Removing Barriers

The Path towards Inclusive Access

Disability Assessment among Syrian Refugees in Jordan and Lebanon

Lebanon Report

July 2018

Australian Aid

humanity & inclusion

iMMAP

An Australian aid initiative implemented by Humanity & Inclusion and iMMAP on behalf of the Australian Government

The four Study Factsheets and reports can be consulted (https://re.tc/disability_factsheets)
Study Data can be accessed on the Project Dashboard (https://re.tc/disability_dashboards)

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This publication has been funded by the Australian Government through the Department of Foreign Affairs and Trade. The views expressed in this publication are the author's alone and are not necessarily the views of the Australian Government.

Acknowledgements

This study was conducted thanks to the joint effort of Humanity & Inclusion (HI) and iMMAP. The final report was prepared by HI Regional Inclusion Technical Coordinator Yahoko Asai, based on the draft prepared by Helen Barley, the short-term consultant, and the statistical review provided by Jonas Herzog, iMMAP.

We extend special thanks to all the people who provided valuable inputs during the study and report writing process, which was led by Marco Campisi, HI Regional Operations Coordinator:

Bahaa Qanier, Tha'ir Karasneh, Sarah Alazaizeh, and Issam Hijjawi for KoBo development, data collection, cleaning and analysis;
Madiha Al Jazi and Duaa Shaalan for training the enumerators;
Julia McGeown, Pauline Thivillier and Lorenzo Villa for their inputs and comments on the report;
Mitchell Loeb, the National Center for Health Statistics' Office of Analysis and Epidemiology's Washington Group expert, as well as Claudia Cappa and Asma Maladwala, of UNICEF, for the use and analysis of the Washington Group's Disability Statistics tools;
HI colleagues in the Middle East Regional Programme, Jordan Mission and Lebanon Mission;
All enumerators in Jordan and Lebanon, including Elham Shorman, Mohammad Yasien and Inass El-Kadiri, for Key Informant Interviews and Focus Group Discussions;
The teachers, school staff and officers, NGOs and UN agencies who shared their perspectives during key informant interviews; and The Syrian refugees who shared their time, information and valuable opinions.
The report was edited by Charlotte Gowdy.
Report and Factsheet graphic design was developed by Mohammed Belo, Issam Hijawi and Shurouq Al-Manaseer, iMMAP.

Finally, we extend our deepest gratitude to the Government of Australia's Department of Foreign Affairs and Trade. Without the Department's commitment to disability-inclusive development and their generous funding, this Disability Assessment could not have been conducted.

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humanity &inclusion
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TABLE OF CONTENTS

EXECUTIVE SUMMARY

Objectives

Concerning the lack of disability data in the Syria crisis context, Humanity & Inclusion (HI) and iMMAP conducted the study aimed at the following:

1. Provide statistically reliable prevalence of disability as well as disability disaggregated data indicators on access to services.

2. Increase understanding of the situation of Syrian refugees with disabilities and their households, compared to their peers without disabilities, in relation to the access to services including education, and key barriers experienced in accessing these services.

3. Recommend inclusive actions to be prioritized by humanitarian actors.

Methods

The study conducted a literature review, quantitative data collection as well as qualitative data collection.

Quantitative data was collected from 2,495 persons of randomly sampled 506 households in the urban setting in Bar Elias as well as Informal Tented Settlements (ITS) in Bar Elias and Arsal in December 2017. In light of the United Nations Convention on the Rights of Persons with Disabilities (UN CRPD), the study defined disability as interactions between personal and environmental factors. Disability was measured by the level of difficulties a person faces when performing basic activities (referred as "domains") regardless of impairments, using the modified Washington Group's Extended Set (WG-ES) (more precisely, Short Set Enhanced plus fatigue) and Child Functioning Module (CFM).

Fourteen Key Informant Interviews (KII) were also conducted in December 2017 to elicit deeper insights on the educational situation of children with and without disabilities.

Findings

Prevalence of Disability

- **22.6% of surveyed Syrian refugees aged 2 years and above had disabilities** (529 persons out of 2,338 persons): 21.0% in Bar Elias and 24.9% in ITS. Understanding disability as the level of difficulties a person is facing when performing basic activities that could put him/her at risk of not participating in society, the prevalence of disability found by the study was markedly higher than the existing disability statistics at around 2-4%, many of which used questions focusing on a person's medical conditions or impairments.
- The study further found that **59.9% of sampled households included at least one member with disabilities.** This finding requires humanitarian actors to examine the impact of disability on households and to consider the needs to promote appropriate parenting skills and support programs for families.

Causes of Disability

- 26.8% of persons with disabilities reported illness or disease as the primary cause of functional difficulties.
- Among persons who reported illness/disease, injury and malnutrition as causes of their disabilities, **38.9% considered that the causes were related to the Syrian conflict.** Among them, anxiety was the most common domain in which they faced difficulties, followed by depression, walking, fatigue and seeing.
- More females (28.3%) than males (25.5%) had disabilities related to illness or disease. Injuries, on the other hand, led to more males having a disability (17.7%) than females (9.3%). This suggests males' higher exposure to risks of injuries in conflicts.

Disability Domains

- The most frequently experienced functional difficulties by adults aged 18 years and above were anxiety (13.0%), fatigue (12.5%) and in the upper body (10.4%). Children aged 5-17 years faced difficulties related to anxiety (10.3%), depression (6.8%) and communication (3.7%) %), while children aged 2-4 years experienced difficulties related to communication (4.7%) and playing (2.5%).
- The fact that **anxiety, depression and fatigue are the common domains for persons aged 5 years and above** may be surprising because often disability data collection is associated with physical, hearing, seeing and intellectual impairments and rarely with mental health and psychosocial issues (anxiety and depression) or fatigue. A range of stressors experienced by Syrian refugees, if not addressed timely and appropriately, could develop to critical conditions that could then lead to disability. It is **particularly worrying that, among children aged 5-17 years, 10.3% exhibit daily anxiety and 6.8% show depression or sadness on a daily basis.** This data suggests the strong need for humanitarian actors to focus on mental health and psychosocial support (MHPSS), with careful attention to the young generation.

Children's Disability by Household Income Level

- 43.8% of children aged 2-4 years and 14.4% of children aged 5-17 years lived in households with an income of 100 USD or less, which shows extreme poverty. This suggests a strong relationship between poverty and disability.

Assistive Devices

- **Persons with disabilities continue experiencing functional difficulties despite assistive devices.** 18.9% of those who use glasses, 35.0% of those who use hearing aids and 65.4% of those who use mobility aids still experience significant difficulties seeing, hearing and walking respectively. The issues could be related to poor infrastructure in Bar Elias in particular, and service providers' capacity to deliver adequate devices with fitting and long-term maintenance and repair services. Often, projects were only able to distribute the initial device, and were not able to cover costs related to repair or maintenance when the devices were damaged or outgrown afterwards.

Access to Services

(Unit of analysis: households with and without disabilities)

UNHCR Registration:

- About **5% of households with disabilities were not registered** (4.2% in Bar Elias and 6.6% in ITS), while **the rate of non-registration was higher for households without disabilities at around 17%** (17.8% in Bar Elias and 15.3% in ITS). It could be possible that households with persons with disabilities that were known before the crisis or at an earlier stage of the crisis were motivated to register for the status and associated services, while households without disabilities were less motivated, or, perhaps their movements back and forth from Syria led UNHCR to unregister them.

Shelter:

- All households in our study had shelters or houses.
- Inaccessible housing conditions affect both households with and without disabilities, with slightly higher rates for households with disabilities. Households with disabilities in ITS reported the highest level of accessibility issues (49.6%).
- Fears around the shelter are a more prominent concern for households in ITS than in Bar Elias, and for households with disabilities. Fears of harm or injuries around the shelter were particularly high for households with disabilities in ITS (65.0%).

Executive Summary

Latrines:

- More families in ITS, especially those with members with disabilities, reported that latrines were not always available (13.9%).
- Around 10% of Syrian refugee households in Bar Elias and ITS reported inaccessible latrines, except for households with disabilities in ITS of whom 17.5% were concerned about accessibility issues to use latrines.
- Households with disabilities in ITS reported the highest level of fear of attack, harassment or arrest (23.4%) and of harm/injuries (34.3%) when using latrines whilst rates among households with disabilities in Bar Elias were much lower. It is possible that public latrines (including those located outside the home) increase persons' perceived fears.

Water:

- Overall, 90% of households in both locations considered that they had access to enough safe water from reliable sources, except households with disabilities in ITS, 21.9% of whom mentioned that they did not have access to water. The study confirmed that **households with disabilities are statistically less likely than households without disabilities to access safe water** ($P<0.01$).
- Perceived barriers were related to the **lack of available services, costs, and "services [that] do not meet my or my family's needs.**" Unavailability of water could be related to the (perceived) poor water quality and insufficient amount which urge refugee households to buy bottled water. Families with disabilities in particular are concerned about the distance to the services and the issues concerning transportation: e.g. to shared water tanks, to the shops where people buy bottled water, or to the humanitarian organizations who could help. Furthermore, 30% of households with disabilities in ITS stated lack of knowledge about the available services as a barrier.
- **Proposed solutions** were increasing the availability and reducing the cost of water provision services, while further information on available water services is required for households with disabilities in ITS.

Health

- The majority of households had health needs in the last six months: **stronger needs were expressed by households with at least one member with disabilities than households without members with disabilities** (81.5% vs 59.1%) with no major difference by location.
- When they had medical needs, **more households with disabilities had difficulties accessing health services at clinics or hospitals** than households without disabilities (17.4% vs 15.8%). Access to medical services is **especially an issue for households with disabilities in Bar Elias** (21.3% could not access needed services).
- Overall, **the cost of medical services** was the major barrier raised by 95.3% of households with disabilities and 78.9% of households without disabilities. By location, all households in **ITS complained that transportation to health services were not accessible, regardless of disability.**
- **Proposed solutions:** Cost reduction of health services was raised as a top priority in both locations by all households, regardless of disability.

Food and Cash Assistance

- **Households with disabilities reported higher levels of access to both food and cash assistance than households without disabilities** in both locations (around 80% vs around 60% for food assistance, and 53% and around 43% for cash assistance). For food assistance in particular, households with disabilities are more likely to access the service than households without disabilities ($P<0.05$). Vulnerability targeting criteria utilized by UNHCR and other service providers could be effectively reaching the most vulnerable households.
- **Lack of documentation** came as the main barrier hindering access to food assistance both for households with and without disabilities, followed by availability of services. Households with disabilities in ITS indicated unsupportive staff as a barrier.

- As for cash assistance, households with and without disabilities identified the **lack of knowledge** about services as the primary barrier. Households with disabilities in both locations seem to face more issues around transportation and staff attitudes and communications than households without disabilities.
- **Proposed solutions:** For food assistance, support to required documents was requested most frequently by all households in two locations, while they proposed information about cash assistance services as a solution. Households with disabilities in both locations show higher needs for supportive staff with appropriate communication skills.

Specialized Services

(Unit of analysis: individuals with disabilities)

- 48.4% of respondents with disabilities mentioned physio, occupational and speech therapies, followed by MHPSS (47.3%) and assistive devices (30.1%).
- However, **57.5% persons with disabilities were unable to access at least one specialized service despite their needs.**
- The **demand for MHPSS is high among children** aged 5-17 (41.8%) and young people aged 18-34 (30.7%). Anxiety and depression are key domains prevalent among children aged 5-17 and persons aged 18 years and above. The data implies that there is limited MHPSS for the young generation. MHPSS was particularly inaccessible in ITS (55.9%).
- The most pressing barrier was the high cost of services, the lack of knowledge about available services and the cost of transportation.
- **Proposed solutions:** reducing the cost of services was most cited by 64.6% of people with disabilities in Bar Elias and 62.2% in ITS. Sharing more information on available services (18.0% vs 18.2%) was also an idea commonly shared as a solution.

Livelihood

The study found more difficult economic conditions among families with members with disabilities; less opportunities for work, lower incomes and higher debts.

- 76.8% of surveyed Syrian refugees aged 18 years and above were not working.
- 85.0% of persons with disabilities were not working, compared to 73.2% of their peers without disabilities. **Persons with disabilities are less likely to be working than persons without disabilities ($P<0.05$).**
- Among persons with disabilities who are working, persons who experience difficulties with anxiety, depression and fatigue had higher chances of working (15.5%, 12.7% and 12.3% respectively) than persons who had disabilities in other domains except for seeing.
- Women have limited chances to remunerated work: only 4.7% of females aged 18+ were working, compared to 45.3% of males aged 18+. Further disaggregation by disability shows that 4.3% of females with disabilities were working compared to 7.9% of females without disabilities. **Gender and disability are the two factors that decrease chance and opportunities for women to access work.**
- Among children aged 5-17, 5.2% were working (N=48), including 9 children with disabilities.
- **Income level:** the most common reported income bracket for households with disabilities was 150,000-299,000 LBP (29.0%) while the majority of households without disabilities (32.0%) reported an income of 300,000-449,000 LBP a month.

Executive Summary

- **Debt level**: 58.7% of households with disabilities had a debt of over 700,000 LBP compared to 50.2% of households without disabilities. Further, more households without disabilities reported the lowest debt level of 0-74,000 LBP (17.2%) than households with disabilities (5.9%). The finding confirms the disproportionate levels of high debt for households with disabilities.

Education

Persons aged 13 years and above

- **Syrian refugees with disabilities are more likely to have never enrolled in school and to be illiterate than persons without disabilities (P<0.05):** 25.5% of Syrian refugees with disabilities never enrolled in school and cannot read or write, compared to 13.0% among their peers without disabilities.
- Non-enrolment and illiteracy were more common among persons with and without disabilities in ITS than in Bar Elias.
- Across all age groups, persons with disabilities have higher non-enrolment/illiteracy rates than their peers without disabilities.
- More persons in the older generation lost opportunities to learn.
- The gender gap is striking. Non-enrolment/illiteracy rates among females without disabilities are nearly double that among their male peers (65.0% compared to 35.0%). The percentage for females with disabilities (71.9%) is 2.5 times higher than males with disabilities (28.1%). The older women are much more likely than the older men to be illiterate or to never have gone to school.

Children aged 6-12 years

- The study found a very **high regular attendance rate** among 574 children with and without disabilities surveyed (70.0% and 80.6% respectively) with higher attendance in Bar Elias than in ITS. Continuous efforts by the Ministry of Education and Higher Education (MEHE) and stakeholders could explain this result. However, these enrolment rates are higher compared to other existing data. The reasons behind this need to be investigated further. Nevertheless, **a statistical test confirmed that children with disabilities are less likely to be attending school than children without disabilities (P<0.05).**
- **Children with disabilities are more likely to never enrol in or to drop-out of school than children without disabilities (P<0.05):** 24.5% of children with disabilities and 14.4% of children without disabilities never enrolled or enrolled but subsequently dropped-out of school.
- **Boys with disabilities are most likely to never enrol in school and least likely to attend education regularly (P<0.05):** 22.9% of boys with disabilities never enrolled in school, compared to girls with disabilities (17.5%), boys without disabilities (12.5%) and girls without disabilities (7.1%). From an education perspective, boys with disabilities in ITS were the most vulnerable of all children in the study sample. The higher risk of child labour and greater exposure to bullying could partly contribute to their limited opportunities for education.
- Children in schools enjoy different aspects of school activities, **but children with disabilities report overall lower rates of enjoyment than children without disabilities. The largest gap is around 'study[ing] new topics'.** This poses a question about teachers' capacity to identify children's specific learning needs, some of which could be related to their disabilities, as well as to provide appropriate personalized educational support using tailored learning materials within mainstream school settings.
- **Barriers for children attending school**: the major barrier for children with disabilities was their psychological distress (25.0%), which was also cited by 19.9% of children without disabilities in school. Stakeholders acknowledged a

gap in the availability and coverage of MHPSS programing. The finding suggests **a clear priority for humanitarian actors in Lebanon to strengthen MHPSS services in close relationship with the education sector.** Other barriers include financial constraints (13.8% for children with disabilities and 20.9% for children without disabilities), children's health conditions (12.5%) for children with disabilities and 14.4% for children without disabilities.

- **Barriers for out-of-school children:** 22.2% of caregivers of out-of-school children with disabilities cited functional difficulties as the major barrier. The second was the lack of documentation (18.5%), which was the most cited barrier by children without disabilities (20.9%), despite the fact that officially, no documents are required for Syrian refugee children to enrol. Financial constraints (19.4%) and missing three or more years of education (14.9%) also hindered the enrolment of children without disabilities. Refused entry is also a practice that excluded both children with and without disabilities from education. Furthermore, interviews with teachers revealed a **strong sense of reluctance** to welcome and support learners with disabilities, and **limited understanding about inclusive education** which benefits both children with and without disabilities.
- **Priority solutions for children currently attending school to continue:** for children with disabilities, caregivers proposed appropriate health care, rehabilitation and psychosocial support (79.5%), more recreational activities (75.9%) and awareness-raising activities to encourage classmates to be friendlier to each other (74.7%). Caregivers of children without disabilities requested more recreational activities (73.3%), appropriate healthcare, rehabilitation and psychosocial support (72.8%), and an improved household financial situation (72.0%).
- **Priority solutions for out-of-school children to (re-)enrol:** The vast majority of children with disabilities (81.5%) suggested that health-related services will help them go back to or newly enrol in school in both Bar Elias and ITS. 55.6% of children with disabilities also proposed to change the school admission criteria concerning the lack of documentation and cases of refused entry. Caregivers of children without disabilities prioritized the solution concerning households' financial issues (67.2%).
- Overall, the findings suggest **the need for a comprehensive programing to bring out-of-school children in or back to school,** including measures at the school level (e.g. school admission criteria, recreational activities, teacher training, awareness-raising for children) as well as interventions at the community level which create a link between schools and services such as rehabilitation and MHPSS.
- **Teachers' awareness-raising and capacity-building on inclusive education is also critical** to welcome children with disabilities in mainstream schools and improve the quality of education for all learners.

Caregivers' perception on inclusive education

- **More than 95% of caregivers believed all children had the right to an education and that they could learn.** However, a sizable number of caregivers (24.3% and 26.3%) agreed to compromise children's education for child marriage and child labour. Furthermore, caregivers showed relatively low expectations for children's academic progress (29.2%).
- Just over half caregivers (57.5%) of caregivers agreed to assist with their child's learning at home. This implies that **about half of the children would receive less support and help with homework at home,** which might make them vulnerable to drop-out, and so more in need of learning support services.
- Caregivers expressed a range of different opinions with regards to inclusion. On the one hand, they showed an overall positive feeling about children's interaction with peers from different backgrounds (77.3%), and belief in children with disabilities' capabilities to learn (88.3%). On the other hand, **19.0% of surveyed caregivers agreed that the presence of children with disabilities negatively affects the learning of children without disabilities in the same classroom. 71.9% of caregivers believed that children with disabilities could learn better in special schools with special teachers.** These caregivers' views could be a factor leading to the exclusion of children with disabilities from mainstream schools and learning spaces.

Executive Summary

Recommendations

1. **Understand disability from a human rights perspective and plan inclusion from the onset of all programs** to ensure the support programs meet the specific needs of 22.6% of the Syrian refugee population who have disabilities at the individual level and of 59.9% of refugee families that have at least one member with disabilities, at the household level.

2. **Build the capacity of stakeholders and collect disability data using the relevant Washington Group Questions for the context.** This study used the WG ES and CFM and found their usefulness in terms of their ability to identify persons who have difficulties with mental health and psychosocial issues, and address the specific difficulties experienced by children. Application of the WG tools as the standardized disability identification tools as well as proper reporting and data-sharing will greatly contribute to the collection and analysis of comparable disability data by different humanitarian actors at a larger scale towards coordinated inclusive programing.

3. **Enhance efforts to consult persons with disabilities, in order to understand their views and provide more tailored services.**

4. **Break fear towards disability, move away from reliance on "disability specialists" and promote disability mainstreaming.**

More specifically, the study points to the following recommendations:

Service providers to:

- Collect **disability data and disaggregate various data by disability** using the WG tools to inform the project design.
- **Identify people and households with disabilities to participate** in the project, through data collection.
- **Establish partnerships with local Community Based Organizations (CBOs) and disability actors** (e.g. **Disabled Peoples' Organizations**/DPOs), to gain a stronger understanding of the true needs of persons with disabilities.
- **Use evidence-base and design projects with a clear inclusion plan.**
- **Budget for inclusion:** based on the existing and/or newly collected data, allocate specific budget lines dedicated to addressing key barriers and promoting inclusion.
- **Ensure children and youth access quality MHPSS services.**
- **Build staff's capacity** on data collection, MHPSS, communications with persons with disabilities.
- **Build education staff's capacity** on **inclusive education and pedagogy with a strong focus on positive discipline** that addresses corporal punishments and verbal abuse as well as **MHPSS** for children and youth.
- Conduct activities to promote social cohesion in order to bring together children with disabilities and their peers without disabilities (e.g. inclusive recreational activities, anti-bullying campaigns), not only at school but also at the community level.
- **Advocate** for inclusion to modify the built environment and methods of communication; to reduce the costs of health services; and to promote inclusive education.

Communities to:

- Conduct **awareness sessions and outreach** and pioneer community-based initiatives to support **inclusive practices.**

Donors to:

- Set the requirements for applicants for funds for **disability inclusive project design**. Specifically, request for partners to include disability disaggregated data and analysis within needs assessments.
- Promote **inclusive budgeting** – e.g. allocation of 5% of the total project budget to inclusion.
- Provide **funding for research and rigorous needs assessments. Allow partners to pilot, and scale-up or change the direction of their inclusion approach.**
- Adjust the **flexibility of funding** (e.g. re-directing budgets from the one-time distribution of assistive devices towards the maintenance and repair of assistive devices).
- Prioritize **multi-year funding** where possible in order to ensure a longer term, more sustainable approach to supporting persons with disabilities.
- In addition to mainstreaming disability into all projects, provide specific funds and support for **MHPSS, inclusive employment and inclusive education.**

Government and local authorities to:

- **Ensure inclusive actions in national plans for response and resilience** through consultations with persons with disabilities.
- **Earmark budgets to support persons with disabilities** to access various services.
- **MEHE to:**
  - Scale-up **teacher training** programs, develop and roll-out guidelines on **inclusive education pedagogy** on how to differentiate the curriculum for children with disabilities to ensure that all children can learn to the best of their abilities.
  - Ensure the availability of **accessible and inclusive learning materials.**
  - Provide **infrastructure according to universal design principles.**

LIST OF TABLES, FIGURES AND BOXES

Tables

Figures

Boxes

LIST OF ACRONYMS

CBO	Community Based Organizations
CFM	Child Functioning Module
CRPD	Convention on the Rights of Persons with Disabilities
DPO	Disabled People's Organization
GOL	Government of Lebanon
HI	Humanity & Inclusion
INGO	International Non-Governmental Organization
ITS	Informal Tented Settlements
KII	Key Informant Interview
LBP	Lebanese Pound
MHPSS	Mental Health and Psychosocial Support
MEHE	Ministry of Education and Higher Education
MOSA	Ministry of Social Affairs
NGO	Non-Governmental Organization
PHC	Primary Healthcare Centres
UN	United Nations
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
USD	United States Dollar
VASyR	Vulnerability Assessment for Syrian Refugees in Lebanon 2017
WFP	World Food Programme
WHO	World Health Organization
WG	Washington Group on Disability Statistics
WG-ES	Washington Group Extended Set

SECTION 1: INTRODUCTION

1.1 Background

Over the last few decades, understanding of disability has progressed, moving away from the medical model, which views disability through the lens of impairment, and towards a rights-based model, which considers the interactions between an individual and barriers in the physical, social and cultural environments which cause activity limitations and participation restrictions.

The Convention on the Rights of Persons with Disabilities (CRPD), adopted in 2006, has been widely ratified and is a driving force behind this shift in our attitudes and behaviours towards persons with disabilities. The CRPD reaffirms that persons with disabilities should enjoy the same basic rights as persons without disabilities, on an equal basis. These basic rights include the right to participate as active members of society, the right to enjoy fundamental freedoms and the right to access justice in cases of violations.

One billion people, or an estimated 15 % of the global population (World Health Organization/WHO, 2011), have disabilities. The most vulnerable among these people are those affected by humanitarian emergencies. Article 11 of the CRPD specifically obliges countries to ensure their protection and safety. In recognition of the need to increase the attention given to this issue, the Charter on Inclusion of Persons with Disabilities in Humanitarian Action was launched at the World Humanitarian Summit in Istanbul in 2016.

> *"Persons with disabilities are disproportionately affected in situations of risk and humanitarian emergencies, and face multiple barriers in accessing protection and humanitarian assistance, including relief and recovery support."*
>
> Charter on Inclusion of Persons with Disabilities in Humanitarian Action (2016)

The Charter calls for humanitarian actors to place persons with disabilities at the heart of decision-making and to make humanitarian actions responsive to the rights and needs of persons with disabilities.

However, despite all the commitments made at the international level, and the ongoing initiatives to support disability inclusion at local levels, persons with disabilities still face exclusion and discrimination. One of the major reasons behind this is the lack of quality disability data, which is necessary to enable humanitarian actors to assess the situation of persons with disabilities and monitor and evaluate the progress of inclusion within humanitarian programing and policy (CRPD Art. 31, Charter 1.9 and 2.3).

1.2 Objectives and Methods

Objectives

Concerning the lack of disability data in the Syria crisis context, HI and iMMAP conducted the study aimed at the following:

1. Provide statistically reliable prevalence of disability as well as disability disaggregated data indicators on access to services in five locations across Jordan and Lebanon (NOTE: this report is dedicated exclusively to Lebanon).

2. Increase understanding of the situation of Syrian refugees with disabilities and their households, compared to their peers without disabilities, in relation to the access to services including education, and key barriers experienced in accessing these services.

3. Recommend inclusive actions to be prioritized by humanitarian actors.

Locations

The study conducted in Lebanon targeted two distinct location types within Bekaa and Baalbek-Hermel governorates: an urban host community in Bar Elias (in Zahle District of Bekaa Governorate) and ITS in Bar Elias and Arsal (in Baalbek District of Baalbek-Hermel Governorate). These three specific locations were selected because of their high concentrations of Syrian refugees and to enable the different camp and host communities living contexts to be represented. For the purpose of reporting, the locations will be referred to as 'Bar Elias' and 'ITS'.

Methods

A mixed approach was used combining quantitative and qualitative data collection.

Quantitative Data Collection

Sampling and inclusion criteria

Random sampling was adopted to reflect and compare the experiences of both registered and non-registered Syrian refugees with the United Nations High Commissioner for Refugees (UNHCR), as well as of both persons with and without disabilities. For Bar Elias, a random sample was generated covering all parts of the town. For ITS, random shelters were selected by satellite.

Enumerators were instructed to go to the identified locations and interview the households closest to the location. If the father of the household was Syrian, and the potential respondents (the mothers or caregivers of the children of the households) agreed to be interviewed, the enumerators would proceed with the survey. Among the identified Syrian households, information of all members was collected.

Study Population

The full Lebanese sample included a total of **2,495 persons** (Table 1). This is the sample size that is large enough to represent the total population of Syrian refugees in the selected locations (see Annex 1 for further details).

Table 1: Study Population in Lebanon, by Location

	Total population Size Registered Syrian refugees (as of July 3rd, 2017, UNHCR)	Required Sample Size	Study Population	
			Households	Persons
Lebanon		400	506	2,495
Bar Elias	346'682	200	284	1,439
ITS		200	222	1,056

Section 1: Introduction

Questionnaires

Questionnaires (see Annex 2) were designed to elicit responses relating to the degree of access to different services at the household and individual levels, as well as responses relating to the perceptions of barriers and to the solutions required to increase access to services. In order to examine the difference in these results between persons with and without disabilities, the study needed to define disability and to apply appropriate tools to identify persons with disabilities.

In light of the CRPD, this study **defines disability as resulting from the interactions between personal and environmental factors.** From this perspective, a person with a given medical condition will not automatically be considered to have a disability. For example, a woman with an amputated leg could be a person without a disability if she lives in an enabling environment and is able to participate in society. One way of identifying the people at risk of not participating in society is to understand the level of difficulties a person faces when performing basic activities (hereinafter referred to as "domains" of functioning) regardless of impairments, using the Modified Washington Group (WG) Extended Set (or, more precisely, the Short Set Enhanced plus fatigue or WS-ES)[1] and Child Functioning Module (CFM). Table 2 shows the age and activity domains covered by each WG tool. For all domains, **the WG recommended cut-off was adopted**[2].

Table 2: Washington Group Tools and Domains by Age Group

<table>
<tr><th colspan="2">Child Functioning Module</th><th>Modified Extended Set</th></tr>
<tr><th>Age 2 to 4 (8 domains)</th><th>Age 5 to 17 (13 domains)</th><th>Age 18+ (10 domains)</th></tr>
<tr><td colspan="3">Seeing *</td></tr>
<tr><td colspan="3">Hearing *</td></tr>
<tr><td colspan="3">Walking *</td></tr>
<tr><td colspan="3">Communication *</td></tr>
<tr><td></td><td colspan="2">Self Care *</td></tr>
<tr><td colspan="2">Learning</td><td rowspan="2"></td></tr>
<tr><td colspan="2">Controlling behaviour</td></tr>
<tr><td rowspan="2"></td><td>Remembering</td><td rowspan="2">Cognition (Remembering or Concentrating) *</td></tr>
<tr><td>Concentrating</td></tr>
<tr><td></td><td colspan="2">Anxiety</td></tr>
<tr><td></td><td colspan="2">Depression</td></tr>
<tr><td>Playing</td><td>Making friends</td><td>Upper body 1&2**</td></tr>
<tr><td>Fine motor</td><td>Accepting change</td><td>Fatigue</td></tr>
</table>

* *Domains covered by the Short Set*
** *Upper body 1 is difficulty raising a 2 litter bottle of water or soda from waist to eye level and 2 refers to difficulty using hands and fingers, such as picking up small objects*

[1] The Short Set (with an * mark in Table 2) plus Upper body, Anxiety, and Depression is the WG Short Set Enhanced. In consultation with the WG expert, Fatigue was added in order to take refugees' stressful life conditions into consideration.
[2] For more details, see Analytic Guidelines: Creating Disability Identifiers Using the Washington Group Extended Set (WG-ES) SPSS Syntax (Washington Group on Disability Statistics, October 23rd, 2017), available at http://www.washingtongroup-disability.com/wp-content/uploads/2016/12/WG-Document-6-Analytic-Guidelines-for-the-Washington-Group-Extended-Set.pdf

The questionnaires were translated into Arabic and reviewed by local experts from HI, the United Nations Children's Fund (UNICEF) and other stakeholders. For the WG-ES, the Arabic-speaking project officer - trained on the WG within the framework of the HI Disability Statistics in Humanitarian Action project[3] - examined the Arabic translations of the national statistics offices of Oman, Egypt and Palestine shared by the WG, and adopted the Omani translation, which was found to be the most accurate. The study used the CFM in Arabic available on UNICEF's website, as it is[4] .

These tools were then transformed into an electronic questionnaire to be administered with tablets using the KoBo data collection software. Integrating the questionnaire logic into the KoBo software ensured that the right people were asked the right questions, and that enumerators did not have to manually skip irrelevant questions.

Data Collection

The enumerator teams received 5 days of training and administered the questionnaire on tablets (Table 3). Each team consisted of one male and one female enumerator, in order to ensure quality, gender sensitive interviews.

Table 3: Enumerators and Data Collection Period

Number of Enumerators	Data Collection Period
20 Lebanese (10 females and 10 males)	4-15 Dec 2018

For children in the households aged 0-17 years old, interviews were conducted primarily with the mothers or primary caregivers. In these cases, interviews addressed the household level questions, as well as individual questions concerning both the mothers or primary caregivers themselves and their children, carefully respecting ethical considerations and advice provided by UNICEF. For individuals aged 18 or over, enumerators directly asked the WG questions, and, for individuals identified as having disabilities, the additional questions focused on persons with disabilities.

Table 4: Question Themes, Unit of Analysis and Respondent

Question Themes (see Annex 2)	Unit of Analysis	Respondent
Basic information relating to household	--	Caregivers of household children
Access to basic services	Household	Caregivers
WG questions	Individual	- Caregivers: for themselves and for their children aged 2-17 - Adults 18+
- Causes of disability - Access to specialized services	Individual (with disabilities only)	- Caregivers: for themselves and for their children aged 2-17 - Adults 18+
Access to education	Individual	Caregivers
Perception of inclusive education	Individual	Caregivers

Collected data was stored on a secure server and checked daily by the iMMAP field coordinator for inconsistencies. Each household survey took approximately 90 minutes to administer. Exact times varied depending on the number of household members and whether or not they were identified to have disabilities.

[3] https://humanity-inclusion.org.uk/en/disability-statistics-in-humanitarian-action
[4] https://data.unicef.org/topic/child-disability/module-on-child-functioning/

Section 1: Introduction

Qualitative Data Collection

Literature Review

A review of existing documents – including reports, summaries, academic and online articles – was conducted in order to understand the situation of Syrian refugees, put the collected quantitative data into perspective and critically analyze this data. Efforts were made to find information focusing on refugees with disabilities in the Lebanese context. While several recent documents provide interesting information, some even dedicating a whole section or chapter to the issues faced by refugees with disabilities (see Section 2), understanding the situation comprehensively and triangulating study findings remains challenging due to the lack of disability disaggregated data and the lack of insights into the real-life experiences of persons with disabilities in different spheres of life.

Key Informant Interviews

In December 2017, 14 KIIs with stakeholders were conducted using semi-structured interview guides in order to elicit deeper insights into the educational situation of children with and without disabilities. Purposive sampling was used to identify KII participants[5]. Table 5 shows the distribution of participants.

Table 5: KII Participants in Lebanon

Teachers/ School staff	NGO	DPO	UN
8	3	2	1

NGO Non-Governmental Organization. DPO Disabled People's Organization. UN United Nations

Bekaa ITS ©HI/ B. Almeras 2017

[5] HI approached stakeholders via existing partnerships, as well as via the network of sector coordination working groups.

Ethical Considerations

Ethical considerations were present from the onset of research design and during the questionnaire administration. During the primary data collection, teams explained the survey's purpose, the collected data's intended use, and the personal data anonymization process. Furthermore, research teams emphasized that participation in the survey was voluntary and that participants could choose to stop at any time, or skip questions that they did not wish to answer. During the quantitative data collection, 16 households refused to take part in the study. No respondents who joined the interviews chose to skip questions or stop the interviews.

Subsequently, research teams gained verbal consent from all household members for quantitative data collection and written consent for KIIs.

In order to manage expectations effectively, the research team clearly explained that participating in the study would not lead to any direct benefits, nor could the team provide diagnostic or individual case management support. At the end of the interviews, information brochures about available services were offered to all households.

The study team shared and discussed the research objectives and implementation plan with key stakeholders in Lebanon, including with UNHCR, UNICEF, and with several NGOs and governmental entities. This took place through individual meetings and presentations delivered during sector coordination working groups. Consultations were also conducted in order to refine the questionnaire.

Data Analysis

All quantitative data collected was fully cleaned and consolidated into a single dataset for both Jordan and Lebanon, including 8,876 rows and 543 columns. In accordance with the analysis plan, a thematic analysis was conducted, based on the different sectors that appear as sections of this report, and using different types of disaggregation in order to elicit further meaning (e.g. location, age, gender, disability domain).

Statistical tests were then run for selected variables in order to establish correlation factors. Specifically, descriptive analyses using multivariate analysis statistical hypothesis tests (chi² for variance, independence, regression analyses, etc.) were used in order to describe and compare the various groups considered by the study and validate the statistical relevance of findings. The R statistical computing and graphics language and environment was used for all statistical analyses. All the major statistical results in this report present restricted standard deviations:

- For findings covering both countries: the margin of error is ±2.3 per cent.
- For country-level findings: the margin of error is ± 4.30 per cent for Syrian refugees in Lebanon.
- For governorate-level findings: the margin of error is ±5.39 per cent for Syrian refugees in Bar Elias and ±6.54 per cent for persons in ITS.

Data Validation

A workshop with key stakeholders was conducted in Beirut on May 9th, 2018, in order to present findings and discuss in detail how findings relate to contextual realities in each location and how to interpret them accordingly. The workshop also engaged stakeholders in a participatory discussion around the key recommendations arising from the study, targeted towards stakeholders including service providers (NGOs and UN agencies), donors, government agencies and communities. This process enabled results to be 'grounded' into field realities.

1.3 Limitations

- This study is one of the first initiatives in which the WG-ES and CFM are used in the humanitarian context. Therefore, there was no similar research against which findings could be compared or analyzed.
- The quantitative survey relied upon the subjective experience and perceptions of Syrian refugees, and did not triangulate or verify the accuracy of responses (e.g. income and debt level, number of days that individuals work a week, regularity of children's school attendance).
- As one of the focuses of this study was the education of children aged 6-12 and given that the CFM was designed for children aged 2-17 years, the whole questions were asked to children's mothers or caregivers, except the WG questions for adults. Due to time and logistical constraints, the study could not conduct focus group discussions with children to collect their direct views.
- Although the WG tools were extensively tested during their global development process, Arabic translations of the study questions were carefully checked, and the whole questionnaire was piloted prior to data collection, thorough cognitive testing was not conducted. Therefore, it remains possible that some questions may not have been clearly understood.

SECTION 2: OVERVIEW OF EXISTING EVIDENCE

This section illustrates the overall situations of Syrian refugees with and without disabilities in Lebanon in terms of population, disability prevalence and the degree of inclusiveness of various services.

Informal settlements in Lebanon © HI/ B. Almeras

2.1 Syrian Refugees with Disabilities in Lebanon

"In the emergency context of Lebanon, given the colossal number of marginalized and vulnerable individuals, the specific needs of refugees with disabilities remain largely unaddressed."
(p. 40. UNHCR, UNICEF & World Food Programme/WFP, 2017)

Overview

The conflict in Syria continues to drive the largest refugee crisis in the world, with over 5.6 million Syrian registered refugees in the region (UNHCR, 2018a). Lebanon is the second largest refugee host country after Turkey, with over 982,012 refugees registered with UNHCR (ibid). As of May, 31st 2018 (UNHCR, 2018b), 35.7% or 350,560 persons resided in the Bekaa area, in which this study was conducted.

Disability Prevalence

Before the influx of Syrian refugees, the prevalence of disability in Lebanon was estimated at 2.0% (ESCWA, 2014, with reference to 2004 data from Lebanon's Central Administration of Statistics). Lebanon's Law on the Rights of Disabled Persons (Law No. 220, 2000) defined disability from a medical perspective, limiting persons with disabilities to 'registered card holders[6] who meet the International Classification of Impairment, Disability and Handicap definition' (p.10, Lakkis, Nash, El-Sibai & Thomas, 2015). This could explain the lower prevalence of disability compared to

[6] Rights and Access, an implementation body of the National Committee for the Disabled, issues the cards at the centres run by the Ministry of Social Affairs, based on the international classification that looks at disability from a mere medical perspective (Human Rights Watch, 2018). Lebanese citizens who voluntarily apply and obtain the card have access to different welfare entitlements, including primary and secondary healthcare, housing, education and employment (Baroud, 2017).

the WHO's global estimation of 15% (WHO, 2011). Lebanon signed the CRPD in June 2007 but has not yet ratified the Convention, meaning that the country is not legally obliged to collect disability data (Article 31). Lebanon has not conducted an official census since 1932 (Lebanese Information Center, 2013).

When it comes to Syrian refugees, UNHCR data in 2013 reported that 1.4% of registered refugees had disabilities, based on its category that cover several impairments (physical [moderate and severe], mental [moderate and severe], visual, hearing and speech impairments) (cited in HI & HelpAge International, 2014). Another more recent study defined disability to include physical, sensorial, and mental/intellectual impairments, and found an overall disability prevalence of 3.5%, with 2.3% among children (UNHCR, UNICEF & WFP, 2017). The rate was 2.7% in Bekaa and 2.9% for Baalbek-Hermel. Based on this, the study also reported that 14% of households in Lebanon had at least one member with disabilities, with a rate of 12% in Bekaa and 13% in Baalbek Hermel. When broadening this out to households including member(s) with specific needs, including chronic health conditions, temporary illness or injuries and those who require support in basic daily activities, 66% of households had at least one member with specific needs (UNHCR, UNICEF & WFP, 2017).

HI and HelpAge International (2014) looked at Syrian refugees with specific needs including persons who have impairments in terms of 5 daily activities (moving and reaching for/using objects, seeing, hearing, speaking, and learning/understanding), injuries and chronic diseases. Accordingly, the study found 21.4% had impairments, 16.2% had chronic diseases and 4.5% had significant injuries in Bekaa and Baalbek-Hermel.

2.2. Inclusiveness of Humanitarian Services

Residency

In May 2015, the Lebanese Government ordered UNHCR to suspend registration for any new Syrian refugees entering the country, concerned by the growing number of refugees in the country that reached around 1.2 million at that time (Janmyr, 2018). A further issue that has limited the legal status of Syrian refugees in Lebanon is the renewal of the residency visa on an annual basis at a cost of 200 USD (IRC & NRC, 2015). In February 2017, General Security waived this fee, along with warnings around the ongoing vulnerability of unregistered refugees (Human Rights Watch, 2017). However, this is based on the conditions that refugees 'registered with the United Nations High Commissioner for Refugees (UNHCR) before January 1, 2015, or obtained residency through their UNHCR certificate at least once in 2015 or 2016'. Hence, despite the waiver, around 500,000 refugees who do not meet these conditions due to their non-registration status with UNHCR, remain marginalized (Human Rights Watch, 2017). UNHCR, UNICEF & WFP, through the 2017 Vulnerability Assessment for Syrian Refugees in Lebanon (VASyR), found that 74% of Syrians aged 15 and over do not have legal residency. Furthermore, the percentage of households in which no members have legal residency leaped from 20% in 2015 to 55% in 2017. The waiver is not systematically applied and some refugees were required to pay 200 USD (UNHCR, UNICEF & WFP, 2017).

The impact of the registration suspension was substantial; 67% of unregistered refugees reported a lack of freedom of movement due to fear of arrest, and 55% reported constrained access to healthcare (IRC & NRC, 2015). Since UNHCR registration is required to secure a legal residency permit, which is required to gain a work permit, refugees who do not have UNHCR registration cannot obtain either of these. Their sole option is to request residency as economic migrants through sponsorship by a Lebanese citizen, and such opportunities are rare. Consequently, unregistered refugees are marginalized both in terms of access to services as well as access to employment.

Shelter

The majority of refugee households (73%) reported living in residential buildings, while 17% were residing in ITS (UNHCR, UNICEF & WFP, 2017). Living conditions are overall poor: homes are overcrowded especially in informal settlements (53%) compared to 28% in residential buildings. In Bekaa, almost half of families (47%) were concerned by overcrowding. Further, the VASyR 2017 found particularly poor shelter conditions in Bekaa (38%), such as unsealed windows, water leaking in roofs, problems with latrines and electricity. Yet, refugee households have to bear the monthly rent of 115 USD in Bekaa

When focusing on the provision of water for Syrian refugee households, UNHCR, UNICEF & WFP (2017) found that 73% of surveyed households in Bekaa and 69% in Baalbek-Hermel (the lowest in the country) had access to improved drinking water sources in their housing area or within a 30 minutes round trip collection time. According to them, affordability and quality of water is the key issue rather than availability of water. At the country level, 34.4% of households reported the source of improved drinking water as bottled mineral water, indicating distrust in the quality of water from tab or tanks or an insufficient amount to cover households' needs. For whatever reason, these households may be forced into higher expenditure in order to access clean drinking water.

In terms of sanitation, 77% of households in Bekaa reported using improved sanitation facilities compared to the national average rate of 86% (UNHCR, UNICEF & WFP, 2017). Furthermore, 53% of families in Bekaa use these facilities among their family members, and do not share with others. The VASyR 2017 also looked at the access to improved sanitation facilities for families that have member(s) with disabilities: a high percentage – 84% – confirmed having access.

Despite some progress, living conditions remain desperate, and it is not surprising that shelter was the second most important concern amongst refugee households (13.9%), following concerns around livelihoods and securing an income (HI & HelpAge International, 2014).

Health

In 2017, only 32% of the Lebanon Crisis Response Plan Health sector appeal was funded, leading to a significant gap in the planned/required provision of health services in the country (JIF, LHIF & SIRF, n.d).

In terms of health needs, 46% of households required health services in the last six months; 89% of whom could access required services, leaving another 11% with limited access (UNHCR, UNICEF & WFP, 2017). When medical needs arise, Syrian refugees can access health services from a range of providers; including 219 public Primary Healthcare Centres (PHC); clinics and mobile medical units operated by NGOs, and private services (WHO, 2016). Secondary health services are not covered by PHC but UNHCR subsidises these services at a rate of 75-90% based on vulnerability criteria, with the remaining 10-25% of the cost being covered by the patient (Baroud, 2017).

When it comes to Syrian refugees with disabilities, the above-mentioned disability card is only for Lebanese citizens and refugees do not receive benefits from it (Lakkis, Nash, El-Sibai & Thomas, 2015). Nevertheless they can access PHC and mobile clinics subsidized by humanitarian organizations, as can refugees without disabilities (Baroud, 2017). The burden of healthcare costs, however, could be heavier compared to households without disabilities. Baroud (2017) reported that 78.5% of persons with disabilities cited the financial burden as the major issue affecting their access to required health services. Oftentimes, basic healthcare at clinics in neighbourhoods are not accessible in terms of physical barriers (e.g. lack of ramps or elevator) as well as staff's attitudes and level of training. This pushes persons with disabilities to seek other and better services at their own expense. Specialized and long-term treatments, necessary to improve conditions of impairments, injuries or chronic illness, are also limited, located far away, and thus become costly with additional expenses for transportation (Baroud, 2017; Women's Refugee Commission, 2013). Inter-Agency Coordination (2015) reported that, while households without disabilities spent 13.6% of their spending on health-related matters, households with members with disabilities had to spend 18.1%. As a result, households including member(s) with disabilities are 9% less likely to have access to primary and secondary healthcare services compared to households with no members with disabilities (Inter-Agency Coordination Lebanon, 2015).

Indeed, financial ability is recognized as a barrier to health services for people in general, regardless of disability. UNHCR, UNICEF & WFP (2017) reported costs for drugs and treatment (33%) and for doctor appointments (33%)

Section 2: Overview of Existing Evidence

as major obstacles to primary healthcare. Other barriers include lack of knowledge on where to find services (17%), being refused entry (14%), 'Inadequate treatment by health centre staff" (11%) and distance to health services (10%).

Specific additional barriers that persons with disabilities face in relation to accessing healthcare include lack of trust of services due to discriminative attitudes and psychological, physical and sexual violence from staff (36%) as well as lack of information on available services (29.2%) (Baroud, 2017).

In terms of mental health, 2.5% of households within the VASyR 2017 reported requiring MHPSS, yet 62% were unable to access these services. Several barriers, such as denial of the service by the service providers (37%), cost for consultation (29%), cost for treatment (25%) and even lack of knowledge about where services are located (15%), limit persons' access to this critical service.

Food and Cash Assistance

In Lebanon, a multi-purpose cash-based assistance system is operational to deliver various support modalities to Syrian refugees using the common e-cards, which were delivered to around 185,000 families (Government of Lebanon/GOL & UN, 2017; Bailey & Harvey, 2017) in addition to other forms of assistance programs. Some recent information is listed below:

- Food assistance by WFP and partners: at the end of August 2017, 877,000 vulnerable individuals received food assistance and agricultural support. The value of food assistance was 27 USD per person per month (GOL & UN, 2018).
- Multi-purpose cash assistance by the Basic Assistance sector: 61,000 Severely Vulnerable Syrians received regular monthly cash assistance (Inter-Agency Coordination, 2018).
- Seasonal cash assistance or UNHCR's "winterization program" reached 700,000 Syrian refugees in 2016.
- Education grants: 72% of children and adolescents aged 5-24 benefitted from different types of educational support during the 2016-2017 school year (UNHCR, UNICEF & WFP, 2017). In 2018, 20,399 vulnerable Syrian refugee households with school-aged children received additional child-focused cash transfers (Inter-Agency Coordination, 2018).

In spite of the above-mentioned support, it is notable that 91% of Syrian refugee households remain food insecure to some extent (94% in Bekaa and 98.6% in Baalbek-Hermel), prompting questions around households' economic vulnerability (UNHCR, UNICEF & WFP, 2017). The study could not find any disability disaggregated information concerning access to food and cash assistance.

Livelihood

Without legal residency, it is hard for Syrian refugees to work. Even with a legal work permit, their engagement is limited to certain sectors, including construction and agriculture/seasonal work (UNHCR, UNICEF & WFP, 2017). Among the working age population of 15-64 years, 56% men and 7.6% women were working at the rate of 13-14 days per month. It is worth noting that 36% of households did not have any member who worked one month prior to VASyR 2017.

With limited work opportunities, families seek various sources of income, ranging from WFP e-cards as the primary source of income (28%), informal credit such as borrowing from shops/friends (16%), construction work (15%), agricultural work (9%), to cash from humanitarian organizations (5%). They also adopt various negative coping strategies by reducing their expenditure on food (79%), healthcare/medicine (53%) and education (31%).

Nevertheless, the average household monthly income is as low as 60 USD per capita (UNHCR, UNICEF & WFP, 2017). This is obviously not enough to meet the very basic needs of food, health-related expenses, rent and others, urging the vast majority of Syrian families – 87% – to borrow money. Costs related to healthcare were one of the main reasons households were falling into debt, as cited by 15% of households (Humanity & Inclusion, 2013). In 2017, 43% of households were in debt by more than 600 USD. It is worrying that 75.9% of Syrian households in Lebanon live below the poverty line (3.84 USD per day). The rates are even higher in Baalbek-Helmel and Bekaa at 94.0% and 90.2% respectively, where the study locations are located.

Persons with disabilities are even more excluded from livelihood opportunities; according to Baroud (2017), 80% of Syrian refugees with disabilities older than 18 years reported being unemployed. Furthermore, households including a member with disabilities reported higher monthly expenditures than households with no members with disabilities. According to a 2015 report, the average monthly expenditure of a household headed by a person with disabilities was 127 USD, compared to 106 USD for a household headed by persons without disabilities (Inter-Agency Coordination Lebanon, 2015). UNHCR, UNICEF & WFP (2017) also found that the expenditure level of 80% of households with children with disabilities did not meet the Minimum Expenditure Basket threshold.

Child labour amongst Syrian refugee children is also present across Lebanon. The VASyR 2017 found 4.8% of children to be working, with a rate of 3.9% in Bekaa governorate and 5.3% in Baalbek-Helmel governorate. More boys (7.1%) than girls (2.1%) are engaged in child labour. Another study in 2015 found over 1,500 children to be living and working on the streets, primarily engaged in begging (43%) as well as street vending (37%), mainly in the areas around Beirut (Consultation and Research Institute, 2015).

Education

The education sector in Lebanon faces severe challenges meeting the needs of an increased number of students; particularly since the education response in 2017 was only funded 73% (No Lost Generation, 2018).

Table 6: Enrolment of Syrian Refugee Children

Registered school-age Syrian refugee children aged 3-18 years

Year	Total	In Formal Education	In Non-formal education	Out of education
2017	**625,222**	264,970 42.4%	92,617 14.8%	267,635 42.8%
2016	**604,133**	247,025 40.9%	54,746 9.1%	302,362 50.0%

Source: p.4. No Lost Generation 2018.

As shown by Table 6, in 2017, 42.8% of school-aged Syrian refugee children in Lebanon were not attending any form of education, down from 50.0% in 2016 but still worryingly high (No Lost Generation, 2018). It is important to note that this data covers children 3-18 years old from pre-primary school to upper-secondary education where the enrolment rate drops significantly (UNHCR, UNICEF & WFP, 2017). This in mind, the VASyR 2017 finds a higher rate of school enrolment for children specifically at ages 6-14 (primary and lower secondary level) at 70% (national level). Geographical disparity exists: Bekaa showed the lowest primary and lower secondary education enrolment at 59% and Baalbek-Hermel at 67%, two lowest among all governorates in Lebanon (UNHCR, UNICEF & WFP, 2017).

The VASyR 2017 assessed the enrolment of children with disabilities disaggregated by gender and age, and found that their enrolment at ages 6-14 was 47%, much lower than the national level enrolment rate of 70% for all children (Table 7). The data also shows that, except children of pre-primary school age, boys with disabilities have more difficulties to continue their education.

Section 2: Overview of Existing Evidence

Table 7: Enrolment Rates of Children with and without Disabilities

Age	Children with disabilities			Children without disabilities
	Total	Females	Males	
3-5 years	8%	3%	11%	15%
6-8 years	52%	67%	42%	
9-11 years	51% → 47%	44%	53%	70%
12-14 years	38%	53%	33%	
15-17 years	8%	14%	0%	23%
18-24 years	7%	19%	0%	n/a

Source: p.41 & 42. UNHCR, UNICEF & WFP, 2017

Multiple barriers have been raised in relation to Syrian refugee children's access to education in Lebanon. Financial constraints were reported by 39% of caregivers of children aged 6-14 years as the main barrier to access (UNHCR, UNICEF & WFP, 2017). Officially, neither children nor parents need valid residency for children to enrol in public schools (Lebanon Humanitarian INGO Forum, 2017). Yet, the lack of legal documentation continues to disadvantage children (JIF, LHIF & SIRF. n.d). Bullying is another concern that pushes children out of school, while demands from families pull children into child labour. Teachers' capacity to deliver learner-centered quality learning is also a major challenge while the will for improvement is deteriorated by various factors; in 2017, only 365 teachers were trained, out of a target of 20,333 (1.3%) (Education Sector, 2017).

For children with disabilities, the barriers are even more extreme. To begin with, at the national level, Lebanon pledged to make all public schools in the country accept children and youth with disabilities and be accessible, and education costs for children with disabilities were to be covered by the MEHE, in accordance with Law No. 200 (2000). However, the country is lagging far behind in its implementation (Human Rights Watch, 2018). Pervasive understanding about "disability" from a medical lens only rather than a social and rights-based approach, ongoing segregation approach rather than inclusion, and gaps between MEHE and the Ministry of Social Affairs (MOSA)[7] have made it hard to establish a comprehensive system to ensure inclusive education for all children, including children with disabilities.

Even though MEHE-supported public schools are free, because there are only a few "inclusive" or at least accessible schools out of a total of 1,279 schools across the country, access is extremely limited (Human Rights Watch, 2018). Associated costs such as transportation further exacerbate restricted access. Furthermore, Human Rights Watch (2018) discovered cases in which children with disabilities were paying admission fees between 70-300 USD per month, additional assistance, and transportation for MOSA-funded educational institutions. School accessibility also remains a key barrier on top of other factors ranging from discriminatory admission policies, poor assessment of children's learning and other needs, no provision of reasonable accommodations, shortage of accessible and inclusive educational materials, lack of trained educational personnel to parents' awareness and distance to school (Ibid). Since Lebanese children with disabilities are already disadvantaged by these environmental, institutional and attitudinal barriers, it is easy to imagine that the situation for Syrian refugee children with disabilities is more exacerbated.

It is worth mentioning the MEHE's recent new initiatives, or the Inclusive School Pilot Project which is implemented with support from UNICEF (No Lost Generation, 2018; Human Rights Watch, 2018; Education Sector, 2017). The program aims to inform the MEHE to support its inclusive education policy development, by presenting the successful inclusion of children with disabilities in schools. 30 public schools across Lebanon are being supported over a two-year period through the recruitment and training of special teachers, paraprofessionals and therapists, and the modification of physical infrastructures. Several other initiatives also exist to promote the inclusion of children with disabilities in education; for example, a school rehabilitation project supported 55 schools out of a total of 123 schools

[7] Human Rights Watch (2018) illustrated that while under Lebanese law, the MEHE is responsible for children with disabilities' education, the mandate is interpreted differently in reality; "children with physical and intellectual disabilities are not part of the 7MEHE school system" said by MEHE officials (p.16). MOSA funds institutions to provide education, but when doing so, they do not follow the MEHE curriculum as it was "not adapted for children with disabilities" and creates its own materials (p.62).

to be accessible (Education Sector, 2017), and 22 children with visual impairments were supported to enrol in schools through teacher training and provision of materials in Braille (Human Rights Watch, 2018). Yet, until these initiatives bring real benefits for all children with disabilities in the country, including Syrian refugees, there is still a long way to go.

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SECTION 3: FINDINGS

3.1 Demographics

A total of 2,495 persons were surveyed in the study, including 1,223 males (49.0%) and 1,272 females (51.0%) (Table 8). The average household size was 4.9 people. As illustrated in Figure 1, 57% of the surveyed population were aged 20 years and below.

Table 8: Number of Surveyed Population and Households, by Location

	Households	Number of Persons	Average Household Size
Lebanon	506	2,495	4.9
Bar Elias	284	1,439	5.1
ITS	222	1,056	4.8

3.2 Disability

3.2.1 Prevalence of Disability

The study found a disability prevalence of 22.6% in Lebanon, within a sample population of 2,338 persons aged 2 years and above (N=529) (Table 9 and Figure 2). This finding is markedly higher than the existing disability statistics, many of which were around 2-4% and which used questions focusing on medical conditions or impairments to identify people with disabilities. Understanding disability as the level of difficulties a person is facing when performing basic activities that could put him/her at risk of not participating in society, the prevalence found by the study is much higher. This urges us to widen the scope of persons of our concern.

When analyzed by location, the prevalence of disability rates was higher in ITS at 24.9% compared to Bar Elias, at 21.0%. When considering the difference between these locations, due to proximity of the ITS locations, particularly Arsal, to the Syria border, it is possible that households with disabilities caused by the Syrian conflict chose to settle in these ITS areas rather than migrate further to urban centres.

Figure 1: Number of Surveyed Populations, by Age and Gender

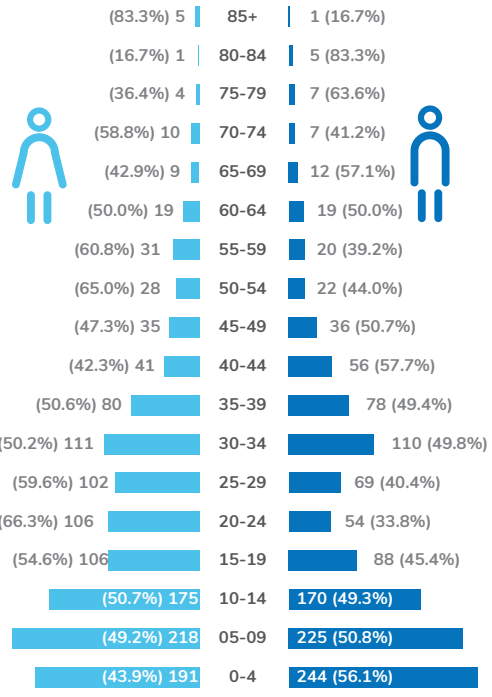
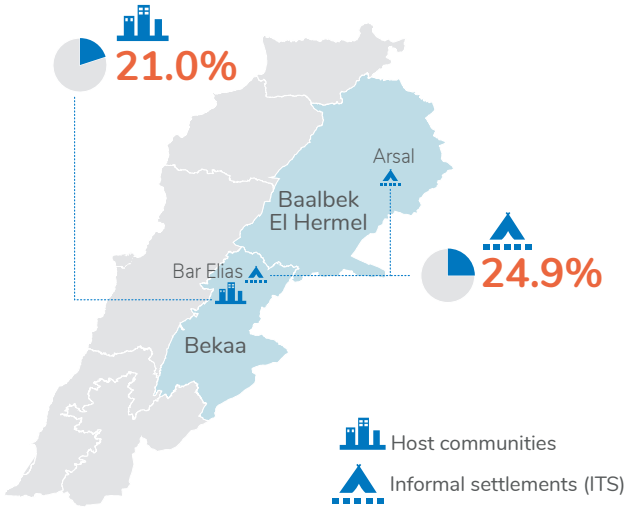


Table 9: Surveyed Population aged 2+ and Disability Prevalence, by Location

	Households	Persons 0+	Persons 2+	Persons with disabilities 2+	Prevalence
Lebanon	506	2,495	2,338	529	**22.6%**
Bar Elias	284	1,439	1,365	287	**21.0%**
ITS	222	1,056	973	242	**24.9%**

Figure 2: Disability Prevalence, by Location



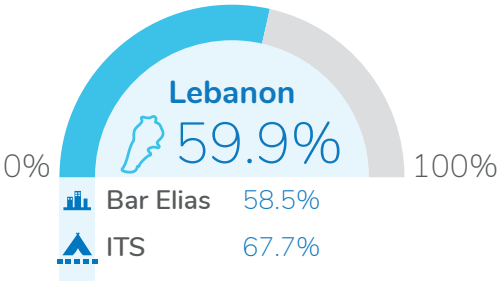
Disability at the household level

The study found that **59.9% of sampled households included at least one member with disabilities.** Reflecting the higher disability prevalence for individuals, ITS shows a higher prevalence of disability at 67.7% compared with 58.5% in Bar Elias.

This finding shows a striking difference, for example, with the VASyR 2017's data which found that 14% of Syrian refugee households included at least one member with disabilities using a question if a person had medical conditions such as physical, sensorial, and mental/intellectual impairments.

Moving to a rights-based definition of disability means that more households with a member with disabilities are identified. This requires humanitarian actors to examine the impact of disability on households and consider the needs to promote appropriate parenting skills and support programs for families. The presence of a family member with disabilities often requires households to provide additional time, physical, emotional and financial efforts for caring and seeking necessary information and services; manage feelings and stress such as doubt concerning diagnosis and anxiety about the future; and address lost opportunities for education or work (Lara & Pinos, 2017). On the other hand, Lara & Pinos (2017) argued that there are a number of positive aspects brought by having family members with disabilities, such as strengthened family cohesion, positive awareness about others' needs, and enhanced knowledge about and collaboration with support programs and facilitators that exist in society. To mitigate negative impacts and promote positive outcomes, it is extremely important to provide support for family empowerment, which could potentially benefit the wider community (Lara & Pinos, 2017)

Figure 3: Disability at the Household Level



Section 3: Findings

Disability prevalence by age and gender

Among the surveyed population across locations, more than 50 % for both females and males were children aged 2-17 years old. People aged 51 years and above comprised about 7-8% of the total population (see the population pyramid in the middle of Figure 4).

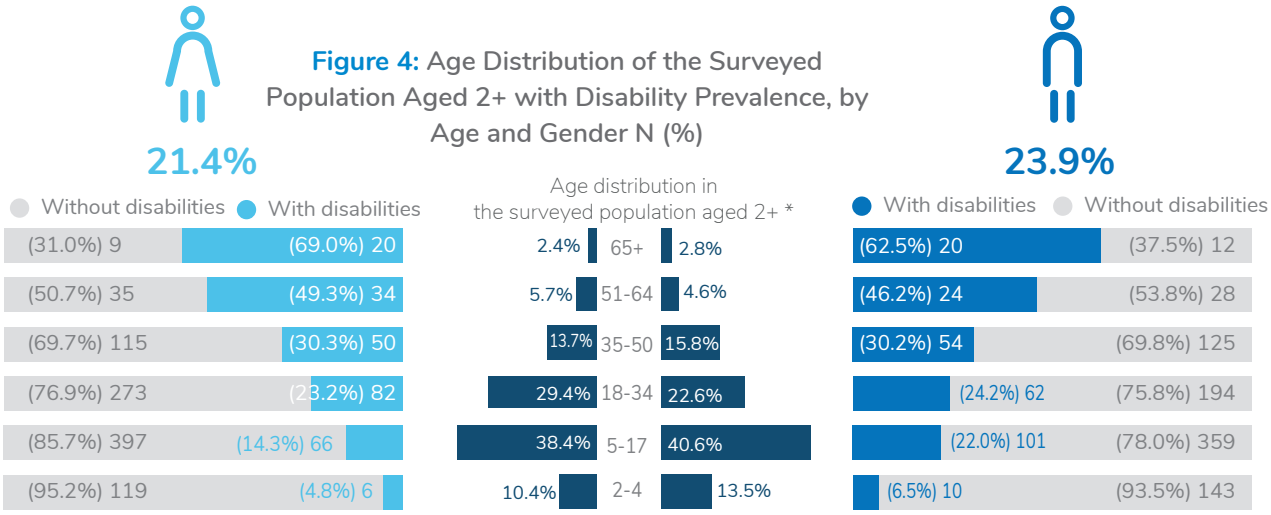
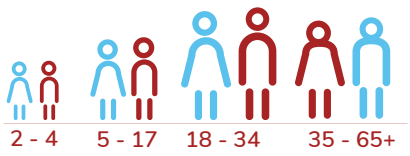


Figure 4: Age Distribution of the Surveyed Population Aged 2+ with Disability Prevalence, by Age and Gender N (%)

*Percentages may not add up to 100% due to rounding

Females experience slightly lower rates of disability than males; among females, disability prevalence is 21.4%, compared to males at 23.9%.

As Figure 4 shows, **disability increases with age.** This is in line with the global trend as well as the 2015 finding in Lebanon (Inter-Agency Coordination). Taking also gender into consideration, the prevalence of disability is higher among young males than among females in age groups 2-34 years; for example, 24.2% for males aged 18-34 years compared with 23.2% of females in the same age group. However, from the 35 years age bracket onwards, more females than males experience disability. The largest gender gap is amongst persons aged 65+, where there is a 6.5 percentage point difference between females and males (69.0% and 62.5% respectively).

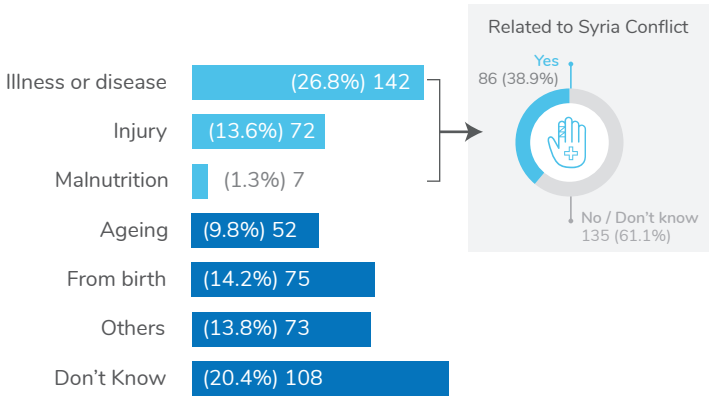


Disability prevalence is higher in younger males than females in age groups 2-34 years, and in older females than males in age groups 35 years and above

3.2.2 Causes of Disability

The study asked individuals with disabilities about the causes of the difficulties they experienced under the WG questions. As Figure 5 shows, respondents reported illness or disease as the primary cause (26.8%), followed by "I don't know" (20.4%), from birth (14.2%), others (13.8%, many of them related to stress from difficult living conditions, death of family members, etc.), injury (13.6%), ageing (9.8%) and malnutrition (1.3%).

Figure 5: Causes of Disability and Relation to the Syrian Conflict N (%)



Among persons who reported illness/disease, injury and malnutrition as causes of their disabilities [8], **38.9% considered the causes were related to the Syrian conflict.** The attribution of disabilities to the conflict is a subjective interpretation and no verification was conducted with the respondents. However, the desk review and discussions with stakeholders suggest various direct and indirect relations between disability and conflict; bombing; gunshot; accidents when fleeing from attacks; limited access to emergency health services due to destruction of hospitals, lack or absence of qualified doctors and medical equipment or medicines; just to mention a few (see for example, HI & HelpAge International, 2014).

Among 86 persons with disabilities who related the causes of their disabilities to the Syrian conflict, anxiety was the most common domain, followed by depression, walking, fatigue and seeing (Table 10). It is likely that traumatic experiences, war-related injuries and other various daily stressors in exile, caused limitations in these domains.

Table 10: Top 5 Domains Persons with Disabilities Related the Causes to Syrian Conflict

	Anxiety	Depression	Walking	Fatigue	Seeing
Lebanon	44	31	30	28	13
Bar Elias	23	18	20	13	11
ITS	21	13	10	15	2

Note: Respondents could identify difficulties in more than one domain

Causes of disability by age

Table 11 illustrates that 62.5% of caregivers of children aged 2-4 and 27.5% of caregivers of children aged 5-17 considered that their children had disabilities since birth. For adults from 18 to 64 years, the primary cause of disability was illness or disease, which rises steadily with age. People in the age group 18-50 also face a high prevalence of disabilities related to injuries (18.8% for the age group 18-34 and 18.3% for the age group 35-50). For persons aged 65 and over, evidently ageing was the leading cause (70.0%).

It is also worth noting that a sizable number of respondents reported that they did not know the causes of disabilities especially for the age brackets 2-34 years.

[8] Among answer choices, causes other than these three (e.g. aging and conditions from birth) are not or less directly attributed to Syria Crisis.

Section 3: Findings

Table 11: Causes of Disability, by Age (N=529)

Top cause Second cause in each age group

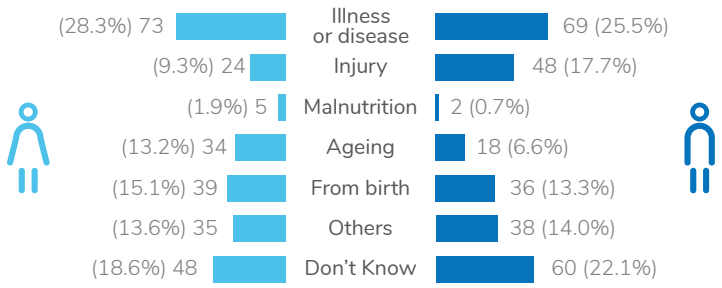
	2-4	5-17	18-34	35-50	51-64	65+
Illness or disease	0.0%	16.8%	**27.1%**	**41.3%**	**44.8%**	15.0%
Injury	0.0%	9.0%	18.8%	18.3%	12.1%	10.0%
Malnutrition	0.0%	1.2%	2.8%	0.0%	1.7%	0.0%
Ageing	0.0%	0.0%	0.7%	6.7%	27.6%	**70.0%**
From birth	**62.5%**	**27.5%**	8.3%	6.7%	0.0%	0.0%
Don't Know	0.0%	11.4%	19.4%	**19.2%**	8.6%	2.5%
Others	**37.5%**	**34.1%**	**22.9%**	7.7%	5.2%	2.5%

Note: "Other" categories require further investigation

Causes of disability by gender

When disaggregating data by causes of disability by gender (see Figure 6), the study found that more females (28.3%) than males (25.5%) had disabilities related to illness or disease. Injuries, on the other hand, led to more males having a disability (17.7%) than females (9.3%). This suggests males' higher exposure to risks of injuries in conflicts. HI and HelpAge International (2014) illustrated their roles in daily activities, such as combatants, fetching food and water, and traveling to check their houses, properties and relatives, could be risk factors.

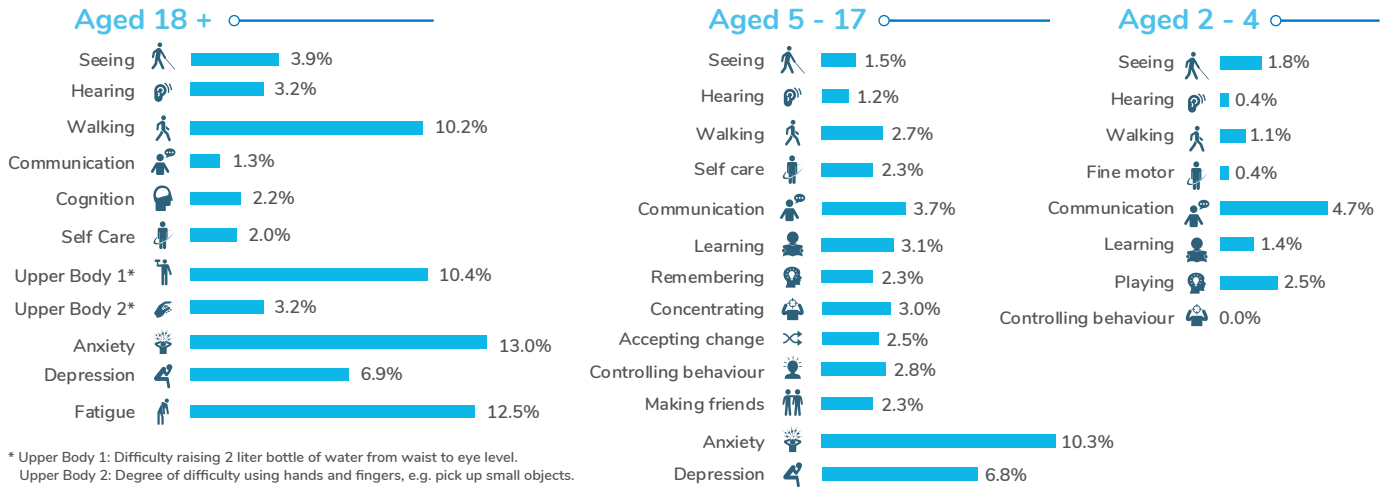
Figure 6: Causes of Disability, by Gender N (%)



3.2.3 Disability Domains

As explained in Section 1, the study asked questions to understand the level of difficulties a person faces when performing basic activities or domains, using the WG tools, depending on the age of the responding household members.

Figure 7: Disability Domains, by Age (%)



* Upper Body 1: Difficulty raising 2 liter bottle of water from waist to eye level.
Upper Body 2: Degree of difficulty using hands and fingers, e.g. pick up small objects.

As shown in Figure 7, the most frequently experienced functional difficulties by adults aged 18 years and above were anxiety (13.0%), fatigue (12.5%) and upper body 1 (10.4%), which refers to the level of difficulty an individual experiences when raising a 2 litre bottle of water from the waist to eye level. Common domains among children aged 5-17 years were anxiety (10.3%), depression (6.8%) and communication (3.7%) %), while children aged 2-4 years experienced difficulties with communication (4.7%) and playing (2.5%).

The fact that **anxiety, depression and fatigue were the most common domains for persons aged 5 years and above** may be surprising because often, disability data collection is associated with physical, hearing, seeing and intellectual impairments and rarely with mental health and psychosocial issues (anxiety and depression) or fatigue. Syrian refugees experience a range of stressors in their lives: grief about their lost families; worries about family members remaining inside Syria; fears about armed groups in host communities; frustrations regarding difficult living conditions, in particular struggles to obtain legal status; financial concerns; tensions with Lebanese communities; violence in communities and many others, on top of uncertainly about the future of their homeland (IMC, 2015; HI & HelpAge International, 2014). These traumas, if not addressed timely and appropriately, could develop to critical conditions and then lead to disability.

It is particularly worrying that, among children aged 5-17, 10.3% exhibit daily anxiety (10.0% in Bar Elias and 10.7% in ITS) and 6.8% (7.4% in Bar Elias and 6.0% in ITS) show depression or sadness on a daily basis.

This data suggests the strong need for humanitarian actors to focus on MHPSS, with careful attention to the young generation.

Disability Domain and location

Analysis of the results for adults aged 18 years and above by location (Table 12) suggests further trends. Anxiety and walking are the most prevalent in Bar Elias, while in ITS, fatigue is markedly pervasive for nearly 20% of persons with disabilities. It is particularly worrying that a high proportion of males felt more tired than their female peers in ITS (19.9% males vs 19.3% females) and although at lower rates, 6.8% of males felt frequently and extensively exhausted compared to of 1.1% females in Bar Elias. Furthermore, the table shows that more males experience difficulties across 8 of the 11 domains in Bar Elias, while in ITS, more females experience functioning issues in 9 of the11 domains: especially depression (10.0% vs 8.5%) and walking (10.4% vs 9.0%). Differences in gender roles in each location and its relationship with disability would need further investigation.

Table 12: Disability Prevalence by Domain, Location and Gender: Adults Aged 18+

● Top cause ● Second cause in each location

	Seeing	Hearing	Walking	Communi-cation	Cognition	Self-care	Upper Body 1	Upper Body 2	Anxiety	Depression	Fatigue
Bar Elias	4.4%	3.0%	**10.5%**	1.0%	1.8%	1.9%	9.5%	3.4%	10.5%	5.3%	7.7%
Male	4.9%	1.9%	10.7%	1.6%	2.3%	1.0%	9.1%	4.2%	11.4%	6.5%	6.8%
Female	4.1%	3.8%	10.3%	0.5%	1.4%	2.7%	9.8%	2.7%	9.8%	4.3%	1.1%
ITS	3.0%	3.5%	**9.8%**	1.7%	2.8%	2.2%	11.7%	2.8%	16.7%	9.3%	19.6%
Male	2.8%	3.3%	9.0%	0.9%	0.9%	1.9%	11.4%	3.3%	16.1%	8.5%	19.9%
Female	3.2%	3.6%	10.4%	2.4%	4.4%	2.4%	12.0%	2.4%	17.3%	10.0%	19.3%

Section 3: Findings

Disability domains by age

As disability prevalence increases with age, certain domains linked to ageing are more prevalent across some age groups (Table 13). The study found persons over the age of 40 are more likely to experience difficulties walking (P<0.01), hearing,

seeing and with fatigue (P<0.05). The proportion of populations in each age group that experience difficulties walking, for example, increased from 4.1% among the 18-34 age group to 45.9% of those aged 65 and over.

Table 13: Dility Prevalence, by Domain and Age

● Top cause ● Second cause in each age group

	Seeing	Hearing	Walking	Communi-cation	Cognition	Self-care	Upper Body 1	Upper Body 2	Anxiety	Depression	Fatigue
2-4	1.8%	0.4%	1.1%	4.7%	--	--	--	--	--	--	--
5-17	1.5%	1.2%	2.7%	3.7%	--	2.3%	--	--	10.3%	6.8%	--
18-34	1.8%	1.3%	4.1%	1.0%	1.5%	0.8%	4.7%	1.8%	13.3%	6.1%	10.8%
35-50	3.5%	1.7%	9.3%	0.9%	2.6%	1.5%	11.3%	2.9%	11.9%	7.3%	11.0%
51-64	5.8%	6.6%	25.6%	0.0%	2.5%	5.0%	23.1%	3.3%	12.4%	10.7%	19.0%
65+	23.0%	23.0%	45.9%	9.8%	6.6%	11.5%	36.1%	18.0%	18.0%	6.6%	24.6%

Note: For age groups 2-17, only domains that are common to 18+ are shown in this table. For other domains, see Figure 7.

For children, anxiety and depression are the main domains of disability experienced by children aged 5-17 years in both locations (Table 14). Following these, children in Bar Elias exhibited difficulties with communication (3.9%) while their peers in ITS struggled with learning (4.4%). Walking is a more prevalent domain of functioning for children in Bar Elias (3.1%) than in ITS, which could suggest that the physical environment is less accessible and more hindering for children with disabilities in an urban setting.

Table 14: Disability Prevalence, by Domain and Location: Children 2-17

	Children 5-17 years		Children 2-4 years	
Bar Elias	Anxiety	10.0%	Communication	4.7%
	Depression	7.4%	Playing	2.7%
	Communication	3.9%	Learning	2.0%
	Walking	3.1%	Seeing	2.0%
	Concentrating	2.2%	Walking	0.7%
	Learning	2.2%	Fine Motor	0.7%
ITS	Anxiety	10.7%	Communication	4.6%
	Depression	6.0%	Playing	2.3%
	Learning	4.4%	Seeing	1.5%
	Concentrating	4.2%	Walking	1.5%
	Controlling behaviour	4.2%	Learning	0.8%
			Hearing	0.8%

For children aged 2-4 years, communication, to be understood by people inside and outside of the household, was the most common difficult domain cited by caregivers, followed by playing, for both locations. Difficulties with communication, for example, could be related to speech impairments but also children's limitations in understanding messages, expressing their responses or both. Playing also requires a complex set of skills not only in terms of physical but also social, emotional and cognitive areas. Further targeted research to help appropriate early interventions would be required.

3.2.4 Children's Disability by Household Income Level

Table 15 illustrates that 18.8% of children with disabilities aged 2-4 years and 28.1% of children with disabilities aged 5-17 years were found in the households with a total monthly income prior to the study of approximately 300-460 USD and 460 USD or more, while the survival level was 435 USD per family of 5, per month, according to the Inter-Agency Coordination (2018). Furthermore, 43.8% of children aged 2-4 years and 14.4% of children aged 5-17 years were in households with an income of 100 USD or less, which shows extreme poverty. The finding suggests a strong relationship between poverty and disability[9].

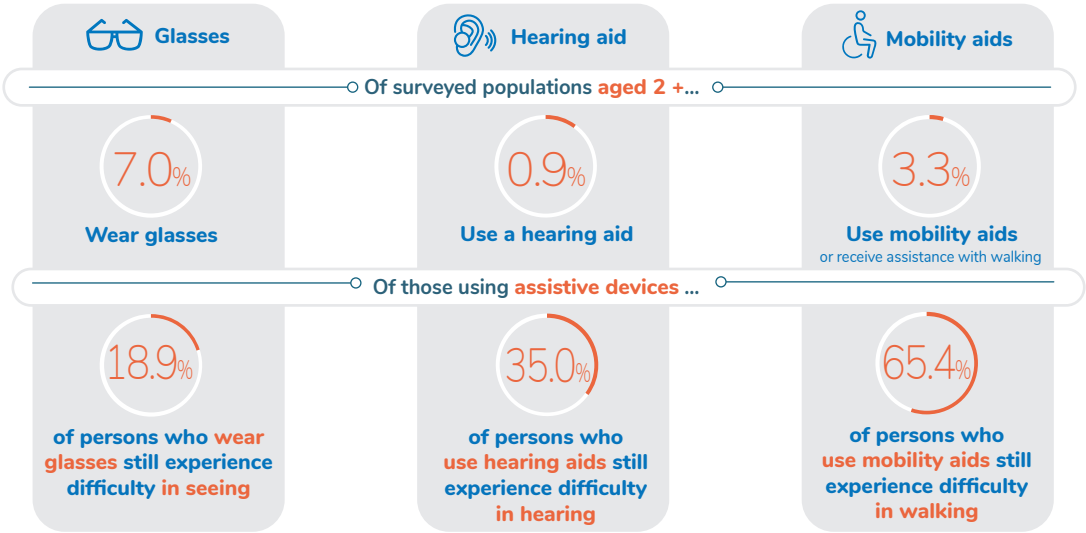
Table 15: Household Income Level of Children with Disabilities, by Age

Total household cash income in the last month (Lebanese Pound/ LBP)	USD	Children with disabilities 2-4 year old		Children with disabilities 5-17 year old	
		Number	%	Number	%
0-74,000	0-49	2	12.5%	14	8.4%
75,000 – 149,000	50-99	5	31.3%	10	6.0%
150,000 – 299,000	100-199	1	6.3%	46	27.5%
300,000 – 449,000	200-299	5	31.3%	50	29.9%
450,000 – 699,000	300-460	3	18.8%	42	25.1%
700,000	460-	0	0.0%	5	3.0%
		(total 16)		(total 167)	

3.2.5 Assistive Devices

Questions from the WG tool about assistive devices revealed that, among 2,338 surveyed persons aged 2 years and above, 7.0% wear glasses, 0.9% use a hearing aid and 3.3% use mobility aids (Figure 8).

Figure 8: Disability and Assistive Devices



[9] See for example: Groce et al., (2011) https://www.tandfonline.com/doi/abs/10.1080/01436597.2011.604520 and Banks, Kuper & Polack (2017) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5739437/

Section 3: Findings

Figure 8 further shows that **users of assistive devices face continued difficulty.** 18.9% of those who use glasses, 35.0% of those who use hearing aids and 65.4% of those who use mobility aids still experience significant difficulties seeing, hearing and walking respectively, thereby identified to have disabilities according to the WG recommended cut-off.

When analyzing the findings from a locational and age perspective (Table 16), urban settings seem to be more discouraging than ITS. Over three quarters of children (77.8%) and adults (76.7%) in Bar Elias who use mobility aids still experience difficulties walking, compared to 16.7% of children and 60.6% of adults in ITS. The higher rates of difficulties walking despite mobility aids in Bar Elias may be linked to poor infrastructures in general, including roads, streets and buildings.

However, the discussion point to be raised here is not just about the physical accessibility but also around the capacity of established networks of service providers to deliver proper devices with fitting, long-term maintenance and repair services. Key stakeholders that the study consulted highlighted that, in Lebanon, the MOSA is responsible for distributing assistive devices, but this only applies to Lebanese citizens, and does not include Syrian refugees. This large gap in service provision forced refugees to turn to private suppliers of assistive devices which can incur additional costs. Furthermore, stakeholders stated that hearing aids tend to be distributed without a proper hearing assessment before, or with any follow-up support. With regards to mobility aids, often due to organizations' budgetary constraints, projects were only able to distribute the initial device, and not able to cover costs related to repair or maintenance when the devices were damaged or outgrown afterwards, as emphasized by stakeholders working in specialized services programing during the study workshop.

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Table 16: Number and Percentages of Persons who Use Assistive Devices and Have Disabilities, by Age and Location

Location		Lebanon	Bar Elias		ITS	
Age group		2+	2-17	18+	2-17	18+
Sample Size		2338	688	680	1271	1205
Glasses	N who wear glasses	164	18	93	12	41
	% of the total age population	7.0%	2.60%	13.70%	2.30%	8.90%
	N who have difficulties even wearing glasses	31	4	19	2	6
	% of those who wear glasses	18.9%	22.20%	20.40%	16.70%	14.60%
Hearing Aids	N who use hearing aids	20	2	1	8	9
	% of the total age population	0.09%	0.30%	0.10%	1.60%	2.00%
	N who have difficulties even using hearing aids	7	1	0	4	2
	% of those who use hearing aids	35.0%	50.0%	0.0%	50.0%	22.20%
Mobility Aids	N who use mobility aids	78	9	30	6	33
	% of the total age population	3.3%	1.30%	4.40%	1.20%	7.20%
	N who have difficulties even using mobility aids	51	7	23	1	20
	% of those who use mobility aids	65.4%	77.80%	76.70%	16.70%	60.60%

3.3 Access to Services

This section presents data related to access to various services, highlighting the difference between households with at least one member with disabilities (shown as households with disabilities) and households without any members with disabilities (shown as households without disabilities). Our sample is 506 households across study locations in Lebanon.

Only for the access to specialized services (3.3.7), the unit of analysis is not households but individuals: the study looks at 529 persons with disabilities aged 2 years and above.

3.3.1 UNHCR Registration

As discussed in Section 2, UNHCR registration for Syrian refugees in Lebanon was suspended in 2015. Our survey found that about 5% of households with disabilities were not registered, while the rate of non-registration was higher for households without disabilities at around 17%. It could be possible that households with persons with disabilities that were known before the crisis or at an earlier stage of the crisis were motivated to register for the status and associated services, while households without disabilities were less motivated, or, perhaps their movements back and forth from Syria led UNHCR to unregister them. Yet, some surveys suggest much higher rates of non-registered Syrian refugees in the country. For example, HI & HelpAge International (2014) found that 14.5% of the total survey sample was unregistered, while 77% was registered and the remainder was pending for registration. Another source estimated about 500,000 unregistered Syrians in comparison with 1,150,000 registered Syrians, indicating that 30% of total Syrians in the country could be unregistered (Daily Star, 2015). Koh (2017) cited a much higher rate of 40%.

Table 17: UNHCR Registration Status, by Disability and Location

	Households with disabilities		Households without disabilities	
	Registered	Not registered	Registered	Not registered
Bar Elias (N=284)	95.8%	4.2%	82.2%	17.8%
ITS (N=222)	93.4%	6.6%	84.7%	15.3%

3.3.2 Shelter: Accessibility, Electricity and Perceived Safety

Our survey found all households had a shelter/house.

Shelter accessibility

Table 18 on accessibility of shelter suggests that inaccessible housing conditions affect both households with and without disabilities, with slightly higher rates for households with disabilities: 45.8% vs 42.4% in Bar Elias and 49.6% vs 48.2% in ITS. Households with disabilities in ITS reported the highest level of accessibility issues (49.6%).

Table 18: Accessibility of Shelter/House, by Disability and Location

	Households with disabilities		Households without disabilities	
	Easy to move around	Not easy	Easy to move around	Not easy
Bar Elias (N=284)	54.2%	45.8%	57.6%	42.4%
ITS (N=222)	50.4%	49.6%	51.8%	48.2%

Electricity

Almost all households in the study reported high rates of access to stable electricity at around 98-99%, as shown in Table 19, with no major difference between households with and without disabilities.

Table 19: Access to Stable Electricity, by Disability and Location

	Households with disabilities		Households without disabilities	
	Stable	Not stable	Stable	Not stable
Bar Elias (N=284)	98.8%	1.2%	97.5%	2.5%
ITS (N=222)	97.8%	2.2%	98.8%	1.2%

Perceived safety

The research also explored whether households fear external factors (attack, harassment or arrest) and fear being harmed or injured in relation to their shelter (Table 20). The findings show that fears around shelter are a more prominent concern for households in ITS than in Bar Elias, and for households with disabilities, except for fear from external factors in Bar Elias. Fears of harm or injuries were particularly high for households with disabilities in ITS (65.0%). The study did not go deeper into exploring the specific safety hazards within shelters which may present threats to the household members. However, this consideration should be taken into account by the shelter sector and other service providers who are conducting household visits or assessing vulnerability.

Table 20: Safety Concerns around Shelter, by Disability and Location

Fear of attack, harassment or arrest around shelter				
	Households with disabilities		Households without disabilities	
	No fear	Have fear	No fear	Have fear
Bar Elias (N=284)	78.3%	21.7%	76.3%	23.7%
ITS (N=222)	61.3%	38.7%	71.8%	28.2%

Fear of harm or injuries around shelter				
	Households with disabilities		Households without disabilities	
	No fear	Have fear	No fear	Have fear
Bar Elias (N=284)	75.3%	24.7%	79.7%	20.3%
ITS (N=222)	35.0%	65.0%	51.8%	48.2%

3.3.3 Latrines: Availability, Accessibility and Perceived Safety

Latrine availability

Table 21 illustrates how Syrian refugees perceived availability of latrines. More families in ITS, especially those with members with disabilities, reported that latrines were not always available (13.9%) than in other location or than households without disabilities. As seen in the previous section, UNHCR, UNICEF & WFP (2017) found a better access to improved sanitation facilities among families with members with disabilities, at the rate of 85%, compared with 61% for general households. Our finding shows a different picture: less availability of latrines among households with disabilities.

Table 21: Availability of Latrines, by Disability and Location

	Households with disabilities		Households without disabilities	
	Available	Not always available	Available	Not always available
Bar Elias (N=284)	92.2%	7.8%	93.2%	6.8%
ITS (N=222)	86.1%	13.9%	90.6%	9.4%

Latrine accessibility

In terms of latrine inaccessibility (Table 22), responses were mixed. Households with disabilities in ITS reported the most restricted access to their latrines (17.5%), compared with 9.4% of households without disabilities. In Bar Elias, on the contrary, households without disabilities reported slightly higher rates of restricted access (11.0% vs 9.6%). Access challenges vary from one person to another, ranging from the width of the door, a slippery floor surface, the space inside to close the door and move around alone or together with caregivers, handrails to keep balance in different positions, the height of the water closet, and many other aspects (Groce, Bailey, Lang, Trani & Kett, 2011). Overall, persons in more than 1 in 10 households could be struggling to use toilets on a daily basis.

Table 22: Accessibility of Latrines, by Disability and Location

	Households with disabilities		Households without disabilities	
	Accessible	Not accessible	Accessible	Not accessible
Bar Elias (N=284)	90.4%	9.6%	89.0%	11.0%
ITS (N=222)	82.5%	17.5%	90.6%	9.4%

Section 3: Findings

Perceived safety

The question around fear of attack, harassment or arrest, as well as fear of harm or injuries when using latrines shows a large difference between the experiences of households in urban versus ITS contexts (Table 23). Households with disabilities in ITS reported the highest level of fear of attack, harassment or arrest (23.4%) and of harm/injuries (34.3%) when using latrines whilst rates among households with disabilities in Bar Elias were much lower, at 5.4% and 9.6% respectively. Since 49% of households in Baalbek-Hermel and 47% in Bekaa were sharing latrines (UNHCR, UNICEF & WFP, 2017), it is possible that public latrines (including those located outside the home) increase persons' perceived fears.

Table 23: Safety Concerns to Use Latrines, by Disability and Location

Fear of attack, harassment or arrest to use latrines				
	Households with disabilities		Households without disabilities	
	No fear	Have fear	No fear	Have fear
Bar Elias (N=284)	94.6%	5.4%	94.1%	5.9%
ITS (N=222)	76.6%	23.4%	84.7%	15.3%

Fear of harm or injuries to use latrines				
	Households with disabilities		Households without disabilities	
	No fear	Have fear	No fear	Have fear
Bar Elias (N=284)	90.4%	9.6%	86.4%	13.6%
ITS (N=222)	65.7%	34.3%	69.4%	30.6%

3.3.4 Water

The study asked if households "have enough safe water from reliable sources for drinking, cooking, cleaning and personal hygiene". Our survey found that overall, more than 90% of households considered they had access to water (Table 24), higher than 73% of households in Bekaa and 69% in Baalbek-Hermel according to the VASyR 2017 (see Section 2), except for households with disabilities in ITS. As with responses to the latrine, households with disabilities in ITS had the least access to water (21.9%). The study confirmed that households with disabilities are statistically less likely than households without disabilities to access safe water (P<0.01).

Table 24: Access to Enough Safe Water from Reliable Sources, by Disability and Location

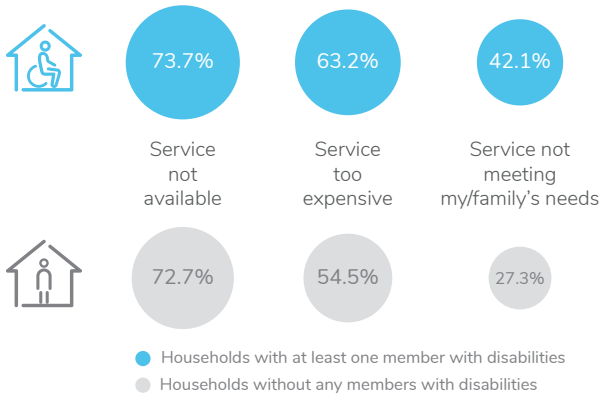
	Households with disabilities		Households without disabilities	
	Have access	No access	Have access	No access
Bar Elias (N=284)	95.2%	4.8%	97.5%	2.5%
ITS (N=222)	78.1%	21.9%	90.6%	9.4%

Households with member(s) with disabilities in Lebanon are significantly less likely to access safe water than households without any members with disabilities (P<0.01)

Barriers to Access Water

When asked about the reasons behind their lack of access to safe water, households with and without disabilities that reported no access to enough safe water cited the same top 3 concerns; lack of available services, costs, and "services [that do] not meet my/ my family's needs" (Figure 9).

Figure 9: Main Perceived Barriers to Access Safe Water, by Disability



Respondents' views on water unavailability could be around poor water quality and an insufficient amount, as noted by the desk review. Interviewees in our study echoed: "*water is not suitable for drinking*" and a "*lack of confidence in water source*" was also expressed. The expense of services may be related to the fact that, as noted in Section 2, a sizable number of families (34.4%) purchase bottled mineral water which affects families' expenditure.

Table 25 suggests that, in addition to the cost of water itself, the distance to the services and the issues concerning transportation are also the key barrier affecting families with disabilities access to water: e.g. distance to shared water tanks, to the shops where people buy bottled water, or to the humanitarian organizations who could help. Persons with difficulties walking would particularly find fetching water every day a challenge even within a short distance. Furthermore, 30% of households with disabilities in ITS stated lack of knowledge about available services as a barrier. Furthermore, although small in number, a total of 5 households in our sample cited lack of documents as a reason hindering their access to this needed service, indicating that their limited legal status might have affected the quality of their accommodation or access to cash assistance that would ensure purchasing or paying water bills.

Table 25: Main Perceived Barriers to Access Water, by Disability and Location

Multiple answers — Top barrier — Second barrier in each location

	Bar Elias				ITS				Lebanon total	
	N	%	N	%	N	%	N	%	%	%
Service not available	6	75.0%	2	66.7%	22	73.3%	6	75.0%	73.7%	72.7%
Service too expensive	6	75.0%	1	33.3%	18	60.0%	5	62.5%	63.2%	54.5%
Services far away and transportation not available	3	37.5%	0	0.0%	6	20.0%	1	12.5%	23.7%	9.1%
Services far away and transportation too expensive	2	25.0%	0	0.0%	9	30.0%	1	12.5%	28.9%	9.1%
Services do not meet my/ family's specific needs	5	62.5%	0	0.0%	11	36.7%	3	37.5%	42.1%	27.3%
I don't know where the services are	1	12.5%	0	0.0%	9	30.0%	2	25.0%	26.3%	18.2%
I don't have documents	1	12.5%	2	66.7%	2	6.7%	0	0.0%	7.9%	18.2%
Sample total	8		3		30		8		38	11

Priority Solutions to Increased Access to Water

In line with the above findings, increasing the availability and reducing the cost of water provision services are positioned as the main solutions. An additional solution, especially proposed by households with member(s) with disabilities in ITS, was for further information on available services.

3.3.5 Health

The study found that the majority of households had health needs in the last six months (Figure 10). The needs were stronger among households with at least one member with disabilities (81.5%) than households without members with disabilities (59.1%). The rates were almost equal in Bar Elias and ITS (see Table 26).

Figure 10 also demonstrates that, among these families who had medical needs, more households with disabilities had difficulties accessing health services at clinics or hospitals (17.4% vs 15.8%). This aligns with the existing data which reflects lower access to required health services amongst persons with disabilities (for example, Baroud, 2017).

By location, more households with disabilities in Bar Elias (21.3%) could not access needed medical services compared to their peers in ITS (12.6%) (Table 26). The study also found that in ITS, more households without disabilities (16.0%) could not access medical services when required, compared to 12.6% for households without disabilities.

During the workshop where the study findings were discussed, stakeholders in Lebanon discussed that the rates of access as outlined above seemed to be higher than in reality. There was a call for further data and investigation into what kind of health services these households were accessing to differentiate levels of access by type of health service, and also to find out more about access to health services at the individual rather than the household level.

Figure 10: Needs and Access to Health Services, by Disability

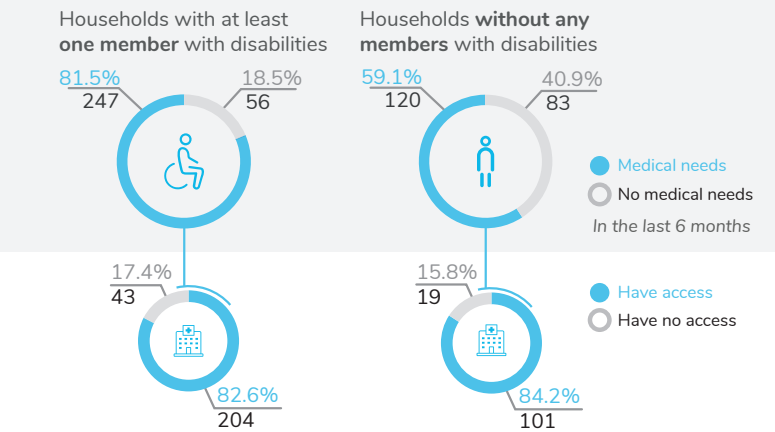


Table 26: Health Needs in the Last 6 Months and Access to Health Services when Needed, by Disability and Location

Health needs in the last 6 months				
	Households with disabilities		Households without disabilities	
	Yes	No	Yes	No
Bar Elias (N=284)	81.9%	18.1%	59.3%	40.7%
ITS (N=222)	81.0%	19.0%	58.8%	41.2%

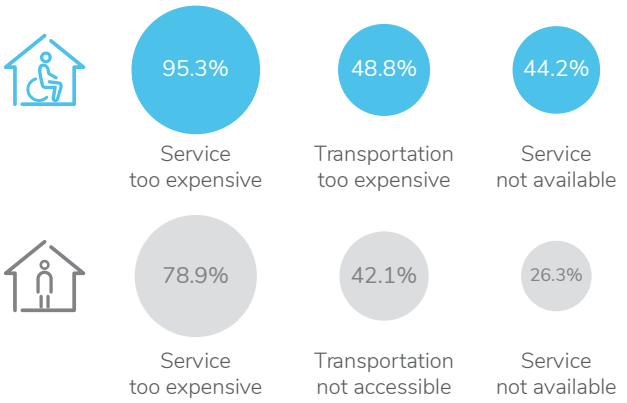
Access to health services when needed				
	Households with disabilities		Households without disabilities	
	Could access	Could not access	Could access	Could not access
Bar Elias (N=284)	78.7%	21.3%	84.3%	15.7%
ITS (N=222)	87.4%	12.6%	84.0%	16.0%

Barriers to Access Health Services

Households with and without disabilities that reported limited access to medical services raised the same top three barriers; cost of services, transportation related barrier, and unavailability of services (Figure 11).

The data disaggregated by locations (Table 27) present interesting trends.

Figure 11: Main Perceived Barriers to Access Health Services, by Disability



- First, all households in ITS complained that transportation to health services were not accessible, regardless of disability, while this factor was not perceived as a problem for refugees in Bar Elias. Further qualitative research would be useful in order to explore the specific accessibility issues experienced by households in relation to transport; it may be that the design of public buses is not accessible, stops are far away from neighbourhoods, or attitudes of the drivers were not accommodating.
- Second, despite subsidies for healthcare, perceived financial burden remains heavier for households with disabilities, combining costs of both services themselves and transportation to reach services. The finding that more households with disabilities were concerned by the cost for services and transportation across locations echoes the economic vulnerability of households with disabilities in relation to health costs found during the desk review.

Table 27: Main Perceived Barriers to Access Health Services, by Disability and Location

Multiple answers ● Top barrier ● Second barrier in each location

	Bar Elias				ITS				Lebanon total	
	N	%	N	%	N	%	N	%	%	%
Service not available	15	51.7%	3	27.3%	4	28.6%	2	25.0%	44.2%	26.3%
Service too expensive	28	96.6%	9	81.8%	13	92.9%	6	75.0%	95.3%	78.9%
Services far away and transportation not available	6	20.7%	1	9.1%	2	14.3%	1	12.5%	18.6%	10.5%
Services far away and transportation too expensive	13	44.8%	4	36.4%	8	57.1%	1	12.5%	48.8%	26.3%
Services far away and transportation not accessible	3	10.3%	0	0.0%	14	100.0%	8	100.0%	39.5%	42.1%
Staff are not supportive	6	20.7%	3	27.3%	3	21.4%	0	0.0%	20.9%	15.8%
Services do not meet my/ family's specific needs	6	20.7%	1	9.1%	5	35.7%	1	12.5%	25.6%	10.5%
I don't know where the services are	2	6.9%	1	9.1%	1	7.1%	2	25.0%	7.0%	15.8%
I don't have documents	3	10.3%	0	0.0%	0	0.0%	0	0.0%	7.0%	0.0%
Sample total	**29**		**11**		**14**		**8**		43	19

Section 3: Findings

Priority Solutions to Increased Access to Health Services

Perceived barriers directly link to respondents' suggestions for priority actions. Cost reduction of health services was raised as the top priority in both locations by all households, regardless of disabilities. Increased availability of services followed. Households with disabilities in ITS also suggested to reduce transportation costs: this was not particularly mentioned in Bar Elias but respondents might have concluded that health services related costs include transportation. Improvement in staff's attitudes and skills in health services was also raised. Interestingly, respondents in ITS did not insist to improve accessibility of transportation; perhaps they perceived this could not be a feasible solution to implement.

3.3.6 Food and Cash Assistance

The study asked questions in relation to households' access to food assistance from WFP and cash assistance or grants (e.g. from UNHCR). Households with disabilities reported higher levels of access to both food and cash assistance than households without disabilities in both locations (around 80% vs around 60% for food assistance, and 53% and around 43% for cash assistance). For food assistance in particular, households with disabilities are more likely to access the service than households without disabilities ($P<0.05$).

This finding indicates that vulnerability targeting criteria utilized by UNHCR and other service providers could be effectively reaching the most vulnerable households. It could also be a reflection of less households without disabilities being registered with UNHCR which is the prerequisite to accessing these humanitarian support programs.

Table 28: Access to Food and Cash Assistance

Access to food assistance				
	Households with disabilities		Households without disabilities	
	Have access	No access	Have access	No access
Bar Elias (N=284)	78.3%	21.7%	57.6%	42.4%
ITS (N=222)	85.4%	14.6%	65.9%	34.1%

Access to cash assistance				
	Households with disabilities		Households without disabilities	
	Have access	No access	Have access	No access
Bar Elias (N=284)	53.0%	47.0%	43.2%	56.8%
ITS (N=222)	53.3%	46.7%	42.4%	57.6%

Barriers to Access Food and Cash Assistance

When asked about the reasons behind refugees' lack of access to food and cash assistance, lack of documentation appeared as the main barrier hindering access to food assistance both for households with and without disabilities, followed by the availability of services (Table 29). For households with disabilities in ITS, unsupportive staff was raised as the second major barrier (30.0%). While the percentage is lower, in Bar Elias, more households with disabilities were also more concerned by unsupportive staff than households without disabilities (19.4% vs 16.0%). This could relate to staff who are responsible at the community level for disseminating information about food assistance services, and their attitudes or a lack of communication skills.

Table 29: Main Perceived Barriers to Access Food Assistance, by Disability and Location

Multiple answers ● Top barrier ● Second barrier in each location

	Bar Elias				ITS			
								
Food assistance	N	%	N	%	N	%	N	%
I don't know where the services are	5	13.9%	14	28.0%	5	25.0%	8	27.6%
I don't have documents	14	38.9%	20	40.0%	7	35.0%	11	37.9%
Service not available	12	33.3%	15	30.0%	4	20.0%	10	34.5%
Service too expensive	6	16.7%	7	14.0%	2	10.0%	2	6.9%
Services far away & transportation not available	7	19.4%	6	12.0%	3	15.0%	2	6.9%
Services far away & transportation too expensive	8	22.2%	4	8.0%	4	20.0%	4	13.8%
Services far away & transportation not accessible	6	16.7%	6	12.0%	4	20.0%	2	6.9%
Staff not supportive/ do not know how to communicate	7	19.4%	8	16.0%	6	30.0%	4	13.8%
Sample total	78		67		64		49	

As for cash assistance (Table 30), households with and without disabilities identified the lack of knowledge about services as the primary barrier, in both locations, and unavailability of services as the secondary reason, except for households with disabilities in ITS. These barriers may influence one another; the perceived lack of services may be strongly linked to lack of information or awareness on what services are available. In ITS, households with disabilities cited the cost of transportation as the second problem. Interestingly, households with disabilities in both locations seem to face more issues around transportation than households without disabilities. For example, 12.8% and 20.3% of households with disabilities in Bar Elias and ITS respectively cited inaccessible transportation, compared to 9.0% and 8.2% of households without disabilities in Bar Elias and ITS respectively. This suggests the importance of transportation for families with disabilities, particularly in the informal settings. Another issue that families with disabilities complained about is related to staff attitudes and communications, as also noted above.

Section 3: Findings

Table 30: Main Perceived Barriers to Access Cash Assistance, by Disability and Location

Multiple answers ● Top barrier ● Second barrier in each location

Cash assistance	Bar Elias				ITS			
	N	%	N	%	N	%	N	%
I don't know where the services are	40	51.3%	26	38.8%	34	53.1%	20	40.8%
I don't have documents	13	16.7%	19	28.4%	9	14.1%	11	22.4%
Service not available	27	34.6%	22	32.8%	13	20.3%	15	30.6%
Service too expensive	9	11.5%	6	9.0%	15	23.4%	5	10.2%
Services far away & transportation not available	10	12.8%	9	13.4%	15	23.4%	7	14.3%
Services far away & transportation too expensive	12	15.4%	6	9.0%	19	29.7%	9	18.4%
Services far away & transportation not accessible	10	12.8%	6	9.0%	13	20.3%	4	8.2%
Staff not supportive/ do not know how to communicate	13	16.7%	10	14.9%	15	23.4%	4	8.2%
Sample total	78		67		64		49	

Priority Solutions to Increased Access to Food and Cash Assistance

When asked about actions to be taken, Syrian families suggested common solutions in light of the perceived barriers explained above (Table 31). For food assistance, support to obtain required documents was requested most frequently by all households in both locations, while they proposed more information about services for cash assistance.

Although in ITS documentation was not mentioned as a major barrier to cash assistance, this clearly remains an issue for households who require support to access cash assistance. Furthermore, households with disabilities in both locations show higher needs for supportive staff with appropriate communication skills, compared to households without disabilities.

Table 31: Proposed Priority Solutions for Improved Access to Food and Cash Assistance, by Disability and Location

One answer only ● Top priority ● Second priority in each location

	Bar Elias		ITS	
Food assistance	%	%	%	%
Support to required documents	27.8%	34.0%	35.0%	34.5%
Availability of services	25.0%	16.0%	10.0%	13.8%
Supportive staff	13.9%	10.0%	25.0%	6.9%
Information about available services	16.7%	18.0%	20.0%	20.7%

Cash assistance	%	%	%	%
Information about available services	47.4%	26.9%	42.2%	24.5%
Support to required documents	12.8%	25.4%	42.2%	24.5%
Availability of services	17.9%	22.4%	3.1%	24.5%
Supportive staff	10.3%	9.0%	17.2%	6.1%

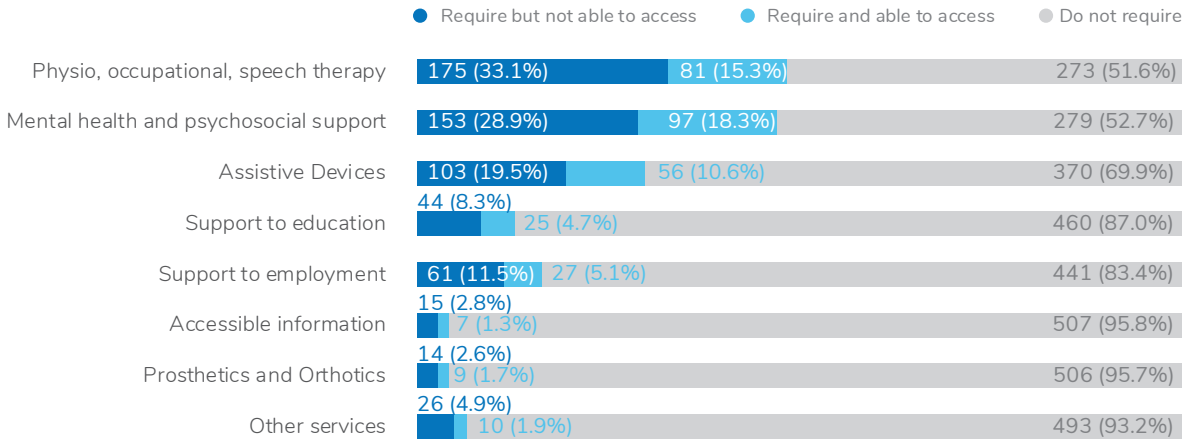
3.3.7 Specialized Services

Note: the unit of analysis in this section are individuals with disabilities aged 2 years and above

Persons with disabilities often require certain services, varying from prosthetics, orthotics, different assistive devices, and physiotherapy to adapted mainstream services such as MHPSS and support to education and employment. When the study asked what service(s) were required (N= 529 persons with disabilities) (Figure 12), 48.4% of respondents mentioned physio, occupational and speech therapies, followed by MHPSS (47.3%), assistive devices (30.1%), support to education (13.0%), support to employment (16.6%), accessible information (4.2%), and prosthetics and orthotics (4.3%). Respondents with disabilities also raised other services including various tests, treatments, surgeries and medications.

Section 3: Findings

Figure 12: Specialized Services by Needs and Access
Multiple answers



However, the study found that, despite needs, not all persons with disabilities could benefit from needed specialized services. Overall, 304 out of 529, amounting to **57.5% of persons with disabilities, were unable to access at least one specialized service despite their needs.**

Breaking this down by three major specialized services demanded by persons with disabilities (Table 32), 57.6%, 50.3% and 33.9% of persons with disabilities who cannot access specialized services required physio, occupational, speech therapies, MHPSS, and assistive devices, respectively. Looking at the data by age, various therapies were requested but could not be accessed by around 25% of people in the 5-50 age group. The needs for assistive devices come from about 20% in each age bracket from 5 years and above. **The demand for MHPSS is high among children aged 5-17 (41.8%) and young people aged 18-34 (30.7%),** then reduces as age increases. As discussed in the previous section, anxiety and depression are key domains that are prevalent among children aged 5-17 and persons aged 18 years and above. The data implies that there is limited MHPSS for the young generation. It would be worth reviewing the inclusiveness, age sensitiveness and coverage of ongoing MPHSS.

Table 32 also presents persons with disabilities' limited access to needed services, by location. Access to physio, occupational and speech therapies and assistive devices seem slightly more difficult to access in Bar Elias (58.4% and 36.0%); on the other hand, persons with disabilities in ITS struggle to receive MHPSS (55.9%).

Table 32: Key Specialized Services Needed but Not Accessible by Persons with Disabilities, by Age and Location

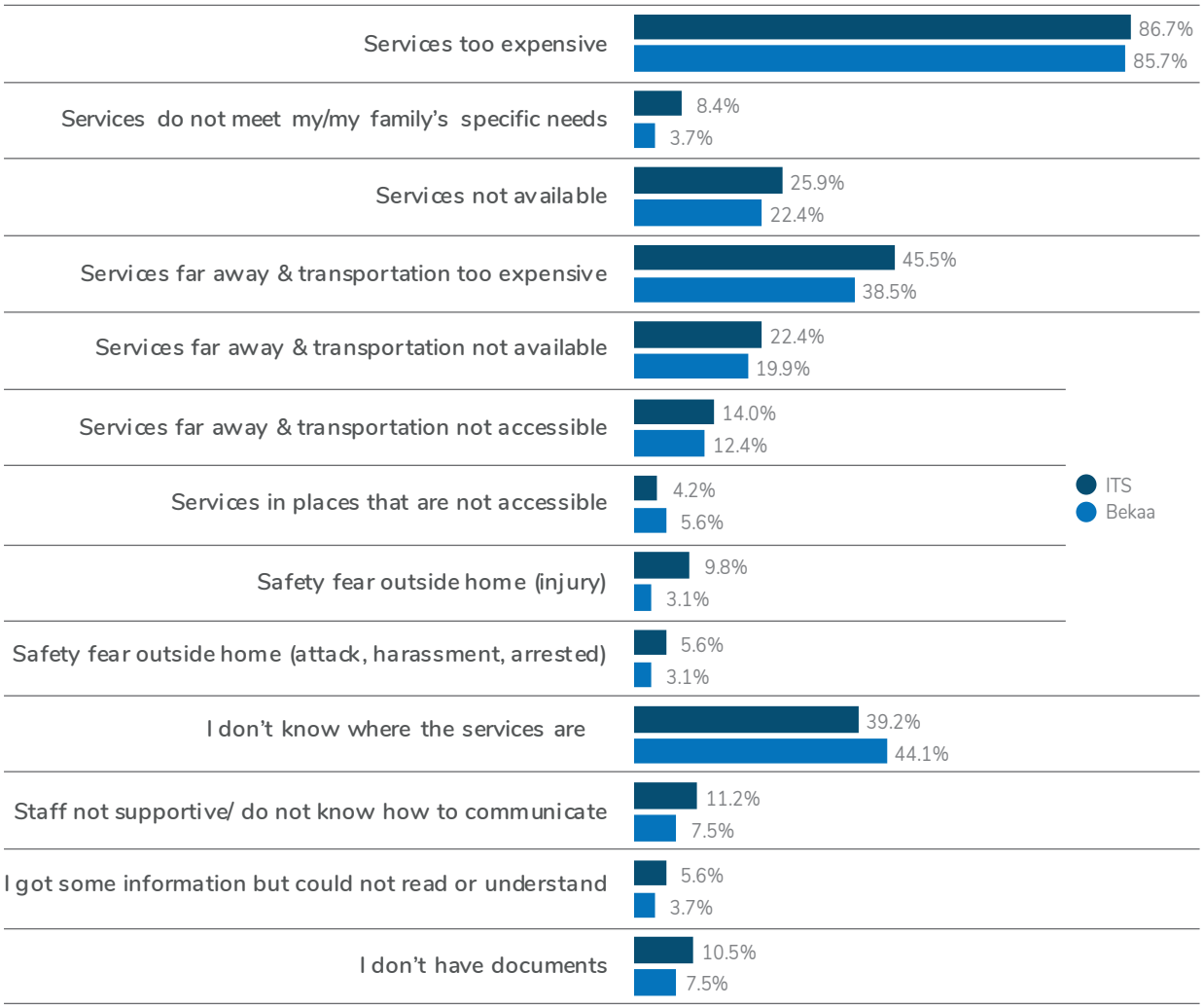
	Physio, occupational, speech therapy		MHPSS		Assistive Devices	
	N	%	N	%	N	%
2-4	6	3.4%	1	0.7%	2	1.9%
5-17	48	27.4%	64	41.8%	21	20.4%
18-34	46	26.3%	47	30.7%	21	20.4%
35-50	40	22.9%	27	17.6%	21	20.4%
51-64	20	11.4%	9	5.9%	18	17.5%
65+	15	8.6%	5	3.3%	20	19.4%
Total	175	57.6%	153	50.3%	103	33.9%
Bar Elias	94	58.4%	73	45.3%	58	36.0%
ITS	81	56.6%	80	55.9%	45	31.5%

Barriers to Access Specialized Services

Various barriers to access specialized services were cited by persons with disabilities who could not access required services. Although there are slight differences in terms of percentages, Figure 13 shows that the needs are quite similar in both locations. The most pressing barrier was the high cost of services (85.7% in Bar Elias and 86.7% in ITS), followed by the lack of knowledge about available services (44.1% vs 39.2%) as well as the cost of transportation (38.5% vs 45.5%). The study found a moderately higher percentage for limited information in Bar Elias, whilst in ITS, a higher percentage was reported for the issue of costly transportation.

Figure 13: Main Perceived Barriers to Specialized Services, by Location

Multiple answers

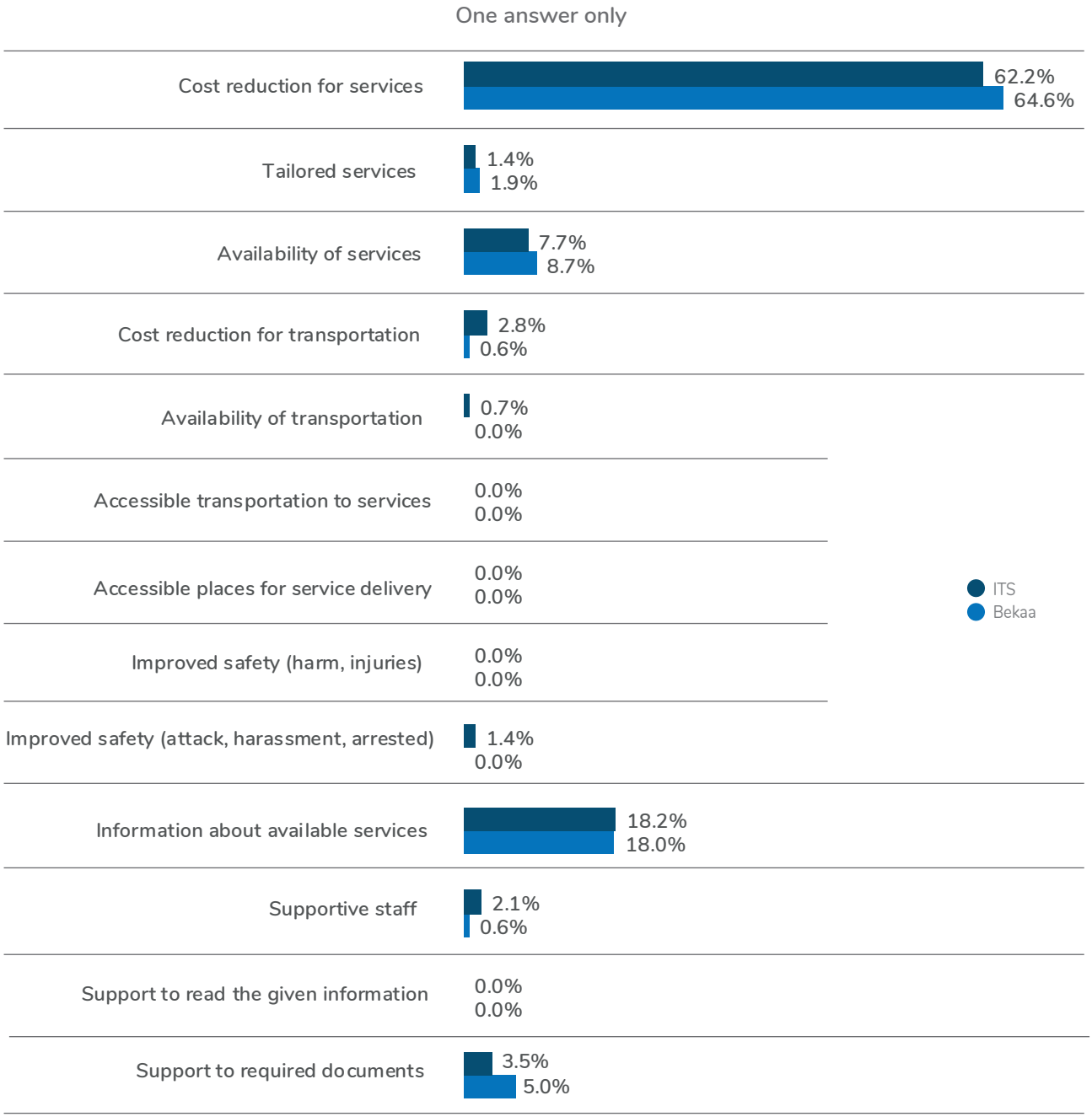


Section 3: Findings

Priority Solutions to Increased Access to Specialized Services

Respondents were further asked to choose only one issue to be solved as a priority (Figure 14). Their overall opinions corresponded to the perceived barriers above and there was no major difference between both locations: reducing the cost of services was most cited by 64.6% of people with disabilities in Bar Elias and by 62.2% in ITS. Sharing more information on available services (18.0% vs 18.2%) was also commonly a shared solution.

Figure 14: Proposed Priority Solutions for Increased Access to Specialized Services



3.4 Livelihood

3.4.1 Work Status

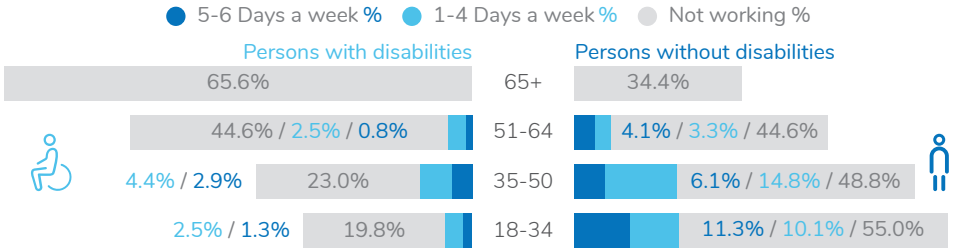
The survey found that 76.8%, or 873 among the 1,137 surveyed Syrian refugees aged 18+ in Lebanon were not working at the time of data collection (December 2017). When breaking this data down by disability, 85.0% of persons with disabilities (294 out of 346) were not working, compared to 73.2% of their peers with disabilities (579 out of 791). The study confirmed that **persons with disabilities are less likely to be working than persons without disabilities (P<0.05).**

85 0%
of persons with disabilities aged 18+ are not working

73.2%
of persons without disabilities aged 18+ are not working

Figure 15: Work Status of Persons Aged 18+, by Disability and Age

Note: The length of the bar in this chart is proportionate to the percentage of persons with and without disabilities in each age group. Percentages are shown as a proportion of persons with and without disabilities with each work status among the total population of each age group.



Key stakeholders in Lebanon shared the view that the reported percentage of persons working (23.2%) was low, arguing that persons who worked informally without UNHCR registration and/or a work permit might have not reported working due to fear of repercussions. In comparison, the VASyR 2017 showed the national level employment-to-population ratio at about 30% among Syrian refugees, meaning that the remaining 70% are either unemployed or not seeking jobs.

Work status by disability and age

Table 33 shows that the proportions of persons with disabilities that are not working are constantly higher than that of their peers without disabilities, across all age groups. The gap is particularly evident among the 18-34 years age bracket; 84.0% of persons with disabilities are not working, compared to 71.9% of persons without disabilities, with a 12.1 percentage point gap.

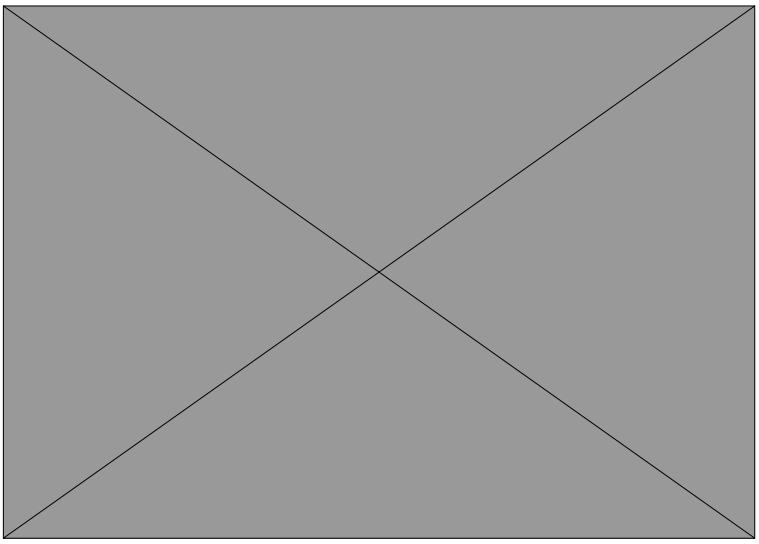
Table 33: Work Status of Persons Aged 18+, by Disability and Age

	Persons with disabilities				Persons without disabilities			
	Total	Not working	1-4 days	5-6 days	Total	Not working	1-4 days	5-6 days
18-34	**289**	218	13	58	**1,095**	804	83	208
		75.4%	4.5%	20.1%		73.4%	7.6%	19.0%
35-50	**333**	275	19	39	**555**	398	28	129
		82.6%	5.7%	11.7%		71.7%	5.0%	23.2%
51-64	**183**	164	0	19	**136**	113	5	18
		89.6%	0.0%	10.4%		83.1%	3.7%	13.2%
65+	**104**	102	1	1	**31**	31	0	3
		98.1%	1.0%	1.0%		91.2%	0.0%	8.8%

Section 3: Findings

When looking at employed persons, persons with disabilities aged 35-50 years showed a slightly higher rate of working for 5-6 days per week (9.6%) than persons without disabilities (8.8%). It is a positive finding that 294 persons with disabilities in our sample were indeed working. As Figure 16 shows, among persons with disabilities working, persons who experience difficulties with anxiety, depression and fatigue had higher chances of working (15.5%, 12.7% and 12.3% respectively) than persons with disabilities in other domains except for seeing (13.0%). This could be the reflection of the situation where persons with anxiety and depression would not necessarily require environmental modifications to work, compared to other impairments.

Figure 16: Percentage of Persons with Disabilities Aged 18 +, Working and Not Working, by Domains

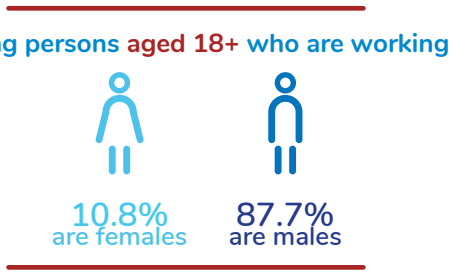


Work status by disability domains

The study found no person with difficulties with self-care who were working, and it is also less common for persons with difficulties with hearing, upper body functioning difficulty, communication, cognition and walking, to work. The statistical test suggests that persons with upper body functioning difficulty are less likely to work, compared to persons with disabilities in other domains (note that the sample for hearing was too small and included no one with self-care difficulties, so the statistical tests did not yield results for these two domains). As per the VASyR 2017, official engagement in work among Syrian refugees in Lebanon is limited to construction and agricultural labour which requires physical exertion. Hence, it is likely that refugees with upper body function issues are unable to access such opportunities.

Work status by disability and gender

The study further revealed limited chances for women to access remunerated work; among the sample aged 18 years and above (618 females and 519 males), only 4.7% of females were working, compared to 45.3% of males. Figure 17 shows the breakdown by disability, gender as well as by age. Furthermore, the study confirmed that males without disabilities aged over 18 were more likely to be working than other groups ($P<0.01$).



Overall, females constituted only 10.8% of the sample group aged 18 years and above who were working, with the remaining 87.7% were dominated by males, despite the female-to-male ratio of 54 to 46 for the sample of the same age bracket (18+).

The study from neighbouring Jordan found that, while women's responsibilities in the household as well as objections from the family are common reasons that prevent women from working, perceived lack of employment opportunities that meet women's preferences, conditions or educational backgrounds are equally significant factors (UN Women, 2017). The same study claimed that in fact, 57% of women wanted to work if they had appropriate opportunities, and this could be the same for females in Lebanon. On a further note, regarding house chores that are assumed to be

under the responsibility of women, the stakeholders consulted during our study emphasized the need for increased information about caregivers, in order to capture their 'unpaid work' of caring for family members with disabilities which could lead to their limited chance to engage in paid work outside home.

Further looking through the lens of gender and disability, the study found that 27.5% of males with disabilities aged 18 and above were working, compared to 76.0% of their male peers without disabilities. Similarly, 4.3% of females with disabilities and 7.9% of females without disabilities were working. **Gender and disability are the two factors that decrease chance and opportunities for women to access work.**

Figure 17: Persons with and without Disabilities Who Are Working, by Age and Gender

	5-17		18-50		51+	
	Female	Male	Female	Male	Female	Male
Number of persons working	5	43	27	224	2	11
With disabilities + without disabilities	(1+4)	(8+35)	(7+20)	(41+183)	(1+1)	(3+8)
Total population	463	460	520	435	98	84
With disabilities + without disabilities	(66+397)	(101+359)	(132+388)	(116+319)	(54+44)	(44+40)

Child labour

In order to gain an insight into trends around children and work, the study sample included children aged 5-17 years. Among the full sample of children aged 5-17 in Lebanon (N=923), **5.2% of children were working** (N=48). While stakeholders in Lebanon felt this rate as being too low, the evidence from the VASyR (2017) also identified a similar rate: among Syrian refugee children, 4.8% reported working. Children working (N=48) represents 15.4% of the total sample of 312 persons who are aged 5 years or older and working (Figure 18).

5.2%

of children aged 5-17 years are working

Figure 18: Age Distribution of Persons Aged 5+ Who Are Working

Section 3: Findings

Our study further assessed that, among the children identified as working, 18.8% had disabilities (N=9, Table 34). Furthermore, the risk of child labour seems to be equal for both children with and without disabilities: 5.4% of children with disabilities and 5.1% of children without disabilities were found working in the study sample.

When looking at the frequency of work, more than half the sample worked 1-4 days per week (29 children, or 60.4%), while 19 children (39.6%) reported to be working 5-6 days a week.

Table 34: Work Status of Children Aged 5-17, by Disability

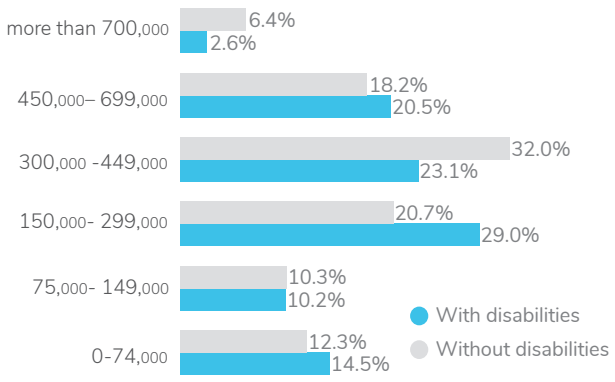
Children with disabilities				Children without disabilities			
Total	Not working	1-4 days	5-6 days	**Total**	Not working	1-4 days	5-6 days
167	158	6	3	**756**	717	23	16
	94.6%	3.6%	1.8%		94.8%	3.0%	2.1%

In terms of location, Bar Elias hosts 56.3% of working children found within the sample (N=27/48) whilst 43.8% were found in ITS (N = 21/48). Furthermore, almost half of the children working in Bar Elias (N=13) were working 5-6 days per week, whereas in ITS, the rate was lower (28.6%) (N=6). Children in the urban setting of Bar Elias could be more vulnerable to the risk of child labour.

3.4.2 Household Income

The study explored households' level of income, asking households to classify their 'total cash income in the last month.' As the enumerators did not specify further, it is possible that households understood "total cash income" in different ways; for example, some might have considered cash assistance as cash income, whereas others considered only income from enumerated work as cash income.

Figure 19: Household Income Level (LBP), by Disability



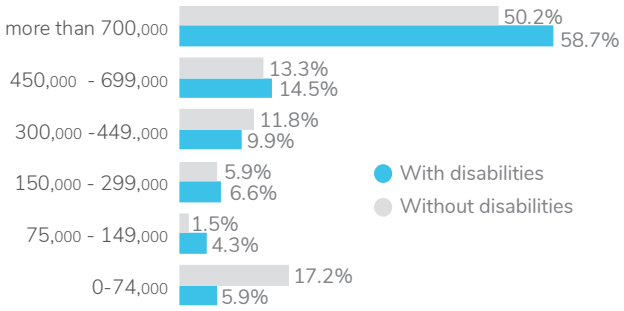
As shown in Figure 19, the most common reported monthly income bracket for households with disabilities was 150,000-299,000 LBP (29.0%), roughly equating to 100-200 USD. On the other hand, the majority of households without disabilities (32.0%) reported the income of 300,000-449,000 LBP a month, roughly between 200-300 USD. A high income of over 700,000 LBP is more reported by households without disabilities (6.4%) than households with disabilities (2.6%). This suggests the exacerbated economic situation of families with disabilities, considering the multiple expenses incurred with medical costs and additional transportation costs for specialized services, on top of all other basic needs such as rent, food, water, electricity, debt repayment, etc.

3.4.3. Household Debt

Households were also asked about the 'total debt accumulated since [their] arrival in the country'. The study found overall high debt levels for both households with and without disabilities over 700,000 LBP (approx. 460 USD). This said, 58.7% of households with disabilities had this level of debt compared to 50.2% for households without disabilities. In addition, more households without disabilities reported the lowest debt level of 0-74,000 LBP (17.2%) than households with disabilities (5.9%). Building upon the existing literature, the finding confirms that the disproportionate levels of high debt for households with disabilities probably link to higher levels of expenditures.

Discussions with stakeholders during the study suggested several follow up topics for exploration; such as the breakdown of the debt itself. For example, how do households perceive their debt; is it manageable or too high? How do they pay it off? What type of debt do they owe and to whom? More information on these topics will enable a greater analysis on how to best support households who have high levels of debt.

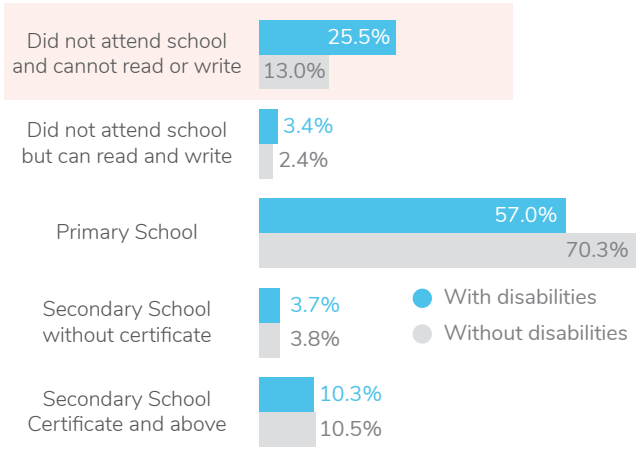
Figure 20: Household Income Level (LBP), by Disability



3.5 Education

The study placed a particular focus on education for children of primary school age, considering the extreme lack of disability disaggregated information at the school level. This section first provides findings about the education level of surveyed persons aged 13 years and above, then explores the educational situation of children aged 6-12, in terms of enrolment, experiences in schools, barriers and priority solutions. It also discusses caregivers' perceptions on inclusive education. The data are disaggregated by disability as well as by location, gender and age as relevant.

Figure 21: Education Attainment of Persons Aged 13+, by Disability



3.5.1 Education Attainment: Persons Aged 13 Years and Above

The quantitative survey found that 25.5% of persons with disabilities in Lebanon never enrolled in school and cannot read or write, compared to 13.0% among persons without disabilities. Statistical tests confirmed that **Syrian refugees with disabilities are more likely to have never enrolled in school and to be illiterate than persons without disabilities (P<0.05).**

Persons with disabilities are more likely to never enroll and cannot read or write (P<0.05)

Section 3: Findings

Disaggregation by location highlights that non-enrolment and illiteracy were more common among persons with and without disabilities in ITS than in Bar Elias (Figure 22). In each location, persons with disabilities reported almost double the rate of illiteracy than persons without disabilities; 22.5% in Bar Elias and 28.9% in ITS, compared with 11.2% and 16.0% of peers without disabilities.

Furthermore, reported rates of persons with disabilities who had completed primary school were lower than that of their peers without disabilities: 58.8% vs 70.2% in Bar Elias and 54.9% vs 70.4% in ITS.

Figure 22: Education Attainment of Persons Aged 13 +, by Disability and Location

Further analysis of persons who never enrolled and cannot read and write, by disability, age and gender, illustrates some trends (Table 35).

- First, across all age groups, persons with disabilities have higher non-enrolment/illiteracy rates than their peers without disabilities. The largest gap is in the 51-64 age bracket, in which 43.1% of persons with disabilities never attended school and cannot read or write, compared to 28.6% among their peers without disabilities.
- Second, more persons in the older generation lost the opportunity to learn. More than half of the persons aged 65 years and above were not able to read or write (52.4% of persons without disabilities and 60.0% of persons with disabilities). Before the crisis, the education system in Syria was quite developed with a high enrolment rate (Al Hessan, 2016), but elderly people did not seem to have benefited from this system.
- Third, the gender gap is striking. Non-enrolment/illiteracy rates among females without disabilities are nearly double that of their male peers (65.0% compared to 35.0%). The percentage for females with disabilities (71.9%) is 2.5 times higher than males with disabilities (28.1%). The older women are much more likely than the older men to be illiterate or to have never gone to school.

Table 35: Number and Percentage of Persons Aged13+ who Never Enrolled in School and Cannot Read and Write, by Disability, Age and Gender

	13-17	18-34	35-50	51-64	65+	Total	Gender balance
Without disabilities	9	47	38	18	11	**123**	
	5.7%	10.1%	15.8%	28.6%	52.4%		
Male	5	19	12	2	5	**43**	35.0%
Female	4	28	26	16	6	**80**	65.0%
With disabilities	5	24	18	25	24	**96**	
	16.1%	16.7%	17.3%	43.1%	60.0%		
Male	2	10	5	3	7	**27**	28.1%
Female	3	14	13	22	17	**69**	71.9%

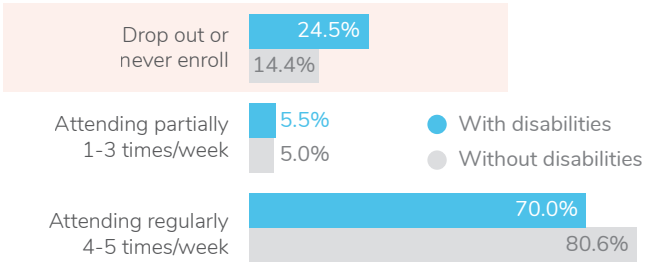
3.5.2 Education: Children Aged 6-12 Years

Enrolment

The study found a very high regular attendance rate among 574 children with and without disabilities surveyed (70.0% and 80.6% respectively) (Figure 23). Continuous efforts by the MEHE and stakeholders could explain this result. However, these enrolment rates are higher compared to other existing data. For example (see Section 2), UNHCR, UNICEF & WFP (2017) reported that 47% children with disabilities and 70% children without disabilities were enrolled in school. The reason behind the high enrolment rate in our study needs further investigation. Nevertheless, a statistical test confirmed that **children with disabilities are less likely to be attending school than children without disabilities** (P<0.05).

Figure 23 also illustrates that 24.5% of children with disabilities (27 out of 110) and 14.4% of children without disabilities (67 out of 464) never enrolled in, or, enrolled but subsequently dropped-out of school. Statistically, children with disabilities are more likely to never enrol in or to drop-out of school than children without disabilities (P<0.05). Reasons for non-enrolment are discussed in detail below.

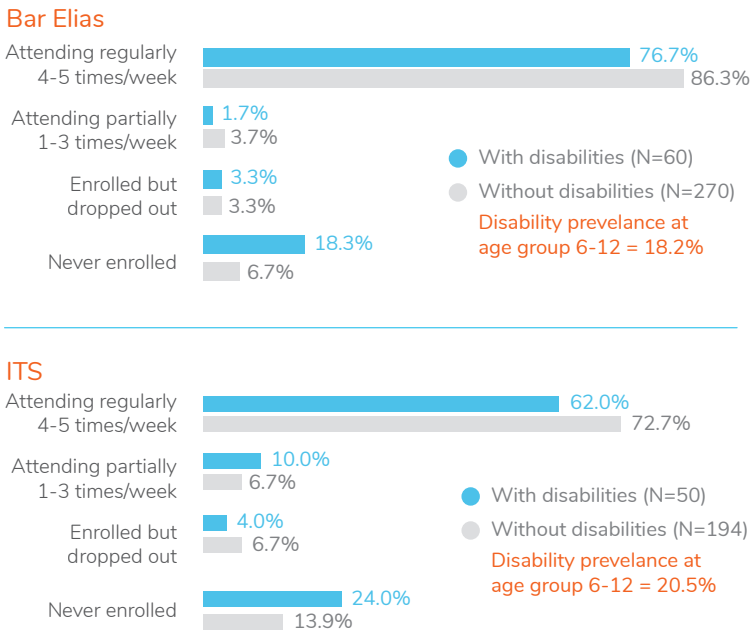
Figure 23: Enrolment of Children Aged 6-12 Years, by Disability



Enrolment by location

In Bar Elias, a total of 21.6% of children with disabilities either never enrolled or enrolled but dropped-out of school, compared to 10.0% of children without disabilities (Figure 24). However, the majority of children reported attending education regularly 4-5 times per week, although the rate was lower for children with disabilities (76.7% vs 86.3%). In ITS, 24.0% of children with disabilities never enrolled compared to 13.9% of their peers without disabilities. The rates of regular attendance also show that children with disabilities are more disadvantaged than children without disabilities (62.0% vs 72.7%). It is interesting to see that, in ITS, more children without disabilities experienced drop-outs than their peers with disabilities (6.7% vs 4.0%).

Figure 24: Enrolment of Children Aged 6-12 Years, by Disability and Location



Section 3: Findings

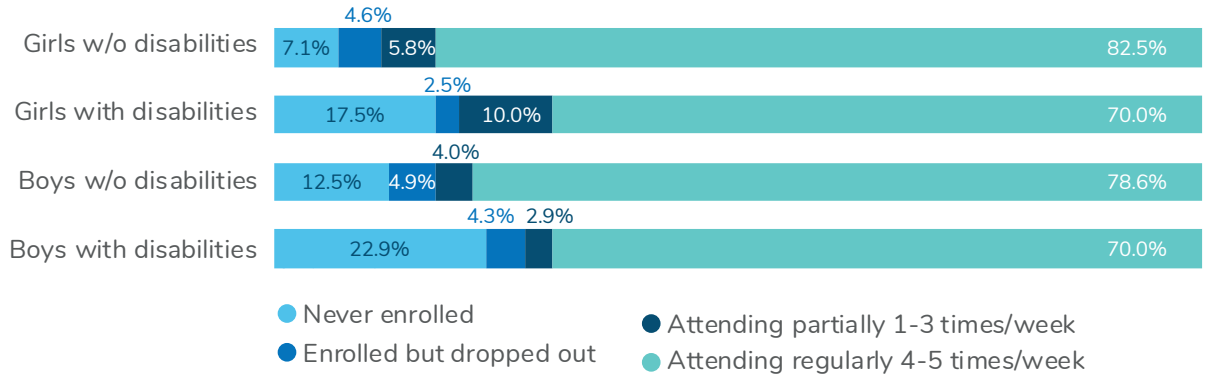
Enrolment by gender

Further analysis of enrolment by disability and gender shows that **boys with disabilities are most likely to never enrol in school and least likely to attend education regularly (P<0.05).** As in Figure 25, 22.9% of boys with disabilities never enrolled in schools. Girls with disabilities reported the highest rate for irregular attendance (1-3 times a week) at 10.0%, although the non-enrolment rate was lower than for boys with disabilities (17.5% - still one in five girls with disabilities never enrolled in or dropped-out of school). As a result, 70% of both girls and boys with disabilities attend school regularly, compared to 82.5% of girls without disabilities and 78.6% of boys without disabilities.

Boys with disabilities are most likely to never enroll

The factors behind low enrolment among Syrian boys and girls with disabilities need further investigation. Nevertheless, the desk review and consultations with stakeholders indicate that higher risks of child labour and more exposure to bullying could be partly contributing to their limited opportunities for education.

Figure 25: Enrolment of Children Aged 6-12 Years, by Disability and Gender



Looking at the data by location (Table 36), boys with disabilities in ITS were the most vulnerable educationally among all children in the study sample. While 30.3% of boys with disabilities in ITS either dropped-out of or never enrolled in school, the rate is only 7.6% for girls without disabilities in Bar Elias.

Table 36: Out-of-School Children, by Disability, Location and Gender

	Bar Elias		ITS	
	Girls	Boys	Girls	Boys
Without disabilities	7.6%	12.8%	17.9%	23.2%
With disabilities	17.4%	24.3%	23.5%	30.3%

Type of education[10]

Among children currently or previously attending schools, formal education was the most common type of education, reported by 65.0% of caregivers of children in the sample. Following this, informal education was attended by 29.2% of children and non-formal education by 5.7% of children. It is important to note that, despite enumerators' explanation about the types of education, caregivers' understanding could vary. During the consultation, stakeholders from the humanitarian community argued that parents or caregivers were often not aware about the various definitions of education and which types were attended by their children. Often, they knew the name of the organization providing education but not the classification of formal, non-formal or informal education.

[10] The study defined the type of education as below:
Formal education: Structured learning with the formal curriculum, with an MEHE certificate obtained upon completion.
Non-formal education: less structured and may or may not be guided by the formal curriculum, and an MEHE certificate is obtained upon completion.
Informal education: less structured uncertified learning support activities conducted at the community level, including psychosocial support, life skill activities, etc. No MEHE certificate.

Figure 26: Type of Education

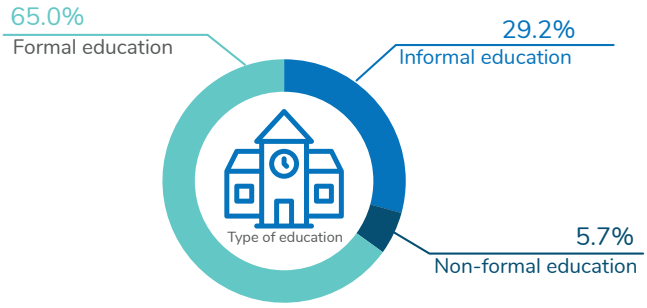
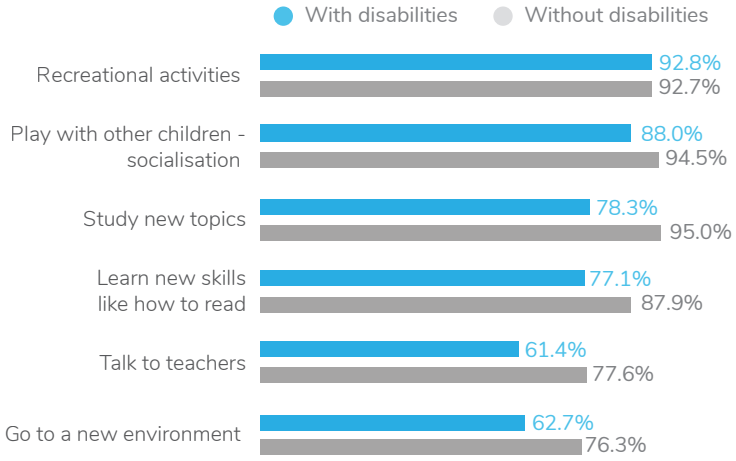


Figure 27: School Activities Enjoyed by Children in Schools, by Disability



More children are attending formal education in Bar Elias (70.1%) than in ITS (57.6%), and slightly higher rates of children without disabilities are attending formal school (65.6%) compared to children with disabilities (62.1%).

The study found, within the sample of children aged 6-12 years, that no children with disabilities attend special schools. As the study will present below, 71.9% of surveyed caregivers thought that children with disabilities could learn better in special schools. While caregivers shared a belief that special schools would provide better quality education than mainstream schools, this is not based on special schools' actual experience. Their belief in special schools could rather be a reflection of their dissatisfaction with the quality of regular schools as illustrated in Section 2.

Experiences by Children Attending School

Figure 27 shows the aspects of school which children with and without disabilities who were attending schools enjoyed (currently, or previously for those dropped-out). Unsurprisingly, children liked fun activities such as sports, games, singing and dancing, and playing with their peers, while they did not rate studying and talking to teachers as highly, in terms of enjoyment. Overall, children with disabilities report lower rates of enjoyment across all school activities, with the exception of recreational activities.

The largest gap is around "study new topics"; 95.0% of children without disabilities reported enjoying this aspect, compared to 78.3% of children with disabilities, at a 16.7% point gap. This poses a question about teachers' capacity to identify children's specific learning needs, some of which could be related to their disabilities, as well as to provide appropriate personalized educational support using tailored learning materials within mainstream school settings. As mentioned in the Section 1, the MEHE promotes inclusive education as a concept and a new initiative Inclusive School Pilot Project is ongoing. However, in reality, classroom environments seem to be overwhelmingly inaccessible and are not at all inclusive for children with disabilities (see for example Human Rights Watch, 2018[11]). Furthermore, the difference among children stating that they are happy to "talk to teachers" is also significant (77.6% vs 61.4% with a 16.2 percentage gap), suggesting the need for improved teachers' attitudes and communication skills towards children with disabilities.

[11] Although this research did not explore experiences of Syrian refugees with disabilities, it illustrates in full details challenges that Lebanese children with disabilities face which could be to some extent similar to Syrian children with disabilities in the same country.

Section 3: Findings

Barriers for Children Attending School

The sample is 480 children, including 83 children with disabilities and 397 children without disabilities.

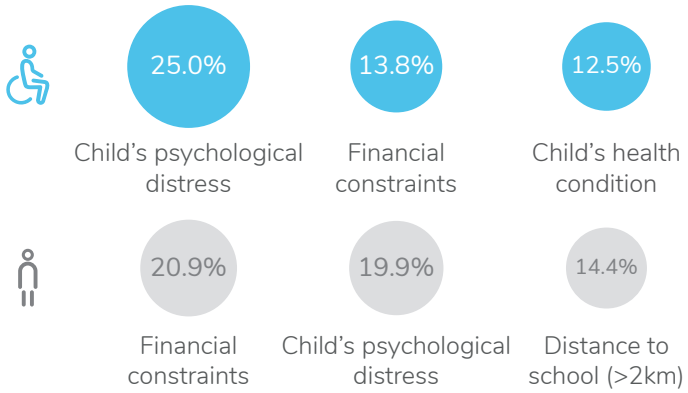
Available evidence showed a number of reasons that keep children out of school (See Section 2). Our study also explored the factors that put children at risk of dropping-out of school, through a disability perspective by asking caregivers to present three barriers in order of priority.

Children with disabilities: 25.0% of caregivers of children with disabilities cited children's psychological distress as the first priority of concern, threatening the child's ability to continue learning – interestingly more than functional difficulties themselves (11.3%), health conditions (12.5%), or financial constraints (see below) (Figure 28 and Table 37). Children's psychosocial conditions were mentioned for girls and boys with disabilities, in both Bar Elias and ITS (Table 38). According to key stakeholders in Lebanon, there is a gap in the availability and coverage of MHPSS programing, and the demand far outweighs the supply of services. This finding suggests a clear priority for humanitarian actors in Lebanon to strengthen MHPSS services in close relationship with the education sector.

Caregivers of children with disabilities were also worried about financial constraints (13.8%, Figure 28): this was the second most frequently cited issue as the top priority, and also repeatedly mentioned as a 2nd and 3rd priority (Table 37). Table 37 also indicates that caregivers' concerns focused more on children's conditions, their interactions with peers and teachers, and access issues (e.g. distance, costs), but not yet on the quality of education (e.g. learning materials, support for learning, limited time for learning).

Children without disabilities: the financial issue came at the top of the first priority, cited by 20.9% of caregivers (Figure 28). The study further found that psychological distress was a concern for children without disabilities (19.9%) and not just children with disabilities. Caregivers of children without disabilities also complained about the distance to school, which was most frequently raised as the 2nd and 3rd priority (Table 37). Looking at the issue of distance by gender and location (Table 38), both boys and girls were affected in urban and ITS settings. It would be worth examining this in relation to the safety fears outside home, which constantly worry approximately 10% of caregivers of children without disabilities. Bullying from Syrian or Lebanese children was not elicited as the most pressing issue, but it emerged when the study asked caregivers the 2nd and 3rd priority (Table 37).

Figure 28: Three Major Perceived Barriers Mentioned as the 1st Priority to Education for Children in School, by Disability



Note: first to third frequently raised barrier as the 1st prioritized barrier

Table 37: 1st, 2nd and 3rd Major Perceived Barriers Children Face in School, by Disability

First Second Third for each column for children without disabilities

First Second Third for each column for children with disabilities

	Children without disabilities				Children with disabilities			
Barriers	1st	%	2nd	3rd	1st	%	2nd	3rd
Bullying, nicknaming, intimidation & violence from Syrian peers	15	3.9%	35	39	3	3.8%	4	12
Bullying, nicknaming, intimidation & violence from children from host communities	10	2.6%	11	13	2	2.5%	3	3
Child's functional difficulties affect learning	6	1.6%	10	21	9	11.3%	6	6
Child's health condition reduce attendance or ability to participate learning	35	9.2%	56	14	10	12.5%	11	4
Child's psychological distress which significantly affects their ability to learn	76	19.9%	22	11	20	25.0%	7	1
Distance to school (>2km)	55	14.4%	90	65	9	11.3%	8	8
Financial constraints (fees, transport, materials)	80	20.9%	54	35	11	13.8%	17	10
Inaccessible classrooms	0	0.0%	0	2	1	1.3%	1	1
Inaccessible toilets	2	0.5%	2	4	1	1.3%	1	1
Not learning or progressing due to poor quality of teaching	6	1.6%	3	3	2	2.5%	1	1
Not learning or progressing due to poor quality of learning materials	0	0.0%	0	0	0	0.0%	0	0
Not learning or progressing due to inappropriate school time	0	0.0%	0	0	0	0.0%	0	0
Not learning or progressing due to lack of accessible learning materials	0	0.0%	0	0	0	0.0%	0	0
Not learning or progressing due to limited learning time at school/ in learning spaces	11	2.9%	6	10	0	0.0%	1	0
Not learning or progressing due to lack of personalized support for my child's learning (e.g. support teacher, sign language interpreter)	0	0.0%	2	1	2	2.5%	0	2
Overcrowded classrooms	2	0.5%	15	25	1	1.3%	4	3
Physical and/or verbal abuse from teachers/staff	11	2.9%	6	15	3	3.8%	4	5
Safety fears for movement outside home	45	11.8%	26	45	2	2.5%	5	5
School time not appropriate	16	4.2%	23	29	3	3.8%	2	5
Teacher/staff do not care about my child	6	1.6%	6	25	1	1.3%	3	5
Toilets not clean and safe	5	1.3%	9	12	0	0.0%	1	5
Other**	1	0.3%	6	13	0	0.0%	1	3
Total	382	100%	382	382	80	100%	80	80
Not applicable (no difficulties)	15		15	15	3		3	3
Sample total	397		397	397	83		83	83

** Other responses include: the school is not recognized in Syria (N=2), the child will come back home too late, and the child has Down Syndrome

Section 3: Findings

Table 38: Top Rated Perceived Barrier as the 1st, 2nd and 3rd Priority for Children in School, by Location, Gender and Disability

	Bar Elias	ITS
Girls with disabilities	(total sample =19) 1. *Psychological distress (N=6, 31.6%)* 2. *Financial constraints (N=5, 26.3%)* 3. *Bullying from Syrian peers (N=5, 26.3%)*	(total sample =13) 1. Psychological distress (N=4, 30.8%) 2. Distance to school (N=3, 23.1%) 3. Bullying from Syrian peers (N=2, 15.4%)
Boys with disabilities	(total sample =25) 1. *Psychological distress (N=7, 28.0%) Financial constraints (N=7, 28.0%* 2. *Financial constraints (N=7, 28.0%)* 3. *Distance to school (N=4, 16.0%)*	(total sample =23) 1. Functional difficulties (N=6, 26.1%) 2. Psychological distress (N=4, 17.4%) 3. Financial constraints (N=4, 17.4%)
Girls without disabilities	(total sample =128) 1. Financial constraints (N=36, 28.1%) 2. Distance to school (N=28, 21.9%) 3. Distance to school (N=24, 18.7%)	(total sample =76) 1. Psychological distress (N=22, 28.9%) 2. Distance to school (N=19, 25.0%) 3. Distance to school (N=13, 17.1%)
Boys without disabilities	(total sample= 104) 1. Psychological distress (N=22, 21.2%) 2. Distance to school (N=22, 21.2%) 3. Distance to school (N=16, 15.4%)	(total sample= 74) 1. Financial constraints (N=15, 20.3%) 2. Distance to school (N=21, 28.4%) 3. Bullying from Syrian peers (N=15, 20.3%)

Note: the same barriers could be mentioned more than once if they were most frequently cited as the first, second or third major concern by different caregivers. Children who said “no difficulties” (N=18) were excluded from the calculation of percentages. “Others” is not ranked.

Barriers for Children who Dropped-Out of or Never Attended School

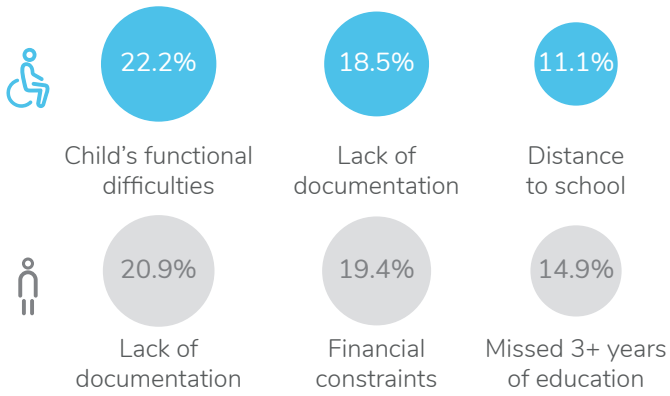
The sample for out-of-school children is 94 including 27 children with disabilities and 67 children without disabilities.

Children with disabilities: 22.2% of caregivers of children with disabilities mentioned children's functional difficulties themselves (such as difficulty seeing, hearing, communicating etc.) as the top concern (Figure 29 and Table 39). This implies two perspectives of caregivers, to be examined further. Firstly, caregivers' negative assumptions that it is not worth taking children with disabilities to schools as children would not benefit from schools which lack staff capacities to effectively support children whose disabilities might affect their learning as well as material resources (analyzed in more detail below). Secondly, their actual experiences of having their children being denied despite their efforts. Table 39 indicates that three to six caregivers out of 27 reported each time that their children with disabilities were refused enrolment in general or due to functional difficulties in particular. Table 40 also shows that two boys with disabilities in ITS were denied enrolment. Refused entry could also be related to the lack of documentation, which was ranked second for the 1st issue of priority (18.5%), despite the fact that officially, no documents are required for Syrian refugee children to enrol. Another issue that children with disabilities face was distance to school (11.1%).

As observed above, the barriers that boys with disabilities face in ITS are critical since they are the most educationally excluded group across the entire study sample. However, the barriers raised by their caregivers were diverse and no clear common issue came up (Table 40). This suggests the need for personalized interventions.

Children without disabilities: the lack of documentation also affects children without disabilities (20.9%), which was repeatedly raised as a barrier to education (Figure 29 and Table 39) in both Bar Elias and ITS (Table 40). Other concerns include financial constraints (19.4%) and missing three or more years of education (14.9%). More boys without disabilities in ITS cited the fact that they have missed three or more years of education as the reason for non-enrolment (Table 40). Once boys become older than the official school age, they feel embarrassed to study with younger peers.

Figure 29: Three Major Perceived Barriers Mentioned as the 1st Priority to Education for Out-of-school children, by Disability



Note: first to third frequently raised barrier as the 1st prioritized barrier

Section 3: Findings

Table 39: 1st, 2nd and 3rd Major Perceived Barriers that Out-of-School Children Face, by Disability

First Second Third for each column for children without disabilities

First Second Third for each column for children with disabilities

Barriers The same list for children attending school plus barriers marked * added especially for out-of-school children	Children without disabilities				Children with disabilities			
	1st	%	2nd	3rd	1st	%	2nd	3rd
Bullying, nicknaming, intimidation & violence from Syrian peers	0		0	0	1		0	1
Bullying, nicknaming, intimidation & violence from children from host communities	1		0	0	0		0	0
Child marriage/engagement*	0		0	0	0		0	0
Child's functional difficulties affect learning	0		1	1	6	22.2%	3	4
Child's health condition reduce attendance or ability to participate learning	0		0	0	0		3	2
Child's psychological distress which significantly affects their ability to learn	0		0	0	0		1	0
Distance to school (>2km)	6		5	5	3	11.1%	1	1
Education not important*	0		1	0	0		0	0
Fears for non-completion of primary education or non-continuation to secondary/further education with valid certificate, despite investment*	0		2	0	0		1	0
Fears of community stigma due to enrolling a child with disability in school (for child and family)*	0		0	0	2		0	0
Financial constraints (fees, transport, materials)	13	19.4%	26	22	0		4	3
Helping with house chores *	0		0	0	0		0	0
Helping with economic activities for the household *	2		1	2	1		1	1
Inaccessible classrooms	0		0	0	0		2	1
Inaccessible toilets	0		0	0	0		0	0
Lack of documentation *	14	20.9%	6	8	5	18.5%	2	3
Missed 3 or more years of education *	10	14.9%	2	1	2		2	0
Not learning or progressing due to poor quality of teaching	1		1	0	0		0	0
Not learning or progressing due to poor quality of learning materials	0		1	0	0		0	0
Not learning or progressing due to inappropriate school time	0		1	1	0		0	1
Not learning or progressing due to lack of accessible learning materials	0		0	2	0		0	1
Not learning or progression due to limited learning time at school/learning spaces	0		0	0	0		0	0
Not learning or progressing due to lack of personalized support for my child's learning (e.g. support teacher, sign language interpreter)	0		0	0	0		1	0
Overcrowded classrooms	4		1	6	0		0	0
Physical and/or verbal abuse from teachers/staff	2		1	1	0		0	0

Refused entry (general)*	4		8	5	2		2	3
Refused entry due to functional difficulties *	1		0	0	2		1	3
Safety fears for movement outside home	0		0	0	0		0	0
School time not appropriate	0		0	0	0		0	0
Teacher/staff do not care about my child	1		2	4	0		1	1
Toilets not clean and safe	0		0	0	0		0	0
Other**	8		8	9	3		2	2
Total	67	100%	67	67	27	100%	27	27
Not applicable (no difficulties)	0		0	0	0		0	0
Sample total	67		67	67	27		27	27

** Other responses include: the school is not recognized in Syria, the child has autism, an unstable family, school materials in English, just moved to a new ITS, the child is too young.

Table 40: Top Rated Perceived Barrier as the 1st, 2nd and 3rd Priority for Out-of-School Children, by Location, Gender and Disability

	Bar Elias	ITS
Girls with disabilities	(total sample =4) 1. Functional difficulties (N=2) 2. (1 response each for 4 different issue) 3. (1 response each for 4 different issue)	(total sample =4) 1. Fears of community stigma (N=2) 2. (1 response each for 4 different issue) 3. (1 response each for 4 different issue)
Boys with disabilities	(total sample =9) 1. *Functional difficulties (N=3)* 2. *Functional difficulties (N=2) conditions (N=2)* 3. *Health conditions (N=2)*	(total sample =10) 1. (1 response each for 10 different issue) 2. (1 response each for 10 different issue) Functional difficulties (N=2) 3. Refused entry (N=2)
Girls without disabilities	(total sample =11) 1. Financial constraints (N=4) 2. Financial constraints (N=6) 3. Financial constraints (N=5)	(total sample =17) 1. Lack of documentation (N=5) 2. Financial constraints (N=6) 3. Lack of documentation (N=4) Financial constraints (N=4)
Boys without disabilities	(total sample= 16) 1. Lack of documentation (N=3) 2. Financial constraints (N=6) 3. Financial constraints (N=8)	(total sample= 23) 1. Missed 3+ years of education (N=7) 2. Financial constraints (N=8) 3. Financial constraints (N=5)

Financial

Note: the same barriers could be mentioned more than once if they were most frequently cited as the first, second or third major concern by different caregivers.

Section 3: Findings

While the above quantitative data collected from caregivers did not turn the spotlight on the school internal factors, face-to-face interviews with key informants from the education sector (see Box 1 below) revealed a **strong sense of reluctance** to welcome and support learners with disabilities, which would negatively affect children's attendance and caregivers' decision not to send their children to school. They tend to send children with disabilities into special schools, believing that special schools would provide better education, quite apart from the fact that this could actually segregate and isolate children with disabilities from their peers, with detrimental effects on social inclusion within the local community. Furthermore, available evidence indicates that the quality of special educational institutions is not at all satisfactory, due to the limited number of qualified teachers, the lack of funding to allocate quality learning materials, the absence of a monitoring system for quality assurance, etc. (see for example, Human Rights Watch, 2018). Our interviewees acknowledged that in any case there were very few special schools in the Bekaa area and available ones were very expensive. An interviewee from a DPO said "children with disabilities are not learning because they cannot afford to go to special schools".

The interviews with teachers and principals also illustrated their **limited understanding about inclusive education** which acknowledge that every child can learn, and, given that all children are different, ensures inclusive and flexible learning support for all learners by removing barriers to learning progressively (Committee on the Rights of Persons with Disabilities, 2016; HI, 2012). One female teacher responded during KII: 'inclusive education refers to students with disabilities. [..] I think all types of impairments require specialists who work at special schools. No matter how much you prepared [in the regular school], [having children with disabilities] learning with other students [without disabilities] wouldn't be fair to or good for both.' As other interviewees also acknowledged, the current learning environment in regular schools are not encouraging for children with disabilities and teachers do not have the capacity to identify and support each child's learning needs. By saying this, the interviewees also imply that even children without disabilities are not supported according to their individual conditions and learning styles. It is essential that teachers and principals in mainstream schools understands inclusive education and the ways to feasibly achieve it, which benefit all children, regardless of disability.

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Box 1: Teachers' Perceptions on Inclusive Education

"[Regular] schools are not well prepared to deal with [children with disabilities]. [My school is] not prepared at all. A lot of equipment is needed so that children with disabilities can move properly... I need to be prepared, the class needs to be prepared and none of this exits. [Children with disabilities coming to regular school] is unfair for them: they might be subject to bullying and they will not benefit as much as if they were in a special school... where there are specialists to deal with their cases. [Learning with peers without disabilities] is unfair for a student with disabilities – he/she will always feel left behind and feel too shy to ask [questions or for support]. [Special schools] are better for them".

A male teacher, 5 years of experience. Never had any student with disabilities in his classroom.

"It's unfair [for children with disabilities to be in mainstream schools] because they will always have to exert efforts to keep up with their peers. It's hard for the student as well as for the teacher who will need to pay a special attention to the student. I think all types of impairments require specialists who work at special schools".

A female teacher, 2 years in service. Currently has a student with disabilities in her class.

"I prefer not to receive students with disabilities in the school, since it is not equipped with the necessary infrastructure, and the teachers are not specialized in dealing with children with disabilities. If a case of physical disability is identified, parents are advised to go to other specialized schools. But if the disability is tolerable (related to reading and writing) then we enrol the students... if we feel the [child with a disability] might affect the class negatively, then we refer him/her to a special needs school".*

A male school principal at a public school, which has a special room for students with difficulties in reading and writing, although there were no students with disabilities at the time of interview.

"There is no [inclusive or special education] training or any kind of planned training. There was a boy with physical disabilities in the 3rd grade [before, and] helping this kid was done at the personal level. It is more like volunteering work. Some teachers and administrators help[ed] the student to move around, we rotate[d] helping him to climb up and down the stairs, and that is all."

A male assistant for school principal at a private school.

"I have an experience in Beirut and from what I have seen, inclusive education is a very successful experience but it is not as widespread as it should be. I know about children with disabilities going to regular schools but there are not many of them and they are struggling because neither the school nor the materials are adapted to their situation".

A project manager, INGO.

* Transcribed exactly as mentioned by the interviewee

Furthermore, without having an official inclusive education policy in the country, school principals and teachers tend to defer responsibilities to the MEHE. "[If I find children with disabilities who are not coming to school] I cannot do much. Such issues are not at our level. It is more related to the MEHE," said a teacher. A male school principal also said: "The school has a school plan, but no elements about education for children with disabilities. We do not receive a lot of such cases [children with disabilities] and we do not feel there is a need [to add a disability component to the school plan]. This is not at our level. This should come from the MEHE".

Section 3: Findings

Priority Solutions for Education

As above, the study revealed a number of barriers that put 480 children who are currently attending school from our sample at risk of school drop-out, as well as prevent 94 children from enrolling in or going back to school. The following section explores solutions proposed by caregivers to ensure that children at school continue schooling and that children outside school will come back to school or enrol for the first time.

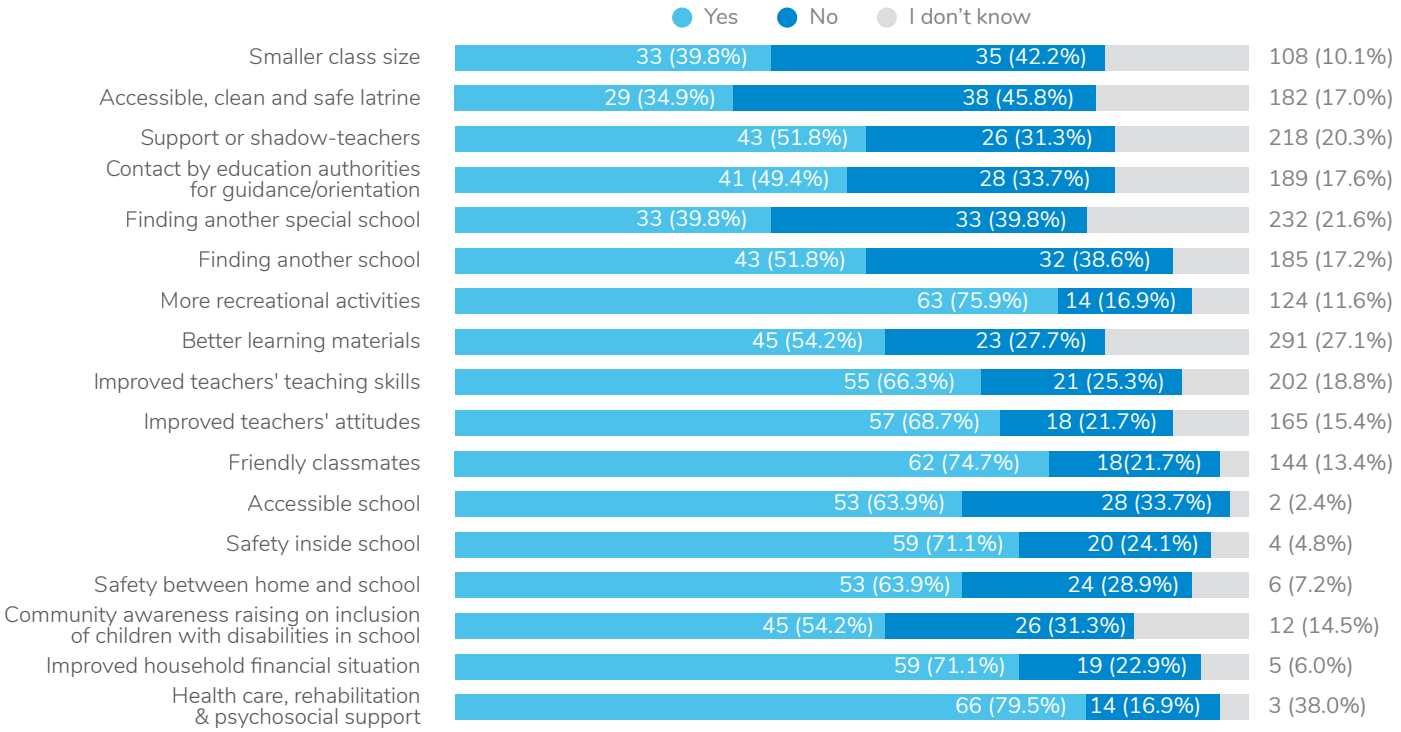
For children currently attending school to continue

(N=480: 86 children without disabilities and 397 children without disabilities)

For children with disabilities (Figure 30), 79.5% of caregivers agreed that appropriate health care, rehabilitation and psychosocial support would help, followed by more recreational activities (75.9%), awareness-raising activities to encourage classmates to be friendlier to each other (74.7%), improved households financial situation (71.1%) and safety inside school (71.1%). Needs for care especially for psychosocial conditions as well as for recreational activities suggest the views of caregivers of children with disabilities that these measures would help improve children's mental wellbeing. Friendly classmates and safety inside schools could be related to the issue of bullying and violence against children with disabilities.

Improved household financial situation
Friendly classmates
Health care, rehabilitation & psychosocial support
More recreational activities
Safety inside school

Figure 30: Proposed Priority Solutions for Children with Disabilities Attending School to Continue Education



When looking at children without disabilities (Figure 31), overall, caregivers proposed to focus on more recreational activities (73.3%), appropriate healthcare, rehabilitation and psychosocial support (72.8%), improved household financial situation (72.0%), and safety between home and school (68.5%). As seen above, financial constraints were the major barrier, but respondents prioritized to ensure that children enjoy activities in school with good physical and psychological conditions. It could be possible that focusing on these aspects will be more effective than targeting the household's financial conditions in order to retain children in schools.

Improved household financial situation

Health care, rehabilitation & psychosocial support

More recreational activities

Safety between home and school

Figure 31: Proposed Priority Solutions for Children without Disabilities Attending School to Continue Education

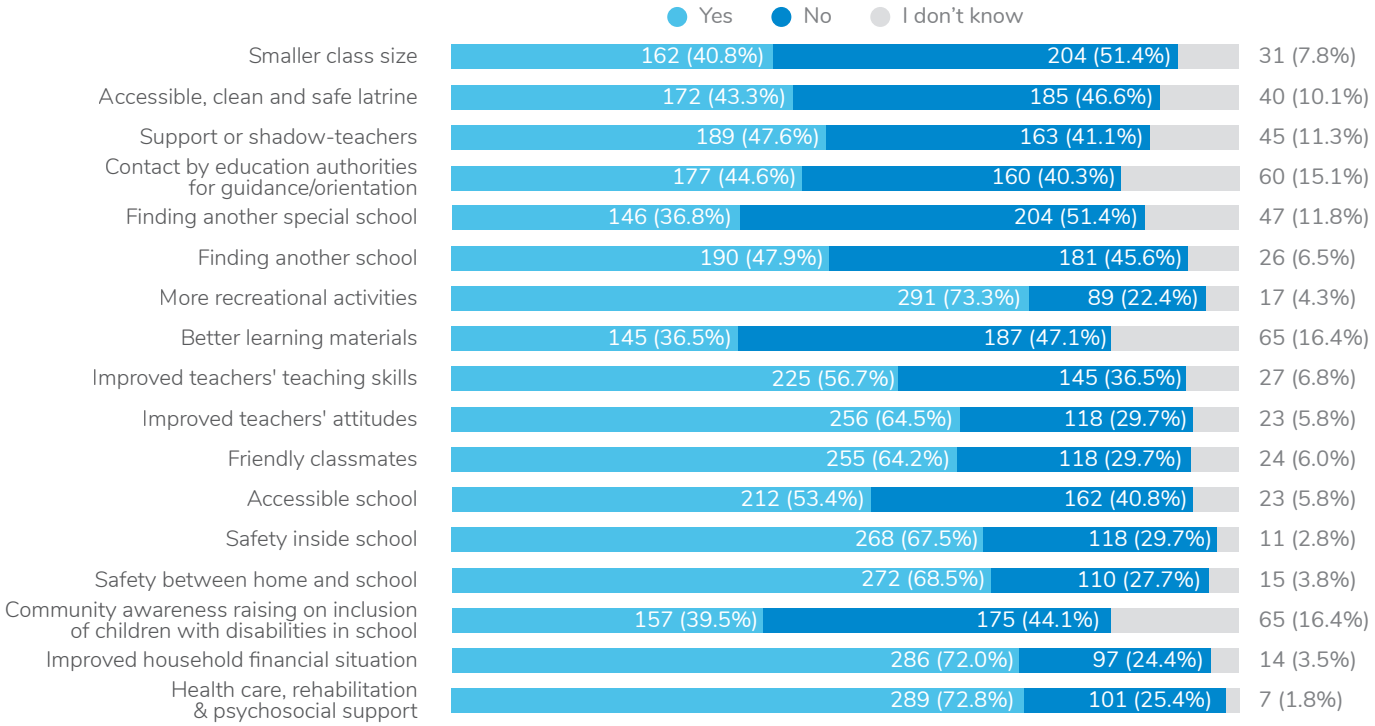


Figure 32 below shows the data breakdown by disability for Bar Elias. Overall, in this urban setting, proper healthcare, rehabilitation and psychosocial support were strongly required for all children (85.1% for children with disabilities and 78.2% for children without disabilities). Expressed needs for medical services for children with disabilities in particular directly link with the previously presented data that more households with disabilities reported limited access to required medical services when needed (see Table 26).

Other solutions proposed by children in Bar Elias include more recreational activities (80.9% and 75.3% for children with and without disabilities, respectively), friendly classmates (72.3% and 70.0%) and improved teachers' attitudes (70.2% and 67.5%). These results suggest that currently, children, especially those with disabilities, do not enjoy schooling to the fullest extent.

The differences between children with and without disabilities become clearer for the solutions related to learning: 66.0% of children with disabilities asked for improved teachers' teaching skills compared to 56.8% of children without disabilities; and 57.4% of children with disabilities needed better learning materials compared to 35.4% of their peers without disabilities. In this regard, it is important to note that about half of the caregivers did not agree to assist children's learning at home (see the following section). Children with disabilities will also benefit from community awareness-raising (59.6% vs 42.0%), reflecting the negative attitudes that children and their caregivers might have been receiving from their peers.

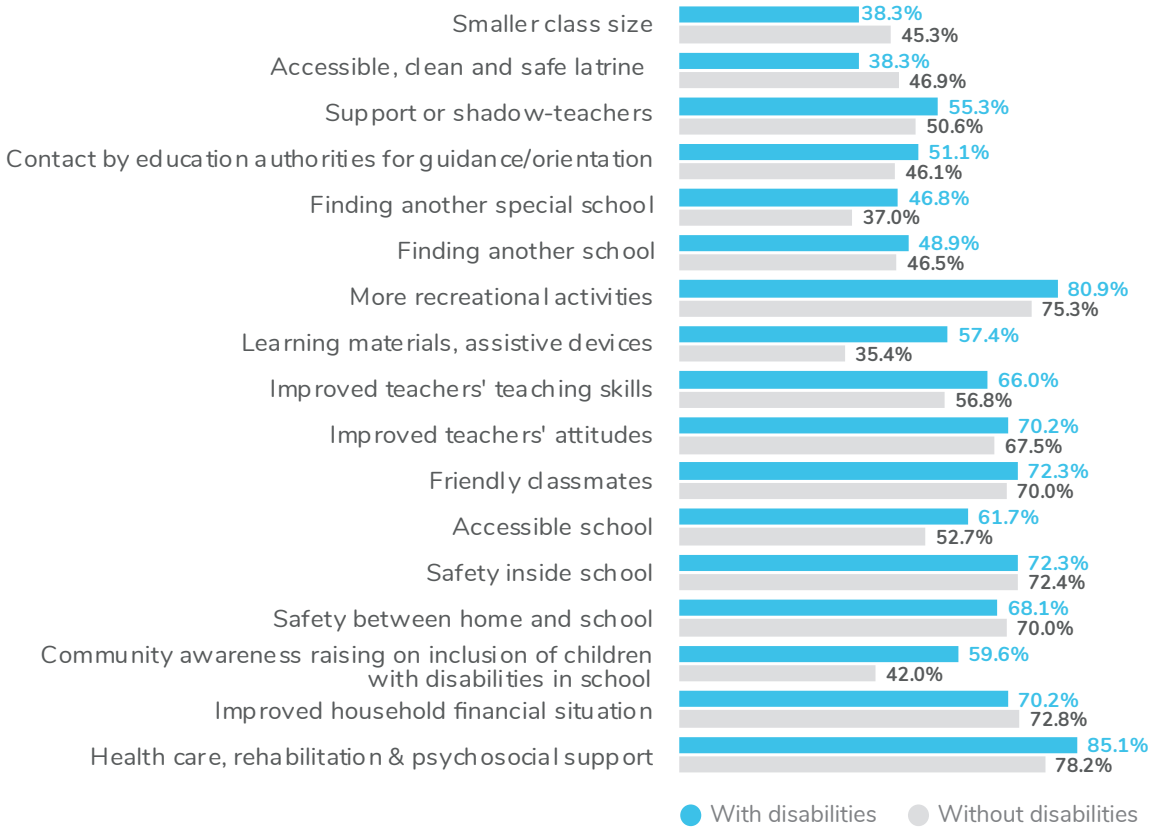
Section 3: Findings

A sizable proportion of caregivers mentioned to improve safety inside school, almost equally – 72.3% of caregivers of children with disabilities and 72.4% of caregivers of children without disabilities indicating the pervasive nature of bullying among peers as well as corporal punishments by teachers, regardless of disability. Further, 70.0% of children without disabilities and 68.1% of children with disabilities also requested to address safety issues between home and school. As seen above, distance to school was a key concern affecting children without disabilities attending school in Bar Elias (Table 38): the longer the distance and the travel time to school, the greater the fears over physical and personal safety. If the journey to school is made safer, the concern about distance to school may be alleviated.

Accessibility improvement at school was also requested; while more needs came from children with disabilities (61.7%), 52.7% of children without disabilities also agreed on this solution idea, as accessible infrastructure will benefit all children.

Figure 32: Percentage of Caregivers in Bar Elias, Agreeing on Different Solutions to Ensure that Children Continue Attending School, by Disability

(N=47 for children with disabilities and N=243 for children without disabilities)



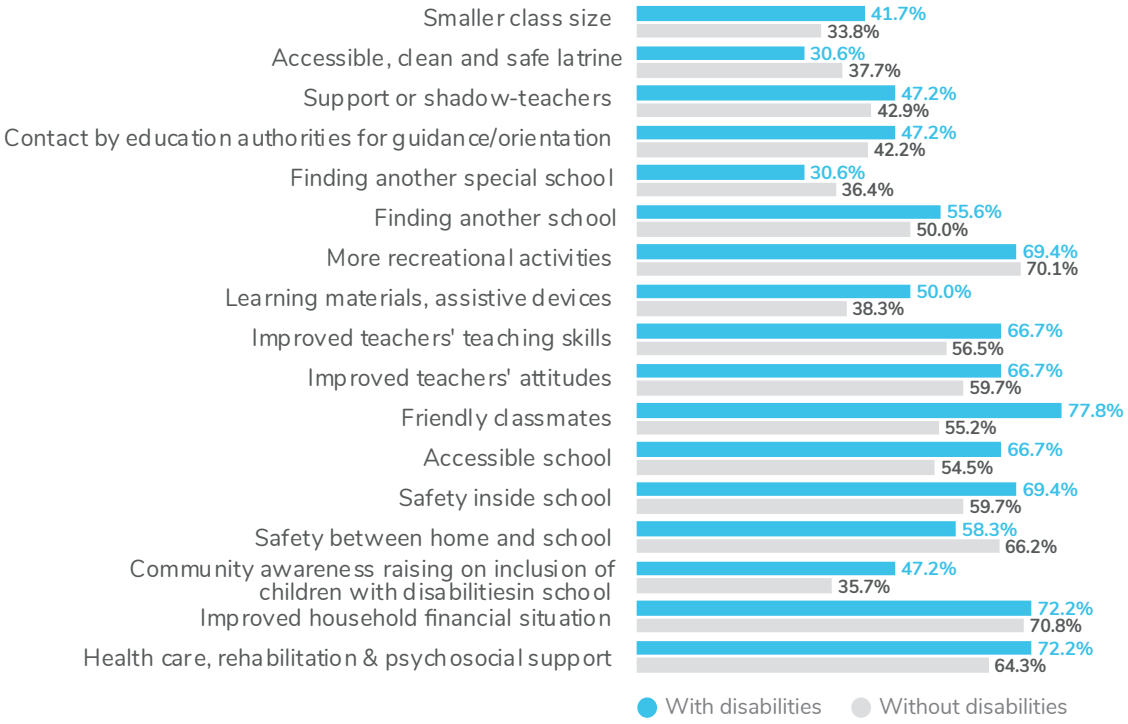
In ITS (Figure 33), the priority solution for children with disabilities was awareness-raising activities to make classmates friendly (77.8%), which shows markedly stronger needs compared with children without disabilities (55.2%). The study found that psychosocial distress was the main obstacle for children with disabilities attending school, and it is possible that pressure on their mental health might have come not only from the war or living conditions but also from persistent bullying or intimidation from peers.

Another solution suggested by children with disabilities was appropriate health-related support and improved household financial situations, both at 72.2%. Measures to address household's financial situation was the most important solution proposed by caregivers of children without disabilities (70.8%).

Recreational activities were highly recommended by both children with and without disabilities (69.4% and 70.1% respectively). Overall, as in Bar Elias, caregivers of children with disabilities expressed more support needs than caregivers of children without disabilities, in relation to teachers' teaching skills (66.7% vs 56.5%), their attitudes (66.7% vs 59.7%), learning materials (50.0% vs 38.3%), school accessibility (66.7% vs 54.5%), safety inside school (69.4% vs 59.7%) and community awareness (47.2% vs 35.7%). Some measures were however more requested by children without disabilities: namely, accessible, clean and safe latrines (37.7% of children without disabilities vs 30.6% of children with disabilities), finding other special schools (36.4% vs 30.6%), and safety between home and school (66.2% vs 58.3%).

Figure 33: Percentage of Caregivers in ITS, Agreeing on different Solutions to Ensure Children Continue Attending School, by Disability

(N=36 for children with disabilities and N=154 for children without disabilities)



Section 3: Findings

For out-of-school children to (re-)enrol

(N=94: 27 children with disabilities and 67 children without disabilities)

The vast majority of children with disabilities (81.5%) suggested that health-related services will help them go back to or newly enrol in school in both Bar Elias and ITS (Table 41). This aligns with caregivers' perceived concerns that the functional difficulties themselves (such as difficulties with hearing or walking) could affect learning by preventing children from accessing the physical schools themselves and the curriculum when they receive education. The underlining issue that would affect this solution is the dire lack of specialized services for Syrian refugees with disabilities. This also links to the cost of services as discussed in the previous section, for which caregivers, mostly from ITS required better household financial conditions (51.9%).

Community awareness raising
Improved household financial situation
Change in the school admission criteria
Health care, rehabilitation & psychosocial support
Finding other schools

Furthermore, approximately half of children with disabilities' caregivers (55.6%) proposed to change the school admission criteria: more accurately, to consistently apply the policy that no documents are required for children to enrol in school. This mirrors the issues around (perceived) required documentation for enrolment and the cases of refused entry. Community awareness-raising to promote the inclusion of children with disabilities in school was agreed (48.1%). Caregivers also mentioned the need to find other schools (also 48.1%), indicating they were not optimistic to find solutions with schools in their neighbourhoods.

For children without disabilities, caregivers proposed the household financial situations to be addressed (67.2%) followed by healthcare, rehabilitation and psychosocial support (62.7%), in both locations. Furthermore, the need to change the school admission criteria was supported by 55.2% of caregivers of children without disabilities. Following this, they prioritized to address safety inside school and safety between home and school (52.2% each). As for children attending school, the issue of safety was raised many times for children without disabilities, requiring immediate interventions.

Safety inside school
Change in the school admission criteria
Health care, rehabilitation & psychosocial support
Improved household financial situation
Safety between home and school

Table 41: Top Three Proposed Priority Solutions for Children Out-of-School to Access Education, by Location and Disability

	Bar Elias	ITS
Children with disabilities (N=27)	(total sample =13) 1. *Health care, rehabilitation & psychosocial support (N=10)* 2. *Review of school admission criteria (N=7) Community awareness (N=7)* 3. *Safety inside school (N=5)Safety between home and school (N=5)Finding other school (N=5) Contact by authority for advice (N=5)*	(total sample =14) 1. Health care, rehabilitation & psychosocial support (N=12) 2. Improved household financial situation (N=10) 3. Review of school admission criteria (N=8) Improved teachers' attitudes (N=8) More recreational activities (N=8)Finding other school (N=8)
Children without disabilities (N=67)	(total sample =27) 1. *Improved household financial situation (N=20) Review of school admission criteria (N=20)* 2. *Health care, rehabilitation & psychosocial support (N=18)* 3. *Accessible school (N=16) Improved teachers' attitudes (N=16)Finding other school (N=16)*	(total sample =40) 1. Improved household financial situation (N=25) 2. Health care, rehabilitation & psychosocial support (N=24) 3. Safety inside school (N=21) Safety between home and school (N=21)

Overall, the findings suggest the need for a comprehensive programing to bring out-of-school children to school, including measures at the school level (e.g. school admission criteria, recreational activities, teacher training, awareness-raising for children) as well as interventions at the community level which create a link between schools and services such as rehabilitation and MHPSS.

As discussed earlier, teachers' awareness-raising and capacity-building on inclusive education is critical to welcome children with disabilities in mainstream schools and to improve the quality of education for all learners. One interviewee who joined a KII, a female teacher, shared her experiences which suggest several aspects that need to be addressed by awareness-raising and training for teachers.

> *"There is a student in my class who has visual impairments. I teach math and I use big handwriting as much as I can. During the tests, I print the test on A3 [paper] for him and I write down the answers he [verbally] tells me, for him.*
> *Some teachers do the same but not all of them. Due to this, he is unfortunately not getting good grades. All of us teachers think it is better for him to be in a "special needs" school. It is a pity. The kid is smart, yet he is not getting good grades because of this lack in everything at school and teachers' level. [When asked about the solutions to challenges faced] I don't believe that it can be solved. The problem is still there, and I cannot do a lot at my level.*
> *[When asked what inclusive schools and classrooms look like] I don't know exactly, but I imagine there should be special equipment like the ones they have in special needs schools. Special desks, special boards, more enhanced education materials that could be addressed to all students in spite of their disability".*
>
> A female teacher, 2 years in service.

First, as the above-mentioned teacher did, there are a number of feasible ways to meet the specific learning needs of each learner that can be implemented without additional resources in mainstream classrooms. Second, a seamless school-wide approach is necessary to ensure that the students' learning needs are addressed comprehensively by all concerned school personnel. The above-mentioned teacher admitted that her efforts remained at her individual level, and due to the absence of support from the whole school, she jumped to the conclusion that a special school could be a better solution for her student with disabilities. Third, it is important to avoid excessive expectations for special schools which are in reality not affordable and limited in terms of number and quality, as revealed by the desk review. In any case, having disability prevalence among the surveyed children aged 6-12 at 19.2%, it is neither logical nor realistic to send all children with disabilities to special schools. Rather, the priority should be given to make mainstream schools and classrooms inclusive and accessible. Desks and materials mentioned by the above-mentioned interviewee were for all children – suggesting that they were not special at all but rather basic, and that such basic equipment were not available in mainstream schools.

Teacher training also needs to address the key study finding of high prevalence of issues around mental wellbeing among children in collaboration with MHPSS service providers.

Caregivers' perceptions on inclusive education

Finally, the study examined caregivers' perceptions (N=506) on inclusive education by asking a series of statements to specify the extent to which they agree, disagree or are neutral about the statement (Figure 34).

In general, the vast majority of caregivers agreed that all children had the right to education and could learn (95.8%, Statement 1) and that education was important for future prospects (96.8%, Statement 2). However, a sizable number

Section 3: Findings

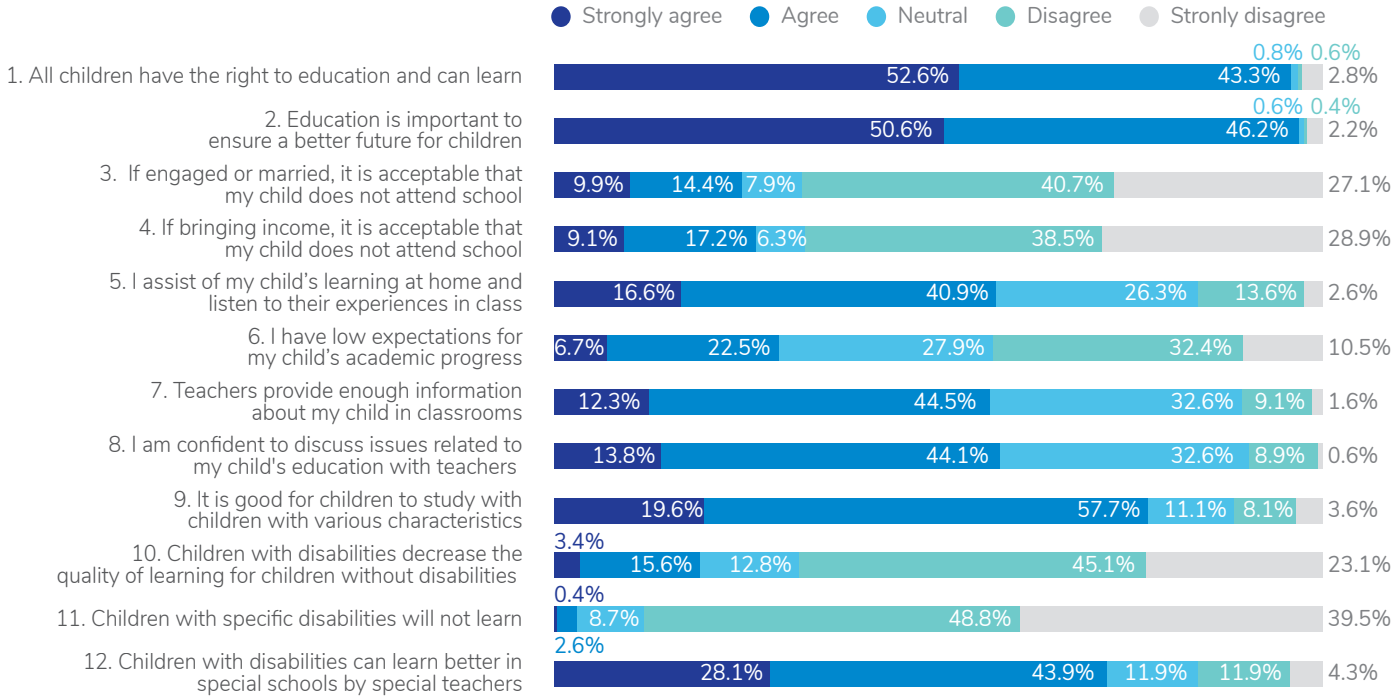
of caregivers (24.3% and 26.3%) agreed to compromise children's education for child marriage and child labour (Statement 3 & 4). Furthermore, caregivers showed relatively low expectations for children's academic progress (29.2% agreed Statement 6 vs 42.9% disagreed). Belief in education is high, yet, it is fragile and could be easily affected by extremely difficult living conditions.

Just over half (57.5%) of the caregivers agreed to assist with the learning of their child at home, while 16.2% disagreed and 26.3% remained neutral (Statement 5). This implies that about half of the children would receive less support and help with homework at home, which might make them vulnerable to drop-out, and so more in need of learning support services.

Caregivers' perceptions about teachers are mixed. About half of the caregivers (57.9%) agreed with Statement 7 on teachers' information-sharing about how their children were doing in classrooms, while 32.6% remained neutral. Furthermore, 57.9% felt confident to discuss issues related to their child's education with the teachers (Statement 8), and again 32.6% neither agreed nor disagreed. This might be reflecting their actual experiences with teachers, and suggest the need for improved relationships.

With regards to inclusion, caregivers showed a range of different opinions. On the one hand, caregivers expressed an overall positive feeling about children's interaction with peers from different backgrounds (Statement 9, 77.3%). They also believed in children with disabilities' capabilities to learn (Statement 11, 88.3% disagreed). On the other hand, one in five caregivers (19.0%) agreed that children with disabilities negatively affect the learning of children without disabilities in the same classroom (Statement 10). Furthermore, without knowing the reality of special schools (see discussion above), a high proportion of caregivers (71.9%) believed that children with disabilities could learn better in separate schools with special teachers. This caregivers' awareness could be a factor leading to the exclusion of children with disabilities from mainstream schools and learning spaces. Similarly to teachers, this finding highlights a lack of awareness among caregivers about the positive effects of inclusive education, and a lack of experience of a truly inclusive school.

Figure 34: Caregivers' Perceptions on Inclusive Education (N=506)



As said, 88.3% of caregivers disagreed or strongly disagreed with Statement 11 children with specific disabilities will not learn. On the other hand, 15 caregivers (3%) strongly agreed or agreed with the statement. The study further asked these caregivers with what types of impairments they thought children would not learn and they expressed that children with intellectual disabilities (93.3%) would not learn, compared to lower percentages for hearing (73.3%), psychosocial (60.0%), physical (60.0%) and visual disabilities (46.7%). This perception echoes the opinions of principals and teachers identified during the interviews (see discussion above) that perceive children with disabilities categorically by types or the severity of their impairments and limits their opportunities for inclusion. Global studies and practices have been demonstrating various inclusive educational approaches that ensure learning for children with severe impairments in the least restricted environments. Awareness and experiences on truly inclusive schools was limited in the study sample.

In addition to the 12 statements above, the study also asked whether caregivers would prioritize any of their children to receive education when needed. Among 506 caregivers, the vast majority (476 or 94%) disagreed to make such a choice, indicating their wish to ensure education for all their children. However, 30 caregivers admitted that they would. When asked about their criteria, 19 caregivers said they would prioritize girls rather than boys; 18 would prioritize young children rather than older ones; and 16 would prioritize children without disabilities rather than children with disabilities. Therefore, the children most at risk of exclusion are male, older children, with disabilities.

SECTION 4: CONCLUSIONS AND RECOMMENDATIONS

The study explored the prevalence of disability among Syrian refugees in Bar Elias and ITS, and provided a number of insights into the level of access to different services that are crucial for their lives, associated barriers as well as required solutions, with statistical data disaggregated by disability. The findings highlighted a number of aspects to be taken into consideration by the humanitarian and development stakeholders in the protracted Syrian crisis.

1. **Understand disability from the rights perspective and plan inclusion from the onset of all programs**

   The study applied the rights-based model of disability by using the WG tools to identify persons with disabilities regardless of their impairments. People with disabilities identified were people at risk of not participating in society (including humanitarian action). Using this rights-based understanding of disability, the study found 22.6% of Syrian refugees have disabilities, which is much higher than the 2-3% prevalence rate from the existing surveys that used the medical approach to disability, and the WHO's global estimation of 15% (WHO, 2011). Furthermore, 59.9% of households have at least one family member with disabilities. These findings indicate that, without an inclusive perspective from the very beginning and throughout all stages of actions, support programs will not be able to address the specific needs of the larger number of individuals as well as households who have members with disabilities than the current assumption of 2-3%.

2. **Build the capacity of stakeholders and collect disability data using the relevant Washington Group Questions for the context**

   Review of the existing knowledge suggested that, in spite of efforts of various humanitarian actors to collect disability data, the methods and applications varied greatly which made it very hard to compare the results and establish a comprehensive assessment of the actual situation. This study used the WG ES and CFM and found a two-fold usefulness. First, persons in this particular humanitarian context experience mental health and psychosocial issues such as anxiety and depression, which can be identified by these tools (note that these domains are not covered by the WG Short Set). Second, children experience difficulties with daily activities in different manners than adults which can be identified by the CFM (again the WG Short Set is not designed for children). It is necessary for humanitarian actors to discuss the application of the WG ES and CFM instead of the WG Short Set, taking into consideration the operational feasibility.

   It is also important to stress that, while the WG tools help to identify persons with disabilities, an assessment of the barriers of the specific contexts requires additional questions to be asked. As done by this study, a barrier analysis and qualitative survey could be combined with the WG tools to help directly link the results of the survey with the design of inclusive interventions.

   These being said, building the capacity of humanitarian actors on disability, inclusion and disability data collection is crucial. Application of the WG tools as the standardized disability identification tools as well as proper reporting and data-sharing will greatly contribute to the collection and analysis of comparable disability data by different humanitarian actors at a larger scale towards coordinated inclusive programing.

3. **Enhance efforts to consult persons with disabilities, in order to understand their views and provide more tailored services**

   The study found that households with disabilities were not more disadvantaged than their peers without disabilities to access certain services such as UNHCR registration, food and cash assistance, probably due to humanitarian actors' efforts to target vulnerable families. Still, more work needs to be done to improve the quality of services to address issues that affect all persons such as accessibility of housing.

On the other hand, the study revealed that households and persons with disabilities face more difficulties to access water, health services, specialized services, work and education, than their peers without disabilities. Quite often, they stated unavailability and costs of services as barriers to access, despite the presence of free services, due to the lack of documentation, limited knowledge about available services and associated costs such as transportation. Other obstacles they complained about include inflexible services that do not meet their specific needs and unsupportive staff, and they proposed more tailored services. Humanitarian actors are required to improve the ways they work to be more inclusive, in order to ensure the equitable access to services for persons with disabilities. This requires a better understanding of persons with disabilities' perceptions and experiences. Direct consultations with the concerned people will be useful.

4. **Break fear towards disability, move away from reliance on "disability specialists" and promote disability mainstreaming**

During the consultations and interviews, a number of caregivers and stakeholders showed a genuine interest in inclusion. This is very positive. At the same time, the study found a common feeling that they were not confident to take actions and required specialists to intervene. While it is true that specialized organizations are needed for specific services, mainstreaming is required for wider inclusion.

The following more specific recommendations address different actors in humanitarian contexts to strengthen inclusive actions. These recommendations incorporate the study findings as well as the outcomes of the workshop organized by the study team on May 9th, 2018 in Beirut, during which various stakeholders reviewed the study findings and discussed actions to be taken by humanitarian actors.

Service providers[12]

Project design

- Collect **disability data and disaggregate various data by disability** using the WG tools, alongside gender, age and location, in order to capture a fuller picture of the situation and vulnerabilities of persons and households with disabilities in underserved areas, and inform project design. Build on the existing data without reinventing the wheel.
  - Concerning accessibility and safety issues around shelter and latrines, promote collaboration between the shelter and WASH sectors to conduct a detailed assessment. Include these aspects within the Vulnerability Assessment of Syrian Refugees in Lebanon.
  - Conduct further research: for example, on livelihood in relation to households' perceptions about their debt level, as well as information on the type of work undertaken, time spent caring for persons with disabilities and the prevalence of persons working without a work permit.
- (Through data collection) **Identify people and households with disabilities to participate in the project.**
  - Introduce common definitions and systems for the registration of people with disabilities using the WG questions (e.g. UNHCR registration)
- **Establish partnerships with local CBOs and disability actors** (e.g. DPOs, specialized NGOs). Conduct home visits and participatory and inclusive Focus Group Discussions. This will contribute to:

[12] An umbrella term referring to organisations operating to provide services for Syrian refugees in Lebanon. This could include UN agencies, international and local NGOs, CBOs, DPOs and local public and private entities

Section 4: Conclusions and Recommendations

  - **Gain a deeper understanding about the specific needs of identified persons and households with disabilities** as a whole at this early stage of the project cycle. Concerning education, conduct friendly and accessible consultations with children to listen to their views and opinions.
  - Enhance the ownership and sustainability of the projects.
- **Use evidence base and design projects with a clear inclusion plan**: for example, children with disabilities for inclusive education, order people for literacy classes, females with disabilities in relation to livelihoods/work. Link proposal writers with field staff in order to ensure that needs are effectively translated into project proposals.
- **Budget for inclusion**: based on the existing and/or newly collected data, allocate specific budget lines dedicated to addressing key barriers and to promoting inclusion. For example, the study findings suggest the need to address **costs of services** (e.g. specific health services that are not available in community clinics), **transportation costs** to reach the services, and the **costs for maintenance of assistive devices**. Explore subsidies for specialized services which are often not affordable for refugee households. Also budget costs for **accessible services** in terms of **accessible facilities** (e.g. shelters, latrines, transportation), accessible information dissemination, and **awareness-raising and training for staff.** Consider the scale-up of the cash assistance programs for education in view of financial barriers that put children in schools at risk of drop-out and keep children out of school, taking into consideration that cash assistance is not a panacea[13].

Project implementation

- Continue the established partnerships with CBOs and disability actors (DPOs, NGOs) to support existing services to be inclusive.
- Disseminate information about services through local partnerships and networks
  - Conduct a **user centric mapping** of key services, integrating both the service providers' and users' perspectives (What do they actually need? What are we offering? Where are the gaps?)
  - Enhance **visibility and communications** around available services, especially in relation to water, cash assistance, specialized services, since these are the main services refugees lack awareness of.
  - Ensure inter-agency information resources that are distributed to refugees are in **accessible formats** (e.g. text, large print, Braille), and that staff are trained in accessible communications.
- **Provide tailored support to refugee households without a legal status** that limits their access to different services.
- **Ensure children and youth access quality MHPSS services** either through support to access existing services (referral, financial support, etc.) or through ad-hoc programing aimed at filling the gaps of the existing MHPSS systems of services (enhance age groups coverage, geographical coverage and quality through capacity-building and financial support or through direct provision if necessary). Enhance coordination and exchange of expertise between actors specialized in MHPSS and in disability/inclusion.
- Engage persons with disabilities as **'role models'** in order to motivate and inspire other persons with disabilities. Hiring persons with disabilities within staff teams will also ensure service providers 'walk the talk' of inclusion.
- **Strengthen coordination** between different stakeholders to respond to gaps in inclusiveness of service provision. Ensure data and information-sharing between different sectors, services and levels (e.g. staff in the main office in the capital and staff in the field) for smoother referrals.
- **Pilot the inclusion approach** while critically examining and recording whether the project is effectively addressing the needs of vulnerable populations. Use results as a rationale for further funding from donors.

[13] See for example, Abu Hamad, B., Jones, N., Samuels, F., Gercama, I., Presler-Marchall, E., & Plank, G. (2017). A promise of tomorrow: The effects of UNHCR and UNICEF cash assistance on Syrian refugees in Jordan. Available at https://www.unicef.org/jordan/ODI_UNICEF_UNCHR_CT_report_final_Low_Res_08.11.2017(2).pdf

Capacity building of staff (throughout the project cycle)

- Conduct awareness sessions and training for frontline staff around disability; e.g. **data collection using the WG tools and data analysis; MHPSS;** and **communication skills** with persons with disabilities and their family members. Also train staff on the **humanitarian operating system** in Lebanon in order to increase awareness of how services are linked together and to further promote complementary approaches and communication between humanitarian actors
- Within education programing in particular:
  - Build teachers' and school principals' capacities on **inclusive education and pedagogy** with a strong focus on positive discipline that addresses bullying as well as MHPSS for children and youth.
  - Train school principals to plan and organize **outreach for out-of-school children**, in partnerships with CBOs/ DPOs and community members. In order to address specific family needs, utilize the referrals to different services. Pay a particular attention to boys with disabilities who are the most educationally excluded.
  - Conduct activities to promote **social cohesion** in order to bring together children with disabilities and their peers without disabilities (e.g. inclusive recreational activities, anti-bullying campaigns), not only at school but also at the community level.

Advocacy

- Advocate to relevant public institutions, humanitarian organizations and donors **to modify the built environment** including public transportation, infrastructure and schools, as well as **methods of communication,** in order to ensure equitable access to services and information.
- Advocate to the government to further **reduce costs, especially of health services.**
- Advocate to and collaborate with the MEHE and education sector actors to promote inclusive education through actions such as;
  - Developing and implementing an **inclusive education policy, national strategy** and/or **action plans.**
  - Developing and implementing the **teacher training curriculum** on inclusive education, including a psychosocial support component.
  - Increasing the **ear marked budget** given for the education of children with disabilities.
  - Improving **schools' accessibility.**
  - Developing **accessible learning materials/aids.**
  - Ensuring support for the roll-out of the **inter-ministerial child protection policy**, once in place, to schools, making specific reference to children with disabilities needs.

Section 4: Conclusions and Recommendations

Communities

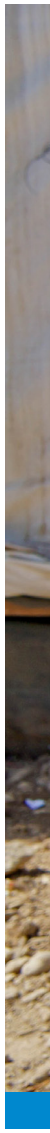
- Conduct **awareness sessions and outreach** to ensure that community members are aware of key services offered by service providers and no persons with and without disabilities are excluded from access to required services. Utilize strong and active community leaders/members (with disabilities) to promote inclusion within the community.
- Create/ join established **community networks** linked with DPOs, engage with service providers and any other relevant stakeholders in community meetings, identify specific barriers that persons with and without disabilities face and remove the identified barriers.
- Pioneer community-based initiatives to support **inclusive practices;** for example, accompanying children with and without disabilities to and from school to ensure that children will not face safety issues (e.g. traffic, harassment).

Donors

- In calls for proposals, set the requirements for applicants for **disability inclusive project design.** Specifically, request for partners to include disability disaggregated data and analysis in needs assessments.
- Add a **'weighting'** for disability inclusion while screening the proposals, in order to support funding decisions based on inclusiveness.
- Promote **inclusive budgeting** – e.g. whatever the sectoral focus of the project, allocate 5% of the total project budget to inclusion such as improving the accessibility of services, staff's capacity-building and awareness-raising among communities towards disability inclusion. Partners then have the dedicated funding to ensure inclusion activities are implemented. In particular, allow funding for **cash for transportation** or the provision of direct transportation within budget lines.
- Provide **funding for research and rigorous needs assessments** in which persons and households with disabilities are fully engaged and consulted. This ensures that funding is invested based on real needs. Also allow partners to **pilot, and scale-up or change the direction of their inclusion approach** based on the pilot results, to better meet the needs of persons with disabilities.
- Adjust the **flexibility of funding**: e.g. shift the budgets from the one-time distribution of assistive devices towards the **maintenance and repair of assistive devices.**
- Prioritize **multi-year funding** where possible in order to ensure a longer term, more sustainable approach to supporting persons with disabilities. This is based on the observation that many projects have a short term funding and consequently result in regular 'breaks' in service provision, preventing the continuity of access.
- In addition to mainstreaming disability into all projects, provide specific funds and support for **MHPSS, inclusive employment and inclusive education.**

Governments and local authorities

- **Ensure inclusive actions in national plans for response and resilience** through consultations with persons with disabilities.
- **Earmark budgets to support persons with disabilities** to access various services.
- **MEHE to** (in line with the ongoing inclusive education pilot):
  - Scale-up **teacher training** programs, develop and roll-out guidelines on **inclusive education pedagogy** on how to differentiate the curriculum for children with disabilities to ensure that all children can learn to the best of their abilities. Consider the addition of a psychosocial support module.



- Ensure the availability of **accessible and inclusive learning materials.**
- Provide **infrastructure according to universal design principles** within schools so that children with disabilities can enjoy full and equal access (e.g. within the forthcoming national needs assessment on school construction). In practical terms, this means a full appraisal of schools to assess the gaps in accessibility and the development of plans to address these gaps.

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REFERENCES

Al Hessan, M. (2016). Understanding the Syrian Educational System in a Context of Crisis. Vienna Institute of Demography Working Papers. 09/2016. Retrieved on June 13th, 2018, from https://www.oeaw.ac.at/fileadmin/subsites/Institute/VID/PDF/Publications/Working_Papers/WP2016_09.pdf

Bailey, S., & Harvey, P. (2017). The DFID/ECHO approach to cash assistance for refugees in Lebanon. Documenting the process. ODI Working paper 525. Retrieved on May 18th, 2018, from https://www.odi.org/sites/odi.org.uk/files/resource-documents/11899.pdf

Baroud, M. (2017). Improving Healthcare Access for Persons with Disabilities in Lebanon: Together for Justice in Service Provision. Retrieved on May 20th, 2018, from https://website.aub.edu.lb/ifi/publications/Documents/policy_memos/2017-2018/20171215_improving_health_access.pdf

Committee on the Rights of Persons with Disabilities. (2016). General comment No. 4. (2016). Article 24: Right to inclusive education. Retrieved on June 15th 2018 from https://www.ohchr.org/EN/HRBodies/CRPD/Pages/GC.aspx

Consultation and Research Institute. (2015). Children living and working on the streets in Lebanon: Profile and Magnitude. February 2015. Page 12. Retrieved on May 18th, 2018, from https://www.unicef.org/lebanon/Final_Study_SBC_En.pdf

The Daily Star Lebanon. (Jan 20th, 2015). Flow of Syrian refugees to Lebanon drops after restrictions. Retrieved on June 15th, 2018, from http://www.dailystar.com.lb/News/Lebanon-News/2015/Jan-20/284715-flow-of-syrian-refugees-to-lebanon-drops-after-restrictions.ashx

Economic and Social Commission of Western Asia (ESCWA). (2014). Disability in the Arab region: an overview. E/ESCWA/SDD/2014/Technical Paper.1 Retrieved on June 17th, 2018, from https://www.unescwa.org/sites/www.unescwa.org/files/page_attachments/disability_in_the_arab_region-_an_overview_-_en_1.pdf

Education Sector. (2017). End of Year Dashboard. Retrieved on May 22nd, 2018, from https://data2.unhcr.org/fr/documents/download/62763

Government of Lebanon & the United Nations. (2018). LCRP 2017-2020: Food Security Sector Chapter (Situation Analysis, Strategy and logframe). 2018 Update. Retrieved on June 17th, 2018, from https://data2.unhcr.org/en/documents/download/64042

Government of Lebanon & the United Nations. (2017). Lebanon Crisis Response Plan. 2017-2020. Retrieved on June 15th, 2018 form https://data2.unhcr.org/en/documents/details/53061

Groce, N., Bailey, N., Lang. R., Trani, J. F., & Kett. M. (2011). Water and sanitation issues for persons with disabilities in low- and middle-income countries: a literature review and discussion of implications for global health and international development. Retrieved on June 13th, 2018, from https://www.ncbi.nlm.nih.gov/pubmed/22048421

Handicap International & HelpAge International. (2014). Hidden Victims of the Syria Crisis. Retrieved on 18 May 2018 from http://www.hi-us.org/hidden_victims_of_syrian_crisis

Human Rights Watch. (2018). “I would like to go to school”: Barriers to Education for Children with Disabilities in Lebanon. Retrieved on May 22nd, 2018, from https://www.hrw.org/report/2018/03/22/i-would-go-school/barriers-education-children-disabilities-lebanon

Human Rights Watch. (February 14th, 2017). Lebanon: New Refugee Policy a Step Forward. Open the door to legal status for all Syrian refugees. Retrieved on May 23rd, 2018, from https://www.hrw.org/news/2017/02/14/lebanon-new-refugee-policy-step-forward

Humanity & Inclusion. (2013). Livelihoods Assessment Report. August 2013. Page 8. Retrieved on May 18th, 2018, from https://data2.unhcr.org/en/documents/download/38678.

Humanity & Inclusion. (2012). Policy Paper: Inclusive Education. Retrieved on June 15th, 2018, from http://www.hiproweb.org/uploads/tx_hidrtdocs/PP08IE.pdf

Inter-Agency Coordination. (2018). Basic Assistance Jan-Apr 2018 Dashboard. Retrieved on June 15th, 2018, from https://data2.unhcr.org/en/documents/download/63967

Inter-Agency Coordination. (2015). Profiling of Syrian Refugees in Lebanon. 2015 Summary report. Retrieved on May 21st, 2018, from https://data2.unhcr.org/en/documents/download/59882

International Medical Corps. (2015). Syria crisis. Addressing regional mental health needs and gaps in the context of the Syria crisis. Retrieved on June 15th, 2018, from https://internationalmedicalcorps.org/wp-content/uploads/2017/07/Syria-Crisis-Addressing-Mental-Health.pdf

International Rescue Committee & Norwegian Refugee Council. (2015). Legal Status of Refugees from Syria: Challenges and Consequences of Maintaining Legal Stay in Beirut and Mount Lebanon. Retrieved on May 21st, 2018, from http://www.refworld.org/docid/56cabc8c4.html

Janmyr, M. (2018). UNHCR and the Syrian refugee response: Negotiating status and registration in Lebanon. The International Journal of Human Rights, 22:3, 393-419. Retrieved on May 21st, 2018, from https://www.tandfonline.com/doi/abs/10.1080/13642987.2017.1371140

JIF, LHIF & SIRF. (n.d.) PROMISE TO PRACTICE: Following through on commitments to support the future of Syria and the region. Page 25. Retrieved on May 20th, 2018, from https://reliefweb.int/sites/reliefweb.int/files/resources/Promise%20to%20Practice_Online.pdf

Koh, L. (October 10th, 2017). Unregistered Syrian refugees face obstacles in Lebanon. Mission Network News. Retrieved on June 15th, 2018, from https://www.mnnonline.org/news/unregistered-syrian-refugees-face-obstacles-lebanon/

Lakkis, S., Nash, G., El-Sibai, N., & Thomas, E. (2015). Article 19. Lebanon: Disability and Access to Information. May 2015. Country report. Retrieved on May 22nd, 2018, from https://www.article19.org/data/files/medialibrary/37983/Disability-and-access-to-information-in-Lebanon,-31-May-2015,-English.pdf

Lara, E.B., & delost Pinos, C.C. (2017). Families with a disabled member: impact and family education. Social and Behavioral Sciences, 237, 418 – 425. Retrieved on June 15th, 2018, from https://ac.els-cdn.com/S1877042817300848/1-s2.0-S1877042817300848-main.pdf?_tid=e3c52deb-f21c-4f8f-9e2f-cdd5806d8a26&acdnat=1530962798_dcdf1fc74c27aa4b7daa0bbff175133a

Lebanese Information Center. (2013). The Lebanese demographic reality. Retrieved on June 17th, 2018 from https://lstatic.org/PDF/demographenglish.pdf

No Lost Generation – Brussels II Conference. (2018). We Made a Promise: Ensuring learning pathways and protection for Syrian children and youth. Retrieved on May 22nd, 2018, from https://nolostgeneration.org/sites/default/files/eman/Highlights/Brussels%20conference%20education%20report.compressed.pdf

UNHCR. (2018a). Operational Portal Refugee Situations. Total Persons of Concern. Last updated 05 July 2018. Retrieved on July 11th, 2018, from https://data2.unhcr.org/en/situations/syria

UNHCR. (2018b). Operational Portal Refugee Situations. Total Persons of Concern. Last updated 05 July 2018. Retrieved on July 11th, 2018, from https://data2.unhcr.org/en/situations/syria/location/71

UNHCR, UNICEF & WFP. (2017). Vulnerability Assessment of Syrian Refugees in Lebanon. VASYR 2017. Retrieved on May 22nd, 2018, from https://data2.unhcr.org/fr/documents/download/61312

WHO. (2016). WHO Support to the Humanitarian response in Lebanon (2 years in review: 2014-2015). Retrieved on May 21st, 2018, from http://www.who.int/migrants/publications/WHO_Lebanon_AnnualReport.pdf?ua=1

WHO & The World Bank. (2011). World Report on Disability. Retrieved on May 12th, 2018, from http://www.who.int/disabilities/world_report/2011/report.pdf

Women's Refugee Commission. (2013). Disability Inclusion in the Syrian Refugee Response in Lebanon. Retrieved on May 18th, 2018, from https://reliefweb.int/sites/reliefweb.int/files/resources/Disability_Inclusion_in_the_Syrian_Refugee_Response_in_Lebanon.pdf

ANNEXES

Annex 1: Household Sampling Methodology

Stratified random sampling is useful method for data collection if the population is heterogeneous. In this method, the entire heterogeneous population is divided in to several homogeneous groups, usually known as Strata, each of these groups is homogeneous within itself, and then units are sampled at random from each of these stratums. The sample size in each stratum varies according to the sampling fraction. Each stratum is then sampled as an independent sub-population, out of which individual elements can be randomly selected.

The sample size determined via the following formulas:

$$n = n^1/(1+(n^1-1)/N) \quad 400 \text{ Households/unit of Analysis}$$

n^1: Sample size from an infinite population, calculated via the formula [$n^1 = Z^2pq/e^2$].

n: Sample size from a finite population

N: Target population

P: Expected prevalence, It usually ranges between 10 and 90, therefore, the most appropriate P value is 0.5 (50%)

Q=1-P

e: Acceptable margin of error, which is the acceptable error of the estimate for the proportion being estimated. Most common rate is 5% for a 95% confidence level

Z: Z value, which is a statistic for confidence level. Most research uses a 95% confidence level, which equates to a 1.96 Z value.

Annex 2: Questionnaire

Arabic version available upon request

Enumerators											
Enumerator 1 (name and surname):	Mobile										
Enumerator 2 (name and surname):	Mobile										
Date of Visit:											
Time of Visit:		Start							End		
Household information:											
Address GPS data		Longitude						Latitude			
Address		Governorate District									

Introduction & Consent

Hello, my name is (name 1) and next to me is my colleague (name 2). We are from Handicap International[14] and we are working to improve lives of vulnerable populations. We are now conducting a survey to understand your and your family members' situation, functional difficulties, and difficulties you may have faced in accessing services in general and inclusive education for children in particular. Understanding factors that affect access to essential services for you and other Syrian refugees will help us improve the ways we deliver services. Your household is randomly selected for this interview with Syrian refugees in (location name).

Do you understand the objective of this survey?
☐ YES
☐ NO (If NO clarify the above again).

The interview will take about one hour and a half. Because there are questions about your child(ren), it would be good to ask all questions to their mother or the child(ren)'s primary caregiver (do not read this note: caregiver in case a mother is deceased or not living with children), except for one set of questions for adults who are 18 years old or above.

All the information we obtain will remain strictly confidential and be kept by HI and its partner iMMAP only. Reports will be presented completely anonymously and will not include information such as names, ages and addresses.

Participation is voluntary and you are free to refuse to participate. When you agree to participate, you may stop at any time or skip any questions that you don't wish to answer.

There is no direct benefit, money or compensation provided to you for participating in this survey. When your family member has specific issues, I am not able to assess or diagnose the situation. But if you are interested, I will provide you with the information about some services we will talk about.

Do you understand the consent and confidentiality?
☐ YES
☐ NO (If NO clarify the above again).

Do you agree to participate in the interview?
☐ YES Thank you for agreeing to participate (go to the questions below).
☐ NO (If NO, stop the interview. Thank the person).

[14] At the time of data collection. Humanity & Inclusion becomes new name of Handicap International on January 24, 2018

Annexes

Household data	
Name of mother/caregiver	
Contact information	Telephone(s): Alternative phone(s):
UNHCR registration	☐ YES ☐ NO

ACCESS TO BASIC SERVICES

Now, I will ask you about your household's conditions and access to basic services.

Housing

• Does your family have a shelter or house?	Yes / No
• Does the house have stable electricity?	Yes / No
• Is it easy to move around the shelter/house?	Yes / No
• Do you have any fear of attack or harassment around your shelter/house?	Yes / No
• Do you have any fear of getting harmed or injured around your shelter/house?	Yes / No

Health

• Did you or another member of your household have any medical need in the last 6 months?	Yes/No
• (If yes), were you or any of your family members able to access medical services at hospitals/clinics?	Yes/No
• If no, why?	If No Go to reasons and enabling factors

Safe water

Does your family have enough safe water from reliable sources for drinking, cooking, cleaning and personal hygiene? If no, why?

Yes

No
Go to reasons and enabling factors*

Latrine

• Is the latrine you use accessible to all of your family members? (for Irbid, ask only this)	
• Is the latrine available anytime during the day, evening and night?	Yes / No
• Do you have any fear of attack or harassment when using/ going to use the latrine?	
• Do you have any fear of getting harmed or injured when going to use the latrine?	

Food assistance

Does your family have World Food Programme food e-vouchers? If no, why?

Yes

No
Go to reasons and enabling factors*

Cash assistance

Does your family receive any cash assistance or grant (e.g. UNHCR visa card)? If no, why?

Yes

No
Go to reasons and enabling factors*

	Jordan	Lebanon
Household Income size What is your household total cash income in the past month?	700JOD – above	700.000 LBP – above
	500 – 699JOD	450.000 – 699.000 LBP
	300 – 499JOD	300.000 -449.000 LBP
	200 – 299JOD	150.000- 299.000 LBP
Household debt What is your total amount of debt accumulated since your arrival to Jordan/ Lebanon up to now?	100 – 199JOD	75.000- 149.000 LBP
	50-99JOD	0-74.000 LBP
	0-49JOD	

REASONS FOR NOT ACCESSING SERVICES

If NOT able to access any services listed above, WHY? Main reasons (multiple answers) READ LIST

- ☐ I do not know where the service or support is available or who can help
- ☐ I got some information but could not read or understand
- ☐ I do not have documents to access services (eg UNHCR card, visa, ID)
- ☐ Safety fears for movement outside home (attack, harassment, arrest)
- ☐ Safety fears for movement outside home (harm, injuries)
- ☐ Services are not available
- ☐ Services are too expensive
- ☐ Services are far away and transportation is not available
- ☐ Services are far away and transportation is too expensive
- ☐ Services are far away and transportation is not accessible (e.g. does not have a lift, handrail)
- ☐ Services are delivered in places that are not accessible (e.g. does not have a ramp, wide door)
- ☐ Services are delivered in places that are not gender sensitive (not comfortable for women or men)
- ☐ Staff are not supportive and/or do not know how to communicate with me/my family
- ☐ Services do not meet my/my family's specific needs
- ☐ Other (specify)

ENABLING FACTORS TO FACILITATE ACCESS TO SERVICES

Among the reasons mentioned, what will be the most important issue which, if solved, will help you access services? (specify one reason)

Individual data

Now I will ask about each of your family members and their status

Name	Age	Work	Education
What is the name of your family member and their relationship?	How old is (name)?	Has (name) worked in the past 7 days to bring an income to your household, with or with-out a work permit (Jordan) / a legal residency permit (Lebanon)? (ONLY for those 5+)	What is the highest level of education (name) attended (or is currently attending)? (ONLY for those 13 +) For persons aged 6-12 years old, refer to separate Qs
1.			
2.			
....			

Annexes

FUNCTIONAL DIFFICULTIES

Now, I am going to ask you additional questions about your ability to do different activities, and how you have been feeling.

Note: Review individuals' name and age, and use the Washington Group (WG) Children Functioning Module (CF-M) 2-4 for children aged 2-4; the CF-M 5-17 for children aged 5-17, and the WG Extended Set of Functioning (ES) Light set for adults aged 18+. Results will be recorded for each individual.

ACCESS TO SPECIALIZED SERVICES

Only for individuals who responded "a lot of difficulty" or "cannot do at all," and other cut-off conditions for at least one domain of WG questions (WF-ES, CFM 2-4 & 5-17)

What is the cause of (name)'s functional difficulties? (Select one)

☐ From birth ☐ Injury ☐ Illness or disease ☐ Ageing ☐ Malnutrition ☐ Others (specify) ☐ Do not know

In case of Injury, Illness or disease, or Malnutrition, ask:

Is this condition due to Syria crisis related incidents since 2011?

☐Yes ☐No ☐ Do not know ☐Refuse to answer

Is [name] able to access the specialized services needed? What are those services? (Select as many as appropriate).

YES	☐ Prosthetics and Orthotics ☐ Assistive Devices (cane, walking stick, walker, crutches, wheelchair, hearing aids…) ☐ Physiotherapy, occupational therapy, speech therapy, ☐ Accessible information (sign language, Braille texts, large print) ☐ Mental health and psychosocial support (e.g psychotherapy, counselling)
NO	☐ Support to employment: (e.g accessible career guidance, employability skill training) ☐ Support to education : (e.g trained (para) teacher, modified learning materials ☐ Others .

Reasons for not accessing services (answer category: same as * above)
If NO, WHY is it difficult to access the given services? Main reasons (multiple answers) READ LIST.

Enabling factors to facilitate access to services
Among those the reasons above mentioned as problems, what will be the major issue to be prioritized, and help you access services? (specify one reason)

ACCESS TO EDUCATION (for children 6-12 years old, with & without FUNCTIONAL DIFFICULTIES)

Now, I would like to ask you about (NAME)'s educational status.

Your children's education status (per child)

Name	Gender	Age	Status	This is an instruction directed at HI enumerators: do NOT read aloud If currently attending or enrolled in school before
	☐ M ☐ F		☐ Attending partially 1-3 times/week ☐ Attending regularly 4-5 times/week ☐ Never enrolled ☐ Enrolled but dropped out (at age of _____) , in grade ___)	Type of school ☐ Public (government) ☐ Private Type of education ☐ Formal education - Ministry of Education (MOE) certificate obtained a. Regular school b. Double shifted school – morning shift c. Double shifted school – afternoon shift ☐ Non-Formal education (catch up) - MOE certificate obtained ☐ Informal education (delivered by Community-Based Organizations [CBOs], educational activities) - NO MOE certificate ☐ Specialized (special needs) a. special unit in mainstream school (resource room) (select the type of school to which the special unit belongs) ☐ Formal education - MOE certificate obtained a. Regular school b. Double shifted school – morning shift c. Double shifted school – afternoon shift ☐ Non-Formal education (catch up) - MOE certificate ☐ Informal education (delivered by Community-Based Organizations [CBOs], educational activities), NO MOE certificate b. Special schools If attending → go to 1, 2 & 4 If not → go to 3 & 4

1. (For a child **attending** school/learning spaces) What does (name of the child) tell you that (name of the child) likes most about the school/learning space? Per Child: READ LIST. Select/record as many as mentioned.

- ☐ To play with other children (socialization)
- ☐ To participate in recreational activities such as sports, games, singing and dancing, music…. (socialization)
- ☐ To study new topics (learning, topic)
- ☐ To learn skills such as how to read and write, or do calculations (learning, skill related)
- ☐ To talk to teachers (interaction)
- ☐ To go to a new environment and have a change from home (home related reasons)
- ☐ Others (specify)

Annexes

2. (For a child attending school/learning spaces) What are your concerns about (name of the child)'s learning and experience at school/learning space? Per child. READ LIST. Select/record as many as mentioned.
→ Among identified, what are the 3 major issues? Please select.

- ☐ Child's psychological distress which significantly affects his/her ability to learn
- ☐ Child's health condition reduce attendance or ability to learn or participate in learning
- ☐ Child's functional difficulties affects his/her learning
- ☐ Financial constraints (fees, transport, materials)
- ☐ Distance to school (>2km) / Safety fears for movement outside home
- ☐ Overcrowded classrooms / Inaccessible classrooms / Inaccessible toilets / Toilets not clean and safe
- ☐ Physical and/or verbal abuse from teachers/staff / Teacher/staff do not care about my child
- ☐ Bullying, nicknaming, intimidation and violence from children from host communities
- ☐ Bullying, nicknaming, intimidation and violence from children from the refugee community (Syrian peers)
- ☐ Not learning or progressing due to:
  - ☐ Poor quality of teaching
  - ☐ Lack of personalized support for my child's learning (e.g. support teacher, sign language interpreter)
  - ☐ Poor quality of learning materials
  - ☐ Lack of accessible learning materials
  - ☐ Limited learning time at school/learning spaces
- ☐ School time not appropriate
- ☐ Not applicable (no difficulties)
- ☐ Other (specify)

3. If your child was **never enrolled in or dropped out of school**, what are the reasons? Per child. READ LIST. Select/record as many as mentioned.
→ Among the reasons identified, what are the 3 major issues? Please select.

- ☐ Child marriage/engagement (if this is mentioned, specify at which age _____)
- ☐ Education is not important (cultural, not useful)
- ☐ Missed 3 or more years of education
- ☐ Fears for non-completion of primary education or non-continuation to secondary/further education with valid certificate, despite investment
- ☐ Lack of documentation (ID/school records/UNHCR Card, visa etc)
- ☐ Refused entry (general) / Refused entry due to functional difficulties
- ☐ Fears of community stigma (for child and family)due to enrolling a child with functional difficulties in school
- ☐ Helping with house chores / Helping with economic activities for the household

(THE LIST CONTINUES: THE SAME ANSWER CHOISES UNDER 2 ABOVE)

4. What will encourage you to send/ send again/ continue sending your child to school? READ LIST and answer 'yes', 'no' or 'do not know' to each.

□ My child gets appropriate health care/ rehabilitation/ psychosocial support	Yes / No / Do not know
□ Household financial situation improves	Yes / No / Do not know
□ School admission criteria changed and my child is encouraged to enrol/ re-enrol	Yes / No / Do not know
□ Community awareness raising sessions undertaken to sensitize people to the idea of children with disabili-ties being in school	Yes / No / Do not know
□ Safety mechanisms put in place from home to school/ learning space	Yes / No / Do not know
□ Safety mechanisms put in place inside school/ learning space	Yes / No / Do not know
□ Nearby school/ learning spaces become accessible	Yes / No / Do not know
□ Other students are encouraged to be friendly	Yes / No / Do not know
□ Teachers are trained to welcome and help every child	Yes / No / Do not know
□ Teachers are trained to teach more effectively every individual child	Yes / No / Do not know
□ Learning materials or aids OR assistive devices (e.g mobility aids) are available	Yes / No / Do not know
□ More recreational activities	Yes / No / Do not know
□ Find another school/ other learning spaces	Yes / No / Do not know
□ Find special school/ learning space with special needs education teachers	Yes / No / Do not know
□ Education, social or other authorities contact me in person for orientation/ orientation visits with children	Yes / No / Do not know
□ Support or shadow-teachers are assigned	Yes / No / Do not know
□ Latrines become accessible, clean and safe	Yes / No / Do not know
□ Smaller class size	Yes / No / Do not know

Other (specify)

Annexes

I will read some statements about education. Please tell me to what extent you agree with the statements. There is no right or wrong answer.

Awareness about inclusive education as a principle and in reality

1. All children have the right to education and all children can learn	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
2. Education is important to ensure a better future for children	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
3. If I have to choose, I prioritize among my children who will access ed-ucation according to gender, disability and age	No	Yes boy or girl	Yes With disabilities or without	Yes Order or younger	
4. If my child(ren) are engaged or married, it is acceptable that s/he does not attend school/learning spaces	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
5. If my child(ren) are contributing to income of the household, it is ac-ceptable that s/he does not attend school/learning spaces	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
6. I assist my child(ren)'s learning at home and listen to what they expe-rience in classrooms	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
7. I have low expectations for my child(ren)'s academic progress	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
8. Teachers provide enough information about my child(ren)'s situation in classrooms, curriculum, homework, class activities, exam, etc	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
9. I am confident and comfortable to discuss any issue related to my child(ren)'s education with teachers and/or staff from the school/learning space	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
10. It is good for children to study with children from different back-grounds and with various characteristics	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
11. Children with disabilities in a classroom will decrease the quality of learning for children without disabilities	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
12. Children with specific disabilities will not learn	Strongly disagree	Disagree	Neutral	Agree If agree somehow, which disability? ☐ Intellectual ☐ Psychosocial ☐ Visual ☐ Hearing ☐ Physical ☐ Communication	Strongly agree
13. Children with disabilities can learn better in special schools educated by specially trained teachers	Strongly disagree	Disagree	Neutral	Agree	Strongly agree

Annexes

Thank you so much for your participation in the survey. Do you have any questions?

If you agree, at another time, I am keen to talk to your child about their opinions and experiences about education. Do you agree? (if yes) If so, I will contact you to make an appointment. Confirm the telephone number.

If you are interested, I have information brochures about different services.

Thank you.

END

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