cluster ultimately supported the allocation of funding to rehabilitation and a medical approach to disability inclusion. This is in keeping with the framing of DI in Afghanistan's HRP/ HNO in 2021 (above), which provided detailed information on the medical needs of persons with disabilities. Similarly, In Syria, at the time of the allocation,

[8] FAMOD noted that of the 25 members of the DWG in Cabo Delgado, 12 are OPDs.
[9] Forum das Associações Moçambicanas de Pessoas com Deficiência (Forum of Mozambican Associations of Persons with Disabilities).
[10] As detailed below, CERF allocation decisions are made in Maputo, with little inout from Cabo Delgado in general. Communication challenges between the DIWGs in Cabo Delgado and Maputo, are over and above these norms.
[11] The very small number of implementing partners is one of the clear constraints across the CD response.
[12] The situation for OPDs is currently very challenging and has deteriorated since the time of the allocation. During the research period, OPDs were no longer being registered as formal organisations by the de facto authorities.
[13] HI, Swedish Committee, ILO, UNFPA

one the DIWG sat in the health cluster. The Syria team stated that once proposals had been developed, they 'had to be cleared with DIWG, VAWG and Cash and Assistance WG' i.e., at the 'technical level'. As noted above, this is clearly in line with the strategy outlined in the HRPs and HNOs for both countries.

The picture in Nigeria was somewhat similar. While OPDs were already on the periphery of international assistance structures at the time of the allocation, there was *no formal mechanism for their consistent engagement* with humanitarian coordination structures[14]. Based on the guidance offered by the CERF secretariat, OCHA reached out to a selection of Nigerian OPDs and specialist organisations (via UNESCO). Not all of those consulted were operational in Northeast Nigeria, nor had a direct remit to engage in humanitarian response, which was seen as resulting to raised expectations of funding. Their advice on the projects submitted was sought in a single session which provided the principal opportunity for dialogue. This group, still on an informal footing, has been consulted subsequently, including for advice on the Nigeria Humanitarian Fund Allocations.

In Venezuela, at the time of the allocation, there was a DWG under the protection cluster, consisting of most local actors and some international organisations. As was the case in other countries, CERF recipient agencies presented their projects for quality assurance and the 'most active' members of the group were invited to give feedback. This was done, in large part, because of the CERF guidance. UNFPA in Venezuela noted the extent to which the consultations with OPDs at project level had enabled greater engagement going forward. They noted that this engagement on DI in GBV programming had sustained since the allocation.

Summary/key findings:

- Especially considering that this allocation was specifically for direct action for DI, the level of engagement with OPDs and/ or expert agencies fell significantly short of what was expected under the guidance provided by CERF in consultation with global experts, and that which is required under the 'must-do' actions in the IASC guidance and the principle which underpins a rights-based approach: 'nothing about us without us'. In simple terms and overall, people with disabilities, and their representative OPDs were not meaningfully involved in upstream country level allocation decisions and did not bring forward their needs or expectations. Across the group of countries, DIWGs were typically in relatively formative states at the time of this allocation. Equally, at the time of the allocations, formal mechanisms for the consistent engagement of OPDs in humanitarian coordination structures were lacking. Additional factors which limited consultation are discussed below.

[14] Although some interviewees made reference to a nascent DIWG in the Protection Cluster, other cluster members could not recall such a group.

- Representatives of DIWGs *did* tend to be engaged in technical checks (essential a technical QA role) *after* key allocation and project design decisions had been made i.e., 'downstream' engagement. Typically, the agencies consulted were active participants in each country's respective Disability and Inclusion Working Groups.
- Given the lack of very clear DI strategies in HRPs and weaknesses in the allocation strategies, consultation with disability experts: including the DIWG, Specialist Organizations, OPDs and umbrella organizations was doubly important.

2.2.3 Other key factors in country level allocation processes

The sections above outline a mixed picture: inconsistent treatment of DI in HRPs and HNOs at the time of the allocation, exacerbated by a lack of engagement with disability experts and OPDs. In the absence of these components essential for the strategic allocation of the DI envelope, a few other factors became especially significant:

a. **The norms (mechanics and politics) of CERF allocations in each respective country, including the role of clusters coherence between the larger UFE allocation and the DI envelope.**
b. **Narrow and outdated perceptions of how to deliver DI in humanitarian responses, including the positioning of the DIWGs within coordination structures.**
c. **Other contextual factors -including the need for efficiency in allocations.**

The norms (mechanics and politics) of CERF allocations in each respective country: The DI envelope was subject to the norms of each country's respective allocation processes. Although the factors below were also very significant, the theme of the envelope did not significantly alter each country's typical allocation mechanics. A number of overarching factors were apparent and are discussed below:

- In interviews in every country, and without any prompting, the 'cake sharing' analogy was raised. Albeit with a slight variance between countries, the sense that every UN agency was entitled to share of the UFE allocations was stark.
- The likelihood of any meaningful consultation with non-UN organisations for CERF allocations seemed low. In part, this was driven by a desire to suppress inter-agency processes if they were likely to be extremely competitive or contentious. These tendencies were also driven by the desire for efficiency, especially given the small size of the grant. These factors led to decisions being made between OCHA, HCs and a limited selection of agencies (country specific examples below). While such strategic decision making is seen as a positive under some circumstances, it was not in keeping with the need to consult experts, especially OPDs and other local experts in this instance.

- Understanding priorities and mainstreaming DI requires deliberate action and accountability from every sector/cluster. At the time of the allocations, DIWGs typically sat in either the protection of health clusters, whether or not they had multi-cluster membership. There was a tendency across the clusters for the 'host' cluster of the DIWG to have a disproportionate influence on the allocation.

In South Sudan specifically, interviewees explicitly described a disconnect between the two allocations. The allocation process for the initial UFE, the larger allocation, ran quickly from the first notification on the 10th of June (with a requirement for a commitment from the HC and the team in country by June 18th). Initial guidance was shared with UN agencies on June 18th and a consultation arranged for June 23rd, between UN agencies and cluster leads. Confirmation of the DI envelope arrived on June 23rd, shortly after the consultation for the first allocation had finished. Confirmation came with the expectation of a recommendation set of projects with an extremely tight timeline. Four agencies received grants from the larger UFE envelope, following a consultative process which ultimately had 'the girl child' as the central theme. In a manner which is typical of CERF allocations, the two large agencies who had not received funding under the main allocation made bids for the DI funding. WFP and IOM made the case for allocations under the DI envelope and there was a brief period of competition.

OCHA staff specified that according to their interpretation of the guidance, the allocation should not be shared (or over-shared). IOM proposed a strategy that is very much in line with IASC guidelines looking at data, barrier removal and empowerment of persons with disabilities and was ultimately seen as presenting the best case. The agency was recognized as having an ongoing engagement with DI and had an established programme and aims coherent with those of the allocation. The resulting allocation was large (relative to other focus countries) and allowed for multi-faceted support to persons with disabilities.

Mozambique was similar in the sense that the allocation process for the DI envelope was separate from the main UFE allocation. The biggest difference, however, was that in Mozambique, the normal mechanics of CERF allocations meant that the prioritisation of the DI envelope was undertaken through the cluster system i.e. a decision was taken in Maputo to allocate the money to the protection cluster. The allocation was ultimately shared between the cluster's four UN agencies. This decision also needs to be seen in the context of a significant funding deficit[15] and competition for resources. In interviews, agencies noted a particular deficit of funding for protection and some tension around this issue. These factors, in combination, meant that each of the four projects received a very small amount of funding

[15] "The rapidly increasing scale of the humanitarian crisis in Cabo Delgado has far outpaced the funding received, while the response has become more complex, with thousands of displaced people located in areas that are hard-to-reach and massive influxes of new arrivals of people in urgent need of assistance into accessible areas. As of mid-July, only US$38.5 million had been received —about 15 per cent of the $254 million required— and several clusters, including food security, were facing imminent pipeline breaks which threatened to cut-off life-saving assistance to people in dire need." Excerpt from reporting

(the four smallest project level contributions across the countries receiving the DI envelope), which further undermined any strategic value in the allocation (see project level below).

In both Afghanistan and Syria, the DIWG was a sub-group of the health cluster at the time of the allocation. In Afghanistan in particular, the allocation process appears linked to a narrow framing of disability as a medical issue. A number of interviewees offered a similar rationale. The Afghan health system does not offer support for physical disabilities, up to the secondary health care level and, even here, services are limited to physiotherapy and not specific to the support required by the typical conflict related injuries including those commonly caused by IEDs and explosive ordinance). While broader aspects of disability inclusion were described as having gained increasing attention in the five years leading up to the allocation, there was a consensus that the extent of physical rehabilitation needs justified the focus of this allocation: "At the time, this allocation was very much needed, the disability part [of the HRP] was severely neglected." One interviewee noted that while the gap in public health service provision was significant, this approach did but not necessarily address the most critical disability inclusion gaps, arguably neglecting the environmental barriers restricting access and participation of persons with disabilities across all sectors.

OCHA staff noted their expectation/aim to have transparent allocation processes, *typically* starting with a call for proposals, a cluster centred process and ultimately a decision by a 'partner selection committee'. For the DI envelope specifically, this allocation was described as a foreshortened process. The two allocations through the UFE were for USD 11 million and USD 1.5 million respectively, the latter being the DI envelope. These were granted on the basis of a concept note request by the CERF Secretariat and discussed at cluster level. Once the $1.5 million allocation was approved, all discussions were reportedly between OCHA, WHO, UNMAS AND UNOPs for project selection: 'OCHA asked us to coordinate it amongst ourselves (mine action and health). Selection criteria typically include 'specialisation and experience', but also the views of affected populations. In this instance, interviewees noted that conflict affected areas were specifically targeted, in part with a view to fulfilling CERF's life-saving criteria. Deconfliction was another specific criterion in this case. WHO specifically avoided working in areas in which other partners had long standing programming and worked with monthly, provincial level data which records trauma cases. UNMAS worked with the – the victim assistance focal point within their government partner agency, DMAC (department of Mine Action etc) (prior to the Taliban takeover), who have a list of accredited partners.

In Syria, the decision to establish the DIWG within the health sector was pragmatic as protection remains a sensitive area with the Syrian Government. In simple terms, WHO and UNMAS (UNOPS) are most closely associated with disability – due to their medical responses to prevent or treat injuries and impairments caused by trauma – but not necessarily with disability inclusion. The quick allocation processes which resulted in these agencies being allocated funding cements the medical/physical disability focus.

In Nigeria, the two envelopes were discussed simultaneously. The allocations triggered dialogue between the senior staff in OCHA and the office of the HC and subsequently between key agencies (HCR, IOM, UNICEF). The allocation was not put to the ICCG to avoid the prospect of diluting the impact of the allocations and raising expectations. The original intent was that two from three bids would be accepted (resulting in two grants of $250K each). Ultimately, all three proposals were seen as compelling. Accordingly, UNHCR received $250K and the other $250K was split between the other two agencies.

In Venezuela, there was 'adequate overlap' between the two allocations to allow complementarity. As was the case in Nigeria, dialogue around the DI allocation took place between the HC and selected agencies only (although there was a presentation to the HCT). UNFPA was seen as having ongoing programming with a DI focus and a good relationship with authorities which could serve as a basis for ongoing work. With WFP and UNICEF had been focusing on using schools as an entry point and leveraging this for disability programming.

Mozambique and South Sudan had several similarities. There was little to no engagement with OPDs and disability experts at the system level at the time of the allocation decisions. The recipient agencies, to varying degrees, had pre-existing relationships with OPDs and had some engagement during project design. In both Mozambique and South Sudan, IOM in particular had pre-existing programming focused on DI and relationships with OPDs.

Other contextual factors -the need for efficiency, the relatively small size of the allocation, the relationship between the two allocation envelopes: The question of efficiency is inevitably linked to the discussion of inclusivity in allocations as discussed above. Numerous studies on pooled funding mechanisms have discussed the tension between efficiency and inclusivity. Part of the challenge faced in engaging OPDs for this round of allocations is linked in part to decision makers drive for efficiency. Specifically in this instance there was a desire to make quick decisions and not to impose too onerous a process for a relatively small amount of money. This factor was compounded when the allocation for the DI envelope was distinct from the larger UFE allocation. The challenge of finding an appropriate balance is a factor in many of the country examples.

In Nigeria, Afghanistan and Venezuela interviewees were open and pragmatic about the choice to limit the number of consultations in the name of efficiency. In Afghanistan, one interviewee noted that even in its formative state, the DIWG was large (now consisting of 100+ organisations) and that the decision to limit consultation to the members of the steering group was pragmatic. Another noted challenges with the timeline "we did have to push some partners […] we are always struggling with that". Additionally, in this instance, they stated that the speed required did not allow for the usual, standard level of consultation with the DIWG, "I don't think that we had the time in this case". In Nigeria, one interviewee was explicit

about the need to engage the few actors best placed to offer an impartial opinion. This notion of consulting 'honest brokers' at the highest-level possible in coordination structures has been recognised as a legitimate tactic to increase the efficiency and the effectiveness of the allocation. In South Sudan, the need for an extremely shortened allocation process was also a significant factor, essentially ruling out the possibility of external consultation.

2.2.4 Country level systems and structures

To what extent did countries implement/realise CERF and IASC guidance in the allocation process:

- Did the country level allocation process incorporate guidance[16]?
- Were projects selected based on how well they intend to incorporate the guidance into the response?
- Was the allocation helpful in directing attention to other cross-cutting priorities?
- Did country offices take advantage of the technical support offered by CERF?

Overall, it seems reasonable to state that countries focused on certain aspects of the CERF guidance, leaning toward those which were relatively easy to deliver and did not interfere with the respective 'norms' of each country's processes. For example, while the guidance was clear in the need for consultation with OPDs, this was done only to the extent that it didn't interrupt the normal processes. The guidance[17] makes no specific reference to the number of projects that could or should be funded. As noted above, South Sudan interpreted the guidance (or conversations around the guidance) as implying that a single project was appropriate. Nigeria aimed for two projects to avoid 'dilution' of the impact; the norms of funding processes rather than guidance saw the allocation divided among the four 'protection agencies'.

This review focused on the DI envelope specifically, not on the larger UFE allocation to which it was appended. The TOR, however, did ask if there was a clear/visible connection between the two. In some countries, recipient agencies pointed directly to complementary elements. As noted above, the two allocations were seen as complementary in Afghanistan, Venezuela, Syria, and Nigeria and disconnected in Mozambique and South Sudan.

The need for funding for OPDs is a recurrent theme. A few interviewees noted that the application of CERF's life-saving criteria had dampened the ability of agencies to include capacity building elements. These views were balanced by others who felt that there was sufficient leeway for interpretation.

[16] That provided by CERF but also the IASC guidance to which agencies have already committed.
[17] CERF Underfunded Emergencies: 2021 - Guidance note on funding for persons with disabilities. June 2021 (at Annex C)

One interviewee noted the importance of the guidance, noting that it provided a solid footing on which the country level staff had to do the technical work.

While several interviewees described a back and forth with the CERF secretariat over the suitability of projects and a few administrative issues, none stated that they had gone back to CERF for technical support.

Did each country level allocation catalyse lasting improvements by strengthening collective structures and systems to enhance the ability of humanitarian actors to develop and implement quality programmes that are inclusive of persons with disabilities?

- Did each country level allocation lead to greater accountability in the system (within and beyond the CERF process), including by increasing and improving the participation of persons with disabilities and organizations of persons with disabilities?

Very consistently, almost unanimously, interviewees believed the DI envelope was a good use of CERF funding. This was true in the limited interview sets in Syria, Nigeria, and Venezuela, as well as in South Sudan. The small number of opposing views came from interviews in Mozambique. One UN staff member in Mozambique stated that thematic allocations by CERF were a retrograde step, a 'throwback' to carrot and stick approaches which attempted to leverage change through funding. It seems likely that these views were linked in part to low funding levels and the competitive funding environment.

Typically, interviewees noted the importance of specific, dedicated funding for DI. The key message was that in the absence of dedicated funding and with multiple, competing priorities, the issue of disability inclusion easily became overlooked, even with the IASC guidance and other commitments in place. One interviewee in Syria, reflecting on the 'Must do' actions in the IASC Guidance noted that actions on Disability Inclusion have been 'Not as loud as the words we speak'. They stated that while the funding didn't create 'magic', it was one positive step in a work in progress. Two other staff in South Sudan and Nigeria noted a lack of real action in the absence of dedicated funding for DI. Very candidly, they stressed that in the face of limited funding, multiple priorities and numerous commitments, mainstreaming DI frequently equated to very little or nothing in terms of practical action.

In Afghanistan, one interviewee noted that momentum for DI had been created since the allocation. They noted that analysis had improved while retaining a health focus but stronger in the HRP. Leadership was also seen as having improved, cross-cutting groups had strengthened and with 'gender, PSEA, and disability all better integrated', with an improved monitoring framework. These were characterised as 'steps in the right direction'.

Has the CERF allocation contributed to improved data collection mechanisms and data disaggregation processes for the participating partners*:* There is no evidence that there was

a significant improvement in the collection of disability related data at the country/system level in any of the countries, although this was the case in a small number of the individual projects. These included IOM in South Sudan, and UNICEF in Nigeria who stated that the allocations had supported analysis which informed their new five-year programme cycle in child-protection. *WFP in Venezuela similarly stated that the CERF funded project had been one initial entry point and that subsequent programming had built on the analysis and relationships built through it.*

Has the provision of the disability envelope directly led to more precise targeting of people with disabilities:

- *Have participating countries used CERF funding to focus on vulnerable groups that would otherwise not have been reached?*
- *Was complementarity with CBPF allocations ensured in the relevant countries?*

At the level of *each individual project*, there is no question that the envelope led to the targeting of persons with disabilities and support persons, even in the case where projects had previously had an inclusive focus. These were relatively small numbers, however. As above, in the absence of systemic change, this change might be considered marginal.

None of the countries under consideration could describe any complementarity between this allocation and allocations from the respective CBPFs at that time. At the time of the research visit, OCHA was considering a special DI focused allocation through the South Sudan Humanitarian Fund. Plans to have a dedicated NHF allocation for innovative DI programming in Nigeria had been postponed at the time of the interview but are still active. Both of these cases were, in part at least, due to be follow on actions from the CERF allocation. Interviews in Afghanistan noted that the DIWG had strengthened since the time of the allocation and has continued to be engaged in AHF allocations but not for subsequent CERF allocations.

Overarching findings/conclusions:

- The DI envelope was subject to the norms of each country's respective allocation processes. The theme of the envelope did not significantly alter each country's typical allocation mechanics. Conversely, the most effective use of the envelope would have required some changes to normal process.
    - In particular, countries emphasised the need for efficiency, choosing to limit consultation as a tactic to ensure that the processes were relatively quick and could meet short deadlines. The fact this was a relatively small allocation exaggerated this thinking.
    - Disability inclusion is relevant to all clusters and themes. The use of standard, cluster-based allocation processes in this case, limited the potential reach of

the allocation. The position of the DIWG in the cluster structure was a key factor across the range of countries[18].

- Competition for CERF funding among agencies was a factor in the allocation in most countries, notably in Mozambique. 'Cake sharing', the notion that all of the agencies are entitled to 'a piece' of the funding was raised unprompted in every country. In some countries, decisions were made among a limited group to avoid competition for the small envelope, one element of the guidance. In broad terms, given the small size of the overall envelope, allocating the funding to one or two agencies arguably increased effectiveness, but at the cost of inclusive consultation. There was a disconnect between the DI envelope and the larger UFE envelope in Mozambique and South Sudan. A higher level of inclusion in decision making would arguably have led to a greater chance of funding to OPDs or other local groups, for whom this funding would have been extremely significant. 'Success' in this respect would have required a higher than typical level of external consultation and purposefully collective working.
- It is impossible to say that data collection and targeting towards the needs of disabled people have been strengthened overall. Section 1 details several structural challenges that presented challenges for DI in humanitarian action at the time of the allocation: data from HNOs was weak and/or inconsistent, with many countries relying on global averages.
- While it is hard to pinpoint immediate, specific improvements at country level in respect of allocation or coordination structures and systems, the general sense of positivity around this allocation is undeniable. It is easy to construct an argument, across the focus countries, that the allocation did maintain or enhance change for DI. Ongoing or planned, incremental improvements in DI subsequent to the allocations are reported in Afghanistan, Nigeria and South Sudan, in which the allocation appears to have been a positive influence.

[18] Afghanistan and Syria – DIWG in health clusters; Mozambique, Venezuela in Protection cluster; Nigeria and South Sudan no formal groups in 2021

2.3 CERF country-level projects:

This section focuses on the projects which received funding through the DI envelope. Its primary focus is on South Sudan and Mozambique, the countries which were the subject of in person visits, including visits at project level. Interviews with Afghanistan, also a focus country, were undertaken remotely. No project visits were possible and the level of detail on the implementation of the individual projects was necessarily more limited.

Were the types of programme interventions proposed in the guidance note the right ones: The majority of projects conformed to the types specified in the guidance. There were exceptions, however, including cataract surgeries undertaken in Nigeria. In interviews, staff stated that they had discussed the guidance and there was a collective understanding that this activity fell within the scope of the envelope. This type of intervention, however, is typically considered to be medical intervention, to be undertaken on the strict understanding that the capacity for follow up and health system strengthening could be sustained i.e., not a DI response per se. The findings at country level find below find that while most of the project types fell into the broad categories outlined in the guidance, additional elements were important. Notably, given the relatively small size of some of the individual grants from each country allocations process, the need for these components of 'direct' support to people with disabilities to be a clear part of broader strategy i.e., to be supported by the bigger projects within which they sit.

South Sudan

As detailed above, IOM was the sole recipient of the DI allocation in South Sudan. IOM's project is an integrated package of support to people with disabilities '*structured in such a way as to bridge the gap in humanitarian services available for the persons with disabilities*'. The project aimed to support 'a total of 15,530- 5,440 men, 5,860 women, 1,935 boys, 2,295 girls, of whom 3,230 are neglected, vulnerable and marginalized persons with disability in priority counties of Aweil South and Tonj South'. The projects key components, described as complementary, were listed as:

- Working with Organisations of Persons with Disabilities (OPDs) to address specific needs and empowerment of persons with disabilities, including provision of assistive devices and mobility orientation, functional adult literacy, business skills, life skills sessions for individuals, women and girl's empowerment and strengthening networks and associations of people with disabilities.
- The provision of 'MHPSS through community-support, focused support and referral to specialized services when needed and possible, to people with disabilities,

including neurological conditions and severe mental disorders and engage caregivers and family members to equip them with relevant skills on emotional self-regulation and self-care, and psychosocial approach to caregiving and providing assistance without gender discrimination'.

- Engagement with 'education actors and schoolchildren on attitudes and perceptions towards disability inclusion seeking to address discrimination, social exclusion, and marginalization to nurture an inclusive mindset and understanding of different forms of disabilities'. Working closely with UNICEF (as Education Cluster and Child Protection Working Group lead)'during elaboration of a non-formal education curriculum for introduction of the extracurricular activity in secondary school settings in Tonj South and Aweil South engaging teachers and secondary school students in sessions pertaining disability inclusive attitudes and perceptions.'

Outreach, 'through awareness raising activities, to the wider community among whom persons with disabilities reside, aimed at addressing the attitudinal and environmental barriers which persons with disabilities face in their day-to-day lives'.

A field visit to project activities in Aweil and Aweil South, with members of IOM's project team, was undertaken on Tuesday 14th and Wednesday 15th February 2023. Meetings were held with local authorities and representatives of local OPDs. As well as visits to project activities, interviews and focus group discussions were undertaken with people with disabilities engaged by the project and caregivers.

IOM staff described the project as building on work in DI in central South Sudan which originated with surveys in approximately 2012. As noted in the project description above, these geographical regions were selected based on their IPC status i.e., they were relatively food insecure and subject to other humanitarian interventions. The intervention logic, therefore, was that persons with disabilities from these communities were eligible for other forms of humanitarian assistance and were especially vulnerable. Although data remains weak, the recognition of the need for inclusive programming stems from this period. The CERF DI envelope was described as the first 'dedicated' funding for DI. Despite the lack of funding for direct action, IOM's programming has always aimed to have a twin track approach, including main streaming and direct action. Capacity building of OPDs has always been a secondary objective, as has changing attitudes to disability in the community.

The short timeline for the CERF proposal meant that there was no time for additional survey work during the design phase. IOM's relatively long-standing experience allowed them to complete the project design relatively quickly and focus group discussions were held before implementation began. Some project activities needed to be compressed to meet the implementation timelines of CERF, time for procurement was described as very tight.

Prior to the project visit on day 1, IOM organized a meeting with an OPD partner. They were positive about their ongoing relationship with IOM and especially their capacity

building approach. They reflected on the benefits of attendance at a regional workshop for OPDs in Kenya. A consultation was also held with the Government's Relief and Rehabilitation Commission Coordinator for Aweil South. He was similarly positive about the ongoing partnership with IOM.

Site visits included a vocational training site. Women with disabilities were receiving training on tailoring, which included business training and the necessary equipment.

Training recipients were extremely thankful for the support. They raised familiar concerns, trepidation about the relatively short length of the training. IOM was clear that this was an emergency intervention and that under the time and resource constraints imposed by the DI envelope, this was a balanced package of support. As above, CERF deliberately lengthened the implementation period to 18 months for this allocation. That extension notwithstanding, participant selection and planning and procurement reduced the length of the time available for implementation.

FGDs were also held with recipients of assistive devices and their support persons. Both had also received psycho-social support. As well as appreciating the devices, recipients, and support persons were vocal in their appreciation of the counselling sessions. Several of them reported a significant and positive change in mindset. Both meetings had a positive spirit.

Mozambique

As detailed above, the Mozambique allocation resulted in relatively small grants to four agencies in the protection cluster: UNICEF, UNHCR, UNFPA and IOM.

UNHCR received an allocation/contribution of US$ 100,000. The project was aimed at engaging, empowering, and protecting persons with disabilities Cabo Delgado province, as recent assessments in Ibo and at Centro Desportivo in Pemba showed that respectively 18% and 20% of IDPs were persons with disabilities and very often services and assistance to them are limited or non-existent. CERF funding contributed to the following key components as described in their proposal:

- **Community-based Protection**: Designed to improve the participation of extremely vulnerable persons with disabilities (e.g., older people, youth, women, and girls) through community engagement, including capacity-building of OPDs. Implemented through five small scale community-based projects to be developed and implemented jointly by persons with disabilities and community-based mechanisms and involving affected communities, governmental and humanitarian organizations with the aim of tackling protection issues identified by persons with disabilities themselves.
- **Access to Life-Saving Information**: Improving access to life-saving information in accessible formats for persons, including information on available service. Communication and information needs assessments targeting persons with disabilities to develop and implement community-based projects aimed at facilitating access to life-saving information for persons with disabilities.
- **Provision of Individual Protection Assistance**: Provision of individual protection assistance to 120 persons with disabilities, including delivery of assistive devices and referral to rehabilitation services in three districts (and others where needs and gaps will be identified).
- Establish an inclusive call centre for reporting of S/GBV for women and young persons with disabilities, including training of call centre staff:
    a. Developing a disability-specific referral pathway for women and girls with disabilities.
    b. Provide S/GBV case management and referral services for women and girls with disabilities.
    c. Conduct GBV awareness raising sessions for persons with disabilities at community level, thereby ensuring proper engagement and support for women and girls with disabilities as well as awareness about reporting mechanics.

UNICEF received an allocation/contribution of US$ 200,001 towards a programme covering child protection and education:

Child Protection: Building the capacity of child protection actors (government, NGOs, and community-based structures) in disability-inclusive programming; identifying and referring children and youth with disabilities to mainstreamed and specialized services; providing community-based rehabilitation (CBR) services and assistive devices in two communities. Trainings of child protection actors to facilitate the access of children and youth to case management and psychosocial support services. Improving the knowledge and attitudes of community members and service providers regarding disability-issues and reducing the protection risks for children with disabilities. Given the lack of specialized services in the health sector (most services are available only in district or provincial hospitals), persons with disabilities will benefit from CBR, enabling access to services in the community.

Education: Targeting 350 children[19] with disabilities in and out of schools in two districts:

- Direct support to 500 teachers (210 women) trained on Inclusive Education (IE) and made sensitive to the specific needs of children with disabilities, undertaken by selected partners with expertise in IE.
- Provision of support, assistive devices, and materials for children with disabilities based on the needs identified by the assessments.

UNFPA received an allocation/contribution of $75,056.00 for GBV programming:

Implementation of life-saving S/GBV prevention and response services targeting women and girls with disabilities in 3 districts of Cabo Delgado. The project recognizes that women and girls with disabilities are among the most vulnerable and socially excluded groups in any crisis-affected community and aims to correct the fact that they may be overlooked during needs assessments, and not consulted in the design of programs and interventions. It also aims to improve access by reducing societal, environmental, and communication barriers, and improving access to information on where to go to seek response services.

[19] approximately 4 per cent of the 8,500 children targeted in the CERF UF round 2 proposal

IOM received an allocation/contribution of US$ 125,000:

One thousand six hundred people with disabilities had previously been identified by assessments undertaken by and with committees of persons with disabilities in 5 displaced sites. CERF funding for CCCM and WASH was to be focused on five sites for displaced people. Funding for MHPSS was to be targeted at two of these sites in Metuge.

Key activities were listed as:

- surveys for specific identification of WASH needs,
- evaluation, and implementation of specialized complaint feedback mechanisms within the camp management that guarantees inclusivity,
- strengthen and create awareness to the local governance structures within the sites,
- implement specific modules of the access disability inclusion toolkit, workshops for participatory design to improve the environmental conditions for accessibility in the sites focused on WASH services, such as construction of household latrines for persons with disabilities and reconstruction of water points to ensure access of safe water and
- provision of MHPSS services. Including awareness raising on disabilities, information dissemination sessions on available services for persons with disabilities, socio-cultural activities, referral to the specialized mental health and protection services,

and counselling and support groups in line with IASC Guidelines on MHPSS in Emergency Settings, IASC Guidelines on Inclusion of Persons with Disabilities in Humanitarian and IOM Manual on Community-Based MHPSS in Emergencies and Displacement.

During the field visit to Mozambique, site visits were undertaken to UNHCR, UNICEF and UNFPA projects. Meetings were held with project staff, community leaders, representatives of local OPD partners. As well as visiting project activities, interviews and focus group discussions were undertaken with people with disabilities and caregivers who had been engaged by the project. These were relatively short site visits to a limited number of activities and not intended to evaluate projects.

The visit to the UNHCR project revolved around a meeting and group discussion with community leaders, staff from Humanity & Inclusion, persons with disabilities, and caregivers who had benefited from the project. The persons with disabilities at the meeting were from the host community in Pemba and had received assistive devices. As in all meetings, the recipients described the devices as life-changing, in terms of their assistance with mobility and recipients' ability to engage socially. While expressing profound gratitude for the mobility, they bemoaned the lack of additional assistance, notably in the form of support for income generation. One UNHCR staff member acknowledged the lack of a livelihoods component.

The visit to the UNICEF project included attending a lesson with a class of boys and girls with and without disabilities. This was a school specifically for children with disabilities, linked to a teacher training centre with a focus on inclusive education. The class was taught in a mixture of Portuguese and sign language. In a meeting with teachers and school management after the class, staff expressed gratitude for the training and cited success in including children with a range of abilities. They went on to make several observations: that the one month of training offered was less than ideal, especially for sign language and braille; that the school needed a significant amount of additional support to be accessible for children with disabilities; especially handrails and accessible toilets and washing facilities (which were described by the staff as extremely basic for all students).

The visit included an example of UNFPA and AIFO's community outreach and education exercises. Its aim was to increase awareness and ultimately referrals. In the DIWG, the issue of case management capacity was raised. Again, the idea of a quick intervention to increase the referrals of especially vulnerable people needs to be matched with the increase in the capacity with case management.

In the meeting with the DIWG in Pemba, members stated that with a reasonable amount of lead time (a minimum of one month in their estimation), they could have constructed a collective strategy for the allocation, most likely focused on accessibility in IDP sites and at distribution sites.

One thread of the discussion at the DIWG in Pemba was around the stockpiling and prepositioning of assistive devices and whether or not it was appropriate. One of the group cited a conceptual challenge of providing assistive devices in humanitarian response, notably that such devices are typically customized after a professional assessment i.e., that the provision of a generic assistive device, however rapidly provided and seemingly essential in the immediate term, has the potential to do harm in the long run. In two instances, references were made to the need for maintenance of devices, and that training to maintain the imported wheelchairs was yet to start. IASC Guidelines states that assistive technology should be a core component of humanitarian assistance (because a lack of AT creates barriers to other essential services) however it requires ongoing service provision (not just the distribution of devices). In the case of the UNHCR project, it was reported that this appropriate and necessary conversation took place during the implementation phase i.e., after the decision to procure the devices.

Afghanistan

After more than 40 years of conflict. Afghanistan is one of the countries with the highest numbers of people requiring humanitarian assistance (18.4 million people at the time of the publication of the HNO in 2021). Afghanistan also sees frequent natural disasters, mass population movements and communicable disease outbreaks. The HRP for Afghanistan in 2021 prioritised a medical approach to disability reflecting the prevailing attitudes amongst humanitarian actors. In very broad summary, conflict related trauma is a key issue in Afghanistan and central to the intersection of health and DI[18]. WHO reports that war trauma cases in 2021 had risen sharply between 2028 and 2021. In addition, while survival rates from war trauma were seen as having improved, Afghanistan is left as one of the countries with the highest populations per capita of persons with disabilities requiring post-operative care, rehabilitation, and prosthetics[20].

As noted above, the total DI envelope for Afghanistan was US $1.5 million. From this, WHO received an allocation of $740,000 USD to strengthen the emergency response in health by supporting post trauma physical rehabilitation and WASH Services to persons living with disabilities Living in Conflict Affected Areas. UNOPS and UNMAS received US$759,903 for the 'provision of victim assistance services in Farah, Kunar and Uruzgan provinces'.

The objective of WHO's project was to 'provide support to the war trauma victims of the neediest and conflict affected areas of Afghanistan in terms of physical rehabilitation, physiotherapy, psychosocial counselling, psychosocial training, social mobilization, and WASH assistance'. WHO aimed to address trauma and physical rehabilitation services to approximately 15,000 people in 3 provinces, Kunar, Laghman, and Paktya. These were seen

[20] Model Disability Survey of Afghanistan

as priorities for the limited amount of funding available, out of the 10 provinces[21] with the highest level of identified needs[22] and programming gaps. The project also aimed to provide persons with disabilities with WASH services: solar powered water pumps (following the drilling of wells), accessible toilets and washing facilities (including ramps, handrails and appropriate hand washing facilities, as well as medical waste management facilities.

The UNMAS/UNOPs proposal notes that women and children are more likely to be adversely affected by disability in Afghanistan; 'severe disability is more prevalent in women than men and more than 17 per cent of children aged 2-17 are estimated to have a disability of some type and severity. In addition, 'women with disabilities face a high risk of domestic and sexual violence[23]'. Reports also state that an estimated '50 per cent of the Afghan population experiences psychological distress and 20 per cent face functional limitations linked to mental health issues'. The project was designed to contribute to the delivery of a comprehensive package of support to persons with disability, specifically physical rehabilitation, mental health and psychosocial support. In parallel, a disability campaign which was to focus on women and revolving around GBV messages in Farah, Kunar and Uruzgan provinces

The services were to be delivered in partnership with national and/or international NGOs specializing in victim assistance and disability inclusion activities. The outputs of the project were due to be physical rehabilitation through static and mobile physical rehabilitation centres (PRCs); the provision of physiotherapy, orthotics and prosthetics (including repairs). 'Soft' components included the provision of mental health and psychosocial support, awareness and communication, disability awareness sessions (including sessions for women with integrated GBV messaging). These were to be delivered in an accessible fashion, including sign language translation during the DIWG Meetings and additional relevant humanitarian coordination meeting. As the projects continued, efforts were to be made to mainstream WASH components into the project in accordance with needs.

As noted above, the UN agencies selected as recipients were seen as having the technical capacity in these specific areas, as well as connections with the appropriate governmental institutions. In the case of the local partners selected, these were also seen as having solid technical track records, as opposed to numerous local organisations in Afghanistan with diverse portfolios. Given the absence of an in-person visit, a limited amount of detail could be extracted from interviews regarding project implementation. Overall, project managers from WHO and UNOPS gave a general sense of progress and satisfaction. This was tempered by a very significant change to the operating and funding environment's following Taliban's takeover of Government.

[21] Laghman, Nangarhar, Paktya, Farah, Baghlan, Kunar, Nuristan, Urozgan, Bamyan, and Zabul
[22] Based on the latest information from Disability Department of MoPH
[23] According to UN Women, women with disability may face up to 10 times more sexual violence.

WHO undertook an after-action review after the first phase of programming and was presented in late 2022. One of the implementing partners, in Paktia, was singled out as having undertaken high quality work and, with this in mind, funding for continuation was being sought. Work had temporarily halted at the time of the interview, however, as a result of the changing operational environment. Work with the other partners had also been subject to intermittent disruption.

IOM applauded the flexibility of CERF after the change in government and additional support for similar initiatives through the Afghanistan Humanitarian Fund.

3 Recommendations

Recommendation for CERF

The following set of recommendations are designed for consideration across thematic allocations, not necessarily limited to DI:

- *The 18-month implementation period for DI related interventions was very well received. Consider allowing an extended period for the allocation process, given the need for appropriate consultations.*
- *Require that technical specialists in each country are consulted at the strategic level. The 'must do' actions from the IASC guidance provide the necessary framing and language.*
- *For further thematic allocations, the capacity for a consultative process and strategic alignment should be a condition [does a DI analysis or strategy exist, is there shared understanding of the priorities for DI, is there an active DIWG which has a consistent role in humanitarian architecture].*
- *Require that recipient agencies include partnerships with OPDs in project design and implementation.*
- *Ensure, in each case that the CERF Secretariat has, or has access to, the expertise required to undertake a technical review of the proposals brought forward. (In the case of DI, engaging technical experts in proposal review for the allocation will ensure projects are in line with rights-based approaches to disability inclusion and with life-saving criteria as well as ensure global best practices are utilized). Consider enhancing in-house expertise on disability inclusion .*
- *Place additional emphasis on the need for complementarity between CERF and CBPFs for thematic allocations. CBPFs can take up consistent action around specific themes that CERF cannot.*

The following set of recommendations are designed for consideration in support of any further DI allocations:

- *Develop further DI capacity within the CERF secretariat through training and coaching.*
- *Building on the work of the DI expert group, ensure the roll out of the revised template via the GMS platform.*
- *It may benefit CERF (and the wider donor community) to develop within the CERF reporting a limited number of specific indicators or data points aimed at capturing efficacy or value-add of DI investments for projects in which addressing DI is the main outcome. This could include data points on issues such as the improved geographic*

reach of programming; inclusion of under-represented impairment groups , the improved availability of DI engagement and/or the extent to which CERF-funded projects are sustained with follow-on funding.

- *For DI- specific allocations it may be beneficial to ensure a longer time period between announcing the grant to the agencies and requesting proposal submission.*

System wide recommendations

These recommendations are designed to promote greater accountability in the system, including by increasing and improving the participation of persons with disabilities and organizations of persons with disabilities

- *Keep working on mainstreaming the 'Must-do actions' (anecdotal evidence of improvements since 2021) with specific attention in proposal review and allocation processes*
- *Ensure that DIWGs (inc OPDs) have consistent and meaningful engagement in humanitarian coordination structures*
- *Consider placement and/or representation of DIWGs in ICCG coordination and consider how to ensure consistent funding support.*
- *Continue to prioritise the capacity strengthening of OPDs. Ensure that this is embedded in HDP nexus approaches and localization efforts/discourse.*
- *Improved mechanism required to enable inter-agency and inter-sectoral analysis strategic planning on disability inclusion – building on improvements to mainstreaming in HRPs and HNOs*
- *UN agencies should undertake stakeholder mapping as to enable more OPDs to participate in decision- making in CBPFs and CERF allocations.*
- *As is relevant and possible within the grant modality consider a requirement to allocate a percentage of funding to OPDs as implementing partners.*

These recommendations are designed to catalyse lasting improvements by strengthening collective structures and systems to enhance the ability of humanitarian actors to develop and implement quality programmes that are inclusive of persons with disabilities.

- *System wide, continue to encourage the prioritisation of dedicated funding for DI-specific action, including though CERF and CBPFs.*
- *Where DI funding is introduced, encourage multi-year funding (2-3 years) in line with good donor practice for raising awareness and addressing DI in emergencies.*