

In synthesis, a person with disabilities is one whose ability to move, think, perceive or express himself or herself is compromised by injury, illness or societal limitations. Clearly, the severity of disability is highly variable from one person to another. Countries with highly developed health and social care systems tend to set thresholds for the administrative classification of disability, which usually means the registration of individuals in official records of people assisted. Thus in the USA, 19.1 per cent of the population is covered by the federal Americans with Disabilities Act. Proportions in Western Europe vary from sixteen per cent to twenty per cent. One in five South Asian Indians lives with disabilities. In Laos, where twenty-five per cent of villages are contaminated with unexploded ordinance, an estimated 45,000 people have physical disabilities such as amputated limbs (Murray 1998). Around the world many more people have less serious cognitive or mobility problems. People with particular pathologies, including, for example, alcoholics, are not classified as having a disability, but to all intents and purposes some of them do. In short, at least one-fifth of the population has some form of disability status.

### **Box 34.1 Children with disabilities in disaster**

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According to the United Nations International Children's Emergency Fund (UNICEF 2007a), over 200 million children – representing about eleven per cent of the global child population – have some type of disability. Disabilities in children include physical disabilities, such as paralysis or orthopaedic impairments; intellectual disabilities, such as Down syndrome or foetal alcohol syndrome; sensory disabilities, such as blindness or deafness; cognitive disabilities, such as autism or learning disabilities; or psychiatric disabilities, such as depression or anxiety disorders.

Conservative estimates suggest that 7 million children with disabilities are impacted by disasters each year (Peek and Stough 2010). Millions more acquire disabilities during childhood as a consequence of disaster. For example, in Haiti, a country where people with disabilities are commonly known as 'kokobés' ('good for nothings'), hundreds of children lost their limbs due to crushing during the earthquake, while others were forced to undergo amputations as a result of secondary infections.

Historically, children with disabilities have been overlooked by disaster researchers and professionals. As such, children with disabilities may be among the least prepared and most poorly served, ultimately experiencing amplified physical, psychological and educational vulnerability.

Children with disabilities are more likely to be poor and to live in low-quality housing, which increases their exposure to hazards. When a disaster strikes, children with disabilities may have a more difficult time taking action, escaping from or withstanding the event. Children with mobility-related disabilities may be placed even more physically at risk if they are unable to evacuate in a timely manner. Even when evacuation is possible, children with disabilities and their families may be less likely to leave the threatened area.

Children with disabilities also encounter barriers during emergency response and recovery. They may find that public shelters do not accommodate wheelchairs or that

announcements are not translated for those who are deaf. Disasters can be particularly hazardous for children with medical disabilities who rely on electricity for their medical support or who need medical care while they are sheltering away from home.

During disaster, parents are also impacted and this may limit their ability to respond appropriately to their child's needs. Following Hurricane Katrina in the USA, some children with disabilities were relocated to nursing homes or other institutions. Placement in these facilities sometimes meant separation from their families or sheltering with only one parent, creating further distress for these children and their caregivers.

To best protect children from the effects of disaster, children with disabilities and their caregivers need to be actively involved and considered in all disaster risk reduction activities. Evacuation procedures should accommodate children with disabilities; shelters must be made physically accessible; and school systems should offer academic modifications such as providing home instruction when schools are closed for extended periods to avoid regression of learned skills. Some children with disabilities may need the community infrastructure to be substantially rebuilt before they can return to their pre-disaster level of independence.

Disabilities fall into numerous categories with principal examples being:

- difficulties of personal mobility;
- inability to see (with possible need to use a guide dog);
- deafness;
- problems of communication and articulation of words (as with stroke-affected people);
- cognitive disorders;
- various medical problems, including those that require constant or frequent use of life-support systems;
- intolerance of chemical or environmental substances;
- psychiatric disorders and panic attacks; and
- infirmity associated with old age.

Smart (2009) discusses categories that are less medical than the approach taken in the list above.

The list is long and diverse and, of course, individuals may have more than one form of disability. Clearly, the different categories should be associated with a varied range of provisions during emergencies, including transport for people with reduced mobility, specialised means of communication for those with cognitive or speech difficulties, provision of portable or substitute equipment for those who depend on life-support systems and psychiatric support for those with mental health problems. The degree of autonomy of people with disabilities is highly variable, according to the nature of their disability and the availability of facilities that support them.

Finally, a study of disability in disasters should also consider those who have permanent injuries in the aftermath of catastrophic events. For example, 1,200 people among those 3,500 reported injured after the 1963 earthquake in Skopje, Macedonia, had permanent disabilities (UNDRO 1982a). Following the earthquake in Haiti, many amputees and people experiencing spinal cord injuries had very little support (Iezzoni 2010). Similarly, some early estimation by the United Nations (UN) and the World Bank suggested that the number of people with disabilities may have increased by twenty per cent in the countries affected by the December 2004 tsunami in South and South-East Asia as a result of the disaster. Such an influx of people with specific needs constitutes a real challenge for organisations in charge of recovery programmes. The situation was particularly critical in Indonesia after the December 2004 tsunami as revealed