Power of Inclusion

Mapping the Protection Responses for Persons with Disabilities Among Refugees in the Middle East and North Africa Region

November 2019

UNHCR
The UN Refugee Agency

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Abdo's wife cooks a meal for her children in their tent at a hosting site for internally displaced families in Aden. Abdo, who has disabilities, fled his home in Taizz with his family when fighting escalated in their area.

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Compiled by independent consultant, Tatjana Klein © United Nations High Commissioner for Refugees (UNHCR)
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Alya shares a ride and a laugh with Mohammed, a wheelchair-bound Syrian refugee whom Alya emotionally supports.

Executive Summary

The aim of the exploratory mapping is to facilitate an improved understanding of the extent to which the current refugee[1] protection response serves persons with disabilities. It establishes a preliminary baseline to inform future strategic and operational planning. The report maps the protection responses to persons with disabilities across 15 countries[2] in the Middle East and North Africa (MENA) region and Turkey.

Refugees and asylum seekers with disabilities face multiple and intersecting forms of disadvantages, are at significant risk of being 'left behind'[3] and are prevented from realising their full rights under a range of international instruments. A large majority of the refugees and asylum seekers in the MENA region and Turkey are in situations of protracted displacement. The multiple and intersecting forms of disadvantages experienced by persons with disabilities require a coordinated, systematic and sustained approach which builds the response capacity and strengthens the national systems to support all persons with disabilities, regardless of status. The mapping documents the current refugee protection response to persons with disabilities through the dual lens of human rights mainly, the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) and the global sustainable development agenda.

All the countries that are part of this study have signed the UNCRPD. As per this convention, the national legal framework is robust, but policies and practices are fragmented and weak. The Article 31 of UNCRPD commits

> "States Parties undertake to collect appropriate information, including statistical and research data, to enable them to formulate and implement policies".

The lack of statistical information has hindered data driven planning related to persons with disabilities, and as a consequence, also implementation, monitoring, and disaggregated reporting. Humanitarian planning do not explicitly cite persons with disabilities as a category for support, and do not include disaggregated indicators and targets.

Refugee children with disabilities are not realising their right to education. The lack of quantitative data is preventing the evidence-based, systematic and large-scale advocacy, programming and fundraising required to address this tragic situation of out-of-school children with disabilities.

The UNHCR community-based protection approach aims to empower communities and increase the participation of marginalized groups including the persons with disabilities. The current social and community initiatives provide an ideal platform for participation and inclusion of persons with disabilities, while also addressing specific issues such as low confidence and societal stigma. When these are addressed through social engagement, it facilitates the transition to education, health and livelihood opportunities. Conversely, social isolation increases risks of violence, exploitation and abuse.

In contexts where equal access to wage employment is difficult for persons with disabilities due to stigma, discrimination and inaccessible work environments, cash assistance where combined with other protection interventions provides an important social protection mechanism. The comparative independence that comes with social protection systems in some countries is missing in the refugee context.

The protection response for persons with disabilities is multifaceted and requires humanitarian, development and host government entities to coordinate and collaborate. Strategic and systematic expansion of partnerships could serve to increase advocacy efforts, improve referral and support options, and ensure the most efficient use of limited funding by leveraging each actor's specialist expertise and vested interests. In the context of refugee situation, partnerships with Disabled People's Organisations and specialized national-level entities is vital to achieving the required scope and scale.

[1] The terms 'refugee' and POC are used in this report to refer to recognised refugees as well as asylum-seekers. The report excludes data on internally displaced, stateless and other populations of concern to UNHCR. Where there are differential experiences between asylum-seekers and refugees, these are highlighted and differentiated.

[2] Algeria, Egypt, Iraq, Israel, Jordan, Kuwait, Lebanon, Libya, Mauritania, Morocco, Saudi Arabia, Syria, Tunisia, United Arab Emirates, Yemen.

[3] 2030 Agenda for Sustainable Development, 193 United Nations Member States pledged to ensure "no one will be left behind".

Key Recommendations

Carry out country level research to guide data-driven advocacy and strategic planning

1. Conduct a mapping of national government health services (as per law or policy and disaggregated by nationality), and document specific barriers to access and inclusion, costs, eligibility and waiting lists.

2. Assess the availability of the rehabilitation services and access to assistive devices for persons with disabilities in the national and local context. Include costs, services, quality and eligibility. Based on the mapping, develop a Directory of Rehabilitation and Device Providers.

3. Review the status of all formal schools which have been supported to become 'inclusive' and commence systematic referrals and follow up. Support research initiatives which seek to analyse the specific status of schools currently considered 'inclusive' and determine the support require for the current schools to accommodate children with autism and intellectual disabilities.

4. Conduct a mapping of national employment services or agencies including NGOs, and gather information related to eligibility for refugees and support for persons with disabilities to access waged employment. Ascertain the extent to which refugees can avail of national employment quotas for persons with disabilities, and advocate to national governments for refugee inclusion in quotas.

5. Based on the findings, and in collaboration with UN agencies, DPOs and humanitarian and development actors, conduct systems level advocacy to garner increased support from bilateral donors and host governments for the participation and inclusion of persons with disabilities under the rights enshrined in the UNCRPD.

6. Improve the identification of persons with disabilities holistically (by strengthening reach out and community-based identification mechanism; using the Washington Group Short Set of Questions on Disability; providing training to the staff; regularly updating proGres as persons with disabilities are identified through ongoing programming) and by having a greater cooperation between government, humanitarian partners, community entities, specialist organisations and disabled people's organisations (DPOs).

Joint humanitarian and development planning, monitoring and reporting

1. Integrate disability data collection methods into agency specific or sector-wide information management systems and processes which link identification, needs assessments and response.

2. Advocate for all regional level Regional Refugee and Resilience Plan (3RP) partners to use data disaggregated by age, sex, and disability in planning and reporting.

3. Update or use existing information management systems (e.g. Activity Info, RAIS) to include fields which disaggregate by disability.

4. Incorporate inclusion of persons with disabilities in all Requests for Proposals (RFPs) and Project Partner Agreements (PPAs), and related reporting requirements with disability disaggregated data.

5. Use existing coordination mechanisms to advocate for all humanitarian actors to collect and use data on persons with disabilities in program management processes.

6. Make the existing system inclusive for monitoring and reporting on referrals across programs, projects, sectors and government and non-government agencies.

7. Adopt the twin-track approach to program planning: disability-specific support and mainstreaming. Sector specific guidelines on universal design and reasonable adjustments provide strategies to improve mainstreaming (e.g. ILO documents for inclusion of persons with disabilities in livelihoods[4]).

8. Advocate for disability-specific (e.g. rehabilitation, assistive devices, respite care) and inclusive indicators and targets in all relevant regional and national humanitarian and developmental response plans and programmes.

9. Integrate activities and budget for reasonable accommodation and universal design into program documents (e.g. transport, workplace adjustments, accessible information, communication aids).

Coordination and Partnerships

1. Develop strategic partnerships between humanitarian actors and the Arab Organization of Persons with Disabilities (AOPD) with the overall goal of ensuring that the needs and priorities of refugees and asylum seekers are included in regional level advocacy campaigns and planning documents.

2. Develop a global strategic partnership with the International Disability Alliance (IDA) and collaborate to develop key points of advocacy to improve the responses for persons with disabilities in humanitarian contexts.

3. Strengthen advocacy and support through strategic alliances amongst international agencies (for example, the ILO for livelihoods, UNICEF for education, the WHO for health and rehabilitation, UNDP for national development planning, as well as UNFPA, and others, where relevant).

4. Develop partnerships between humanitarian agencies and NGOs with technical expertise, for example, Humanity & Inclusion (HI) and Help Age International.

5. Develop partnerships between humanitarian agencies and national DPOs and CBOs.

6. Explore private partnerships for practical support with items such as assistive devices or as part of Corporate Social Responsibility priorities.

Training and capacity building

1. Collaborate with DPOs to create joint resources, e.g. training materials and resource directories.

2. Conduct a Humanitarian Training Needs Analysis (TNAs) based on a structured survey disseminated to direct partners, and key agencies engaged in the humanitarian response in each country. Based on the collated findings

[4] International Labour Organization (2016). Promoting Diversity and Inclusion through Workplace Adjustments. Geneva. Available at https://www.ilo.org/wcmsp5/groups/public/---ed_norm/---declaration/documents/publication/wcms_536630.pdf, retrieved 9/9/2018.

of the TNAs, identify, source and/or develop a suite of training products which can be tailored and contextualised to different country contexts. Draw on existing training content and develop partnership for capacity development activities with agencies (e.g. WHO, HI, ILO, UNICEF, HelpAge International) where possible.

3. Develop partnerships with higher education institutions for systemic capacity building, especially in countries with a lack of qualified social welfare and psychology university degrees or cadre.

4. Support initiatives and partnerships with government and NGOs who are working to increase the rehabilitation workforce, including training and retention of rehabilitation personnel.

Initiatives to promote social inclusion, empowerment and self-reliance

1. Develop strategies for minimum participation of persons with disabilities on all refugee self-management committees.

2. Proactively promote a diverse representation of persons with disabilities in all social activities.

3. Prioritise children and youth with disabilities for engagement in social activities to address protection risks.

4. Improve inclusion of persons with disabilities in initiatives to support small business development, such as microcredit and entrepreneurial skills development.

5. Support employment opportunities for persons with disabilities (host population and refugees) within UNHCR and other international agencies and NGOs (recognizing the knowledge they have of inclusion, as well as their potential to act as role models and to reduce stigma).

Six year old Habasah and five year old Ali are two of the of the children at the Early Learning centres (ELC) for children with specific needs run by UNHCR's partner Intersos.

Ali is hard of hearing, and has been attending classes at the centre since Dec 2017. Habasah has a mental disability.

This centre is in Kharaz refugee camp, and is one two such centres. The other centre is in the Basateen area (in Aden, southern Yemen) and serves refugees children with specific needs living in urban areas. Mokhatar has a mental and physical disability according to the teachers at the centre.

Setting the context

Refugees and asylum seekers with disabilities face multiple and intersecting forms of discrimination, are at significant risk of being 'left behind'[5] and are prevented from realising their full potential and face barriers to enjoying their rights under a range of international instruments. Persons with disabilities can be among the most marginalised members of their communities, and their vulnerability is often exacerbated in situations of forced displacement. Stigmatisation, isolation and perceptions that they are a "burden" to their families can further compromise their dignity, safety, security and access to services. The protection of persons with disabilities has increasingly been the renewed focus of attention at the local and regional level – both in humanitarian and resilience responses – due to the dynamics of armed conflict, the patterns of human rights violations and the resulting forced displacement. In this context, the aim of the exploratory mapping is to facilitate an improved understanding of the extent to which the current refugee[6] protection response serves persons with disabilities. It establishes a preliminary baseline to inform future strategic and operational planning. The report maps the protection responses across 15 countries[7] in the Middle East North Africa (MENA) region and Turkey.

> *"Refugees and displaced persons living with disabilities are amongst the most hidden, excluded and neglected of all displaced persons"*[8]

Persons with disabilities are among the most marginalized in any crisis-affected community[9]. They are over-represented among those living in poverty[10], and face barriers to accessing protection, assistance and solutions. They are at heightened risk of violence, including sexual and domestic abuse, exploitation by family members and multiple and intersecting forms of discrimination. Furthermore, they are more likely to face barriers to accessing humanitarian assistance, education, livelihoods, health care and other services[11]. The mapping documents the current refugee protection response (and the intersection of disability and displacement) through the dual lens of human rights and the global sustainable development agenda.

From its inception, UNHCR has used a rights-based approach to work with refugees, asylum-seekers, returnees, stateless persons and internally displaced persons[12]. In addition, the rights of persons with disabilities are protected through the UNCRPD. Recent decades have seen a shift away from the previous, charity and/or medical models, to a social model and rights-based approach. The following components of the UNCRPD are relevant to this report:

- Human rights – recognizing the need to promote and protect the rights of all persons with disabilities, including those who require more intensive support;
- Sustainable development – emphasizing the importance of mainstreaming disability issues as an integral part of relevant strategies of sustainable development;
- Diversity – recognizing further the diversity of persons with disabilities.

In addition, addressing the needs of persons with disabilities is fundamental to the achievement of the global sustainable development agenda (Sustainable Development Goals 2030 Agenda)[13] which all governments and the United Nations have committed to. Persons with disabilities, including refugees, are among the groups that are at the highest risk of being "left behind" and the Sustainable Development Goals (SDGs) targets may not be met if their right to social inclusion and participation is not addressed across all the Goals. A large majority of the refugees and asylum seekers in the MENA region and Turkey are in situations of protracted displacement.[14] The response to these situations has been evolving with increased coordination between humanitarian and development agencies and increased donor support for systems strengthening. The multiple and intersecting forms of disadvantage experienced by persons with disabilities require a coordinated, systematic and sustained approach which builds the capacity of host governments to support all persons with disabilities, regardless of status.

[5] 2030 Agenda for Sustainable Development, 193 United Nations Member States pledged to ensure "no one will be left behind".

[6] The terms 'refugee' and POC are used in this report to refer to recognised refugees as well as asylum-seekers. The report excludes data on internally displaced, stateless and other populations of concern to UNHCR. Where there are differential experiences between asylum-seekers and refugees, these are highlighted and differentiated.

[7] Mauritania, Morocco, Algeria, Tunisia, Libya, Egypt, Israel, Jordan, Lebanon, Syria, Iraq, Turkey, Yemen, United Arab Emirates, Saudi Arabia, Kuwait

[8] Reilly (2007), Disabilities among refugees and conflict-affected populations, Forced Migration Review Journal 35, retrieved https://www.fmreview.org/disability-and-displacement/rachael-reilly

[9] General Assembly, One Humanity: Shared Responsibility, Report of the Secretary-General for the World Humanitarian Summit A/70/90 (2 February 2016), available from undocs.org/A/70/709

[10] World Health Organization and the World Bank, World Report on Disability (2011) http://www.who.int/disabilities/world_report/2011/report.pdf

[11] UNHCR 2019, Need to Know Guidance: Working with Persons with Disabilities in Forced Displacement, https://www.unhcr.org/4ec3c81c9.pdf

[12] More specifically, UNHCR also has numerous guidance materials to ensure protection responses are participatory, non-discriminatory, and sensitive to the specific needs of all persons of concern (POCs). Operational activities are guided by the age, gender and diversity (AGD) and community-based protection (CBP) approaches. Relevant documents include: Policy on Age, Gender and Diversity (2018), http://www.unhcr.org/protection/women/5aa13c0c7/policy-age-gender-diversity-accountability-2018.html; Need to Know Guidance on Working with Persons with disabilities in Forced Displacement (2011), http://www.unhcr.org/4ec3c81c9.pdf; UNHCR Executive Committee Conclusion No 110 (2010) on Persons with Disabilities http://www.unhcr.org/excom/exconc/4cbeb1a99/conclusion-refugees-disabilities-other-persons-disabilities-protected-assisted.html. The principle of non-discrimination is referenced in other UNHCR documents and handbooks.

Background-Literature Review

Disability, displacement and conflict

More than one billion people worldwide, or about 15 per cent of the global population, have a disability. People with disabilities are recognized as among the most marginalized and at-risk population in any crisis-affected community. An estimated 9.7 million people with disabilities are forcibly displaced as a result of conflict and persecution and are victims of human rights violations and conflict-related violence.[15] Armed conflicts and emergency situations increase the barriers faced by persons with disabilities. In crisis situations, persons with disabilities require the same assistance common to all those affected, in addition to specific requirements related to disability [16]. Addressing vulnerability in a humanitarian emergency is highly challenging. The context of disability, displacement and conflict creates a situation with multiple cause and effect scenarios. The key findings of the literature review and the qualitative information from this study found that: firstly, disability with displacement and conflict creates a situation of increased vulnerability [17]; secondly, disability and displacement reduce family and community support systems, as well as limited or variable access to national services; thirdly, the prevalence of disability is higher in displacement contexts due to the number of conflict acquired impairments and the creation of new barriers; and finally, the experience of disability in a context of displacement and ongoing conflict creates multiple barriers which also impede the response capacity of humanitarian actors.

Conflict acquired impairments, disruption of services and the creation of new barriers increase the prevalence of disability in displacement contexts. The WHO cites an increase from 15 per cent in any given population, to 18-20 per cent in humanitarian settings [18]. Disability and displacement in a conflict situation (e.g. Iraq, Libya, Syria, and Yemen) significantly impedes access to services. In some cases, morbidity of persons with disabilities in a disaster has been estimated at a rate four times higher than those without disabilities [19].

Disability and gender

Negative attitudes, perceptions and practices towards people with disabilities are present in many communities but are multiplied in the context of displacement. In refuge setting, the extent to which the culture of the country of origin accepts and includes persons with disabilities matters a lot for creating protection space and welling-being for persons with disabilities. Culturally embedded attitudes about gender significantly impact the experience of disability, and vary depending on social, cultural and religious contexts. Firstly, the prevalence of certain types of disability can vary between males and females. In some cases, impairments are acquired because of gender roles. For example, according to the experience of the Fred Hollows Foundation, there is a significant gender disparity in the impact of blindness, and some causes are due to the caring role that women have.[20]

Secondly, cultural attitudes and assumptions impact the level of support and education provided by the family. For example, a girl with a slight impairment may be fully functional, but considered impure and unfit for marriage, making education unnecessary in the eyes of her parents. By contrast, a boy with a more severe impairment within the same household might be sent to school and given support that greatly diminishes the influence of the impairment [21]. In the long term, access to education has an impact on the experience of disability. Similarly, some families may prevent women and girls with disabilities from participating in social activities outside the home. In addition, while gender equality is an important aspect of development, women and girls with disabilities are often excluded from mainstream development programmes. Girls with disabilities are less likely to be included in youth or recreational programmes [22].

Thirdly, household and gender roles change when someone has a disability. Men with disabilities may have less opportunity to work, making women in the household responsible for income and assistance. During the focus group discussion, some male participants expressed a sense of low self-esteem due to their inability to work. Women with disabilities may find it hard to continue performing the many duties expected of them by their family, spouse and society. They may subsequently be alienated from their family, abused by a husband or stigmatised by the community.

[13] Refugees and asylum-seekers with disabilities are at increased risk of multidimensional disadvantage. With the adoption of the 2030 Agenda for Sustainable Development, 193 United Nations Member States pledged to ensure "no one will be left behind". Five factors are key to understanding who is being left behind and why: discrimination; place of residence; socio-economic status; governance; and vulnerability to shocks (UNDP 2015).

[14] Protracted refugee situation is defined as "one in which refugees find themselves in a long-lasting and intractable state of limbo. Their lives may not be at risk, but their basic rights and essential economic, social and psychological needs remain unfulfilled after years in exile. A refugee in this situation is unable to break free from enforced reliance on external assistance" (UNHCR 2014). It is further clarified that "refugee populations as persons who have lived in exile for the duration of five years or more without sign of resolution" (UNHCR 2014) is considered as protracted.

Disability and violence

The mapping and review of literature provides evidence that persons with disabilities are disproportionately susceptible to violence. The WHO cites stigma, negative traditional beliefs and ignorance as factors, and highlights the increased risk of physical, sexual, psychological and emotional abuse, neglect, and financial exploitation. Women with disabilities may be particularly exposed to forced sterilization and sexual violence[23]. Two systematic reviews on violence and disability conducted in 2012 [24] found that

> *"both children and adults with disabilities are at much higher risk of violence than their non-disabled peers".*

The review on the prevalence and risk of violence against children with disabilities[25], published in July 2012, found that overall children with disabilities are almost four times more likely to experience violence than non-disabled children.

> *"Children with disabilities are 3.7 times more likely than non-disabled children to be victims of any sort of violence, 3.6 times more likely to be victims of physical violence, and 2.9 times more likely to be victims of sexual violence. Children with mental or intellectual impairments appear to be among the most vulnerable, with 4.6 times the risk of sexual violence than their non-disabled peers".*

Persons with disabilities may be isolated in their homes, overlooked during needs assessments and not consulted in the design of programs. Persons with disabilities have difficulty accessing humanitarian assistance due to a variety of societal, environmental and communication barriers. This decreases access to information about prevention and support services as well as accessing the available services.

[15] https://www.hrw.org/news/2018/12/03/un-wars-impact-people-disabilities
[16] International Disability Alliance, Article 11, http://www.internationaldisabilityalliance.org/art11
[17] World Health Organization (2011). World Report on Disability. Geneva. Available at https://www.who.int/disabilities/world_report/2011/report.pdf, retrieved 23/09/2018.
[18] World Health Organization (2011). World Report on Disability. Geneva. Available at https://www.who.int/disabilities/world_report/2011/report.pdf, retrieved 23/09/2018.
[19] Peters, Susan J. (2009). Review of marginalisation of people with disabilities in Lebanon, Syria and Jordan. United Nations Educational, Scientific and Cultural Organization: Paris. Available at https://unesdoc.unesco.org/ark:/48223/pf0000186600_eng, retrieved 23/09/2018
[20] https://www.hollows.org/au/what-we-do/ending-avoidable-blindness
[21] Peters, Susan J. (2009). Review of marginalisation of people with disabilities in Lebanon, Syria and Jordan. United Nations Educational, Scientific and Cultural Organization: Paris. Available at https://unesdoc.unesco.org/ark:/48223/pf0000186600_eng, retrieved 23/09/2018.

Disability and education

In non-displacement contexts, studies have found that disability is a stronger correlate of non-enrolment in school than either gender or class. Empirical evidence from across the world indicates that children with disabilities tend to have lower enrolment rates than children without disabilities [26]; therefore, achieving Sustainable Development Goal 4 (Education) is not possible if the barriers facing children with disabilities are not systematically addressed.

Poverty, marginalization and discrimination are the main barriers to inclusive education [27]. It is estimated by the United Nations Educational, Scientific and Cultural Organization (UNESCO) that over 90 per cent of children with disabilities in low-income countries do not attend school; and an estimated 30 per cent of the world's street children live with disabilities. [28] Poverty is both a cause and effect of lack of access to education.

> *"Children with disabilities who are excluded from education are virtually certain to be long-term, lifelong poor [...] Children with disabilities from poor families continue not to be educated, and the cycle of poverty goes on".* [29]

[22] World Health Organization (2010). Community-Based Rehabilitation Guidelines-Social component, Geneva. Available at https://www.who.int/disabilities/cbr/guidelines/en/, retrieved 12/11/2018.
[23] World Health Organization (2010). Community-Based Rehabilitation Guidelines-Social component, Geneva. Available at https://www.who.int/disabilities/cbr/guidelines/en/, retrieved 12/11/2018.
[24] / [25] Hughes K, Bellis MA, Jones L et al. (2012) Prevalence and risk of violence against children with disabilities: a systematic review and meta-analysis of observational studies. Lancet. 2012; 380: 899-907, retrieved Dec 2018, https://www.who.int/disabilities/violence/en/
Hughes K, Bellis MA, Jones L et al. (2012) Prevalence and risk of violence against adults with disabilities: a systematic review and meta-analysis of observational studies. Lancet. 2012; 379: 1621-1629, retrieved Dec 2018, https://www.who.int/disabilities/violence/en/
[26] UNESCO, 2015, Global Education Monitoring Report: Summary on Disabilities and Education (paper covering 2010-2015) retrieved 08 July 2019, https://en.unesco.org/gem-report/sites/gem.../GAW2014-Facts-Figures-gmr_0.pdf.pdf
[27] UNESCO (2007) Education for all by 2015. Will we make it? Education for All global monitoring report, http://unesdoc.unesco.org/images/0015/001548/154820e.pdf, accessed 5 May 2010).
[28] UNESCO (2010) Children with disabilities. Paris, UNESCO (undated, www.unesco.org/en/inclusive-education/children-with-disabilities, accessed 5 May 2010).
[29] World Health Organization (2010). Community-Based Rehabilitation Guidelines-Education component, Geneva. Available at https://www.who.int/disabilities/cbr/guidelines/en/, retrieved 12/11/2018.

Disability and health

A social model of disability and a human rights approach to health have yet to be systematically reflected in the design and delivery of service systems in the MENA region [30]. The key facts cited in the WHO Report [31] are:

- Persons with disabilities have the same general health care needs as others but are three times more likely to be denied healthcare;
- 50 per cent of people with disabilities can't afford healthcare;
- Persons with disabilities are four times more likely to be treated badly in the healthcare system;
- Persons with disabilities are 50 per cent more likely to experience catastrophic health expenditure, and the out-of-pocket health care expenses can push a family into poverty;
- Production of hearing aids only meets 3 per cent of needs in developing countries;
- 75 million people need a wheelchair, but only 5-15 per cent have access to one;

The findings of the mapping identified multiple barriers to accessing healthcare. As refugees with partial and limited access to national healthcare systems, the barriers (according to the WHO) are compounded for refugees living in the MENA region due to the following factors [32]:

- Absent or inappropriate policies and legislation;
- Economic barriers to health interventions such as assessments, treatments and medications, which often require out-of-pocket payments;
- Physical and geographical barriers;
- Communication and information barriers;
- Poor attitudes and knowledge of health workers about people with disabilities;
- Poor knowledge and attitudes of people with disabilities about general health care and services, meaning people with disabilities may be reluctant to use health services;

Family members may experience challenges related to the lack of support systems available for people with disabilities including stress-related physical and emotional illness, reduced ability to care for other children, reduced time and energy for work, reduced social interaction and stigmatization [33]. The review of secondary literature found limited research on the experiences of caregivers in situations of displacement. In the absence of national level support systems, the role of family is increased. Traditional community-based rehabilitation (CBR) approaches advocate for leveraging the role of caregivers, particularly to support rehabilitation [34]. Increasing the capacity of caregivers provides a sustainable approach with the proviso that the role is acknowledged and supported.

[30] Hakim, Guillermo; Jaganjac, Nedim. 2005. A note on disability issues in the Middle East and North Africa (English). Washington, DC: World Bank. http://documents.worldbank.org/curated/en/912231468110689787/A-note-on-disability-issues-in-the-Middle-East-and-North-Africa

[31] World Health Organization (2011). World Report on Disability. Geneva. Available at https://www.who.int/disabilities/world_report/2011/report.pdf, retrieved 23/09/2018.

[32 / 33 / 34] World Health Organization (2010). Community-Based Rehabilitation Guidelines-Health component, Geneva. Available at https://www.who.int/disabilities/cbr/guidelines/en/, retrieved 12/11/2018.

Disability, poverty and access to livelihoods

The link between increased likelihood of poverty and disability is well established through several scholarly articles and reports, most notably the WHO World Report on Disability [35].

Where reliable statistics are available, these show that the unemployment rates of persons with disabilities are higher and, more significantly, their labour market participation rates are well below those of people without disabilities [36]. People with disabilities face many barriers to finding decent wage employment [37]. Lack of physical and communication accessibility in addition to discriminatory attitudes and policies is a major barrier for persons with disabilities: discrimination, as well as inaccessible public transport, workplaces and communications mean that it may be impossible for people with disabilities to get to work and do their job [38].

Social protection measures are intended to provide a safety net. The UNCRPD requires States to recognize the right of persons with disabilities to social protection and to the enjoyment of that right without discrimination on the basis of disability (Article 28). Most people, both with and without disabilities, in low-income countries rely on informal systems of social protection based on the family and local community. [39] In contexts where the family and community are fragmented due to displacement, family and community support options are limited. The result can be strained relations, exploitation, and in some cases, abuse and neglect.

[35] World Health Organization (2011). World Report on Disability. Geneva. Available at https://www.who.int/disabilities/world_report/2011/report.pdf, retrieved 23/09/2018.
[36] International Labour Organization (2015). Disability Inclusion Strategy and Action Plan 2014-17: A Twin-Track Approach of Mainstreaming and Disability-Specific Actions. Geneva. Available at https://www.ilo.org/wcmsp5/groups/public/---ed_emp/---ifp_skills/documents/genericdocument/wcms_370772.pdf, retrieved 09/09/2018.
[37] World Health Organization (2010). Community-Based Rehabilitation Guidelines-Livelihoods component, Geneva. Available at https://www.who.int/disabilities/cbr/guidelines/en/, retrieved 12/11/2018.
[38] World Health Organization (2010). Community-Based Rehabilitation Guidelines-Livelihoods component, Geneva. Available at https://www.who.int/disabilities/cbr/guidelines/en/, retrieved 12/11/2018.
[39] Community-Based Rehabilitation: CBR Guidelines; https://www.ncbi.nlm.nih.gov/books/NBK310964/

Data Collection Methods

The mapping study was exploratory. The recommendations highlight the need for additional disaggregated data for tailored and inclusive programming and research into inclusive national services for refugees.

Data Collection Tool	Data Sources
Semi-structured interviews	With assigned disability focal points in all countries
Quantitative survey	Completed by eight countries
Key informants (KIs) interviews	Sector focal points and, staff from the partners
Focus group discussions	Sector focal points and, staff from the partners With persons with disabilities in Jordan, Lebanon and Egypt (Annual participatory assessment notes prepared based on the discussion with persons with disabilities were received from Iraq, Algeria, Mauritania and Yemen)
Secondary literature	Reports, tools, and policy and practice documents (e.g. Referral Pathways, ToRs for Committees)
Good practices and case studies	Completed by eight countries

Limitations

As anticipated, and as is documented in other reports and legal instruments [40], data disaggregated by disability is limited, and constrained a scientific and evidence-based approach to impact analysis. The method adopted in the mapping involved a review of secondary information to complement and further validate the findings of the primary research. In some sections of the report, in cases where primary sources were limited, secondary sources are used to convey statistical trends. Other limitations included a low response rate on the quantitative survey and an overall limited consistency in the responses across countries (timing, quantity, quality).

Reports and documents pertaining to disability-specific responses provided data on current activities. However, it was not possible to ascertain the extent of the impact (the percentages) because the overall data field from the UNHCR registration sources, and other sources such as governments and NGOs, significantly under-represents the actual number of people with disabilities due to lack of systematic reporting system in place.

There is no information loop which links protection responses back to identified needs, nor back to initial classification in the current registration system. Thus, an impact evaluation was not possible.

Regarding the inclusion of persons with disabilities across all programs, sector data currently does not disaggregate with disability. All internal UNHCR and NGO partner reports clearly disaggregate by age, location, nationality and sex but not by disability status. Secondary sources such as humanitarian and development reports also do not disaggregate by disability.

[40] World Health Organization (2011). World Report on Disability. Geneva. Available at https://www.who.int/disabilities/world_report/2011/report.pdf, retrieved 23/09/2018. UN Convention on the Rights of Persons with Disabilities

Key Findings

Wherever feasible, the key findings have been framed using the sectoral and functional distinctions commonly used in the MENA humanitarian and development sector responses.

Definition:
"Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participa-tion in society on an equal basis with others." [41]

Population Data and Information Management

UNCRPD Article 31 – Statistics and data collection

1. States Parties undertake to collect appropriate information, including statistical and research data, to enable them to formulate and implement policies to give effect to the present Convention.
2. The information collected in accordance with this article shall be disaggregated.

The importance of data collection and data disaggregation is highlighted in many documents and the UNCRPD commits states to this. Information management also remains a challenge to establishing an objective, valid and evidence-based baseline of the protection response for persons with disabilities. To adequately measure the protection response for persons with disabilities, the link and feedback loop between identification, protection assessments and protection support needs to be established.

Data and Trends

Due to the broad definition, the number of individuals who meet the definition of "persons with disabilities" is large. A 2011 joint report [42] by the WHO and the World Bank estimates that there are one billion people, i.e. one out of every seven people, with a disability across the globe. Most of this group has non-visible impairments, that is, the person's disability is not necessarily obvious to other people. The World Report on Disability estimates that 15 per cent of the world's population has a moderate or severe disability and that this proportion is likely to increase to 18-20 per cent in conflict-affected populations. Conversely, the inclusion of disability in collecting data in emergency and humanitarian contexts is very scarce, and publications [43] have referred to the 'invisibility' of persons with disabilities in crisis contexts.

UNHCR uses a statistical online population database (proGres) to register persons of concern and uses codes[44] to collect and flag specific needs and circumstances in biodata. Some of the codes which are relevant to this survey include those classified as Disability (DS) and as Serious Medical (SM). UNHCR is currently in the process of revising all special need codes linked to persons with disabilities, and to ensure alignment with the Washington Group Questions [45] on persons with disabilities, as a widely- used and tested tool in a variety of settings.

As of November 2018, there are 6,734,615 people of concern to UNHCR residing in the MENA region and Turkey. According to UNHCR registration data, as at November 2018, 93,494 persons are registered with a disability code. This figure with disability code is a significant under-identification (as compared to the figure cited by the WHO) and based only on the codes entered by UNHCR at the time of registration (and during continuous registration processes, or other staff and partners during the courses of protection monitoring and interventions) and does not include persons with chronic medical conditions, mental illness and other sources of registration (e.g. the Government in Turkey).

Under-identification of persons with disability is a common concern across the region either due to lack of awareness within the people of concern, concealment of disabilities or challenges in collecting disability related information at registration. It becomes challenging due

[41] United Nations (2006). Convention on the Rights of Persons with Disabilities (CRPD) A/RES/61/106, New York. Available at https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities.html, retrieved 11/11/2018

[42] World Health Organization (2011). World Report on Disability. Geneva. Available at https://www.who.int/disabilities/world_report/2011/report.pdf, retrieved 23/09/2018.

[43] "Hidden victims of Syrian Crisis" made by HelpAge and Handicap International in 2014; "Migrants and Disability: Invisible in the emergency" a study made by the Italian DPO, FISH, in 2015 Inclusion of persons with disabilities in the Global Refugee Compact (Giampiero Griffo, Chairperson of Italian Network on Disability and Development-RIDS Michele Falavigna, Advisor of Italian Association Raoul Follerau- AIFO) https://www.unhcr.org/events/conferences/5a0ac3bb7/presentation-mr-giampiero-griffo-chairperson-italian-network-disabilityand.html

[44] https://emergency.unhcr.org/entry/43322/identifying-persons-with-specific-needs-pwsn, (see Annex II following this link)

[45] http://www.washingtongroup-disability.com/washington-group-question-sets/short-set-of-disability-questions/

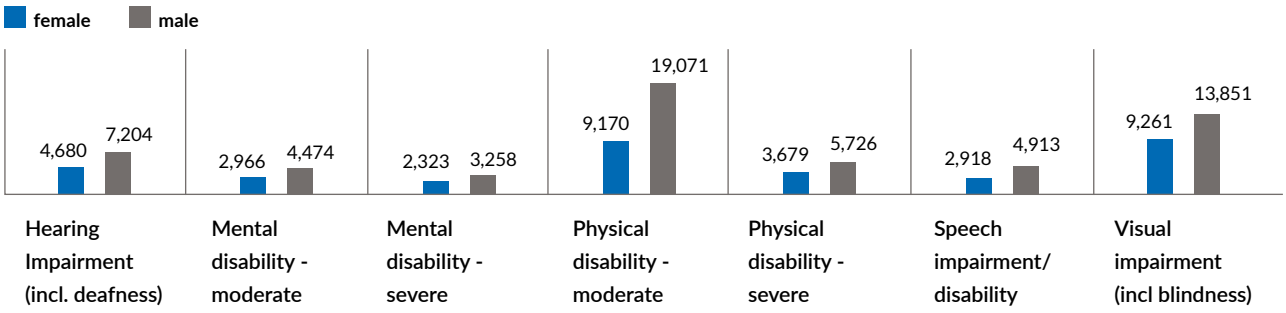
to differing interpretations of who is 'counted' as being a person with a disability, and the possibility that persons may be coded in proGres as having 'medical needs' rather than 'disabilities'.

The following tables provide current registration data as per the progress and may not reflect the actual number of refugees and asylum-seekers with disabilities. The data below has been included to show trends and overall variances between gender, age, types of disabilities and should be viewed as percentages and patterns, rather than actual numbers.

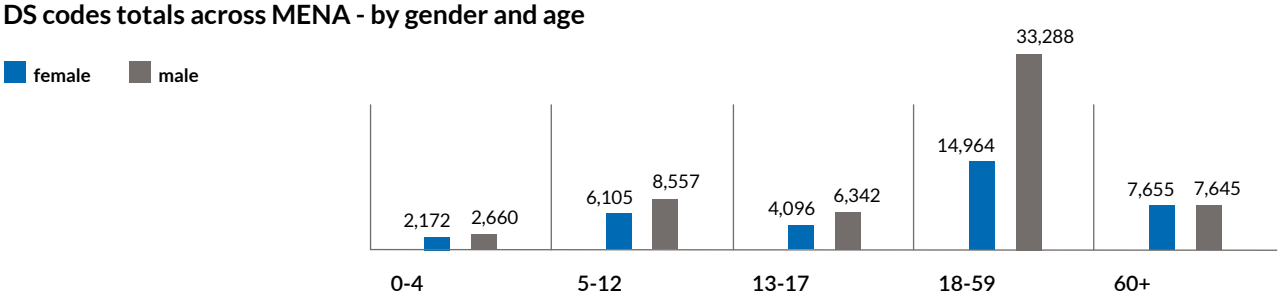
Total figures downloaded from UNHCR Global Focus[46] and below specific needs code data extracted from proGres in Nov 2018.

	TOTAL Refugees and Asylum-seekers	Nos with a DS code	% DS	Nos with chronic Illness code	% of PoCs with Chronic illness	Nos with Mental Illness code	% of PoCs with mental illness code	Total revised possible DS	Revised % with possible DS status
Algeria	100,614	78	0.08	75	0.1	5	0.0	158	0.2
EGYPT	289,231	5,094	1.76	6973	2.4	450	0.2	12,517	4.3
IRAQ	290,710	5,933	2.04	6821	2.3	380	0.1	13,134	4.5
ISRAEL	55,208	201	0.36	111	0.2	42	0.1	354	0.6
JORDAN	734,841	25,865	3.52	25606	3.5	1616	0.2	53,087	7.2
KUWAIT	1,637	55	3.36	40	2.4	8	0.5	103	6.3
LIBYA	45,020	246	0.55	121	0.3	28	0.1	395	0.9
LEBANON	1,014,223	38,607	3.81	108104	10.7	1732	0.2	148,443	14.6
MAURITANIA	78,183	962	1.23	110	0.1	25	0.0	1,097	1.4
MOROCCO	6,779	38	0.56	271	4.0	51	0.8	360	5.3
SAUDI ARABIA	2,334	16	0.69	18	0.8	0	0.0	34	1.5
SYRIA	37,537	1,291	3.44	2975	7.9	507	1.4	4,773	12.7
TUNISIA	769	16	2.08	35	4.6	5	0.7	56	7.3
TURKEY[47]	3,789,203	14,004	0.37	12119	0.3	1899	0.1	28,022	0.7
UAE	7,634	96	1.26	43	0.6	7	0.1	146	1.9
YEMEN	280,692	992	0.35	271	0.1	217	0.1	1,480	0.5
TOTALS	**6,734,615**	**93,494**	**1.59**	**163,693**	**2.5**	**6972**	**0.3**	**264,159**	**4.4**
			AVERAGE		**AVERAGE**		**AVERAGE**		**AVERAGE**

DS code by type across MENA - total numbers by gender



DS codes totals across MENA - by gender and age



• Lebanon (10.7%) and Syria (7.9%) have the highest level of chronic illness. This may be due to how 'chronic' illness has been defined by the country operation.

• Low rates in Libya (0.55%) and Yemen (0.35%) might be due to the additional challenges faced by persons with disabilities in accessing registration or reception centres. In Yemen, all registration activities were suspended in the North between August 2016 and November 2018.

• The team in Morocco explained that the dispersion of people of concern throughout the country at times makes persons with disabilities difficult to be identified in remote locations, which might explain the low rate of disability (0.55%).

• The rates of identification of mental illness are very low in all locations, and likely due to the challenges in definitions and stigma associated with disclosure.

• The number of males aged between 18-59 years with a disability code is double that of females. This may be a result of conflict acquired injuries and due to increased isolation of women with disabilities as well as higher rates of stigma that they experience. Whilst it is well recognised that men have poorer health outcomes than women (in situations with equal access to health care)[48], this does not account for the significant disparity, and thus, it is likely that a larger proportion are due to conflict acquired injuries and isolation and stigma experienced by women with disabilities.

[46] UNHCR, Global Focus UNHCR Operations Worldwide, data retrieved Jan 2019, http://reporting.unhcr.org/node/28

[47] In Turkey, the government of Turkey maintains the registration data of the people of concern.

[48] "Research has shown that if men and women received similar nutrition, medical attention, and general health care, women would live longer than men This is because women, on a whole, are more resistant to diseases and less prone to debilitating genetic conditions" cited in https://en.wikipedia.org/wiki/Gender_disparities_in_health

Registration

The identification of persons with disabilities is not limited to formal registration by UNHCR, and thus, accurate identification and related data management requires internal and external coordination. Persons with disabilities are identified through home visits, community-based identification mechanisms, partners and government entities of host countries. Specific challenges to effective and accurate registration are:

- Initial registration is easily accessible for most persons of concern upon entry. However, ongoing outreach, follow up or continuous registration, and access to services is challenging across the region because persons of concern are widely dispersed in rural and remote locations (after the initial entry registration).
- Registration takes place in certain location but significant number of persons of concern live outside the city and persons with disabilities face difficulties in accessing the registration process.
- Registration (and verification exercises) interviews are very time constrained. Ensuring that each persons of concern receives adequate time and support with communication (e.g. access to sign language interpreters) to fully assess the specific status of persons with disabilities is complex and requires additional training. Despite the time constraints, registration staff shared how teams were committed to ensuring that each persons of concern had time and space to communicate independently.
- In urban and rural settings, persons with disabilities often remain hidden due to the limitations on reach out practices [49]. Failing to identify persons with disabilities can increase their vulnerability and protection risks by denying them access to the appropriate identification and response mechanisms.

Identifying the persons with disabilities remains a fundamental challenge in humanitarian situations. Failing to identify persons with disabilities can increase their vulnerability and protection risks by denying them access to the appropriate response. To improve the identification of persons with disabilities holistically (through enhancing registration, expanding reach out, working with community-based identification mechanism, and creating enabling environment for people to disclose their disability situation during registration), greater cooperation between government, humanitarian partners, community entities, specialist organisations and local disabled people's organisations (DPOs) is required.

Assessment and response monitoring

Several assessments and surveys point to a higher percentage of persons with disability among the registered refugee population. In Egypt, 14 per cent of surveyed households report having a member in their household with a disability and 4 per cent of assessed individuals report having a disability. [50] In Lebanon, 14 per cent of households reported at least one family member with disability (a slight increase from 12 per cent of households in 2016). [51] The recent vulnerability assessment report [52] of Jordan shows that the overall incidence of disability in the population sample as 21 per cent (previous figure on it was 14.7 per cent [53]) of individuals in the sample having at least one disability. When described at the case and household-levels this percentage jumps to 37 per cent of cases and nearly half of households have one or more members with at least one disability. Disability is identified using the WG Questions.

The overall identification of persons with disabilities requires a systematic, staged, prioritized approach and standard operating procedures (SOPs) to guide what happens after initial identification and registration where resources are necessary for this purpose. The Egypt and Lebanon operations have implemented 'comprehensive social assessments' for persons with specific needs (includes persons with disabilities) as part of a shift to a case management approach. The rationale for implementing an assessment process (after identification or registration) is due to the multifaceted, and potentially complex and cross cutting nature of the protection response that might be required to address barriers to access and participation.

UNHCR and partners have several electronic monitoring and reporting platforms to continuously review the protection responses across the MENA region. One UNHCR managed platform, the Refugee Assistance Information System (RAIS), was established to facilitate monitoring of support and assistance provided on an individual basis, recorded against the UNHCR unique identifier generated by the proGres registration system. It allows for cross referencing of proGres codes (e.g. on Disability, and Serious Medical) to the support provided. As such, it is the only platform capable of monitoring

[49] To know more about the current reach out and communication practices within Syria and Iraq situation see -https://data2.unhcr.org/en/documents/download/63810
[50] UNHCR, Vulnerability assessment of Syrian Refugees (Egypt 2016), https://data2.unhcr.org/en/documents/download/61529
[51] Vulnerability Assessment of Syrian Refugees in Lebanon 2017, https://data2.unhcr.org/en/documents/download/61312
[52] Vulnerability assessment framework, population study 2019; https://reliefweb.int/sites/reliefweb.int/files/resources/68856.pdf
[53] Six years into exile, the challenges and coping strategies of non-camp Syrian refugees in Jordan and their host communities, https://data2.unhcr.org/en/documents/download/51182

individual unmet needs. This information management system avoids duplication of support and has the capacity, with data sharing agreements, to generate protection response data across a range of sectors and agencies. Key Informants (KIs) noted that consistent usage of RAIS (or similar systems) needed to be scaled up, to adequately monitor the persons with disabilities response.

Monitoring and reporting on referrals across programs, sectors and government and non-government agencies poses an additional and specific challenge, particularly in a context with increased referrals to host government agencies. For example, even if NGOs refer persons with disabilities to government agencies for support but are not readily able to access the outcomes of specific referrals. In another instance, NGOs refer children directly to schools for enrolment, but the process is self-managed by families, and thus, individual outcomes are not systematically tracked. The implication is that it is not possible to know how many children with disabilities tried to access formal education but were denied access. An increase in the identification of persons with disabilities will require increased collaboration and information management systems set up to monitor and report on multi-sectoral and multi-agency including the government responses.

This is Edle, he is a social worker with Intersos, UNHCR's protection partner. He works at the Early learning centre (ELC) in Kharaz camp.

Edle is adored by the children. They have their own special handshakes and greetings. Here is sits near Yasser. Yasser was born with Cerebral Palsy.

'The children love coming here. It is a place they feel comfortable and at home. The school is a safe haven for them. They have friends and they feel normal'. said Edle, one of the social workers working for Intersos, UNHCR's protection partner at the camp.

Favourable Protection Environment

The rights of people with disabilities need to be recognized in national constitutions, legislation and policies. Once their rights are legally recognised, then courts, administrative bodies, tribunals, and in some cases human rights institutions, can provide supports or interventions when the rights of persons with disabilities are violated [54]. All countries that were part of this study within MENA and Turkey have signed the UNCRPD and the UNCRC. Mapping of the national legislation across the 16 countries found that legislative protection is robust [55], but the implementation and practices are weak. Furthermore, the practical implementation of some of the legislation is not ensured for the host population. For example, national formal inclusive education options are limited, despite legislation protections for children with disabilities to access education. In countries where specialised schools do exist for nationals and are funded by the government, refugee access is variable, and not clearly protected through policies and practices.

Similarly, Egypt and Jordan have allocated legal quotas for persons with disabilities to employment (5 per cent of all employees) openings for their nationals. Anecdotal evidence suggests that the implementation, monitoring and enforcement of the employment legislation is fragmented, even for the host population. However, the barriers for refugees are compounded due to limited and partial 'work rights'. These examples serve to highlight that the inclusive legal protection for refugee persons with disabilities under the national legal framework is unclear, fragmented and generally not applied. The extent to which the legal protections adequately meet the rights of persons with disabilities varies significantly based on the context of the host country, the extent of access to national systems, country of origin, host country context and factors related to culture.

Favourable protection environment is significantly affected by the host country development status. Mauritania and Yemen are ranked as Least Developed Countries (LDCs), and exhibit the lowest indicators of socio-economic development, with the lowest Human Development Index ratings [56]. This is relevant to the mapping because the key informants and consulted persons with disabilities consistently shared that "there are extremely poor rehabilitation services, there are limited psychologists and limited surgeons". In some operations, the available standards of basic services for persons with disabilities are far lower than, generally required. On health, even, there is no access to medicine for epilepsy, no access to quality psychosocial support, and no access to corrective surgery.

In the contexts of the UAE, Saudi Arabia and Kuwait, the overall standards of living, including health and education standards, are higher. However, refugees irregularly resided in these countries face barriers due to the partial and limited access to national services. Private services are not affordable for refugees and asylum seekers with disabilities.

Refugees in Turkey, Jordan, Lebanon, Iraq and Egypt experience a relatively favourable environment with access to national services (albeit limited and partial), active national Disabled People's Organisations (DPOs) and a range of humanitarian and development actors who could be engaged and work collaboratively to advocate for increased access and inclusion. In Turkey, the government provides access for refugees to government services. In Lebanon, UNHCR collaborates with the national NGOs and DPOs, thereby increasing the scale and quality of the protection responses for refugees with disabilities.

However, despite the relatively favourable environments, the consistent finding in Turkey, Jordan, Lebanon, Egypt and Iraq was the overall limited systematic referral to, and collaboration with, national agencies. This is partly due to varying interpretations, policies and practices related to 'access to national systems'. These relatively favourable environments can be leveraged through sustained and systematic advocacy and mapping of national services, and improved collaboration and strategic partnerships.

The experience of persons with disabilities is affected by nationality, age, gender, type of disability and many other factors. Although, a detailed analysis of each cross-cutting

[54] World Health Organization (2010). Community-Based Rehabilitation Guidelines-Social component, Geneva. Available at https://www.who.int/disabilities/cbr/guidelines/en/, retrieved 12/11/2018.

[55] For examples In Turkey the Law on Disabled People and on Making Amendments in some Laws and Decree Laws (2005) includes very specific provisions and articles to protect the right of persons with disabilities. In Jordan, the Law on the rights of persons with disabilities – law number 20 (2017) seeks to contextualise and promote implementation of the UNCRPD. In Morocco, following the ratification of the UNCRPD in 2009, its 2011 constitutions guaranteed the rights of persons with disabilities on the basis of equal opportunities and non-discrimination. In 2015, Morocco had an Integrated National Strategy for the Promotion of Human Rights for Persons with Disabilities, a framework law strengthening the rights of persons with disabilities, and Law No. 07-92 on the social protection of persons with disabilities.

[56] https://en.wikipedia.org/wiki/Least_Developed_Countries

perspective was beyond the scope of this mapping, a preliminary finding suggests that country of origin affects access to services, funding and stigma. Key Informants provided qualitative examples of differential access and inclusion of persons with disabilities based on nationality. In some cases, this is enshrined in national policy, in others it appears as discriminatory treatment. Operations like Jordan, Egypt and Lebanon have structured coordination mechanisms to support both older persons and persons with disabilities through the same mechanism. However, the observation of the key informants suggests that older persons with disabilities were under-supported in humanitarian and development interventions across the region. In addition, key informants raised the concern that interventions for persons with physical disabilities or mobility limitations were 'generally' much better supported than persons with other disabilities. There is a significant gap in knowledge and the extent to which people with other forms of disability are accessing and participating in mainstream sector services and supports.

Accessibility of the physical environment

UNCRPD Article 9
To identify and eliminate obstacles and barriers and ensure that persons with disabilities can access their environment, transportation, public facilities and services, and information and communications technologies.

Issues related to the physical accessibility vary across countries, locations and sectors. This section serves to summarise the general challenges and uses examples to elucidate common themes.

Access to public services buildings, service providers' offices and various community spaces remains a key challenge for persons with disabilities. Very few buildings have been constructed with universal design principles in mind. The urban and high-rise environments in large cities remain particularly challenging. Similarly, persons with disabilities highlighted that physical access to public buildings, schools and community centres in many places is inadequate and challenged by lack of practical assistance. Although this mapping did not include a specific mapping of all NGO premises, key informants indicated that, in general, not all NGO premises were easily accessible. Multiple challenges can be faced in making buildings accessible. Firstly, renovations are sometimes not as easy or inexpensive as expected. Secondly, there may be two to three different levels of approvals (the owner of the building, the local government authority, the ministry level authority). Even with the best intentions, funding and approvals can result in delays.

Since large majority of the refugee populations across the operations live in urban, rural and peri-urban setting, safe, efficient and accessible transportation remains a key concern for persons with disabilities. Finding transport is another barrier for persons with mobility limitations, as in the large and dispersed urban settings the costs for taxis is high to travel across the cities and available public transportation systems are not disability-friendly.

Focus group discussions finding indicates that the persons with disabilities face difficulties linked to accessibility even within the camp settings [57] as the roads and paths are not paved, and housing allocation does not consider mobility issues. Additionally, the participants of the focus

[57] Zaatari Camp (Jordan), reports on Domuz Camp (Iraq) and Kharaz Camp (Yemen).

group discussions indicated that some communal facilities are accessible, but the vast majority do not have ramps or rails and suggested to keep the accessibility issue for persons with disabilities as a minimum requirement while designing a camp or establishing the public facilities.

Good Practice

Jordan – UNHCR Reception Centre
Recent initiatives to improve accessibility indicated increased signage, with a system of mobile ramps. UNHCR staff regularly make announcements to large groups to ask whether anyone has specific needs or requires assistance or support.

Lebanon: UNHCR Reception Centre
The Centre is fully accessible with ramps to all main rooms and buildings, and a system of mobile ramps for rooms used less frequently. All persons of concern are consistently asked whether they require specific support (upon arrival). The reception has up to eight wheelchairs for persons of concern with limited ability to stand for longer periods. Persons with disabilities are fast tracked for assistance. Reception related standard operating procedures specify processes to address barriers to access and inclusion. It was mentioned that improvements could be made in identifying persons with disabilities who might be less 'visible', and that an approach which supports access whilst ensuring no stigma, is important.

The mapping identified the need for a comprehensive review of the public services facilities (e.g. police station, court, health and education) commonly used by the persons of concerns, and the achievement of a feasible balance between both short- and long-term priorities, and between cost and the rights of persons with disabilities to accessible infrastructure and communication.

Accessibility of information and communication

UNCRPD Article 21
Countries are to promote access to information by providing information intended for the general public in accessible formats and technologies, by facilitating the use of Braille, sign language and other forms of communication and by encouraging providers to make on-line information available in accessible formats.

Access to information is a fundamental means for accessing other protection support for people in displacement setting. A key activity of the humanitarian response is to disseminate information about services and support. However, the review of key planning, reporting and legal documents found that there is currently very limited adaptation of materials to ensure comprehension by a wide range of audiences including people with disabilities. UNHCR and the humanitarian response sector use a wide range of methods to disseminate information, with an increasing focus on social media options, such as Facebook and Twitter, and text messaging via WhatsApp. The increased use of technology can facilitate accessibility for persons with disabilities. The brief review did not find any adaptation of materials for these media platforms. For example, flyers disseminated as part of registration processes were not available in 'easy-read' versions. Information disseminated via WhatsApp does not consistently include an audio file. Specific information on the use of Braille or sign language was not available. In the absence of formal sign language support, persons with disabilities use and commonly relay on locally developed sign languages [58]. Additionally, in cases where a person of concern can use the official sign of the language of origin (e.g. Amharic), access to sign interpreters for languages other than French, English and Arabic, is highly unlikely.

A systematic assessment of current Braille and sign, language and literacy skills, would facilitate the feasibility and relevance of activities related to skills development courses, and the value of the use of interpreters and Braille materials, in the short- and long- term.

[58] A father and son from Sudan were observed communicating in 'informal' sign language during a FGD in Cairo.

Public attitudes towards persons with disablities

UNCRPD Article 8
As a change of perceptions is essential to improve the situation of persons with disabilities, ratifying countries are to combat stereotypes and prejudices and promote awareness of the capabilities of persons with disabilities.

UNHCR and humanitarian actors implement a range of activities to reduce the stigma and discrimination experienced by refugees including the persons with disabilities. This is particularly relevant when there are tensions between people of concern and host communities. Despite efforts made, however, the participants of the focus group discussions highlighted that the stigma experienced by refugees with disabilities was compounded. The implication is low self-esteem and lack of confidence to participate in services and support programs. For example, one teenage male, who is blind, shared:

"I was invited to attend the Youth Group but initially was very scared and assumed that the other 'normal' youth would never accept anybody like me. I was worried that they would tease me".

Good Practice

Jordan: Parent-Child Group
A Parent-Child Group was established and is comprised of approximately 70 per cent Syrian and 30 per cent Jordanian caregivers. The participants of the focus group discussions clearly highlighted that disability status came with far greater stigma than refugee status. The parents were 'united' and welcomed the social support of the group because both Jordanian and Syrian parents shared the same exclusion from family, neighbours and community.

Turkey, Lebanon, Mauritania, Egypt and Jordan shared examples of UNHCR supported activities on the International Day of Disabled Persons, and this was an ideal opportunity to promote positive role models and to initiate collaborations with national DPOs and government agencies and integrate it in ongoing activities.

"The main struggle I've faced during my life is how other people treat me, like I'm somehow incapable. The best way to fight misconceptions is for people to see you engaged in life. When they see me teaching or playing with the band, they begin to understand that I'm not defined by my disability."

Quoted by Syrian refugee Ehsan Al Khalili teaches music in a UNHCR-funded community centre in Azraq refugee camp, Jordan [59]

[59] https://www.unhcr.org/news/stories/2017/12/5a201bfc4/syrian-refugee-uses-musical-talent-fight-disability-myths.html

Coordination and Partnerships

The lack of focused coordination mechanisms to ensure multifaceted programming for persons with disabilities is one of the greatest gaps, and the most complex to address within the current systems. The lack of updated and disaggregated statistical information further limits evidence driven program planning, and as a consequence, also implementation, monitoring and evaluation.

A review of the 3RP Annual Reports and planning documents found limited information on persons with disabilities, although these documents emphasize or reflect broadly on age, gender and diversity inclusive approaches. Indicators related to persons with disabilities, for mainstream and disability specific programs, were absent. For example, the UNHCR Results Based Framework, includes indicators for 'specific needs' (e.g. unaccompanied minor) with one indicator aims to specifically support persons with disabilities. In Egypt, Jordan and Lebanon, this indicator has been used to plan for a range of rehabilitation services and assistive devices. Requests for Proposal (RFPs) from bilateral and philanthropic donors specified the need for gender analysis in funding proposals. However, there is generally no requirement for disaggregation by disability. RFPs often include questions on 'strategies to address diversity' but that this section is often completed with strategies to ensure inclusion of ethnic, religious or other forms of diversity, with limited consideration for persons with disabilities.

In the context of the above, the planning frameworks do not explicitly cite persons with disabilities as a category for support, and do not include disaggregated targets by disability status. Findings suggest that this may be due to an assumption of inclusion across all sectors. Whilst this may be a valid assumption in some cases, evidence is lacking. Further, the qualitative findings of this mapping suggest that the current protection response would benefit from targets, quotas and elements of affirmative action to ensure full participation and equity.

Similarly, there is a gap in partner agreements to promote, and ultimately, ensure accountability for inclusion of persons with disabilities. As a result, the current extent of inclusion is weak and fragmented. Deficiencies in setting indicators, sharing information and managing information are current barriers to effective monitoring, reporting and evaluation (as discussed in the information management section).

Exception to a few operations, there are no external coordination mechanisms specifically for persons with disabilities. Other coordination mechanisms (e.g. Protection Working Groups, MHPSS, Education Working Group) also do not give adequate or systematic attention to ensuring inclusivity of persons with disabilities. Time-bound 'taskforces' may prove beneficial (short-term) to support, coordinate and advocate for, the goal of inclusion across all sectors. The coordination mechanisms to provide a holistic response, in general, are weak, ad hoc or fragmented. For instance, a child aged 11 years is currently supported through a specific child protection response. The child is also documented as out-of-school and as 'diagnosed' with cerebral palsy. The current information sharing and referrals systems, are not systematic. Follow up and monitoring is also fragmented, and the coordination between sectors is weak. Thus, even though a child may be supported through a child protection response, there is no systematic mechanism for other needs to be addressed or monitored, including education, rehabilitation, or medical care, if required.

Good Practice

Jordan: The Disability Task Force (DTF)

The DTF was initially established in 2016 as a time-bound working group to address two core topics:

- Identification of persons with disabilities; and
- Improved access to quality specialized services.

The initial outcomes were:

- Produced Guidelines for prioritization of disability-specific services for refugees and other vulnerable populations in Jordan (October 2016) for improved access to quality specialized services;
- Established DTF focal points at Working Groups and development of Key Messages (2017) to advocate for disability inclusion.

The initial TOR was expanded to ensure that the needs of persons with disabilities or in disabling situations (elderly and people with injuries) are thoroughly considered in the humanitarian response. Currently the DTF is working on Interagency Referral Pathways for persons with specific needs, including persons with disabilities and an update of the mapping. The DTF is reaching out to other working groups at the national and camp level to increase awareness and mainstream disability in other sectors and has actively sought to strengthen cooperation with government (Ministry of Labour, Higher Council for the Rights of Persons with Disabilities).

Good Practice

Lebanon: The Disability and Older Age Working Group

UNHCR co-leads the coordination of protection and response activities in Lebanon with the Ministry of Social Affairs (MoSA) through the Protection Working Group. In June 2013, the Disability and Older Age Working Group (DaOAWG) was established under the Protection Working Group. The DaOAWG has since served as a platform for several interagency initiatives on disability inclusion and mainstreaming. DaOAWG includes representatives from DPOs, local organisations, international organisations, academic institutions, and UN agencies.

Abdo's wife and children sit in their tent at a hosting site for internally displaced families in Aden. Abdo, who has disabilities, fled his home in Taizz with his family when fighting escalated in their area.

The protection response for persons with disabilities is multifaceted and requires all humanitarian, development and host government actors to coordinate and collaborate. The current response is fragmented, particularly in large operations, and relatively small scale. The systematic expansion of partnerships could serve to increase advocacy efforts, improve referral and support options, and ensure the most efficient use of limited funding by leveraging each actor's specialist expertise and vested interests. UNHCR operations across the MENA region have all engaged in informal and formal partnerships to increase the benefit for persons with disabilities. Examples of strategic initiatives include: Humanity & Inclusion (HI) for training and capacity support; Help Age International for working with older people; red crescent societies for health and rehabilitation cooperation; various time-bound initiatives with other UN agencies particularly UNICEF; and national DPOs and CBOs.

Good Practice

Morocco: National Level Strategic Partnerships

In 2015, Morocco developed an Integrated National Strategy for the Promotion of Human Rights, including Persons with Disabilities. As of 2018, refugees in Morocco benefit from a partnership project. The project Change of Perspective: to Promote the Human Rights-based Approach to the Perception of Disability in Morocco (2018-2020)" was implemented by four United Nations agencies in Morocco; UNESCO, UNDP, WHO and UNFPA, with their national partners. It aims to change sociocultural norms by reversing prejudices and negative stereotypes of persons with disabilities. UNHCR engages with the national partnership project, and through its implementing partner. UNHCR also facilitates coordination, ensures collaboration with other humanitarian actors, and liaises with the host government.

Partnerships with Disabled Person's Organisations

In the context of protracted refugee situations across the MENA region and in Turkey, partnerships with DPOs as well as national NGOs and CBOs who specifically support and advocate for persons with disabilities, are vital to achieving the required scope and scale. Large scale humanitarian operations, with access to government services (often limited to urban areas) can significantly benefit from these partnerships. Examples of potential benefits include:

- Joint national and regional level advocacy to ensure all persons with disabilities have access to mainstream development and ensure the protection and benefits of the UNCRPD and SDGs reach more people with disabilities;
- Involving communities and jointly raising awareness about issues facing refugees with disabilities;
- Increasing participation of refugees with disabilities in social forums, events and activities organised for host populations;
- Joint advocacy for specific initiatives such as inclusive education;
- Increased access for refugees to key expertise, services and support (information, education, and training) based on the extensive experience of many DPOs;
- Capacity building for UNHCR and partners on inclusion of persons with disabilities;

Samer Boulos attends a UNHCR-supported children's centre run by Caritas in Beirut. Ball games help him to interact with others in the group.

Good Practice

Lebanon: Collaboration with DPOs

UNHCR in Lebanon operates within a context of many national DPOs, NGOs and CBOs established in the 1980s to support persons with disabilities after the civil war. UNHCR in Tripoli has arrangements with four of these national organisations, offering the following support to refugees: inclusion in social activities, events and camps; vocational training; access to prosthetic devices; and information and awareness raising. In addition to the more formal services, refugees benefit from the complementary expertise and collaboration between national NGOs, international NGOs, UNHCR and other UN agencies. This 'community of practice' has resulted in regular coordination meetings and partnership arrangements and has improved the response for refugees in Tripoli.

UNHCR and Lebanese Physically Handicapped Union (LPHU) have collaborated on initiatives to improve support for persons with disabilities in the humanitarian response:

- A recent advocacy campaign to the Ministry of Education highlighted the physical inaccessibility of schools and shed light on the issues facing children throughout Lebanon.
- The LPHU has been receiving an increasing number of phone calls from refugees on their Hotline. They have provided information and advice about accessible services and supports.
- LPHU has been providing guidance to an increasing number of humanitarian coordination forums.
- A joint training initiative for security guards at a UNHCR reception facilities.

Moreover, the mapping found an overall low level of knowledge and expertise among the service providing in supporting access and equitable participation of persons with disabilities. A common theme across all countries was a request for training to enhance support for persons with cognitive and sensory disabilities.

Good Practice

Lebanon: Training and Capacity Building

In partnership with an NGO, UNHCR is developing a training module on children with disabilities to conduct with outreach volunteers countrywide. An accessibility assessment had identified the need to change attitudes of staff. Acknowledging the key role of security guards at reception centres, the LPHU delivered training to 70 protection security guards. Individual follow up action plans were developed for guards to put their knowledge and skills into practice. A training package was developed by UNHCR and Humanity & Inclusion on working with persons with disabilities in 2016. Over 150 UNHCR frontline protection staff in all five governorates in Lebanon were trained, as well as over 30 staff from key partners, including government social workers working directly with persons with disabilities.

Security from Violence and Exploitation

UNCRPD Article 16
Laws and administrative measures must guarantee freedom from exploitation, violence and abuse. In case of abuse, States shall promote the recovery, rehabilitation and reintegration of the victim and investigate the abuse.

UNCRC Article 19 (Protection from all forms of violence)
Children have the right to be protected from being hurt and mistreated, physically or mentally. Governments should ensure that children are properly cared for and protect them from violence, abuse and neglect by their parents, or anyone else who looks after them.

UNCRC Article 34
Governments should protect children from all forms of sexual exploitation and abuse.

UNCRC Article 39 (Rehabilitation of child victims)
Children who have been neglected, abused or exploited should receive special help to physically and psychologically recover and reintegrate into society. Particular attention should be paid to restoring the health, self-respect and dignity of the child.

SDG 5.2
Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation.

Secondary sources [60] cite evidence of a close link between disability and risk of violence. Due to the lack of quantitative data for the mapping, the findings should be considered as preliminary, and subject to a more rigorous review of all sexual and gender-based violence related information management sources across the region. The qualitative information cited in this report provides anecdotal evidence to support a finding of an increased likelihood of violence, with specific relevance to refugees in the MENA region. Evidence of increased vulnerability and stressors of displaced populations, and high levels of social isolation of persons with disabilities (particularly children not engaged in education, and families displaced from communities of origin), serve to prompt a call to action.

Lack of knowledge and skills amongst disability specific programs (for example, NGOs who support rehabilitation) on how to recognise and respond to disclosures of violence and enhance knowledge about referral mechanisms [61] remain some of key priorities. Due to a focus on mainstreaming and inclusion, there is an assumption that persons with disabilities will be included in the overall prevention, mitigation and response. At present, it is not possible to accurately measure the extent of inclusion of persons with disabilities in preventative activities, and the data for response is indicative of under-reporting.

Child protection

> "My daughter was harassed by teachers for being partially deaf, and students in the class did not like her. She was strong but after some time we decided it was not good for her to go to school."
>
> A focus group discussion participant (caregiver) reflected her frustration

> "My parents never sent me to school in Syria because they were worried that I would be bullied."
>
> A focus group discussion participant

Children with disabilities expose to various risks across the region. Children also experience violence, exploitation and abuse if they are children of disable parents.

> "My husband is deaf, and we have three children. My son has been raped on the way to school (more than once), and I feel so hopeless because my husband can't help so much, and I look after everyone in the family, and I can't manage with everything."
>
> A focus group discussion participant

Children with disabilities are less likely to know about their rights because they are more likely to be excluded from school, and other forms of social participation. Although no quantitative data is available to demonstrate the extent of violence experience by the children with disabilities, the focus group discussions participants

[60] See https://www.unhcr.org/569f8f419.pdf; See also, https://www.unfpa.org/sites/default/files/pub-pdf/Final_Global_Study_English_3_Oct.pdf; see also https://www.womensrefugeecommission.org/gbv/resources/document/download/1283&usg=AOvVaw1YAESBoqoWXth-It7yzSmG

[61] In Egypt and Lebanon have standard operating procedures on referral SOPs for Persons with Specific Needs which includes persons with disabilities as a sub category.

have indicated that caregivers and families are aware of the increased protection risks that their children face.

There are reports of 'violence against, abuse of and use of corporal punishment on children with disabilities, including abandoned children with disabilities, in the home, in alternative care and day-care settings and in schools' in Morocco [62]. Some key informants referred cultural and social attitudes about children with disabilities as a barrier to prevent family and community members from reporting cases. Although UNHCR and partners works to provide protection response to children with disabilities across the region, the service providers still lack required essential skills for working with children with disabilities. A few key informants mentioned that there has been no formal training on how to ensure children with disabilities are able to access various prevention initiatives, for example, 'safe spaces'. Lack of knowledge and skills have an impact on effectively work and engage with children with disabilities. For example, there has been no systematic training on adjustments that might be beneficial when conducting the Best Interest Procedures (BIP) with children with cognitive or sensory impairments. Additionally, the current Best Interest Procedures and related documents don't include specific guidance on how to ensure access and inclusion for children with disabilities.

The following instances of child protection incidences increase vulnerability of families and children, with compounding factors, ultimately contributing to violence against children. The key compounding factors for violence against children with disabilities include: 1) social and physical isolation; and 2) communication and attitudinal barriers to disclosing and describing incidents of violence, abuse or exploitation.

Case Study:
Abuse by money-lender
The local partner for Persons with Disabilities identified two separate cases of sexual abuse against young boys (both with intellectual disabilities). The children disclosed their experiences to social workers. The children had previously not been engaged in any form of education or social activities. Had the children not been attending the UNHCR-supported education activities, these children would not have been identified.

Case Study:
Rat bites due to immobility
This Syrian family had not registered, and thus, had not been identified by UNHCR, the government or NGOs prior to the incident. They attended the local hospital with their young daughter for treatment of several open wounds. The hospital contacted UNHCR because the wounds were found to be the result of rat bites. The child has cerebral palsy and had been sleeping on the floor unable to move and was repeatedly bitten by rats. The family is now being supported by UNHCR and partners.

Case Study:
A family in need
The situation of one family highlights the need for holistic support and a coordinated response across sectors. A family of four came to the UNHCR office pleading for support. Two teenage boys, both with autism, had been violent towards their two younger siblings, mother and neighbours. The father is not able to generate income because he stays home to protect the family and neighbours. They are at risk of eviction from the house due to complaints. The parents don't know how to manage the behaviours and requested support, and to have some form of respite, practical assistance or education and training for the boys. They have never been to school, and there is currently no affordable service or support in place to address the boys' support needs. The family is now being supported by UNHCR and partners.

[62] https://assets.publishing.service.gov.uk/media/5b2378d340f0b634cb3dd823/Disability_in_North_Africa.pdf (referred to CRPD, 2017, p. 3)

These case studies highlight that supporting activities (social, recreational, educational) that engage all children with disabilities in some form of weekly social mechanism, provide a forum for children to be identified or to self-disclose. Importance of home visits and understanding of the protection risks and safety of the home environment remains crucial for ensuring effective response. Disability specific programming in Jordan, Lebanon, Yemen, Mauritania and Egypt integrates home visits for these reasons. Moreover, the role of the various sector as well as partners in identification of persons with disabilities could contribute to enhance the referrals for services.

Additionally, the focus group discussion with caregivers highlighted the challenges of caring for children with severe disabilities. Stigma results in limited community networks and supports, parents are isolated and have limited skills to manage difficult behaviours. This is exacerbated by having more than one child to care for, and limited access to education for their child. Parents shared many positive experiences about their engagement with the UNHCR-supported NGO activities, particularly the skills to protect and care for their children. The ongoing parenting information, education and peer support was deemed invaluable.

Examples from the operations highlights that that whilst general awareness had been increasing, these efforts require systematic, coordinated and comprehensive approach to ensuring protection for children with disabilities.

Sexual and Gender-Based Violence

Cultural and social attitudes about persons with disabilities prevent survivor and family from reporting of violence. The deeply embedded social and cultural challenges in disclosing incidences of SGBV are well documented, and the humanitarian sector has the capacity to respond to these challenges. High levels of stigma, which often takes the form of verbal abuse and serves to exacerbate isolation of persons with disabilities, remains the key concerns. This is reportedly higher for women with disabilities. However, the compounding effect of disabilities which impact communication (speech, hearing, vision, intellectual, mental), and often lack of confidence, require additional measures to actively support disclosure. These challenges to reporting are not only an obstacle to aiding persons with disabilities who are survivors but contribute to them being more at risk in the first place because the perpetrators know it will be harder for the survivor to report what happened to them or to be believed. Even where refugees are eligible for national services, obstacles persist in the form of prohibitive costs, language barriers, distance, and other factors. SGBV survivors with disabilities, including men and boys, face particular difficulties in reaching facilities and accessing services, and specialized services tailored to their needs are limited. The review of secondary literature highlighted the increased prevalence of SGBV but UNHCR data was not available to confirm this. Key informants have also noted that the multiple vulnerability stressors impacting families with persons with disabilities combined with social attitudes, may increase negative coping mechanisms such as early marriage.

It is observed that SGBV prevention and mitigating activities are not inclusive and targeted for persons with disabilities or are designed on a limited scale despite the existence of resources. UNHCR has worked with partners across the region to strengthen the quality of the SGBV response and systems, including information management systems with disaggregated data by disability. The data cited in the 3RP annual reports only reflects on very high-level indicators and do not disaggregated data with disability. This confirms that the systematic use of the disaggregated fields in various information management systems on sexual and gender-based violence across the region requires additional support and capacity building to generate reports. In particular, UNHCR and partners need to use the UNHCR tool (e.g. proGres) to maintain necessary data disaggregation. A few key informants indicate that although sector staff have been trained in how to communicate with survivors of SGBV but not specifically on adapted communication which may be required for some persons with disabilities. There has been no effective mechanism on how to ensure persons with disabilities are able to access various prevention, mitigation and awareness raising initiatives, for example, ‘safe spaces’. Overall, the SGBV case management response is very comprehensive and makes regular and systematic referrals to health and mental health services and professionals.

Health and Rehabilitation

UNCRPD Article 25
Persons with disabilities have the right to the highest attainable standard of health without discrimination on the basis of disability. They are to receive the same range, quality and standard of free or affordable health services as provided other persons, receive those health services needed because of their disabilities, and not to be discriminated against in the provision of health insurance.

UNCRPD Article 26
To enable persons with disabilities to attain maximum independence and ability, countries are to provide comprehensive habilitation and rehabilitation services in the areas of health, employment and education

SDG 3.8
Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.

SDG 3.8.2
Proportion of population with large household expenditures on health.

SDG 3.7.1
Proportion of women of reproductive age (aged 15-49 years) who have their need for family planning satisfied.

The findings and recommendations are related to four aspects of healthcare. Firstly, health promotion and preventative support and services, and the extent to which persons with disabilities have access to information. Secondly, the extent of access to health care settings, particularly access to surgery and medications for chronic conditions. Thirdly, the extent to which persons with disabilities are supported with rehabilitation, assistive devices and other specific health care needs. Finally, the extent of access to mental health and psychosocial support. At the time of the mapping, there was no disaggregated data available to determine the extent of participation and inclusion of persons with disabilities in the mainstream health response.

Health promotion

Health promotion initiatives are relatively limited in the refugee response, and issues of accessibility (transport, building and mechanisms for information dissemination) pose an additional barrier for persons with disabilities. According to the WHO, people with disabilities are at risk of secondary conditions (i.e. health problems or complications which are related to their primary health condition)[63].

Participants of the focus group discussion gave examples of secondary health conditions which could be mitigated through increased access to prevention and mitigation guidance materials. A common theme amongst people with paraplegia was the issue of pressure sores and back pain. In some operations, partners conducted training and provided information and guidance on how to prevent pressure sores including awareness raising sessions on self-management and risk mitigation for chronic conditions, this practice is not common across the region. There has not been any systematic training or guidance on the risks of secondary health condition, nor other topics of specific relevance to persons with disabilities. Partnerships with specialist agencies (e.g. Humanity & Inclusion), may prove mutually beneficial and cost-efficient approach in this respect.

A key informant gave an example of a nationwide vaccination campaign targeted at school settings, clinics and community centres which was less likely to reach parents of children with disabilities for some of the following reasons: caregivers of children with disabilities often focus on the disability, and don't automatically think that other conditions can also affect their children; caregivers may de-prioritise vaccinations in the context of multiple healthcare demands and costs; children are less likely to be in the education settings where the health promotion materials are disseminated; and finally, caregivers are more likely to be socially isolated, and thus, less likely to access information. This example serves the types of issues which may pose a barrier to effective health promotion for persons with disabilities and families.

[63] World Health Organization (2010). Community-Based Rehabilitation Guidelines-Health component, Geneva. Available at https://www.who.int/disabilities/cbr/guidelines/en/, retrieved 12/11/2018.

Medical care

Medical care refers to the early identification, assessment and treatment of health conditions and their resulting impairments, with the aim of curing or limiting their impacts on individuals. Medical care can take place at the primary, secondary or tertiary level of the health-care system. [64] As with other mainstream sector responses, the extent to which persons with disabilities are included in the mainstream health sector response was not ascertained due to the lack of disaggregated data. Additionally, mobility and transport constraints make it difficult for persons with disabilities to travel to health care settings, while the health care settings are also not physically accessible.

In addition to the more general barriers faced by persons with disabilities, key Informants and participants of the focus group discussions highlighted significant variations based on context (host country, location, nationality). In some operations language is cited as the key barriers for persons with disabilities accessing healthcare, while in others the limited availability of the specific services outside urban centres have significant impacts for geographically dispersed populations. In the context of expensive cities, the cost of medical care is particularly a concern for persons with disabilities, while services and medical supplies in the public facilities for persons with disabilities are found often limited across the region. In some instances, there are long waiting lists for secondary and tertiary healthcare, and while the participants of the focus group discussion had experienced discrimination in healthcare settings in various operations.

Case Studies:

The cost of medication and transport

> "The medicine that my daughter requires is not available in the camp, and we need to travel to a clinic outside. The cost of transport to the clinic, and the medicine is too high. Recently, I've stopped giving her the medicine because we can't afford it. I can't earn any income because I need to look after my daughter, but I need more money than others because I need to pay for medicines." A Syrian mother of one child

> "I have two children, and one of them has a disability and is not able to go to school. I have cancer and need money to pay for the cancer treatment. I'm interested in the cash-for-work program so I can pay for the medication, but it is difficult with my illness and my two children." A Syrian mother of two children

Case Study:

Cost of long-term healthcare:

> "A Syrian male who had been caring for his severely disabled brother, abandoned him on the street. We followed up and he said, "I can't do it anymore. I can't care for him because we are struggling to survive. Please look after him". He requires full time hospitalisation for the rest of his life. For now, we have been paying for his hospitalisation, but it is very expensive, at more than $10,000 per year, and we are not sure how this can be sustained. Where does this money come from? We need a sustainable solution." A Key Informant referred a case.

Case Study:

Surgery to prevent deterioration of condition

A Syrian family of five; two sons aged 20 and 22 years old, and a 27-year-old daughter. The daughter has severe intellectual and physical disabilities. The deformed spinal cord requires an operation that is not very common. It is available in the country but is very expensive, hence unaffordable by the family. If her spinal cord is not corrected, it will continue to affect her lungs and respiration, which will be life threatening in the future. The head of the family is unemployed and his chances of finding employment are very slim as he is in his late 50s.

The examples highlight that gaps in current medical care, particularly medication and surgery, have a significant negative impact on health and well-being. Based on the barriers in accessing services, it is likely that persons with disabilities are under-represented in the mainstream healthcare response. Efforts are needed to improve regular cross sectoral communication and coordination so that medical response for persons with disabilities can be improved.

[64] World Health Organization (2010). Community-Based Rehabilitation Guidelines-Health component, Geneva. Available at https://www.who.int/disabilities/cbr/guidelines/en/, retrieved 12/11/2018.

Mental Health and Psychosocial Support

The current response for persons with disabilities in the domain of mental health and psychosocial support is limited to disability specific programs. This does not reflect the global best practice of mainstreaming of persons with disabilities across all programs and sectors. However, like other non-disability specific responses, the data to validate the extent to which persons with disabilities access are included in the mainstream mental health and psychosocial support (MHPSS) response, was not available. Response activities in Lebanon, Egypt, Libya, Syria, Yemen and Jordan include counselling, peer support, general information and guidance as well as psychosocial support. Qualitative feedback about current programs was extremely positive, with many respondents sharing how the MHPSS related support contributed to reduced social isolation. The reinforcing cycle between mental wellbeing and social isolation was an important theme shared by all respondents.

Whilst the current activities serve to address some basic needs related to general counselling, the need for some persons with disabilities to access qualified mental health professionals (psychiatrists, psychologists), persists and remains an unaddressed need. To follow are examples from the mapping:

Case Study:
Mental health, stigma and social isolation

> "There was case of a Somali female with a mental disability, who had been living on the streets, all alone with no family. UNHCR provided her with clothes, and temporary shelter and referred her to a doctor for access to medication. The medication had some positive impact, but we were not able to find long term accommodation for her. We looked for supported accommodation but people were scared of her, and did not want her in the house with their children. Finally, we found a family to support her, and she is taking her medication and doing better."

Good Practice

Syria: Home based rehabilitation and psychosocial support

The program allows children to be supported at home by a dedicated family member who is the "training companion" of the child. Intensive training is provided to enable the training companion to guide the home-based rehabilitation and psychosocial support. The companion is supported through periodic follow-up visits to the community centre so that additional capacity-building can be provided, and regular home visits by the team of psychosocial support outreach volunteers. Families of children with developmental delay or autism enrolled in this program also receive psychosocial support through tailored activities.
An additional component of the program includes different types of social and recreational activities conducted in the community centre, aimed at building the social component, through promoting the integration of children with developmental delays or autism with other children. This program has been running since 2015.

In conclusion, the mapping found that barriers to the mainstream healthcare responses persist, and additional focus on access and equitable participation should be prioritized.

Rehabilitation

The mapping found that persons with disabilities faced significant barriers in attaining the maximum independence and ability to access basic needs and participate fully in all activities. Access to rehabilitation is a foundation for independence and participation. The WHO defines "rehabilitation" as "a set of measures that assist individuals to achieve and maintain optimal functioning in interaction with their environments"[65]. A common theme during the focus group discussions was pain. Participants referred to living in pain, needing assistance to alleviate pain and surgery to improve the underlying causes of pain. A study conducted by UNHCR in Israel report [66] yielded similar findings of the practical implications of the persons' disabilities on their daily life, constant pain ranked on top (mentioned 17 times out of 22).

Rehabilitation is one form of support to alleviate pain, and to promote independence and optimal functioning. The mapping identified several access barriers to the rehabilitation services across the operations. It includes non-availability or limited availability of the rehabilitation services in various operations; affordability to the services for refugees and asylum seekers and even if they are available; and lack of specialist services, expertise and national human resource capacity (e.g. limited university qualified speech therapists, occupational therapists) where access to national rehabilitation services is available. Additionally, funding constraints mean that specialist equipment (e.g. tilt tables) is not available. Further, the need for equipment means that persons with disabilities are limited in the rehabilitation that can be done independently, and at home. Some key informants mentioned that home-based rehabilitation was difficult due to the lack of equipment that could be distributed for independent and sustainable home-based care. Separately, the lack of services for persons with intellectual or sensory disabilities is highlighted as a gap or barrier across the operations.

Good Practice

Lebanon: Orientation and mobility (O&M) training for refugees who are blind

The O&M program was the only one of its kind. Orientation refers to the ability to know where you are and where you want to go, whether moving from one room to another or walking downtown. Mobility refers to the ability to move safely, efficiently, and effectively from one place to another (cross streets, use public transportation). O&M Training was provided to refugees. The independence gained with the white cane and practical skills to navigate was extremely impactful and empowering for people who are blind or with low vision.

Community-Based Rehabilitation

The WHO recommends that educating people with disabilities is essential for developing knowledge and skills for self-help, care, management, and decision-making. People with disabilities and their families experience better health and functioning when they are partners in rehabilitation. [67] The WHO community-based rehabilitation (CBR) approach is based on caregivers, families and communities developing the skills and capacities to provide rehabilitation locally (i.e. without the need to access expensive national or private services). Historically, CBR was a means of providing services focused on rehabilitation to people living in low-income countries using local community resources. During the mapping some examples, benefits and challenges of community-based rehabilitations were identified. There was an instance where the operation had provided training to NGO staff about community-based rehabilitation but did not include caregivers of the persons with disabilities, and when the project and funding cycle ended, the sustainability of this activity became questionable. In contrary, in other operations (e.g. Libya, Jordan, Egypt and Lebanon), the success of current training initiatives for persons with disabilities to prevent sores, do exercises and use equipment, demonstrated the positive impact of a CBR approach. Separately, the experiences of rehabilitation workers show that how challenging it was for caregivers to commit to doing additional rehabilitation at home. The issues were related to lack of time, competing priorities with livelihoods and other children, and a general limited understanding of the benefits of supplementing the centre sessions with home-based activities.

[65] World Health Organization (2010). Community-Based Rehabilitation Guidelines, Geneva. Available at https://www.who.int/disabilities/cbr/guidelines/en/, retrieved 12/11/2018.
[66] UNHCR Israel Operation (2018), Assessment of Access to Services for Asylum-Seekers with Physical, Sensory and Cognitive Disabilities
[67] World Health Organization (2011). World Report on Disability. Geneva. Available at https://www.who.int/disabilities/world_report/2011/report.pdf, retrieved 23/09/2018.

Good Practice

Libya: Empowering people with a disability
UNHCR and two INGOs collaborated to deliver disability awareness sessions-empowering people with a disability. Eighteen persons with disabilities from different nationalities attended the sessions. They mentioned that they did not know how to use some of the equipment and that awareness sessions help them to improve their daily lives. The sessions included techniques on the use of assistive devices, specifically the correct methods of using crutches, canes and walkers; bandage severed limbs correctly treat and gauze severed limbs; and bed sores, their types and how to prevent them using practical methods of special pillows, moving frequently and mattresses.

In resource constrained and humanitarian contexts where access to formal services is often fragmented and unreliable, the only viable and sustainable option is to implement projects to build the capacity of persons with disabilities, caregivers, families and communities to acquire the skills and to sustain the rehabilitation support.

Some forms of rehabilitation support are most effective, feasible and sustainable in the home environment. The Home-based Rehabilitation Program in Syria provides a good practice example. Similarly, an NGO in Jordan implements the Portage Program which supports children in their homes. It involves training the family to break down simple tasks such as dressing, eating, toileting and washing, into small steps. This helps children, even with the most complex impairments, to develop to optimal independence.

Assistive devices

The review of UNHCR and NGO partner reports found that the provision of assistive devices comprises a large proportion of the current response for persons with disabilities. In Lebanon and Jordan, participants of the focus group discussions expressed appreciation for the provision of wheelchairs, hearing aids, glasses, walkers, and white canes. However, the response has been sporadic, with limited scope for sustainability and not based on a systematic needs assessment.

The conflicts in Libya have prevented persons with disabilities' access to these essential resources. In south Yemen, persons with disabilities receive assistive devices through a UNHCR-funded national NGO. The NGO partner in Libya described how the security situation in Tripoli had affected the delivery of the assistive devices. The complete lack of access to some devices (e.g. walkers, prosthetics) as well as delays in the provision of more common devices such as reading glasses were highlighted as the recurrent concerns linked to access to assistive devices.

The participants of the focus group discussion in Jordan and Lebanon highlighted the link between assistive devices and access to education. One young Syrian boy in Jordan shared how he had waited for eye glasses. Once received, he was able to start school. A girl who had initially been waiting for medical boots had later been enrolled in school. A Syrian boy in Lebanon explained how significant the impact that an electric wheelchair can have on quality of life and ability to function independently.

As highlighted by the key informants, the current challenges and barriers to accessing devices include: lack of availability of specialised devices (prosthetics, medical boots, white canes) in many countries; lack of funding for specialised devices with higher costs, such as electric wheelchairs. Additionally, there is currently no quantitative data available on specific types and numbers of devices required that can be used to inform annual program planning for. In Jordan, the closure of one of the NGO projects in Zaatari camp (not UNHCR funded) has left a significant gap in the provision of hearing aids in the camp.

In Turkey, there is potential for persons with disabilities to receive government funded devices. However, at the time of the mapping, information about the number of persons with disabilities supported with devices was not available. In Lebanon, Algeria, Morocco, Jordan and

Egypt, there is potential for persons with disabilities to access low cost devices from government health or disability services. However, there are currently no systematic referrals to government agencies due to limited information about providers, variable access for refugees to national insurance coverage, high costs and long waiting lists. In Egypt, the government health system provides hearing aids to refugees. However, the current waiting list is at least 12 months. In Lebanon, Jordan and Egypt, UNHCR has been funding assistive devices since at least 2016. Reports document that diapers, mattresses, glasses, hearing aids, wheelchairs and walkers have been provided. However, there is no information on the extent to which supply has met demand and needs of persons with disabilities. Qualitative information suggests that there are waiting lists for some devices (including hearing aids, air mattresses) and that devices with higher costs are not available, such as electric wheelchairs.

Despite the challenges and barriers, the study identified future opportunities and good practices. An NGO in Iraq shared an example of a successful advocacy initiative which resulted in the provision of wheelchairs and hand supporters. Given the tangible nature of assistive devices, it may be possible to leverage funding through global Corporate Social Responsibility (CSR) initiatives, on the proviso that risks, and quality controls are overseen by qualified health professionals.

Good Practice

Jordan: Innovations in electric wheelchairs
Participants of the focus group discussion in the Zaatari camp shared how the Co-Creating Sustainable Solutions Project had supported the development of an innovative approach to walkers and wheelchairs. Two brothers set up their own small enterprise creating and selling electronic wheelchairs by reusing parts of old machinery and donated bicycles.

In Lebanon, national DPOs shared how they had been engaged in the production of assistive devices since the end of the civil war. Involving persons with disabilities in the production of devices provides livelihood opportunities, whilst at the same time also increasing the supply of low-cost devices which might otherwise not be available on the market. Initiatives which support livelihood generation and the increased supply of low-cost and sustainable devices should be prioritised.

In conclusion, full participation of persons with disabilities in all aspects of the healthcare response requires additional prioritisation. Support for rehabilitation initiatives and assistive devices (to ensure independence and optimal functioning), remains a core priority and remains underfunded. Current global best practice and the UNCRPD recognise that rehabilitation must be addressed in order to facilitate participation in mainstream essential services.

Caregivers

Some people with disabilities may require a caregiver to assist with activities of daily living, and to facilitate their full inclusion and participation. Caregivers can help to navigate environmental factors (e.g. when the environment is inaccessible, communication barriers). The mapping found that caregivers have been supported by a number of UNHCR-funded programs, and have benefitted from activities which reduce social isolation, stress, and provide practical skills and knowledge to build capacity to be a 'caregiver'. The following themes were shared by caregivers during the focus group discussions:

Social isolation: In Jordan, both Jordanian and Syrian caregivers who were part of the focus group discussion shared examples of being excluded from social events due to the stigma. The caregivers from Egypt and Lebanon expressed concern about social isolation and psychological distress on them. Most key informants confirmed that psychosocial support (individual counselling and peer group support) for caregivers should be given priority. Caregivers of children with disabilities expressed feeling isolated from their communities due to stigma, and because of logistical and practical barriers to participation. Caregivers are less likely to report due to lack of information about services and support, and in some cases, due to the dual stigma.

Lack of confidence in managing difficult behaviours and in providing appropriate support: The focus group participants from Egypt and Jordan expressed gratitude for education and training in positive 'behaviour management' that had been provided by UNHCR partners. The key informants in Yemen also referred to the importance and benefits of such training. Additionally, the key informants in Yemen and Jordan referred to the vital role of caregivers in providing supplementary rehabilitation. Given the fluctuations in project funding, and the challenges of resource poor environments, the advantages of a CBR approach are clear.

Livelihoods and social protection: A common concern raised in all focus group discussion was the lack of livelihood opportunities for caregivers. A mother of four children in Cairo expressed frustration at not being able to earn income due to the lack of education opportunities for her youngest child with autism. Her other children were at school, but she was not able to work due to the waiting list for funding for her youngest to access education. Mothers in Zaatari camp shared ideas for how they could support each other with childcare if they were given opportunities to work under the cash-for-work program, or to set up small businesses. Three mothers in Cairo referred that if they can receive support for home-based business can help to address the challenges of being a caregiver, including requiring more cash for rent, and being unable to work outside the home.

Case Study:

Sudanese mother of two children with disabilities

A Sudanese mother of two children with disabilities participated in the focus group discussion. Both daughters had an infection which had resulted in physical and significant cognitive impairments. When she shared her situation with the group, tears flowed, and she seemed to find it painful to express the multiple factors and stressors that she was experiencing. She shared how she was unable to leave the house due to the lack of available transport options for a wheelchair and paid high rent costs because others did not want to share a dwelling with her due to the noise that the children made.

UNHCR funded initiatives which support persons with disabilities with 'specific needs' also support caregivers. Education, training, peer group support and counselling has been provided for caregivers in Libya, Egypt, Lebanon, Jordan, Iraq and Yemen. The key informants highlighted the positive impact of such initiatives with the view that support for caregivers will ultimately ensure sustainable support for children with disabilities, particularly in resource constrained contexts.

One of the children at the Early Learning centres (ELC) for children with specific needs run by UNHCR's partner Intersos. This centre is in Kharaz refugee camp, and is one two such centres. The other centre is in the Basateen area (in Aden, southern Yemen) and serves refugees children with specific needs living in urban areas.

Education

UNCRPD Article 24
States are to ensure equal access to primary and secondary education, vocational training, adult education and lifelong learning. Education is to employ the appropriate materials, techniques and forms of communication. Pupils with support needs are to receive support measures, and pupils who are blind, deaf and deaf-blind are to receive their education in the most appropriate modes of communication from teachers who are fluent in sign language and Braille. Education of persons with disabilities must foster their participation in society, their sense of dignity and self-worth and the development of their personality, abilities and creativity.

UNCRC Article 28: (Right to education)
All children have the right to a primary education, which should be free.

UNCRC Article 29 (Goals of education)
Children's education should develop each child's personality, talents and abilities to the fullest.

SDG 4.5
Eliminate gender disparities in education and ensure equal access to all levels of education and vocational training for the vulnerable, including persons with disabilities, indigenous peoples and children in vulnerable situations

SDG 4.5.1
Parity indices (female/male, rural/urban, bottom/top wealth quintile and others such as disability status, indigenous peoples and conflict-affected) for all education indicators on this list that can be disaggregated

SDG 4.1
Ensure that all girls and boys complete free, equitable and quality primary and secondary education leading to relevant and effective learning outcomes.

Based on the data currently available in proGres, there are 14,662 children aged between 5-12 years and 10,438 children aged between 13-17 years who are registered in MENA region as children with disabilities. The extent to which these children are currently engaged in formal education was not ascertained due to the data management and coordination challenges. In Lebanon, having a disability significantly affected the ability of Syrian children and adolescents to attend school, with almost half (44%) of children with disabilities indicating that they cannot attend school due to their condition. Other listed barriers were common to all other Syrian refugee children, such as the cost of transportation (11%), the cost of educational material (7%), learning difficulties (7%), and the need to work, which was cited by 8% of children with disabilities. [68]

Based on the anecdotal and qualitative information of this study, it is 'likely' that 'many of these children with disabilities are not enrolled or attending school. The qualitative data suggests that children with mental disability (5,622), and children with severe physical disabilities (2,390) are even less likely than other children with disabilities.

Children with autism are not able to access education in any of the countries and parents of children with autism are seeking parenting support such as behaviour management and respite care. Most of the key informants from the operations shared the gap in provision of education and support for children with autism and children with intellectual and mental disabilities.

National contexts

Access to government and formal education varies across these countries. Despite the overall positive trends in gaining access to public education across these operations, the mapping found that children with disabilities are clearly being 'left behind'. Further, whilst the policy environment is now increasingly protective of refugee children, some of the practical barriers have persisted for all refugee children. Barriers include: travel distances between home and the nearest school; language, (for example, the need for French in many of the North African operations); resource constraints to address the specific requirement for children with disabilities; concomitant fear and distrust by parents of sending their children to a school where they may face stigma and violence; funding for certain nationalities (for example,

places for non-Syrian refugees might be limited in some contexts); limited access to early childhood education for children with disabilities; and years of missed education making re-entry difficult. Within the context of these challenges, and to enhance access and quality of education for children with disabilities humanitarian and development partners need to prioritize responses and advocate for inclusive public education systems at all levels. Funding, capacity and readiness of host country national systems to ensure appropriate inclusion (i.e. not integration or segregation, see Annex 2 "Definition of Terms"), pose barriers that will require a dedicated and resource intensive approach, at least initially.

An implicit reason is the underestimation of the resources and practical realities that are required for public education systems to become more inclusive. There has been significant progress in supporting physical accessibility but there remains an assumption that, with some limited time invested in teacher training, and the addition of a 'resource room', the school and all teachers will be able to include all children with disabilities. There is international debate as to definitions of what constitutes 'inclusion' and what is more indicative of 'integration'. Further, the resources (advocacy for each individual child to each individual school, case management, assessment of various learning disabilities requested by the schools) required to actively support refugee access to the limited number of inclusive education options, is under-acknowledged.

The systemic and global challenges in implementing inclusive education are cited in several sources. One study identified serious gaps in implementing inclusive education in developing countries [69]. Another review of 13 countries' progress on UNCRPD implementation found that there are still many barriers including lack of adequately trained teachers, accessible buildings, peer support and challenging bullying, with much more integration than inclusion [70]. Humanitarian and development actors have not explicitly highlighted the specific barriers to inclusive or specialized education for children with disabilities. In the absence of quantitative evidence-based data, the mapping study relied heavily on qualitative feedback about additional challenges faced by children with disabilities.

In Lebanon and Jordan, the access of refugee children to government formal education has continued to expand with the protracted nature of the Syria crisis, and increased international support. In Lebanon, there are 28 schools that have been supported to become more inclusive. Similarly, in Jordan, schools in two camp locations have been supported to become more inclusive, and the current double shifted schools have received support for additional resource rooms and inclusion. Despite the conducive environments of Lebanon and Jordan, barriers persist: children with physical disabilities faced fewer challenges than children with intellectual disabilities; despite the benefits of the new inclusive schools, there was a sense that these do not have the capacity to include children with moderate to severe intellectual disabilities without significant additional training and capacity building; the numbers of inclusive schools remains so low that children who do not live locally, are not able to access them; referral mechanisms between partners remain weak, in part, due to delays in data sharing arrangements; children experience dual discrimination, as a child with a disability and as a refugee; parents may be distrusting of the acceptance of their child, by peers and educators; and teacher training needs to increase significantly for truly inclusive education to be in effect.

At a systemic level, the Jordanian Ministry of Education's National Education Strategic Plan highlights multiple priorities in teacher professional development, including in inclusive education. The challenge is that teachers have only limited time for professional development and with the volume of content that is anticipated to be covered in the next three to five years, there is a practical challenge of available time for teachers to be engaged in training related to inclusive education.

Some other factors are also prevalent across the region that create barriers to access education for children with disabilities. Without quantitative evidence-based data to support or refute the assumptions, during the study the qualitative feedback received from the various sources underlined the following issues faced by children with disabilities.

- The children from non-Arabic specking communities were more likely to be excluded due to language and discrimination. In some situations, children with intellectual disabilities are excluded, and schools require medical diagnoses and educational assessments before

[68] Vulnerability Assessment of Syrian Refugees in Lebanon https://data2.unhcr.org/en/documents/download/67380
[69] Boer, Anke & Srivastava, Meenakshi & Pijl, Sip. (2013). Inclusive education in developing countries: a closer look at its implementation in the last 10 years. Educational Review.
[70] Cited in http://worldofinclusion.com/whats-happening-with-inclusive-education-around-the-world/

making the decision on enrolment. Designated national institution can conduct such assessments, but they are at a cost.

In many instances, the inclusive schools are not available, or the available public schools are overcrowded and full in some areas, and the travel distances pose a barrier for children with disabilities. For instance, a key informant referred a situation of three children, where two were blind and one on the autism spectrum.

> "When the partners worked together to find a school for these children but could not find one. The capacity and schools are just not there…There was one child with an intellectual disability, and we found a place for that child".

- In the operations where education options for children with disabilities are limited, UNHCR works with partners to identify solutions at the local level (through mapping of the local services and providing targeted support). For instance, a deaf or hard-of-hearing child who is unable to speak is supported to enrol in an inclusive school, while in another instance a child with psychosocial disability is able to receive extra support classes.

- Across the region, UNHCR jointly with partners engaged in advocacy to secure access to the formal and specialised schools for children with disabilities. At this stage, the limited number of places available for children with disabilities and limited number of inclusive schools available in a country context, means the majority of children with various disabilities are likely to be remaining out of school. Additionally, children face dual barriers of language and the limited number of schools that are indicated as 'inclusive'.

- Across the region, there is limited information and awareness about which government schools are inclusive. In cases where the schools are known, then they are often full, and have long waiting lists.

Meet Ibrahim and Haroon- they are five years old. Ibrahim is always Smiling, Haroon is a little harder to impress. Boys boys have a form of speech impediment making it difficult for them to be understood. Bu they are getting help and their teachers tell me they are making good progress.

Snapshot of UNHCR supported practices and related challenges

In many countries, UNHCR coordinates closely with Education Ministries, UNICEF and other partners to promote access of refugee children into national education systems. Due to the barriers faced by some refugee children in accessing the national systems, UNHCR has supported a range of education related interventions; as an interim measure, partly to mitigate child protection risks, and to identify and monitor the scope and scale of the current 'gap'.

In Egypt, the UNHCR response is to fund an NGO partner to identify suitable education options (inclusive and specialised), and to administer cash-for-education grants. There are currently 288 children supported with cash-for-education grants at over 24 specialised education schools at an average cost of $500-$870 per year per child in tuition, and $175 in transport. The NGO attempts to enrol children in inclusive government school settings but often the school is not able to meet the needs of the child, and the schools considered to be inclusive are widely dispersed across urban centres, therefore the travel distances between home and the inclusive school pose an additional barrier. The UNHCR supported partner has established a strategic partnership with another NGO (supported through UNICEF), for referrals for hearing assessments and hearing aids. This informal partnership has resulted in an increased access for children with hearing impairments. UNHCR Egypt together with the government is currently mapping all public schools which may provide an option for inclusion, as well as continuing to identify sustainable, quality and low-cost providers of specialised education.

In Jordan, 300 children are supported through the Portage Program (home-based early intervention), and 200 parents participated in awareness sessions where one of the topics was related to education opportunities for children with disabilities. In addition, 60 children are supported with specialised education through a partner who provides rehabilitation, assistive devices and other disability specific support.

Despite the efforts, in some situations, children with disabilities were not able to register in formal education. In a situation where the caregiver was not able to enrol the child referred that

> "My 7-year-old daughter has a disability, and I was advised to enrol her at a public school. When I tried, they said that they could not enrol her. They did not give a specific reason, just that they were not able to accommodate her needs."

In another instance the caregiver shared a situation and reflects that

> "My 6-year-old daughter wants to go to school like her sisters. Every day, she puts a school bag on her back, and pretends that she will also go to school with her sisters. So far, we tried to find a school that will accept her, but we have not been successful."

In Lebanon, there are 28 inclusive public schools supported through international funding, but they are dispersed, and distances pose a travel or transport barrier. Additionally, it is unlikely that these schools will have the capacity to include children with intellectual disabilities. The Ministry of Social Development runs a special education centre for Lebanese children with moderate to severe disabilities. With the support of donors, the centre recently expanded to include an afternoon shift for refugee children. Places are very limited, and the location is only in Beirut and can involve up to four hours of daily travel for children based in the north of the country. In sharing the differential challenges faced by the educators of the Lebanese morning shift as compared to the Syrian shift in the afternoons, the biggest difference was the extent of mental health issues related behaviours amongst Syrian children with disabilities.

UNHCR offices in some operations have tried to find the solutions for children with disabilities. For instance, in Lebanon, UNHCR together with partners has compiled a list of approximately 1,000 children with disabilities (mainly with autism spectrum disorder) who they have systematically tried to enrol in education but there are no low-cost options. Specialised education is expensive, costing approximately $8,000 per year per child. This example raises the issue of decision around prioritisation of support and setting of precedence and expectations.

In Yemen, two centres in the south have provided comprehensive group and individual early intervention and education services. The objective is for children, who successfully complete their individual education program and demonstrate improvement in functioning, to be able to access the regular education system and institutions. In 2016 (11 children), 2017 (8 children), and 2018 (12 children) were referred and enrolled in the formal primary schools. The total number of refugee children enrolled in the two centres is 168.

Good Practice

Yemen: The Al-Basmah Foundation for Persons with Disabilities

The centre provides children with disabilities with support, rehabilitation and social inclusion. Students study the same curriculum taught by public schools, but the curriculum is adapted to suit the capacities of the children. The centre was closed in 2015 for eight months after funding was suspended. During the closure, the centre's employees (including teachers) worked as volunteers to continue education services. Two mothers of refugee children commented: "We are satisfied with the services that Al-Basmah Centre delivers for our children with disabilities, the centre is amazing for its interventions."

Cross Cutting Themes

Safety in schools

In situations where refugee children are able to overcome the barriers to accessing formal education, incidences of stigma and bullying were reported. A mother of a thirteen-year-old girl who has seizures and wears a hearing aid (from ear damage as a result of missile fire in Syria) had been attending formal school but recently changed schools. The mother had explained to the teacher about the seizures. The teacher was not welcoming of having a 'difficult' situation in the classroom. In addition to the specific cases of bullying, there is an anticipation of bullying. A Key Informants reflects that

> "It takes a long time to build the trust of parents, and for parents to allow children to participate in activities. We have been working with families for decades and they know and trust us. It will take time for the Syrian families to feel comfortable to allow their children to participate in the summer camp. We are making progress, but trust is an issue".

In a separate focus group discussion, a 15-year-old Syrian boy who is blind shared how he had never attended school because his parents feared how he would be treated by other students. They felt he would be safest at home.

Therefore, issues of trust and mechanisms to ensure safety in schools need to be strengthened concurrently to other initiatives. It is a cycle which requires multiple interventions at the same time so that formal education environments are seen as a safe and quality option for children with disabilities.

Another cross-cutting theme which emerged was the link between assistive devices and education. An eight-year-old boy, requiring specialised eyeglasses, had been struggling to remain in school, and had been absent because he could not see. As soon as he had received the glasses, started doing well in school, and his mother expressed her gratitude for the support of UNHCR and the NGO partner.

Case Study:

Supported to re-engage with formal schooling

Farid is a thirteen-year-old Syrian boy with autism symptoms, learning difficulties and hyperactivity. He had been attending the Syrian community school. However, he faced mistreatment and harassment due to his hyperactivity, poor memory and inability to focus. Farid was seen as a troublemaker and was eventually expelled. He started to attend activities in the UNHCR-supported community centre. A community worker engaged Farid in some interactive activities using methods and materials like cubes, puzzles, memory cards and helped him with reading and writing. Recently, Farid enrolled at a local school and started to achieve some development in learning, reading and writing. The community centre provided him with a safe space, with the needed care and support, which enhanced his feeling of security and self-confidence to transition to formal school.

Case Study:

Early intervention facilitates access to formal education[71]

Yara is a 12-year-old Somali refugee and has an artificial leg, development delays and brain atrophy. Doctors say that as she gets older, her disabilities will become more difficult and complicated. However, her determination and positive attitude have helped her build hope that each day can bring some new beauty or happiness. This attitude has helped her to overcome many challenges. Yara graduated from a certificate program, under the sponsorship of UNHCR. After this initial education, she entered a public school where students with disabilities and special needs are included with the rest of the school population.

Vocational Training, Communication Skills and Lifelong Learning

Youth are interested in accessing vocational training, language and literacy (learning Braille) and computer skills. As documented by WHO:

> "While non-formal education is often considered a second-best option to formal education, it should be noted that it can provide higher-quality education than in formal schools. Non-formal education can be preparatory, supplementary or an excellent alternative (where necessary) to formal schooling for all children". [72]

The current context of limited access of youth to education and training calls for urgent and short-term measures. Similar to the situation for primary aged children, without data it is difficult to plan. It is likely that many youth (aged 18-24 years old) with disabilities have had limited exposure to formal education. Referrals to

[71] Adapted for this mapping study, from the short film, YARA by Yasser Abdul Baki (Association of Development for People with Special Needs ADPSN [UNHCR partner]).

[72] World Health Organization (2010). Community-Based Rehabilitation Guidelines-Education component, Geneva. Available at https://www.who.int/disabilities/cbr/guidelines/en/, retrieved 12/11/2018.

formal national education systems should be prioritised but in contexts where the years of missed education and limited language and literacy is a barrier, then participation in alternate non formal or vocational education should be considered.

Case Study:
Utilizing existing skills available within the community
Two young Syrians, both blind, shared their varied experiences. The female had learnt Braille from a young age because her family had been able to afford for her to go to a school for blind children. The male had never been to school and knew no Braille. During the discussion, she offered to teach him and others Braille. The group brainstormed the best approach and agreed that she could deliver Braille classes through the existing community centres.

The case study provides a good practice example of the type of community-based approach (aligned to the UNHCR community-based protection approach and the WHO community-based rehabilitation activities) that can be used to provide language, literacy and life and vocational skills training. In terms of costs, effectiveness, impact and sustainability, activities which engage persons with disabilities as role models and trainers of others, meet all the criteria for good practice initiatives particularly in the short-term, and with resource constraints.

Case Study:
Overcoming from the higher education barriers
Asma is a Syrian refugee who is blind and is in her second year of a self-funded bachelor level degree. She expressed extreme frustration at the challenges that she has faced.

> "The professors have been nice but have made no changes to delivery or access to materials. I am unable to read materials and have been lucky that I found a friend who reads all the materials out loud and I write them in Braille. My friend has been busy, and she is finding it harder to support me. Sometimes, she reads the notes to me, the evening before the exam, and it is too late. She has mentioned that she may not be able to help me in the future. I think I need to change universities and courses. I've heard that another university may be more supportive of my needs. It has been so difficult. I always think about giving up but then I get my determination back."

Asma's example highlights the challenges that may be faced and needs a review to better understand the challenges that might be faced during the course of higher education study, and to put in place measures to mitigate these challenges.

Higher Education

UNHCR is committed to the provision of higher education opportunities for persons of concern globally. Through the Albert Einstein Academic Refugee Initiative (the DAFI programme[73]), UNHCR supported 6,723 students in 2017[74]. Data with disability status was not available but the DAFI Annual Report cited two examples of current tertiary scholarship recipients in Africa. The DAFI Guidelines seek to support inclusion.

The extent to which accessibility and inclusion is supported in national higher education institutions was not ascertained. However, a female Syrian student who is blind, and independently enrolled in a university, highlights challenges that may be faced for persons with disabilities in higher education.

[73] For more information, see - https://www.unhcr.org/dafi-scholarships.html
[74] UNHCR (2017) DAFI Annual Report

Community Empowerment and Self-management

UNCRPD Article 29
Countries are to ensure equal participation in political and public life, including the right to vote, to stand for elections and to hold office.

UNCRPD Article 30
Countries are to promote participation in cultural life, recreation, leisure and sport… guaranteeing that persons with disabilities have the opportunity to develop and utilize their creative potential not only for their own benefit, but also for the enrichment of society. Countries are to ensure their participation in mainstream and disability-specific sports.

UNCRC Article 31 (Leisure, play and culture)
Children have the right to relax and play, and to join in a wide range of cultural, artistic and other recreational activities.

SDG 16.7
Ensure responsive, inclusive, participatory and representative decision-making at all levels

SDG 16.7.1
Proportions of positions (by sex, age, persons with disabilities and population groups) in public institutions (national and local legislatures, public service, and judiciary) compared to national distributions

SDG 16.7.2
Proportion of population who believe decision-making is inclusive and responsive, by sex, age, disability and population group.

The persons with disabilities and their families are often socially isolated. Increased engagement through existing community initiatives provide examples of good practices which can be expanded, with relatively low, additional resource investment. Lack of access to information and communication barriers make the persons with disabilities further isolated. Such barriers for those with hearing or speech impairments, and sometimes those with mental disabilities, which makes them further isolated. Persons with disabilities' ability to participate in community dialogue, receive feedback and access to complaint mechanisms remains limited or often overlooked.

UNHCR is committed to apply the community-based approaches to protection and continues to ensure that support mechanisms are strengthened in order to address social isolation, facilitate discussion on sensitive subjects, increase the participation of marginalized groups, counter stigma and discrimination, and reduce risks of SGBV and other forms of violence and abuse[75]. The mapping study found that current UNHCR community-based initiatives provide the ideal platform for the implementation of some of the good practice activities recommended by WHO (Social and Empowerment Components[76]).

Participation

The participation of people with disabilities in self-management is an important approach to empowerment. Participation in formal community engagement mechanisms enables people affected by issues to be at the centre of decision-making and to influence change. Humanitarian actors face various challenges towards ensuring equal participation of the persons with disabilities. Where community structures remained weak, they do not encourage persons with disability to participate in the structures. In Jordan, the Community Support Committee (CSC) is a good example of collaboration between refugee and host populations as well as actively sought a diverse representation across age and gender, and nationalities, still ensuring

[75] UNHCR (2016), Accountability to Affected Populations Report
[76] World Health Organization (2010). Community-Based Rehabilitation Guidelines-Empowerment component, Geneva. Available at https://www.who.int/disabilities/cbr/guidelines/en/, retrieved 12/11/2018.
World Health Organization (2010). Community-Based Rehabilitation Guidelines-Social component, Geneva. Available at https://www.who.int/disabilities/cbr/guidelines/en/, retrieved 12/11/2018.

participation by persons with disabilities remains a challenge. Many persons with disabilities are not known to the community, and issues of self-esteem inhibit self-promotion and participation. Various good practices show that UNHCR offices have taken proactive measures to ensure increased representation of persons with disabilities. The below reflection from the operation show how the process takes time, and benefits from initial engagement in community-based activities or initiatives, with a gradual transition to self-management roles.

Case Study:
Success in community volunteerism
A young male who had been regularly engaged in the youth activities of the community development centre, expressed an interest in chairing a Youth Committee, and was later elected via formal process. This created a momentum for other young people with disabilities to join community activities, which then, in turn, created a more inclusive environment.

Good Practice

Egypt: Training to CBOs
UNHCR trained the Oromo Volunteer Association in how to engage persons with disabilities in social activities and events. The expectation is that the training will set the foundation for other initiatives for proactive support inclusion in social activities and leadership structures.

Iraq: Peer-led discussion
Community entities are involved in the discussion about social inclusion for people with disabilities. Peer-led focus group discussions, including persons with disabilities and caregivers are frequently organized, and findings reported in both Protection Sector and Cluster.

The participation of persons with disabilities in community leadership positions is a vital component to changing attitudes, reducing stigma and creating the momentum required to reduce to encourage wider participation and inclusion.

> "Before I was invited to attend the community youth program, I sat at home with nobody to talk to. I've never been to school. I like talking and so I felt so very lonely. My brother was always rude to me because he wishes I was 'normal', and the rest of my family just ignores me. My life was so sad and lonely, and I never imagined having the friends that I have now. It all changed after going to the youth program...it is not very often but I made friends the first time and we are still in regular contact by phone. My whole life has changed."

Social events and activities

According to WHO, participation in recreation, leisure and sports activities may be one of the few opportunities people with disabilities have to engage in community life beyond their immediate families[77]. To the extent that it is feasible and not stigmatising, there should be proactive targeting of persons with disabilities to social events and activities. In Iraq – Community Centres provide safe space for persons with disabilities to engage in their own issues. In Lebanon, Egypt and Jordan, the persons with disabilities referred peer-support group and network as one of the effective ways of engagement within the community.

Yemen: Community Committees
In 2013, refugees with disabilities established committees in the urban area of Basateen-Aden and in Kharaz camp in Lahej governorate, southern Yemen. The committees were established by the persons with disabilities themselves, through elections in the community with the support of UNHCR's community-based protection partner. UNHCR through its partner supports the committee in Aden with office rent, telecommunications and transport cost. Both committees are active in identifying persons with disabilities, conducting surveys, referring persons with disabilities to relevant partners, and representing persons with disabilities in meetings with UNHCR and other agencies.

[77] World Health Organization (2010). Community-Based Rehabilitation Guidelines-Social component, Geneva. Available at https://www.who.int/disabilities/cbr/guidelines/en/, retrieved 12/11/2018.

Good Practice

Lebanon: Community Development Centres

Community Development Centres (CDCs) provide a safe space for persons with disabilities to participate in decisions and activities, engage in programs and benefit from support networks. To cite examples of inclusion for persons with disabilities:

- Enhancing accessibility of centre premises: As per the CDC minimum standards, centres are located on the ground floor or ensure that a functional lift is available. Currently around 80 per cent of UNHCR supported CDCs are accessible to persons with disabilities.
- Ensuring inclusive services and activities: In 2018, more than 5,000 persons (around 70 per cent females) with physical, mental, intellectual or sensory impairment accessed CDCs to benefit from services, seek updated information, or participate in activities. The diversity component is also mainstreamed across awareness raising activities of the life-skills package.
- Increasing participation in decision making processes: more than 40 persons with disabilities are members of community groups which provide support by sharing information with communities, raising community concerns and implementing activities. In addition, one specific community group of 10 persons with visual impairments was established. Youth with disabilities has been also prioritised by different youth groups, who will be trained and will conduct awareness and participative activities in 2018.
- Implementing mobile activities: CDCs have initiated mobile activities to be able to reach those with limited mobility or residing in distant locations. Around 10 per cent of those who benefited from mobile activities are persons with disabilities.

Role Models and Community Volunteers

Several sources made the link between the inclusion of persons with disabilities in community volunteer roles, and an overall reduced stigma and change in perceptions and attitudes. Given the overall low participation of persons with disabilities in the labour market, the impacts of social isolation and the importance of role models in creating momentum, an affirmative action approach is recommended. Further, according to WHO, gaining skills and knowledge can lead to increased confidence and self-esteem, which is an important part of the empowerment process [78]. A community volunteers mentioned that

> "As a family we were isolated, we used to have minimum contact with people. Through the reach out initiative, we are in contact with people on a daily basis…It's an empowering experience. When you see other people with vulnerabilities, it helps you to cope with your own."

Another community volunteer referred that

> "Persons with disabilities have so much potential, with support, we can build their capacities and potential. The right activities for persons with specific needs can help them to be true motivators and life changing for the community."

Case Study:

Self-Initiated Sports Club

Five young Sudanese men with disabilities arrived in a country of asylum in 2016 after fleeing war and internal conflicts. The men had been champions in different national sport teams in Sudan. Two years ago, the group came up with the idea to establish a sports centre for persons with disabilities. With UNHCR support, the group presented their idea and UNHCR's (through a partner) under its Community Empowerment Project provided start-up funding. The sports club became a reality and they named it "Shemoukh" (Pride). It is now a gathering forum for hope and support.

[78] World Health Organization (2010). Community-Based Rehabilitation Guidelines-Social component, Geneva. Available at https://www.who.int/disabilities/cbr/guidelines/en/, retrieved 12/11/2018.

Good Practice

Lebanon:

The Refugee Outreach Volunteer (ROV) Initiative

UNHCR operates a network of 678 ROVs as of June 2019 from Lebanese and refugee communities who (a) disseminate information on health services, access to education, legal services, and protection related issues; (b) identify vulnerable cases for referral to humanitarian services; and (c) support communities to implement solutions to common protection concerns. The program includes 20 ROVs with disabilities. However, all ROVs countrywide are trained on disability inclusion through the standard ROV induction program, including a specialised training on safe identification and referral. UNHCR continues to strive toward an overall target of 15 per cent.

Hassan said he had not left his room for one year prior to working as a ROV. He is now a role model for others, and his life perspective has changed.

Zaina lives with her family and had previously felt very depressed because of her family's disappointment and frustration at her inability to contribute to the family livelihood due to difficulty using one of her arms and hands. UNHCR staff shared that she had been experiencing severe anxiety and depression. She is now accessing psychosocial support and she highlighted the positive impact of the program on her self-esteem and worth.

> "My family has changed the way they treat me! Not because I earn so much but just because I am contributing."

The mapping concludes that social and community initiatives provide an ideal platform for initial participation and inclusion. This then comes with a significant multiplier effect, access and equitable participation in other domains.

Remas Abdelqawi is a sprightly six years old. Her family fled the violence at Taizz frontlines two years ago. Her mother is thrilled with Remas progress since visiting the physiotherapy centre for four months. Remas Despite her paralysis, she shared a huge smile when she saw her new toys.

Self-reliance and Livelihoods

UNCRPD Article 27: Persons with disabilities have equal rights to work and gain a living. Countries are to prohibit discrimination in job-related matters, promote self-employment, entrepreneurship and starting one's own business, employ persons with disabilities in the public sector, promote their employment in the private sector, and ensure that they are provided with reasonable accommodation at work.

UNCRPD Article 24: States are to ensure equal access to primary and secondary education, vocational training, adult education and lifelong learning.

UNCRPD Article 28: Countries recognize the right to an adequate standard of living and social protection; this includes public housing, services and assistance for disability-related needs, as well as assistance with disability-related expenses

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SDG 4.4: Substantially increase the number of youth and adults who have relevant skills, including technical and vocational skills, for employment, decent jobs and entrepreneurship

SDG 8.5: Achieve full and productive employment and decent work for all women and men, including for young people and persons with disabilities, and equal pay for work of equal value

SDG 8.5.1: Average hourly earnings of female and male employees, by occupation, age and persons with disabilities

SDG-8.5.2: Unemployment rate, by sex, age and persons with disabilities

The link between disability and limited access to livelihoods is cited in several studies [79]. All adult focus group discussions participants cited getting a job as the highest priority goal. Participants felt that with access to a job, they could purchase medicine, be more self-sufficient and less dependent on family members. The issue of self-esteem and lack of independence was a theme of the mapping; perhaps more prevalent amongst refugees than amongst other populations. Livelihoods in the context of displacement tend to be informal, sporadic and rely on the interdependence of family and community. The comparative independence that comes with social protection systems in developed countries, is missing in the refugee context. Moreover, legal protection and minimum employment quotas which sometimes facilitate access of host communities to wage employment, have not yet included refugees.

Persons with disabilities face various obstacles while accessing to livelihood and vocational training opportunities. To re-quote the observation of a community volunteers,

> "My family did not accept me because of disability. They saw me as worthless because of my inability to contribute to the household income".

The current suite of vocational training initiatives offered through the humanitarian responses are limited, and generally, not easily suitable for persons with disabilities. Further research into the link between vocational training and labour market opportunities for persons with disabilities was recommended. In Israel, the UNHCR Israel Report[80] found that of the 22 participants, only three indicated that they actually have a stable job. When asked whether they would be able to perform a manual job in future, a total of 19 replied positively, though with some limitations.

[79] World Health Organization (2011). World Report on Disability. Geneva. Available at https://www.who.int/disabilities/world_report/2011/report.pdf, retrieved 23/09/2018.
World Health Organization (2010). Community-Based Rehabilitation Guidelines, Geneva. Available at https://www.who.int/disabilities/cbr/guidelines/en/, retrieved 12/11/2018.
United Nations Global Compact and International Labour Organization (No year provided). Guide for Business on the Rights of Persons with Disabilities. New York. Available at https://www.unglobalcompact.org/library/5381, retrieved 22/9/2018.

[80] UNHCR Israel Operation (2018), Assessment of Access to Services for Asylum-Seekers with Physical, Sensory and Cognitive Disabilities (unpublished internal report)

Persons with disabilities who participated in the mapping study expressed the desire to 'be independent' and to 'stop being a burden' on the family. Some cross-cutting themes include:

- Lack of disaggregated data on the extent to which persons with disabilities are engaged in livelihoods programs.
- Challenges related to humanitarian and development coordination within the various sectors and agencies. Some working in humanitarian sector indicated that they were not aware of livelihoods opportunities, while those working in livelihood indicated that they have not received the 'list' of persons with disabilities who had expressed interest and readiness for work.
- The introduction of a 15 per cent quota (as per WHO estimates of persons with disabilities) in project partnership agreements need serious consideration. If the quota is not achieved in the short-term, the indicator itself can promote change and increased targeted, and affirmative action strategies.
- In contexts where legal employment is partial or fully permitted, the environments or buildings are not accessible, and there is no system, standard operating procedures and funding for reasonable accommodations.
- In countries where national level quotas and government supported national employment agencies are in place, inclusion of persons with disabilities within these systems, should be prioritised and advocated.
- Livelihoods sector personnel are interested in training and capacity building in strategies to support access for persons with disabilities into livelihoods.
- Persons with disabilities consistently expressed interest in vocational skills development (aligned to labour market needs) and start-up funds and entrepreneurial skills. To quote a young person in Lebanon:

> "If we can get vocational skills, then we can look after ourselves."

This finding is consistent WHO Guidelines, Self-employment provides the main opportunity for people with disabilities in low income countries to earn a livelihood. [81] Despite the relatively limited scale of initiatives supporting persons with disabilities to sustain livelihoods, several good practices and individual case studies were identified.

Good Practice

Turkey: Vocational training for youth
A partner agency ran a successful vocational training program for youth with disabilities. There were no employment outcomes but the engagement in training had benefits for confidence, self-esteem, and reducing stigma.

Jordan: Initiating collaboration with authorities
The livelihoods team held a meeting with the Inclusion Officer at the Ministry of Labour to discuss access for persons with disabilities. This provides an example of an initial action that has potential for future collaboration and success.

Jordan: Innovations in electric wheelchairs
Participants of the focus group discussion in the Zaatari camp shared how the Co-Creating Sustainable Solutions Project had supported the development of an innovative approach to walkers and wheelchairs. Two brothers set up their own enterprise creating and selling electronic wheelchairs by re-using old machinery and donated bicycles.

Egypt: Quota for persons with disabilities in livelihood program
UNHCR had already included a quota of five per cent persons with disabilities in the project partnership agreement of the livelihoods partner. In this context, the partner and UNHCR established contact with national employment centres to advocate for persons with disabilities to job placement. The approach and relationships can be developed in future projects in Cairo. The quota served to raise awareness.

Israel: Advocacy for access to vocational training
National level advocacy for increased access to vocational training and employment services has been ongoing. The team continued to follow on referrals that had been made.

[81] World Health Organization (2010). Community-Based Rehabilitation Guidelines-Livelihoods component, Geneva. Available at https://www.who.int/disabilities/cbr/guidelines/en/, retrieved 12/11/2018.

Case Study:

Access to Livelihoods and Self Reliance

Musaab, 35, a lawyer from Iraq arrived in a country of asylum in 2017 with his wife and two children. He looked for jobs everywhere but whenever employers saw his amputated hand, they turned him down. After a few months, he learnt to speak the language of the country of asylum and continued tirelessly to look for work. Musaab was referred to the livelihoods team who supported him to find a job with a company. Musaab highly appreciated the support. He said his financial situation had improved greatly and he is now able to provide for his family. His children are successful in school. He said,

> "I feel hopeful for the future of my children, I am more productive and able to support my family."

Case Study:

Perseverance and conflict

Mohammad was born in Somalia in 1985. At age six, a high fever caused paralysis, through which he lost the ability to move the lower half of his body. In 2004, he escaped conflict in Somalia. In 2010, Mohamed joined the electronics workshop through the UNHCR Micro-credit Program for persons with disabilities and set up a Wi-Fi business, spreading internet service through a satellite. In 2014, he took a loan to expand the business. He received additional loan from the local partner to set up a Wi-Fi project. In 2016, Mohammed added new devices to expand the broadcast of his Wi-Fi to an extra area. His children now attend school. The project's success also created new job opportunities for three young men from the same area. He hired them to help him with the business. He joined a group savings with his friends.

The case studies and good practices demonstrate the great potential of refugees to innovate, to persevere and to use their skills and strengths to contribute to the countries that are hosting them. They show resilience and the ability to adapt, as well as the potential capacities awaiting to be rightly invested, regardless of the perceived disability a person might have.

Social Protection and Cash-Based Interventions (CBIs)

According to WHO,

> "Exclusion from work represents the loss of a significant amount of productivity and income and therefore investments to offset exclusion are required."[82]

The review of secondary literature confirms that social protection mechanisms are an important component in ensuring equality and independence for persons with disabilities. The mapping study found qualitative evidence to suggest that persons with disabilities are more likely to be recipients of cash assistance programs. However, it is important to maintain the data disaggregation with disability to demonstrate the actual delivery of such support.

In contexts where equal access to wage employment is difficult due to stigma, discrimination and inaccessible work environments, cash assistance provides an alternative to employment support. For some, social security is the only option. In many contexts across MENA, cash assistance forms a vital form of social protection for persons with disabilities. Many participants of the focus group discussion indicated that cash assistance gives them autonomy to answer their needs.

In addition to the other challenges, participants of the focus group discussion and key informants explained that living with a disability 'costs more'. WHO documents the extra costs of being disabled, including the costs of carers, transport, and adaptations to accommodation. Costs are often met under social assistance measures in high-income countries, but seldom in low-income countries[83]. Whilst the information on specific impacts of cash on persons with disabilities has not been established, the questions that were raised for further exploration during the mapping were as follows:

- Given the additional cost of medicine, (and potentially transport to access essential services-health, rehabilitation, education), to what extent are CBIs a feasible mechanism for this additional support?
- Given the additional cost of rent and possible home modifications, to what extent are CBIs a feasible mechanism for providing this additional support?
- Given the additional cost for special education (in the short term), to what extent should cash-for-education be an approach that is implemented in other countries?

[82] World Health Organization (2010). Community-Based Rehabilitation Guidelines-Livelihoods component, Geneva. Available at https://www.who.int/disabilities/cbr/guidelines/en/, retrieved 12/11/2018.
[83] Ibid

There are many vulnerability factors that combine to determine eligibility for cash, and specific recommendations on the way forward (in light of the above questions) should be based on quantitative as well as qualitative evidences.

Conclusion

The lack of disaggregated data has made for a preliminary study based on qualitative and anecdotal evidence. However, evidence from secondary sources combined with the specifics and depth of the responses shared by persons with disabilities and key informants, indicate that the protection response for persons with disabilities requires an immediate and coordinated humanitarian and development response to address rights violations: limited access to education; increased risks of violence; inadequate access to medication and health care; poor mental health compounded by stigma and social isolation; lack of affirmative action initiatives to overcome barriers and discrimination e.g. in employment; and limited financial and resource investment to address unmet needs (partly due to lack of evidence required for annual operational planning and budgeting). Aspects of the mapping study depict a dark, seemingly insurmountable and complex intersection of multiple and compounding, systemic and attitudinal barriers; to access, to equitable participation and to inclusion in mainstream initiatives.

Then shines the light: the perseverance, the optimism, the ideas, the innovation, and the inspiration of the people, as shown by the case studies and comments taken from persons with disabilities. The success and impact of current programs, and the commitment of UNHCR staff and humanitarian partners to initiate, advocate and support the way forward provides the platform for future action. [84]

> "We will be answerable to the people we serve and strive to ensure that their voices, perspectives and priorities are heard and acted on – by all those whose decisions have an impact on their lives."

[84] UNHCR Strategic Directions 2017-2021

Recommendations by Section

1. Population Data and Information Management

1. Develop a comprehensive, costed and phased operational plan to guide the integration of the Washington Group Questions into relevant UNHCR data collection tools across MENA.
2. Strengthen disability inclusion into existing information management systems (such as Refugee Assistance Information System) and processes which link identification, assessments and response. Monitoring and reporting require a feedback loop.
3. Advocate for all regional level 3RP partners to collect and use data disaggregated by disability for planning and reporting.
4. Update existing information management systems (e.g. Activity Info, Refugee Assistance Information System,) to include fields which disaggregate data by disability.
5. Incorporate indicators for persons with disabilities in all request for proposals and project partnership agreements.
6. Strengthen disability inclusion in existing system for monitoring and reporting on referrals across programs, projects, services, sectors and government and non-government agencies.

2. Favourable Protection Environment

1. Initiate a mapping of the services which refugees and asylum-seekers can access (as per law and policy). Determine the extent to which the current practice supports or prevents access and inclusion, and the specific barriers to inclusion.
2. Coordinate with national Disabled Persons' Organizations and other actors to conduct joint advocacy initiatives to revise national policies (where relevant) and ensure practice reflects policy and legal protection.
3. Develop a phased and costed action plan to improve the accessibility of camps, pubic facilities, reception centres and all core infrastructure consistently utilised by persons with disabilities. Adopt the principle of universal design.
4. In collaboration with Disabled Persons' Organizations, support access to a pool of trained sign language interpreters.
5. Support access of persons with disabilities to sign language and Braille learning courses and classes.
6. Promote and support the use of accessible information and communication formats in all activities.
7. Work with persons with disabilities, community leaders and community-based forums to create awareness about disability.

3. Coordination and Partnerships

1. Adopt the twin-track approach (disability-specific support and mainstreaming). Sector specific guidelines on universal design and reasonable accommodation provide strategies to improve access and inclusion (e.g. ILO documents for inclusion of persons with disabilities in livelihoods [85]).
2. Advocate for disability-specific (e.g. rehabilitation, assistive devices, respite care) and inclusive indicators and targets in all relevant regional and national humanitarian and developmental response plans and programmes.
3. Integrate activities and budget for reasonable accommodation and universal design into program documents (e.g. funding for transport, workplace adjustments and communication aids).
4. Establish structures and fund human resources for Inclusion Officers in humanitarian agencies.
5. Ensure that external coordination mechanisms (regional, national, sub-national) integrate activities to improve accessibility and inclusion in annual planning, monitoring and reporting documents.
6. Develop strategic partnerships with the Arab Organization of Persons with Disabilities (AOPD) to ensure that refugees and asylum seekers are included in regional level advocacy campaigns.
7. Develop a global strategic partnership with the International Disability Alliance (IDA) and collaborate to develop key points of advocacy to improve the responses for persons with disabilities in humanitarian contexts.
8. Strengthen advocacy and support for refugees with disabilities through strategic alliances with other international agencies (for example, ILO for livelihoods, UNICEF for education, WHO for health and rehabilitation, UNDP for national development planning, and others where relevant).
9. Develop partnerships with agencies with technical expertise, e.g. Humanity & Inclusion (HI) and Help Age International.
10. Develop strategic alliances with development partners and donors who are supporting government national systems strengthening: Education, Health, Labour, Social Development, and others.
11. Develop partnerships between humanitarian agencies and national Disabled Persons' Organizations and relevant Community-Based Organizations.

4. Security from Violence and Exploitation

1. Review Child Protection and Sexual and Gender-Based Violence Information Management systems and implement disaggregated data provision with disability in monitoring and reporting.
2. Systematically integrate training content related to inclusion of persons with disabilities in Child Protection and Sexual and Gender-Based Violence sub-sector activities, and mainstream training courses and modules.
3. Systematically reduce the social isolation of children with disabilities, caregivers and adults with disabilities through a range of social, recreational, peer support, education and training initiatives that support the building of peer networks between persons with and without disabilities.
4. Develop strategies to provide access to information about violence, exploitation and abuse to persons with disabilities and ensure awareness about confidentiality, disclosures, services and supports.

5. Health and Rehabilitation

1. In line with a community-based rehabilitation approach, develop training of trainer materials and short workshop courses aimed at building the capacity of persons with disabilities to train and coach others in the self-management of chronic conditions.
2. Ensure that persons with disabilities receive accessible information related to mainstreaming health promotion campaigns.
3. Conduct capacity building of national or donor funded health professionals in the provision of accessible and inclusive medical care.
4. Continue to advocate for access of refugees and asylum seekers, including those with disabilities, to national health care systems.
5. Provide training to all actors involved in mental health and psychosocial support services in how to effectively engage and support persons with disabilities in mainstream services.
6. In partnership with national Disabled Persons' Organizations, advocate to host governments for legal and policy reform to ensure access for refugees

[85] International Labour Organization (2016). Promoting Diversity and Inclusion through Workplace Adjustments. Geneva. Available at https://www.ilo.org/wcmsp5/groups/public/---ed_norm/---declaration/documents/publication/wcms_536630.pdf, retrieved 9/9/2018.

to low cost, national rehabilitation and assistive device providers.
7. Conduct a mapping of national and NGO rehabilitation and assistive device providers. The mapping should include costs, services, quality and eligibility.
8. Continue to provide and expand support for caregivers: peer group support; training in positive behaviour management, rehabilitation and other course content as identified; individual counselling; and increased recognition of the role of caregivers

6. Education

1. Conduct phone surveys in each country, to ascertain the response to the following question:
how many children with disabilities are currently in education? If not, what are the barriers?"
2. Assess the status of all formal schools which have been supported to become 'inclusive' and commence systematic referrals and follow up.
3. Document the outcomes of referrals, and record reasons for denied access (e.g. full, or doesn't have capacity to meet the educational needs of the child). Use the data to advocate to donors for increased support for inclusive education.
4. Support children to overcome practical and environmental barriers, e.g. long distances between home and school and inaccessible public transport facilities, access to rehabilitation and devices.
5. Engage in high-level donor and government advocacy campaigns and strategic partnerships to increase the capacity of national systems to include all children with disabilities.
6. Advocate for disaggregation of national enrolment and participation data by disability and refugee status, and by early childhood education, primary and secondary levels.
7. Advocate to introduce a quota of 15 per cent for all vocational training initiatives.
8. Advocate for inclusion of persons with disabilities (in collaboration with other agencies, e.g. ILO) in Technical and Vocational Education and Training (TVET) institutions.
9. Advocate to introduce a quota for existing university scholarships to improve equal access by persons with disabilities.
10. Conduct a review of Higher Education institutions to determine the extent of inclusion, and specific barriers which may be faced by a student with a disability. Collaborate with the Higher Education institution to address challenges.
11. In contexts where access to specialised education is deemed more feasible (in the short term), conduct a mapping of special education providers (private and government).

7. Community Empowerment and Self-management

1. Develop strategies for minimum participation of persons with disabilities on all refugee self-management committees.
2. Proactively promote a diverse representation of persons with disabilities in all social and community-based activities.
3. Prioritise refurbishments of community spaces for physical accessibility.
4. Prioritize children and youth with disabilities for engagement in social and community-based activities to address protection risks.
5. Continue to support formal and informal peer groups, and access to sport and recreation.
6. Develop partnerships with existing self-help groups (in the host population, and with Disabled Persons' Organizations) and provide support to community-led initiatives developed for protection and well-being of the persons with disabilities.
7. Increase inclusion of persons with disabilities in volunteer programs to include a higher proportion of persons with disabilities.

8. Self-Reliance and Livelihoods

1. Increase inclusion of persons with disabilities in existing small business initiatives through microcredit and entrepreneurial skills development activities.
2. Conduct a mapping of national employment services and agencies, and gather information related to eligibility for refugees and supports for persons with disabilities to access waged employment.
3. Advocate to national governments regarding inclusion of persons with disabilities as part of national quotas.
4. Form a collaboration with the ILO and relevant partners, and jointly advocate to government agencies (Ministry of Labour and employment agencies) for increased inclusion of refugees with disabilities.
5. Assess the viability and relative impact of introduction of cash-for-medication, cash-for-education, cash-for-transport, and cash-for-rehabilitation.

Annex 1 - Definition of Key Terms

Refugee – A refugee, according to the Convention, is someone who is unable or unwilling to return to their country of origin owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion.

Asylum-seeker – An asylum-seeker is an individual who has sought international protection and whose claim for refugee status has not yet been determined. As part of internationally recognized obligations to protect refugees on their territories, countries are responsible for determining whether an asylum seeker is a refugee or not. This responsibility is derived from the 1951 Convention relating to the Status of Refugees and relevant regional instruments and is often incorporated into national legislation.

Rehabilitation – "A set of measures that assist individuals, who experience or are likely to experience disability, to achieve and maintain optimum functioning in interaction with their environments"[86]:

- Prevention of the loss of function
- Slowing the rate of loss of function
- Improvement or restoration of function
- Compensation for lost function
- Maintenance of current function[87]

Other Definitions (as defined by the CRPD)[88]

Communication includes languages, display of text, Braille, tactile communication, large print, accessible multimedia as well as written, audio, plain-language, human-reader and augmentative and alternative modes and formats of communication, including accessible communication technology.

Reasonable accommodation means necessary and appropriate modification and adjustments not imposing a disproportionate or undue burden, where needed in a particular case, to ensure to persons with disabilities the enjoyment or exercise on an equal basis with others of all human rights.

Universal design means the design of products, environments, programmes and services to be usable by all people, to the greatest extent possible, without the need for adaptation or specialized design. "Universal design" shall not exclude assistive devices for particular groups of persons with disabilities where this is needed.

Inclusive education is an education system that includes all students, and supports them to learn, whoever they are and whatever their abilities or requirements. This means making sure that teaching and the curriculum, school buildings, classrooms, play areas, transport and toilets are appropriate for all children at all levels. Inclusive education means all children learn together in the same schools [89]. The UNCRPD states that 'education is a fundamental human right for every child with a disability'. What is and is not inclusive education [90]:

- Exclusion: Students with disabilities are denied access to education in any form.

- Segregation: Education of students with disabilities is provided in separate environments, and in isolation from students without disabilities.

- Integration: Placing students with disabilities in mainstream educational institutions without adaptation and requiring the student to fit in.

- Inclusion: Education environments that adapt the design and physical structures, teaching methods, and curriculum as well as the culture, policy and practice of education environments so that they are accessible to all students without discrimination. Placing students with disabilities within mainstream classes without these adaptations does not constitute inclusion.

[86] WHO 2011
[87] WHO CONCEPT PAPER WHO Guidelines on Health-Related Rehabilitation (Rehabilitation Guidelines), http://who.int/disabilities/care/rehabilitation_guidelines_concept.pdf
[88] UN Convention on the Rights of Person with Disabilities (2008)
[89] UNICEF, 2017, Including children with disabilities in quality learning: what needs to be done? Retrieved from: https://www.unicef.org/eca/sites/unicef.org.../IE_summary_accessible_220917_brief.pdf
[90] UNICEF, 2017, Understanding Article 24 of the Convention on the Rights of Persons with Disabilities. Retrieved from https://www.unicef.org/eca/sites/unicef.org.../IE_summary_accessible_220917_0.pdf

Acronyms

3RP	Regional Refugee and Resilience Plan (3RP)
AOPD	Arab Organization of Persons with Disabilities
BIP	Best Interest Procedures (for child protection)
CO	Country Office
CBI	Cash-Based Interventions
CBO	CommunityBased Organisation
CBP	Community-Based Protection
CBR	Community-Based Rehabilitation
CDC	Community Development Centre
CP	Child Protection
CWD	Children with Disabilities
DPO	Disabled Persons Organisation
DFP	Disability Focal Points
FGD	Focus Group Discussion
HI	Humanity and Inclusion (formerly, Handicap International)
IDA	International Disability Alliance
IMS	Information Management System
ILO	International Labour Organization
KI/s	Key Informant/s
MENA	Middle East and North Africa
MHPSS	Mental Health and Psychosocial Support
NGO	Non-Governmental Organisation
PA	Participatory Assessment
POCs	Persons of Concern
PPA	Project Partnership Agreement
proGres	Profile Global Registration System
PSN	Persons with Specific Needs
PSS	Psychosocial Support
PSWG	Protection Sector Working Group
PWD	Persons with Disabilities
RAIS	Refugee Assistance Information System
ROV	Refugee Outreach Volunteer
RFP	Request for Proposal
SGBV	Sexual and Gender-Based Violence
SOP	Standard Operating Procedure
TNA	Training Needs Analysis
UNCRPD	United Nations Convention on the Rights of Persons with Disabilities
UNCRC	United Nations Convention on the Rights of the Child
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
WGQ	Washington Group Questions
WHO	World Health Organization

PHOTOS

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