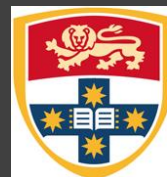


# Refugees with Disabilities in Pakistan: An Introductory Report



**UNHCR**  
The UN Refugee Agency



THE UNIVERSITY OF  
**SYDNEY**

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## Abbreviations

ADTF	Ageing and Disability Taskforce
CAR	Commissionerate of Afghan Refugees
CBID	Community-Based Inclusive Development
CDU	Community Development Unit
CHEF	Community Health and Education Forum
CRPD	Convention on the Rights of Persons with Disabilities
DPO	Disabled Persons' Organisation
GoP	Government of Pakistan
ICF	International Classification of Functioning, Disability and Health
NGO	Non-Government Organization
POR	Proof of Registration
PPVR	Population Profiling, Verification and Response exercise (2011)
RSD	Refugee Status Determination
SAFRON	Ministry of States and Frontier Provinces
UNHCR	United Nations High Commissioner for Refugees
WHO	World Health Organization

## 1. Introduction

This report forms part of a larger project which aims to shed light on the experiences of an often-overlooked group: refugees and other displaced persons who have disabilities. The project, entitled *Protection of Refugees with Disabilities*, was led by a team from the Faculty of Law at the University of Sydney, Australia. Commencing in 2012, it involved fieldwork in six countries: Malaysia, Indonesia, Pakistan, Uganda, Jordan and Turkey. The project evaluated access to humanitarian assistance and legal protection for persons with disabilities, as well as participation in various aspects of daily life. Fieldwork was completed in 2014 and reports and other publications are now available which share some of the key findings from this research.<sup>1</sup>

This report originates from a short field trip to Pakistan undertaken by members of the *Protection of Refugees with Disabilities* project team from the Faculty of Law, University of Sydney in 2013. The need to improve mechanisms for identifying refugees with disabilities and recording information about their disability and assistance and accommodation needs was a key challenge uncovered in the research.<sup>2</sup> We were fortunate to discover in Pakistan that UNHCR and the Pakistani government had recently undertaken a large scale census-like exercise with the Afghan refugee population in Pakistan. The 2011 *Population Profiling Verification and Response* exercise (PPVR)<sup>3</sup> included specific questions related to disability which were closely aligned with current international standards. The data relating to persons with disabilities has been extracted and compiled with extensive assistance from UNHCR staff in Islamabad and provides greater detail than that which is currently publicly available. This data forms the basis of this report: an analytical overview of the experiences of Afghan refugees with disabilities in Pakistan.

After summarising the key findings, the report presents an overview of the refugee situation in Pakistan and the PPVR exercise. This is followed by a detailed analysis of

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<sup>1</sup> Our publications can be accessed at: <http://blogs.usyd.edu.au/refugees-disabilities/> .

<sup>2</sup> See Smith-Khan, Crock, Saul & McCallum 'To "Protect, Promote and Ensure": Overcoming Obstacles to Identifying Disability in Forced Migration' 28(1) *Journal of Refugee Studies* 38.

<sup>3</sup> See UNHCR, SAFRON & CAR, *Population Profiling, Verification and Response Survey of Afghans in Pakistan, 2011*, Doc Ref: PPVR/HHS/MAR 2012.

PPVR data relating specifically to disability. Background on the project is provided at the end of the report.

## 2. Key Findings

- **8.2%** of all Afghan refugees, and **15%** of adults (18 years and above) have **disabilities**. Poor sight is the most commonly reported disability (5%), followed by poor hearing and problems with walking.
- Nearly **40%** of those with disabilities have **multiple functional difficulties**.
- **3.3%** of all Afghan refugees reported suffering from **one or more chronic diseases**. Nearly a third of those with chronic illnesses also have functional difficulties (almost 1% of the total population surveyed).
- **Disability prevalence is substantially higher amongst adult women** than adult men. The analysis raises serious concern for the health and wellbeing of the adult female population, as it suggests that **women are dying younger, and for those still living, quality of life is poorer**.
- Disability prevalence amongst the elderly (60 years and above) is higher than global estimates: 46.6% versus 43.3%.<sup>4</sup>
- **Reading glasses were the most commonly requested assistance** (16% or 12,700 pairs of glasses), followed by financial support, institutional care, psycho-social counselling and wheel chairs or walking frames.
- **Education and literacy rates appeared to be slightly lower** if the respondent had a functional disability, with the age and gender of the individuals having a much greater impact on the rates (older and female = lower rates).
- **Income - those with disabilities were slightly less likely to be employed**, but those that were employed actually earn more on average than those without disabilities.
- **Disabled respondents were slightly more likely to have been abused or violently attacked** (0.8% compared with 0.3%). It seems likely that there has been underreporting of incidents, particularly those involving women and girls, probably due to the key respondent approach to the data collection.
- **Further research into how the disabilities were caused is recommended**, specifically whether people are employed in specific jobs because of their

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<sup>4</sup> The latter figure is the average for the elderly in lower income countries. In higher income countries, this drops to 29.5%. See WHO/World Bank, *World Report on Disability* (2011) 27.

disabilities, or were their disabilities are acquired while working. Causality between impairment and chronic illness should also be investigated. In addition, it would be helpful to understand if the disabilities arose in Pakistan or Afghanistan.





### 3. Overview

The discussions with these various stakeholders, along with a review of existing literature, allowed the researchers to develop an understanding of the refugee situation in Pakistan. A short summary is provided below.

#### 3.1 Registration and Refugee Status

There were around 1.62 million Afghan refugees in Pakistan as of the end of 2013. They mostly arrived in 1979 and several later influxes and are prima facie refugees, who are registered by the Government of Pakistan (GoP) and hold Proof of Registration (PoR) cards, but have not undergone individual refugee status determination. As of December 2013, there were 631 refugees from other countries of origin, including around 456 Somalis. These persons are registered and recognized as refugees on an individual basis by UNHCR in accordance with its mandate, rather than by the GoP. Although the GoP is no longer registering newly arriving Afghans (since 2010), it has continually extended the validity of the PoR cards held by those who had been previously registered.

Given the role that the GoP has played in registering Afghans, UNHCR's registration and refugee status determination (RSD) includes newly arrived Afghans, who cannot register with the GoP, as well as those who are identified as having particular protection needs that cannot be addressed in Pakistan and are therefore being considered for resettlement to a third country. Refugees with resettlement needs must be individually registered and granted refugee status by UNHCR before they can be submitted to resettlement countries for their consideration.

#### 3.2 Assistance and identification of vulnerable persons

According to CCAR and UNHCR, the Afghan refugee population is largely integrated into the mainstream community, at least in terms of their socioeconomic position. The refugee population is scattered over every province in Pakistan, with just under 40% living in 76 refugee 'villages' (former camps), mostly in Khyber Pakhtunkhwa province. Others live in various rural or urban areas across the country.

Those living in the villages have access to basic services provided by UNHCR and partners, but are expected to generate their own income. The 60% living outside the refugee villages have access to few refugee-specific services, and generally rely on mainstream institutions, such as national hospitals and schools.

The CAR Khyber Pakhtukhwa runs a number of Community Development Units (CDUs) which have generated various activities, including the development of committees within the refugee population, education services, income generation and microfinance programs and youth welfare organisations.<sup>5</sup> They also run a number of Basic Health Units in various villages. Both of these act as points of contact for refugees with particular assistance needs. They coordinate with other NGOs to source appropriate services and assistive devices and identify and refer vulnerable persons to UNHCR.

The 2011 PPVR exercise was also used as a means of identifying particularly vulnerable persons who required specific assistance or who were suitable for resettlement. The findings of the PPVR will be explored in more detail below.

### 3.3 Resettlement

Resettlement from Pakistan as a protection tool and durable solution has been used very minimally in the past and limited to particularly vulnerable individuals, as mentioned above. In 2012, there were only 166 accepted cases and 116 departures.<sup>6</sup> However, in May 2012, the Governments of Afghanistan, Iran and Pakistan as well as UNHCR signed the Solutions Strategy for Afghan Refugees (SSAR) which includes enhanced resettlement as one important pillar and Pakistan was designated by UNHCR as a priority country for the strategic use of resettlement. These developments generated increased resettlement quota and operational support, in particular from Australia, in order for UNHCR Pakistan to increase its processing capacity. During 2013, 1,345 individuals were accepted for resettlement by different countries and 1,107 departed. In 2014 and 2015, the resettlement target is 2,200 persons per year.<sup>7</sup>

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<sup>5</sup> CAR, Khyber Pakhtunkhwa, Peshawar, 'CDU (Community Development Unit), online, available: <[http://kpkcar.org/projects.php?project\\_id=6](http://kpkcar.org/projects.php?project_id=6)>.

<sup>6</sup> UNHCR Pakistan, *Fact Sheet*, March 2013, online, available: <<http://www.unhcr.org/5000210e9.pdf>>.

<sup>7</sup> UNHCR Pakistan, *Fact Sheet*, March 2013, online, available: <<http://www.unhcr.org/5000210e9.pdf>>.

As mentioned above, non-Afghan and Afghan refugees with particular protection needs that cannot be addressed in Pakistan are prioritised for resettlement. These may include refugees with disabilities.



## 4. The Population Profiling, Verification and Response Survey of Afghans in Pakistan, 2011 (PPVR) and Refugees with Disabilities

A joint initiative of the Ministry of States and Frontier Regions (SAFRON), the Government of Pakistan, and UNHCR, the PPVR exercise was carried out between November 2010 and December 2011. It targeted both registered and unregistered Afghans living in Pakistan and covered 135,452 households, made up of 974,961 individuals in various areas throughout the country, in camp (settlement), urban and rural locations. This equates to approximately 53.4% of the Afghans registered with the Government of Pakistan at that time.

It aimed at collecting detailed and accurate census-like data on the Afghan population, which could be used by the Government of Pakistan, UNHCR, other organisations and the Government of Afghanistan, to inform their respective strategies and design appropriate programs and responses to best suit the identified characteristics and needs of this group.<sup>8</sup>

### 4.1 Disability in the PPVR

The PPVR included a section related to disability. The questions reflect the standards developed by the *International Classification of Functioning, Disability and Health* (ICF), which has been extensively tested and promoted by the World Health Organisation (WHO).<sup>9</sup> Questions developed using the ICF involve asking whether the person has difficulty with seeing, hearing, walking, self-care and remembering or concentrating.<sup>10</sup> The data collected relied on self-reporting. Further, the surveys were generally taken from two representatives for each household, where possible: the male head of household and a female member of the household, so data was not always collected directly from the household member in question.

UNHCR staff noted that where people were asked about medical conditions, they came across several cases where reported conditions were less severe than

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<sup>8</sup> SAFRON, CAR and UNHCR, *Population Profiling, Verification and Response Survey of Afghans in Pakistan, 2011: Final Report* 26.

<sup>9</sup> See WHO, *International Classification of Functioning, Disability and Health*, online, <<http://www.who.int/classifications/icf/en/index.html>>.

<sup>10</sup> Washington Group on Disability Statistics, Short question set. See: [http://www.cdc.gov/nchs/washington\\_group/wg\\_questions.htm](http://www.cdc.gov/nchs/washington_group/wg_questions.htm)

reported in the existing information on file. However, the strength of asking questions about functionality is that it avoids the need to rely on persons correctly naming medical conditions and focuses more simply on what they can do, and what they have difficulties with.

Further, asking questions about a number of functions allows a more in-depth picture of the difficulties faced by people, rather than limiting each person to one particular difficulty or category. However, it is important to remember that the raw data collected reflects the number of reports of each functional difficulty, rather than the number of participants identified as having a functional difficulty. For example, one person could have difficulties in three different areas. What became clear when comparing the results presented in the PPVR report with the raw data provided for further analysis was that there had been confusion over this point. So while the report gives the figure of 103,418 persons identified as having some form of disability, this figure actually corresponds to the total number of reports of difficulty, while the number of persons to whom these reports relate is 79,954.

When asking about psychosocial difficulties, the questionnaire limited this to those persons who were depressed or behaved ‘confused or disoriented’ as a result of ‘shock, trauma, serious distress or (a) violent encounter’. This may have somewhat controlled the responses collected, excluding persons who did not consider their difficulties to be related to one of these causes.

Finally, it is worth noting that relying on self-reported functional difficulties does not ensure a definitive assessment of disability: the UN *Convention on the Rights of Persons with Disabilities* limits persons with disabilities to those having ‘long-term’ impairments<sup>11</sup>, and this may not be the case for all those who identify functional difficulty at one particular point of time, as these impairments may be transitory. Rather, these questions act as an initial means of flagging potential disabilities, and would then require further follow-up and assessment. However, for ease of description in this document, those who reported experiencing one or more functional difficulty will be referred to as persons with disabilities.

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<sup>11</sup> CRPD art 1.

Respondents were also asked whether they required assistance for their functional difficulties, and if so, what were the two most important types required. It is not completely clear whether the latter question was designed to only identify assistance needs that had not been met, or all assistance, including that already available, and feedback from UNHCR suggests that this question could have been interpreted either way.

The PPVR report includes a basic summary of the data collected relating to disability. Due to the census-like nature of the exercise, it was clear that it had the potential to provide insight into the experiences of and challenges faced by Afghans with disabilities in Pakistan. With extensive support from the information management and data analysis team (Edgar Scrase and Shafqat Mehmood) at UNHCR Islamabad, the researchers were able to gather the information outlined below.<sup>12</sup>

In its 2011 *World Report on Disability*, WHO stresses the need for more research which evaluates different approaches to disability identification and data collection, in order to ‘improve the validity of estimates’. It further advocates for the development of ‘better measures of the environment and its impacts on the different aspects of disability.’<sup>13</sup> Keeping this in mind, the current report will explore in greater detail the data collected related to disability that was collected during the PPVR, and evaluate the means of collection, questions asked and areas where more investigation is needed.

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<sup>12</sup> UNHCR Pakistan contributed time and relevant data without financial compensation/benefit.

<sup>13</sup> WHO/World Bank, *World Report on Disability* (2011) 46.





## 4.2 Functional difficulties

Of the 974,961 persons covered by this survey, 79,954, or **8.2% reported having one or more functional difficulty**. Of these, nearly 40% had multiple difficulties, and nearly 15% had difficulty with three or more functions. 14.9% of adults surveyed (62,527 individuals) reported having one or more functional difficulty, close to the WHO global average of 15.6%.<sup>14</sup>

Data collectors were required to record information on disability relating to every member of each household, through responses given by a female household representative. In each household, the female household representative was asked questions related to disability as follows:

- ‘Does any household member - including children and elderly - have difficulty seeing?’
- ‘Who has difficulty seeing?’
- ‘How much difficulty has <name> seeing? (some difficulty, a lot of difficulty, total/absolute loss)’

The same questions were asked for hearing, speaking, walking, self-care (‘such as washing all over or dressing’), and remembering or concentrating. They were also asked ‘because of shock, trauma, serious distress or violent encounter, does any household member suffer from depression or behaves confused or disoriented?’ Finally, they were asked, for any of those identified as having moderate or severe difficulty, ‘what would be the two most important ways in supporting their needs?’

For certain questions, reports were limited based on the age of the persons concerned, since certain difficulties were considered unidentifiable below a certain age. For example, difficulty with seeing and hearing was limited to those aged one year or above, speaking and walking from four years and over, difficulty with self-care from eight years of age, and remembering and concentrating and confusion or disorientation applied to persons aged 12 or over. Percentages calculated are nonetheless based on the total surveyed population, for ease of comparison.

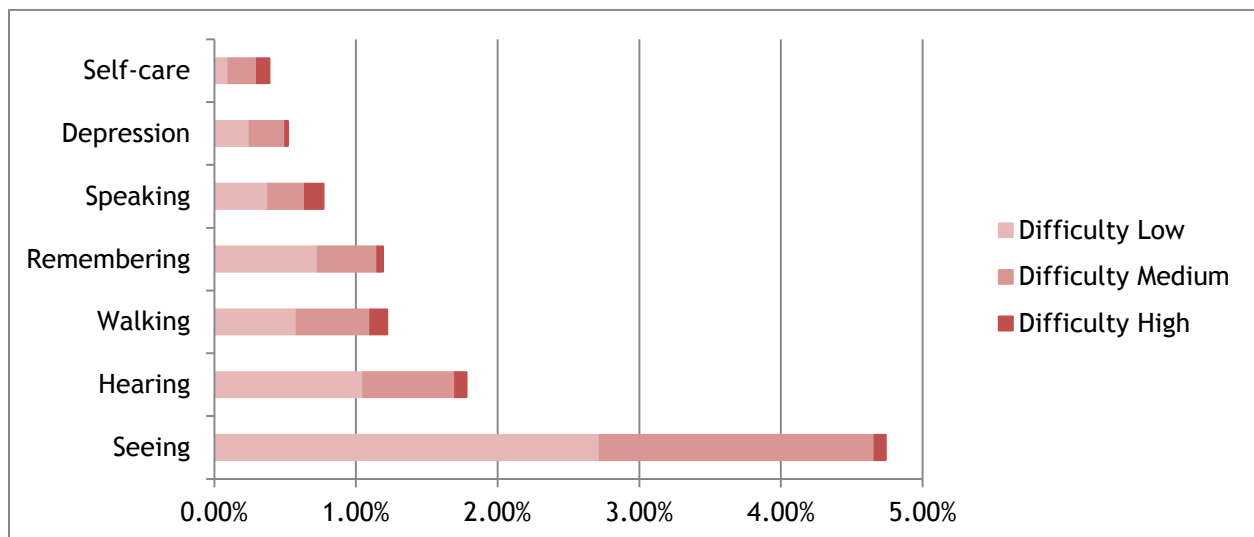
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<sup>14</sup> See [http://www.who.int/disabilities/world\\_report/2011/report/en/](http://www.who.int/disabilities/world_report/2011/report/en/)

Considering that functional difficulty is greatly skewed towards the older segments of the population, these exclusions are unlikely to significantly impact on the accuracy of the data.

By far, the most common functional difficulty was sight, with 4.7% of all persons surveyed reporting some level of difficulty seeing (or 57.8% of persons with functional difficulties). Next most common was hearing, affecting 21.7% of persons with disabilities, and 1.8% of the total surveyed population. Following this was walking difficulties (1.2% of the total population) and difficulties remembering or concentrating (1.2%).

**Figure 1: Reports of functional difficulty, by severity, as a percentage of total surveyed population**

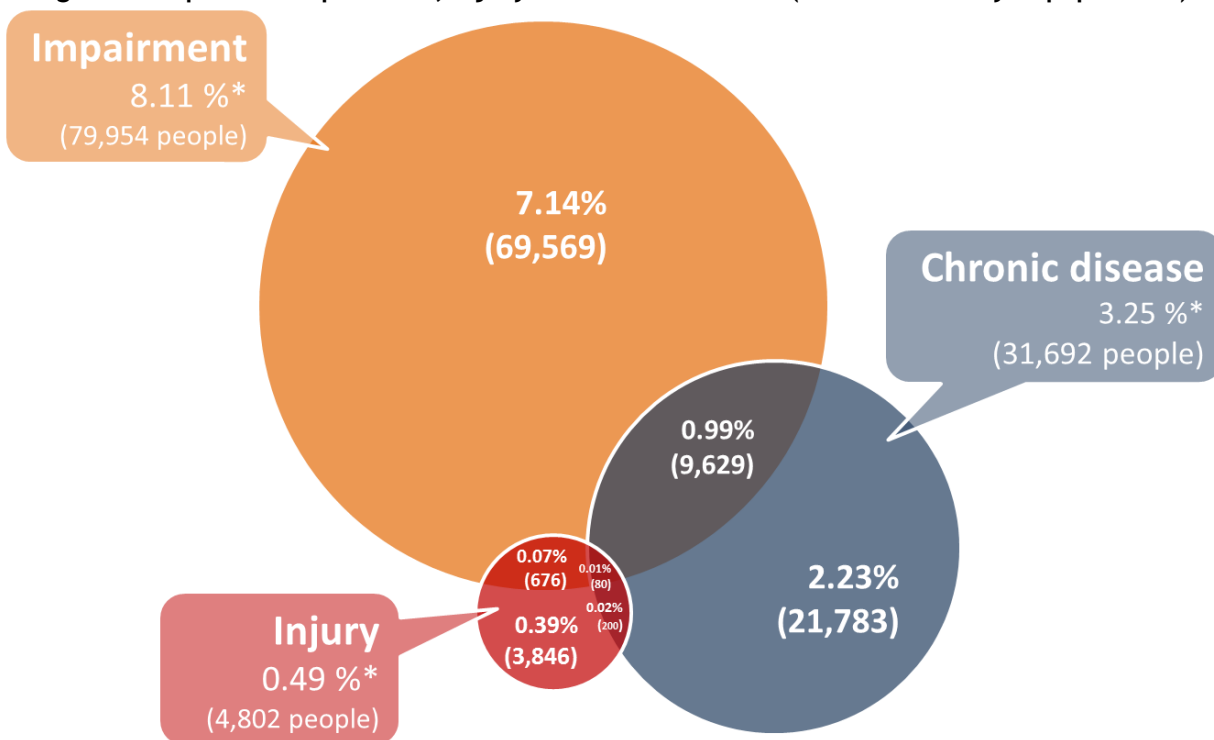




### 4.3 Disability: impairment, chronic illness, and injury

The PPVR also included questions on chronic illnesses and recent injury acquisition. Figure 2 below shows the numbers of people who reported functional difficulties (or ‘impairments’), chronic diseases and recent injuries, indicating areas where these overlap. Chronic diseases included diabetes, heart disease, stroke, cancer, hepatitis, asthma and HIV/AIDS. Injuries were limited to those which had occurred in the past month.<sup>15</sup>

Figure 2: Reports of impairment, injury and chronic disease (% of total surveyed population)

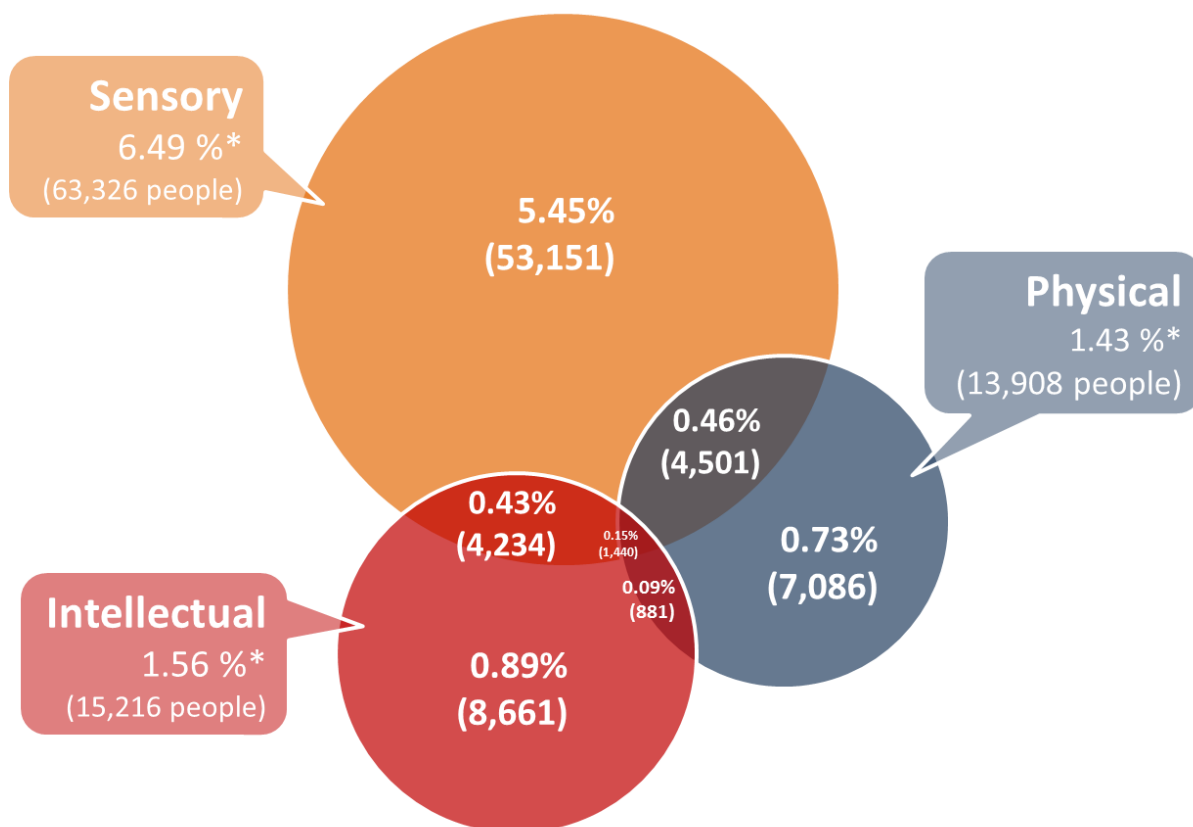


\* Of total Population Surveyed

Almost 1% of the population surveyed reported having one or more functional difficulties (impairments) as well as a chronic disease. Put it another way, 13.8% of those with functional difficulties also have chronic diseases. Given this significant proportion, it would be valuable to investigate causal links in this population between chronic illness and disability acquisition.

<sup>15</sup> Figures 2 and 3 are modelled on those used in HelpAge International/Handicap International, *Hidden victims of the Syrian crisis: disabled, injured and older refugees* (2014), pp. 12 & 20. A difference in the data is that the PPVR limits injuries to those sustained within a month of the survey being conducted. In the Syrian report, injuries included those ‘that [have] the potential to impact the function of the body, therefore a potential disabling impact’: p. 22. There was no time limit mentioned.

**Figure 3: Functional difficulties grouped as sensory, physical and intellectual impairments (% of total surveyed population)**



**\* Of total Population Surveyed with these types of impairment**

In Figure 3, the functional difficulties have been divided up to make the data comparable with the way disability statistics are commonly categorised: sensory impairments, physical impairments and intellectual impairments. Sensory impairments include difficulties with seeing, hearing and speech. Physical impairments include difficulties with walking and self-care. Intellectual impairments include difficulties with remembering or concentrating, and confusion or disorientation. What may be different to other models using these categories is that this graph allows multiple reports per individual, and shows where these have occurred. For example, 0.46% or 4501 individuals were reported to have both physical and sensory difficulties.

#### 4.4 Age, gender and disability

When the data is broken down into age and gender, some interesting patterns emerge. Firstly, there are a higher percentage of females facing functional difficulties than males: 9.0% versus 7.5%. Despite elderly persons (60 years and over) making up only 4% of the overall surveyed population, they constitute 22.6% of those experiencing functional difficulties. Of all elderly participants, 46.6% reported a functional difficulty: this is above the WHO average of 43.4%.<sup>16</sup> 41.7% of elderly men and 53.5% of elderly women experience functional difficulty. Amongst the adult population, the rate is 15.0%, slightly lower than the 15.6% WHO global estimate.<sup>17</sup> However, when broken down by gender, the difference is large: whereas only 11.0% of men between 24 and 59 years were identified as having a functional difficulty, this percentage increased to 18.5% of women. Percentages were much smaller in the younger age groups, with considerably less disparity across genders.

The overall gender disparity in the elderly population should also be noted: for every 140 men, there were only 100 females, despite the ratio being 100:100 in the 15-24 age bracket and 100:99 in the 24-59 age bracket. This suggests the need for further investigation regarding the high rates of functional difficulty reported across adult and elderly females. These figures together create serious concern for the health and wellbeing of the adult female population, as they suggest that women are dying younger, and for those still living, quality of life is poorer. For reference, in the 1998 Pakistan census<sup>18</sup> the difference between genders in the elderly population was lower at 119:100<sup>19</sup>. Based on 2010 population extrapolations from the 1998 census, this has been estimated to drop to 82:100<sup>20</sup>. Even based on the 1998 census, it is clear that the gender disparity in the elderly Afghan population is significantly greater.

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<sup>16</sup> This was the average for the elderly in lower income countries. In higher income countries, this drops to 29.5%.

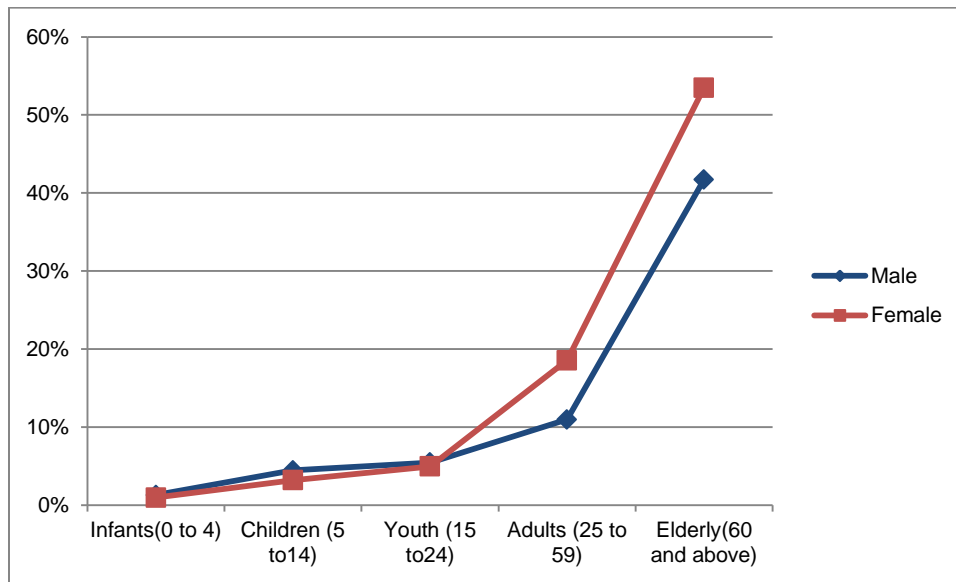
<sup>17</sup> WHO/World Bank, *World Report on Disability* (2011) 27.

<sup>18</sup> <http://census.gov.pk/index.php>

<sup>19</sup> <http://census.gov.pk/datacensus.php>

<sup>20</sup> [http://en.wikipedia.org/wiki/Demographics\\_of\\_Pakistan](http://en.wikipedia.org/wiki/Demographics_of_Pakistan) (Sex ratio estimated in 2006 for adults over 65)

Figure 4: Reports of functional difficulty, (% of age/gender group)



#### 4.5 Households

Overall, 39.6% of households surveyed have at least one member with a disability. The percentage is higher in female headed households, where 43.2% (or 1,504 of the total 3,479) households have a member with a functional difficulty. In total, 1,859 individuals with disabilities are members of female headed households, meaning that a number of these households have more than one member with a disability. Out of the 886 child headed households, 52 (5.8%) have a member with a functional difficulty. There are a total of 251 members of child-headed households who have disabilities, meaning that *many* of these households have multiple members with disabilities.

#### 4.6 Assistance

Basing the identification of disability on functionality questions is in line with current understandings of disability. However, to develop a more complete and accurate understanding of disability, it is essential to consider the way an individual's social and practical surroundings interact with their impairment to either overcome or exacerbate functional difficulty. For example, where someone has difficulty seeing, it is necessary to establish whether or not they have glasses that adequately overcome this difficulty, in order to assess whether or not they effectively have a disability.

Further, accurate and complete data on assistance needs is essential to combating the social and environmental barriers that create disability.

As mentioned above, a question was included which asked participants with disabilities ‘the two most important ways in supporting their needs’. From the data collected, the most commonly identified need is for 'reading glasses' (15.9%, or 12,696 people).

**Figure 5 Assistance needs of persons with medium or severe functional difficulty**

Assistance required/Needs	N	%
Not mentioned	43,686	54.6
Reading glasses	12,696	15.9
Financial support	7,771	9.7
Institutional care	6,251	7.8
Hearing aid	3,437	4.3
Psychological counselling	2,472	3.1
Wheel chair	1,035	1.3
Walker / walking frame	661	0.8
Home care	437	0.6
Crutches	410	0.5
Other	349	0.4
Elderly care	313	0.4
No needs	297	0.4
Prosthesis (artificial leg, arm or hand)	139	0.2
<b>Total</b>	<b>79,954</b>	<b>100.00</b>

While the wording of the question is ambiguous on this point, UNHCR advises that enumerators were trained to ask this question in order to identify currently unmet needs. Information like this, which flags outstanding needs, is useful to UNHCR and its partners in providing appropriate targeted services and identifying the gaps in existing programmes.<sup>21</sup> It could also be useful in creating key indicators of vulnerability: where a certain type of assistance is scarce, persons identified as having functional difficulties that require that type of assistance would be flagged as particularly vulnerable. This could inform both assistance responses and resettlement assessments.

<sup>21</sup> WHO/World Bank, *World Report on Disability* (2011) 40.





## 4.7 Education

Young people of school age (5-18 years) who had functional difficulties were slightly less likely to access education than those without functional difficulties (41.0% versus 44.5%). Of those with functional difficulties, persons with sight difficulties were most likely to attend school (52.3%) and those with self-care difficulties were least likely (7.5%). Less than a third of those with speaking (31.3%) or walking (26.6%) difficulties and less than a quarter of those with cognitive difficulties (21.4%), or with depression (23.3%) attended school.

Out of those with functional difficulties, 28.6% said they did not attend school due to their disability or poor health, compared with just 2% of children overall. Another 21.1% did not go because their family did not allow them, less than the average of 34%, primarily girls. For 13.7%, the reason given was that schooling was too expensive, very similar to the overall average of 13%. Over 10% of children with functional difficulties did not attend school as they needed to work to help their family, less than the average of 18% of all children.

Families were also asked to provide the travel time<sup>22</sup> to the nearest schools for primary and secondary-aged boys and girls. Just over half of the households were within 15 minutes from the nearest girls' school (50.2%), with 56.1% in close proximity to a boys' school. Another 33% of households had a boys' or girls' school less than 30 minutes away.

While knowing the distance to schools allows some insight into the potential challenges for students with mobility difficulties, such as difficulty with walking, it would be useful to explore in greater detail the school environment itself, as this could present a number of barriers, including physical accessibility. A range of other issues could discourage students with disabilities from attending: these could range from lack of suitable toilet facilities, to discrimination or bullying. In some cases, not having suitable glasses could prevent a student from attending school: a device which was identified as the most common need amongst the surveyed population. Where

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<sup>22</sup> Note that due to the way the PPVR questions were phrased it is not possible to differentiate between the modes of transport, so some respondents may be quoting walking times while others would have quoted the time taken to drive.

education is seen as a financial investment by the family, some families may elect not to send a child with a disability to school, even where his or her siblings attend.<sup>23</sup>

Further, many of these issues may remain relevant even where children are attending school. In our research in Malaysia and Indonesia, we discovered that many children who were attending school faced significant barriers to fully participating in classes. This could be the case for some of those with functional difficulties who are enrolled. So while data may show enrolment numbers, this does not indicate the quality of the educational experience. In addition, it would be interesting to conduct further research as to whether having a functional disability impacts on dropout rates. Both of these two areas would benefit from closer attention.

#### 4.8 Literacy

Respondents were asked whether each household member who was at least 12 years old could read and write. Overall, those who do not have a disability are more likely to be literate. 51.4% of males and 16.4% of females aged 12 or over and who do not have a disability are literate. For those with functional difficulties, the rates drop to 37.4% and 9.6% respectively. However, given that the elderly are overrepresented amongst those reporting functional difficulties, it is valuable to examine literacy across different age groups.

When disaggregated, the biggest divergence is in young males, aged 12-14, 15-19 and 20-24. In these groups, those without disabilities have higher literacy rates, with a difference of a least 4% in each of these groups. The youngest group has the widest gap: amongst 12 to 14 year-old boys, those with functional difficulties have a literacy rate of 61.9%, compared to others (70.2%). Interestingly, males with disabilities who are between 40 and 59 years are more likely to be literate<sup>24</sup>. Females

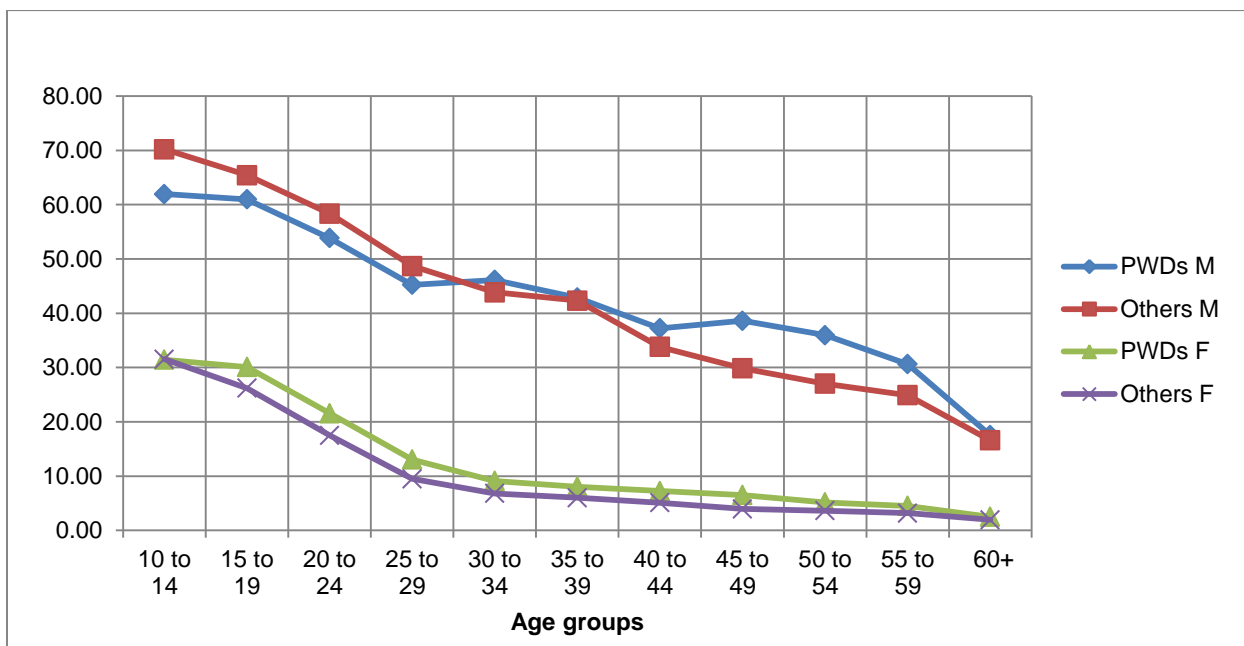
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<sup>23</sup> In their fieldwork in the other countries, the researchers have come across families where this is the case.

<sup>24</sup> It is hard to say whether this is a statistical fluke. In some cases the difference in literacy rates reaches as high as 9%. There could be a number of possible explanations. Many of the functional difficulties experienced may be linked to chronic illnesses which may be more common amongst higher socioeconomic groups (eg diabetes, heart disease etc). Literacy levels are likely to be higher amongst these groups. Another point of consideration is that since there is no clear information about the age at which functional difficulties began, it could well be possible that many in this group were educated before acquiring impairments/conditions which led to their disabilities.

are quite similar across all age groups, with rates among those with functional difficulties being slightly higher than those without, except amongst the youngest age group, where their literacy rates are marginally lower (31.4% versus 31.5%). In these age groups, it is difficult to determine whether there is any link between literacy levels and disability, given that it is not known whether the persons had a disability at the time when they were being educated.

Figure 6: Literacy levels of those with disabilities and others, by age and gender (%)



This data highlights significant differences in access to basic education between the older generations and the younger ones, indicating that education is much more accessible to the latest generation than its predecessors. While this is encouraging, there is still a large disparity between the genders with less than a third of young females being literate, compared with around two thirds of boys (between 12 to 19). Finally, while females with functional difficulties are as literate as the general female population, young males with functional difficulties are less likely to be literate than those without functional difficulties. This seems to indicate that while the younger generation generally have better chances to access education than earlier generations, males who do not have functional difficulties have an advantage

over those with functional difficulties. However, the most significant difference is gender-related, with males having much more chance of being literate than females of the same age.



## 4.9 Income and employment

While persons with disabilities are less likely to be employed (25.2% versus 29.1% of others), those who do work earn more, on average, than those without a disability. The difference is particularly marked for females, with female workers with disabilities earning about four times as much as those without disabilities. 34% of those persons with disabilities who are employed are working in an ‘elementary occupation’ and a further 50% are ‘sales or service workers’ or ‘craft and related trades workers’. It is possible that begging may contribute to these higher averages. Begging is widespread in Pakistan, and often includes persons with disabilities.<sup>25</sup> A DPO representative in our discussion mentioned coming across a refugee child with a disability who had been locked in his home by his family. The family explained that they had done this to prevent the child’s uncle from using him as a beggar, as he had been doing in the past. The authors have heard of anecdotal reports from refugee communities of children being kidnapped and subsequently employed as beggars and sometimes even with their limbs being distorted on purpose to improve their prospects. This issue would benefit from further research.

The other possibility is that persons may have acquired their functional difficulties through work which is hazardous but relatively well paid. The PPVR Report considers this, presenting data on the percentage of persons with various functional difficulties employed in certain industries. It explores the various health conditions and function difficulties experienced by carpet weavers, and notes that over 50% of both male and female carpet weavers have difficulty with sight, over 18% have difficulty with hearing and more than 10% with walking.<sup>26</sup> What is missing is data on causation: while it is likely that carpet weaving could lead to sight difficulties, it

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<sup>25</sup> Nadia Azam, ‘Beggary as an Organized Crime in Pakistan’, Master’s Thesis, University of Kansas, 2011, Available at: [http://kuscholarworks.ku.edu/bitstream/handle/1808/9735/Azam\\_ku\\_0099M\\_11884\\_DATA\\_1.pdf?sequence=1&isAllowed=y](http://kuscholarworks.ku.edu/bitstream/handle/1808/9735/Azam_ku_0099M_11884_DATA_1.pdf?sequence=1&isAllowed=y). See also news reports such as: Mobeen Azhar, ‘Child victims of Pakistan’s ‘begging mafia’’, *BBC World Service*, 1 June 2013, <<http://www.bbc.com/news/magazine-22729351>>. Begging involving persons with disabilities is also an issue in Afghanistan. See for example IRIN, ‘Afghanistan: Beggars will be arrested’, *IRIN*, 5 November 2008, <<http://www.irinnews.org/report/81298/afghanistan-beggars-will-be-arrested>>

<sup>26</sup> SAFRON, CAR and UNHCR, *Population Profiling, Verification and Response Survey of Afghans in Pakistan, 2011: Final Report* 62.

could also be that persons who already have difficulty with sight become employed in this field, as do others with hearing and walking difficulties. Data related to disability acquisition would help to clarify these figures and could also assist in targeted assistance or prevention.

#### 4.10 Food

The table below shows how many meals per day were available to the population surveyed. The data shows that age and gender were more likely to determine food quantity, rather than disability.

Across the total surveyed population, women were the most likely to have three or more meals (92.2%), followed by children (83.7%), and men were least likely (77.7%). This pattern was true for both those with and those without disabilities.

**Figure 7: Meals per day by location and disability status (%)**

Disability	Meals per day	Adult Males				Adult Female				Children			
		Camp	Urban	Rural	Total	Camp	Urban	Rural	Total	Camp	Urban	Rural	Total
Yes	Unclear	4.70	3.70	3.07	4.16	0.55	0.44	0.72	0.54	12.73	10.50	11.22	11.80
	One	0.76	1.28	1.43	1.02	0.23	0.20	0.19	0.21	0.11	1.63	2.38	0.91
	Two	17.10	18.06	18.57	17.61	9.67	4.33	3.64	7.14	1.60	2.18	3.15	2.00
	Three	77.18	76.82	76.74	77.00	89.15	94.75	95.21	91.77	50.75	63.29	61.84	56.29
	Four	0.20	0.08	0.11	0.15	0.32	0.22	0.22	0.28	27.02	17.56	16.59	22.56
	Five	0.06	0.06	0.08	0.06	0.08	0.07	0.01	0.07	7.79	4.84	4.82	6.44
	Total	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00
No	Unclear	5.95	3.42	3.23	4.62	1.02	1.20	1.69	1.20	16.53	12.07	13.32	14.44
	One	0.76	0.97	0.78	0.84	0.21	0.23	0.10	0.20	0.10	1.59	0.89	0.75
	Two	16.73	16.22	16.76	16.56	9.90	3.12	2.35	6.29	2.11	1.92	2.59	2.13
	Three	76.30	79.26	79.14	77.80	88.47	95.24	95.71	92.02	48.63	66.21	67.32	57.85
	Four	0.14	0.06	0.05	0.10	0.28	0.13	0.11	0.20	25.10	14.21	12.60	19.24
	Five	0.12	0.06	0.04	0.09	0.11	0.08	0.04	0.09	7.52	4.00	3.29	5.59
	Total	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00

Women with disabilities were more likely to have access to three or more meals a day in rural (95.5%) or urban areas (95.0%) than those in the refugee villages or ‘camps’ (89.6%). Differences for men and children were not significant. It may be

timely to note that due to their long stay in Pakistan (first big wave of arrival occurred in 1979) no refugees in Pakistan receive food rations, including those living in the refugee 'villages', and must rely on their own income to support themselves. Also, it was suggested by UNHCR that those electing to live in camps were likely to be those who were less financially advantaged and therefore more in need of the free services provided there. This may explain the lower level of access to food.

Men with disabilities who lived in rural and urban areas were slightly *less* likely to have three or more meals per day (76.9% and 77.0%) than other men living in those locations (79.2% and 79.4%). Conversely, men with disabilities in camps were slightly *more* likely to have three meals than those without disabilities (76.6%).

Similarly, children with disabilities were more likely to have three or more meals than those who did not have disabilities (85.6% versus 81.3%). Overall, children living in camps had greater access to food than those living elsewhere.





(77.4%) were slightly *more* likely to have three meals than those without disabilities (76.6%).

Finally, children with disabilities were more likely to have three or more meals in camp (85.6%) and urban areas (84.7%) than in rural locations (83.2%). Of those living in camps, children with disabilities were more likely to have three or more meals than those who did not have disabilities (85.6% versus 81.3%). This reflects a wider trend in which children living in camps are more likely to have three or meals than those living elsewhere. It is promising to note that across all age and gender groups, persons with disabilities living in camp situations are actually more likely to have access to three or more meals a day than those without disabilities.

#### 4.11 Water

Persons with disabilities were more likely to have a water source close to them than those without. 59.5% of persons with disabilities had a water source inside their home or compound (compared with 54.9% of others). However, persons with difficulty walking only have a very marginally higher chance of having a water source in their home (55.9%) than those without disabilities. This suggests that the other 44.2% of persons with difficulty walking may need to rely on someone else to collect water for them. This could also be a challenge for persons with other functional difficulties, such as severe sight impairment, or those who become disoriented.

#### 4.12 Sanitation

Participants were asked about their household's toilet facilities. Persons with disabilities had a higher chance of having access to a more sophisticated facility than those without disabilities. 13.8% had access to a flush latrine and 9.5% to an improved latrine<sup>27</sup>, compared with 11.1% and 8.5% for those without functional difficulties.

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<sup>27</sup> Note from UNHCR's data analyst: 'An improved latrine is a facility that hygienically separates human excreta from human contact. Improved facilities include flush/pour flush toilets or latrines connected to a sewer, -septic tank, or -pit, ventilated improved pit latrines, pit latrines with a slab or platform of any material which covers the pit entirely, except for the drop hole and composting toilets/latrines. Unimproved facilities include public or shared facilities of an otherwise acceptable type, flush/pour-flush toilets or latrines which discharge directly into an open sewer or ditch, pit latrines without a slab, bucket latrines, hanging toilets or latrines which directly discharge in water bodies or in the open and the practice of open defecation in the bush, field or bodies or water.'

Unfortunately, it was not possible to identify whether the flush latrines were squat or seated style, meaning that it was not completely clear exactly how suitable or accessible the available toilets were for persons with functional difficulties such as walking. However, it is likely that the majority are squatting style toilets. It is of concern that amongst those with walking difficulties, 20.3% had access to either no toilet or only an open pit. For health and hygiene reasons, this is of course a concern to the population more generally, but may pose extra challenges in terms of accessibility for those who have difficulty standing. More detailed information about the configuration and location of sanitation facilities is necessary in order to determine whether this is a barrier for persons with disabilities.

#### 4.13 Abuse/Violence

The PPVR survey included a number of protection-related questions. One asked respondents whether someone in the household had experienced physical or mental harm while in Pakistan. In terms of total figures, reports of violence were quite low. There was a small difference between those with functional difficulties and those without. 0.3% of persons without functional difficulties reported having experienced violence or torture, while the rate was 0.7% amongst those with functional difficulties.

**Figure 8: Reports of physical and mental harm, by disability status**

	Male		Female		Overall	
	N	%	N	%	N	%
Persons with disabilities	462.0	1.3	136.0	0.3	598.0	0.7
Persons without disabilities	2285.0	0.5	321.0	0.1	2606.0	0.3

Without asking further questions, it is impossible to ascertain the reason for this slight disparity. It could be that persons acquired functional difficulties as a result of the abuse they experienced. Conversely, they may have already had a functional difficulty and been attacked or abused as a result of discrimination related

to this difficulty. It is possible that the former is true for some and the latter for others, however, further exploration of the issue would be needed to uncover and address trends. This area merits further attention, especially since persons with disabilities have a heightened risk of experiencing abuse.<sup>28</sup>

A question regarding the source of or reason for the harm was added after the survey began to be implemented. While this means that the data is incomplete and does not deal explicitly with disability, it does give some level of insight into potential reasons for harm. By far the most common type of harm was that perpetrated by police or detention authorities, which affected 1,902 persons. However, for females, the most common source of harm was that inflicted by members of the same household or community (85 mentioned this).<sup>29</sup>

The other point to be noted is that there are much lower reports of violence experienced by females overall. Given the sensitivity of asking the head of a household whether its female members have suffered harm inflicted by fellow household members it may be imagined that harm against females has been largely underreported. Even amongst males, the reports of harm are so few that it is possible that underreporting occurs for both genders. It would be similarly difficult to uncover harm inflicted due to disability discrimination. This is a challenging issue to overcome and there are no easy responses, but it is important to consider how best to address this possible underreporting, as well as the occurrence of such harm itself.

Since the PPVR was conducted, UNHCR has been working towards improving and standardising data on sexual and gender-based violence reporting. One indication of underreporting is that often incidents from the past are only uncovered once a family commences the process of applying for asylum.

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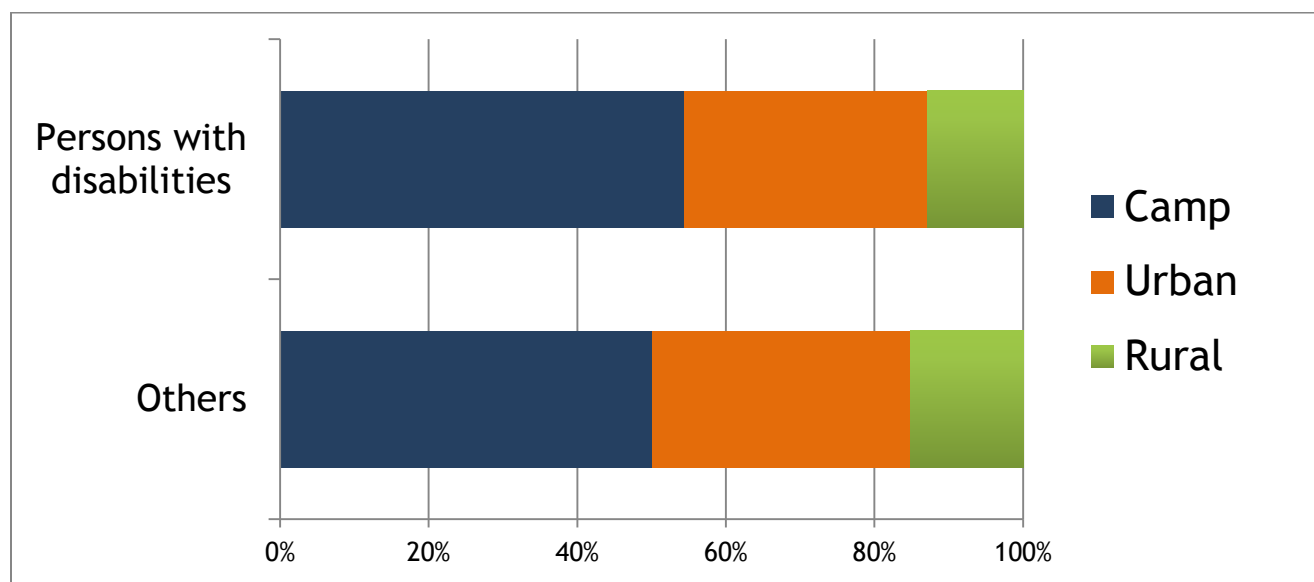
<sup>28</sup> Handicap International and Save the Children (2011) *Out from the Shadows: Sexual Violence against Children with Disabilities*, Save the Children Fund viii; WHO/World Bank, *World Report on Disability* (2011) 59.

<sup>29</sup> SAFRON, CAR and UNHCR, *Population Profiling, Verification and Response Survey of Afghans in Pakistan, 2011: Final Report* 81-3.

#### 4.14 Location

Refugees with disabilities are more likely to live in camp-like situations, in the refugee villages, than their counterparts who do not have disabilities. 54.3% of refugees with disabilities surveyed lived in camp situations, as compared with only 50.1% of those without disabilities.

Figure 9: Location of persons with disabilities, compared with others



#### 4.15 Acquisition

As mentioned earlier, from the questions asked, it was difficult to ascertain information about disability acquisition. From the available data, we can conclude that at least 35% of those with disabilities acquired them in Pakistan, as this is the percentage of those identified as having a disability that were born in Pakistan and have never returned to Afghanistan. However, it was not possible to discover the cause of disabilities or in which country or at what age they were acquired. Exploring disability acquisition amongst Afghans living in Pakistan would be a valuable line of enquiry for future research.



## 5. Discussion: where to go from here?

The 2011 PPVR provides an important foundation for identifying refugees with disabilities in Pakistan. It identified 79,954 Afghans in Pakistan who report having functional difficulties. Based on the data collected in that survey, we have explored various aspects of the lived experience of these persons, highlighting areas of particular concern. It is our hope that this survey and the valuable data that it has provided will form the foundation for further efforts to ensure the accommodation of displaced persons with disabilities in Pakistan.

The survey's section on disability has demonstrated the benefits of adopting a functionality-based approach - not least of which is the identification of a significant number of persons with disabilities. The fact that these questions were asked within the broader framework of the PPVR has provided the researchers with the opportunity to explore the various aspects of the participants' lives and experiences, as outlined in the sections above.

This exploration has brought to light a number of issues, as well as areas that remain unclear. The high prevalence of disability amongst the elderly, and the disparity between males and females, indicates the need to prioritise further investigation into the wellbeing and needs of female Afghans and the elderly (of both genders) in Pakistan.

Literacy and education are areas that also need attention. The most significant divide is according to gender: females generally remain much less likely to access education than males. Males with disabilities also have slightly less access than their non-disabled counterparts. For those who do attend school, little is known of the challenges that those with disabilities face in the classroom and environs.

The employment and income of persons with disabilities would benefit from further investigation. The exploitation of persons with disabilities in activities like organised begging, including the creation of disabilities for this purpose, is a serious protection concern. Given that refugees with disabilities are earning substantially more than average - especially women - this raises the need for further investigation.

Another area where we have little information is the acquisition of disability. Having data on the main causes of disabilities may help in the design and implementation of prevention exercises. Knowing which disabilities were acquired in Pakistan could further support such initiatives, and provide insight into the connection between protection concerns and disability acquisition.

Finally, information on assistance needs could provide valuable evidence when advocating for targeted funding or missions. For example, the data demonstrates that a large number of persons have difficulty seeing and need glasses, and given that a significant difference between the situation of refugees compared to the local population can be identified, this would provide clear support for a targeted funding campaign.<sup>30</sup> Future research should evaluate the response by UNHCR and its partners to the PPVR findings, on both individual case management, and program design levels.

These findings also carry a broader significance: the inclusion of a section on disability that reflects international recommendations allowed the disaggregation of the data included in the above report. This provides a valuable model for organisations working with refugees and other displaced persons. Where registration and verification exercises incorporate disability-specific questions, we gain a rich source of information about the experiences of refugees with disabilities. This should lead to improvements in services and planning and, ultimately, to improving the situation for people with disabilities in forced migration.

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<sup>30</sup> This is particularly striking considering that the refugee population is now largely integrated from a socio-economic perspective.



## 6. Background: The project

The Protection of Refugees with Disabilities project is a three-year research project, which commenced in 2012 and was completed at the end of 2014. It was funded by the Australian Department of Foreign Affairs and Trade and led by Professors Mary Crock, Ron McCallum and Ben Saul, of the Faculty of Law at the University of Sydney. The aims of the project included the development of a rapid assessment tool for identifying potential disabilities amongst displaced populations. It also sought to evaluate the approach of UNHCR and its partners in providing inclusive and appropriate assistance and protection to refugees with disabilities.

During the first year of the project, the team undertook fieldwork in Malaysia and Indonesia. In these countries, the researchers held interviews with UNHCR and its key partners, as well as with local human rights NGOs and Disabled Persons' Organisations (DPOs). They also carried out interviews using an individual questionnaire which aimed at identifying refugees with disabilities, as well as evaluating their displacement experience. In Malaysia, they also spoke with leaders from the refugee communities and in Indonesia they were able to enter an immigration detention centre and speak with refugees and asylum seekers there. In August and September 2013, the researchers travelled to Uganda, where they carried out similar research in the urban refugee population, as well as in two refugee settlements in the south-western region. In 2014, they undertook similar fieldwork in Jordan and Turkey, covering both camp and urban refugee populations.

Researchers Mrs Laura Smith-Khan and Mr Bilal Khan travelled to Pakistan in April 2013 to investigate the possibility of making Pakistan a case study for the Protection of Refugees with Disabilities project. While there, they met with:

- **United Nations High Commissioner for Refugees (UNHCR) officials**, Irene Van Rij (Community Services), Mariia Maslei (Resettlement) and Alexander Lewis (External Relations). They provided an overview of UNHCR operations in Pakistan, as well as outlining relevant activities related to refugees with disabilities.

- Representatives from around 25 **DPOs and NGOs**. The researchers held a three-hour ‘interactive session’ in Islamabad. Participants came from the greater Islamabad area, various cities in Khyber Pakhtunkhwa province and Lahore (Punjab province). Participants from Karachi (Sindh province) as well as Professor Mary Crock (Sydney) joined the session via Skype.
- Dr Imran Zeb Khan, the then Joint Secretary of the Ministry of States and Frontier Regions (SAFRON), Government of Pakistan, who was promoted to **Chief Commissioner of Afghan Refugees** during the research trip.
- **Saaya**, an Islamabad-based DPO. The researchers attended a members’ meeting, an awards ceremony and a peer counselling session.

## 7.1 Government of Pakistan

The researchers were able to secure a meeting with Dr Imran Zeb, who was the senior Joint Secretary within the Ministry of States and Frontier Regions. During the one hour meeting at the Ministry, he gave an overview of the situation of refugees in Pakistan, as well as explaining current policy developments. The researchers explained the project to him and how they would hope to implement further research in Pakistan. Dr Zeb expressed his support for the project and offered logistical assistance for its implementation. He suggested that the team write a letter outlining the proposed field work. He also spoke via telephone with Professor Crock, the Chief Investigator of the project.

The completed letter was delivered to him and he drafted an official letter, giving permission for the research team to undertake the proposed research in Pakistan. This letter was copied to the UNHCR Country Representative, as well as the Commissionerate of Afghan Refugees (CAR), Peshawar, with specific instructions to provide any assistance needed. During the research trip, Dr Imran Zeb became the Chief Commissioner for Afghan Refugees, and is therefore directly responsible for the CAR. He is and has been heavily involved in the development of government and regional refugee policy, and this is now his sole focus in his new role.

## 7.2 UNHCR

The UNHCR meeting involved a 90 minute discussion with the three officials, which provided an overview of operations in Pakistan. The officials also offered to share more detailed data. Subsequently they provided a copy of the Population Profiling, Verification and Response Survey of Afghans in Pakistan, 2011 and the questionnaire which was used to collect the data gathered for the PPVR exercise, which covered nearly one million Afghans in Pakistan. On closer inspection, the research team was pleased to discover that the questions related to disability used in the PPVR were based on functionality, very similar to those used in the Protection of Refugees with Disabilities project. While questions relating to acquisition and assistance needs were limited, the data available on functionality makes the PPVR a valuable resource for the research team. Reports of functional difficulties can be measured against other variables, such as age, gender, location, income, occupation and access to education to gain insight into the experience of refugees with disabilities in Pakistan. UNHCR have since extracted, compiled and provided substantial data using variables identified by the research team.

## 7.3 DPOs and NGOs

The session with the DPOs and NGOs was organized with the assistance of the Community Based Inclusive Development (CBID) Network Pakistan, which provided logistical support in arranging and running the session. The session was hosted in the offices of the Community Health and Education Forum (CHEF) International in Islamabad.

The session identified a number of organisations which had been involved in operations related to either refugees or IDPs. In particular, one organization based in Peshawar, had been directly involved in the RAHA program ('Refugee Affected and Hosting Areas'), which forms part of the SSAR and aims at strengthening peaceful co-existence between host and refugee communities. The head of this organization, along with other participants, offered their assistance in implementing any field work in the future. Many of the other organisations had worked with IDPs, following the floods and the conflict in Swat. All expressed an interest in engaging with and

including refugees in their activities in the future. A lawyer specializing in the rights of persons with disabilities was also present, and he offered to connect the team with an NGO that offers legal aid to refugees in Pakistan.

The team was also given the opportunity to further publicize the research through an interview with the editor in chief of Pakistan Special magazine, the largest circulated magazine for persons with disabilities in South Asia. Laura Smith-Khan featured on the front cover and in a five-page spread in the April 2013 issue.

After returning to Australia, Laura Smith-Khan was able to make contact with Mr Talal Waheed, the Coordinator of the Ageing and Disability Taskforce (ADTF), who provided information about the ADTF, its current projects and future direction. Founded in 2010, the ADTF is comprised of 11 national and international organisations, including some whose representatives attended the DPO/NGO interactive session. The ADTF's focus is on the recent emergency humanitarian situations *within* Pakistan, involving internal displacement, but since the end of 2012, they have aimed at expanding the breadth of their activities to include refugees. This is due in part to encouragement from UNHCR. Talal Waheed has been involved in the network for some time, but has been its Coordinator since 2012.

#### 7.4 Remote collaboration

The final stage of the research involved remote collaboration between Laura Smith-Khan at the University of Sydney and Edgar Scrase and Shafqat Mehmood in UNHCR, Islamabad. This involved identifying key variables and extracting relevant data to be analysed. All parties were then involved in preparing figures and tables. Laura Smith-Khan drafted the written analysis and discussion and consulted and received feedback from the team at UNHCR. The collaboration led to this final document.



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