Disability & Age Task Force, Azraq
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ACCESSING SERVICES DURING COVID 19: PERSONS WITH DISABILITIES AND OLDER PERSONS IN AZRAQ CAMP

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The DATF Azraq report is a joined effort by members of the Disability and Age Task Force (DATF Azraq) of Azraq Camp, Jordan. The Task Force is co-chaired by UNHCR and Nour Hussein Foundation (NHF) and the participating members of the survey were Mercy Crops, IOCC, Holy Land, NHF who provide direct services to persons with disabilities and older persons.

The purpose of this report is to:

a) To identify challenges (if any) faced by persons with disabilities and older persons during the pandemic induced lockdown in Azraq Camp.
b) Areas service providers had delivered, gaps, analysis and recommendations.

Objective

The Covid 19 pandemic is a rare instance in modern times that posed challenges worldwide. It is imperative that the interventions, challenges, improvisation of the service delivery in a refugee camp is documented.

The scope of this document is limited to access to services targeting persons with disability and older persons only. Sector based challenge was included in the questionnaire and conducted from the perspective of availability and accessibility of the said services for persons with disability and older persons specifically.

Definition

The terminology used in this document specifically related to persons with disabilities and older persons are employed from the following international definitions:

The Convention on the Rights of Persons with disabilities and its optional Protocol (CRPD, 2006, A/RES/61/106) defines person with disabilities to "include those who have long-term physical, mental, intellectual or sensory impairment which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others".[1]

The United Nations defines older persons as those who are over 60 years of age.[2]

Overview

As of September 7th, 2021, Azraq Camp hosts a total of 38,333 refugees. UNHCR has a total of 1418 persons with disability who are registered as of May 2021. The number of older persons in the camp as of September is 825 individuals[3].

At the onset of Corona Virus in early 2020, in March, the Kingdom of Jordan underwent a total lockdown that restricted movement of people. Those living in the Azraq refugee camp equally experienced the lockdown measure. To ensure continuous access to service; UNHCR, SRAD and operational partners continued to stay and deliver with due diligence to the safety measures provided by the Ministry of Health in Jordan.

While efforts were in place, persons with disabilities and older persons face layers of challenges that stems not only through physical limitations but through underlying unseen medical conditions, low self-esteem, perceptions and acceptance of family and community members that exacerbates their access and challenges. In some situations, positive protection from family members may result in unintending isolation as stated by a mother, who is the caregiver for her adult son. He has disabilities and auto immune concerns:

"I kept him at home now with the pandemic and do not let him to go out for his own safety, I am worried if he contracts Covid 19, it will affect him badly."[4]

[1] UNHCR, Emergency Handbook, Persons with Disabilities: https://emergency.unhcr.org/entry/43586/persons-with-disabilities Article 1, Convention on the Rights of Persons with Disabilities.
[2] UNHCR, Emergency Handbook, Older Persons: https://emergency.unhcr.org/entry/43586/persons-with-disabilities
[3] Data obtained from UNHCR ProGress Database.
[4] Female participate in UNHCR NHF facilitated focus group discussion on Covid 19 Vaccine Awareness Campaign. Village 2, Azraq Camp. April 19th 2021.

The risk between those with certain types of disabilities and Covid19 is legitimate. Particularly those with physical difficulties that affect their immune system, lung infection or other related factors that can put them at a higher risk for serious complications[5]. Thus, this mother's concern and measures seems legitimate but doing so limits the affected persons' mobility and interaction with others subjecting them into further isolation. Additionally, persons with disability are at heightened risk of Covid 19 because they may experience barriers to implementing basic hygiene measures, difficulties in physical distancing due to the need of additional support and the need to touch things within their environment to obtain information. They often have greater healthcare requirements and poorer health outcomes[6]. As such, the fear persons with disabilities and their family members face in ensuring their safety and well being does result in extreme measures as indicated above.

Similarly, for older persons Covid 19 risks associated with mortality or developing serious Covid 19 symptoms leading to mortality has affected those in the camp[7]. In addition to facing decline in physical abilities to perform tasks, illness to related to old age and coping mechanism of isolation has added tremendous anxiety for older persons.

In terms of program implementation for service providers, the shift to virtual platform was introduced swiftly to ensure continuity of services. Vocational trainings and access to education amongst others were shifted to online platform. While the community was quick to embrace this new method, it was not without challenges such as adaptation to the new format that excludes actual human interaction which provided space for question and answer, direct observation and guidance, lacking smart devices to enable such connection, digital illiteracy and illiteracy which hinder usage or understanding applications on smart devices. Those with disability and older persons who face situation such as severe visual or hearing impairment, intellectual impairment, unfamiliarity with smart devices to communicate or other usages makes the online platform a challenging platform to work with. Those that require in person specialised treatment such as occupational therapy, speech therapy and physiotherapy were unable to do so, and caregivers may or may not have the knowledge and the ability to fill the gap.

As such, it is of essence that the challenges faced by persons of concern who are older and those with disabilities during the times of covid is identified and recorded to help shape our subsequent responses and service provision.

Methodology

This report was a product of extensive work done in the following format:

1) Discussion with technical experts and service providers in the camp[8],
2) Desk review of existing reports, relevant information within each organisation,
3) Interviews with persons of concern- done via telephone due to Covid 19 restrictions,
4) Electronic research[9].

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[5] **…** some people with disabilities might be more likely to get infected or have severe illness because of underlying medical conditions, congregate living settings, or systemic health and social inequities. All people with serious underlying chronic medical conditions like chronic lung disease, a serious heart condition, or a weakened immune system seem to be more likely to get severely ill from COVID-19. Adults with disabilities are three times more likely than adults without disabilities to have heart disease, diabetes, cancer, or a stroke. Accessed at People with Disabilities, Centre for Disease Control and Prevention, https://www.cdc.gov/ncbddd/humandevelopment/covid-19/people-with-disabilities.html

[6] Policy Brief, A Disability Inclusive Response to Covid 10, May 2020, United Nations. Accessed at: https://www.un.org/sites/un2.un.org/files/sg_policy_brief_on_persons_with_disabilities_final.pdf

[7] Older adults are more likely to get very sick from COVID-19. Getting very sick means that older adults with COVID-19 might need hospitalization, intensive care, or a ventilator to help them breathe, or they might even die. **The risk increases for people in** their 50s and increases in 60s, 70s, and 80s. People 85 and older are the most likely to get very sick. Accessed at Covid-19 Risks and Vaccine Information for Older Adults, Centre for Disease Control and Prevention, https://www.cdc.gov/aging/covid19/covid19-older-adults.html

[8] NHF, Mercy Corps, IOCC

[9] **Documents referred to were**:
i)Covid 19 Response: Applying the IASC Guidelines on inclusion of Persons with Disabilities in Humanitarian Action, IASC. Accessed at https://data2.unhcr.org

The survey was done through telephone calls owing to Covid 19 safety measures by trained staff members who work directly with the targeted population. Reported challenges were largely related to the need of repeating questions due to poor cellular network or time constraints (1000h to 1400h) is usually the active time of the day. Aside from these, no other challenges were reported by participating partners.

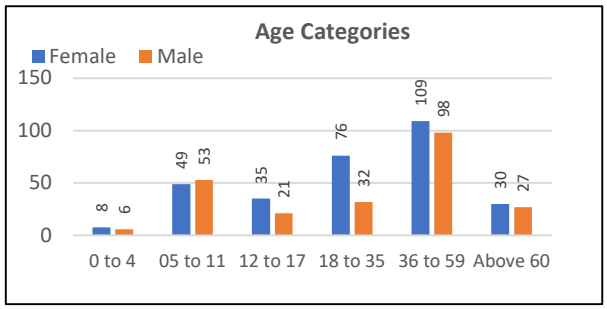
Target Group:

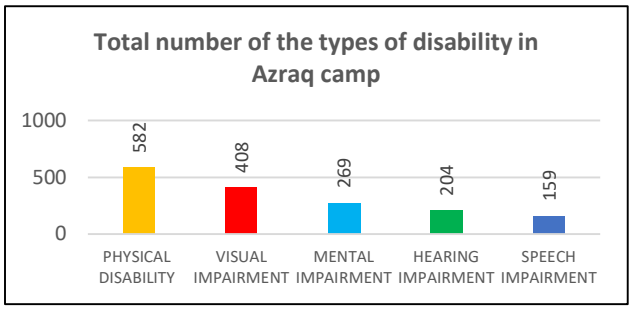
The age target group were as follows:

1) Babies and toddlers between the ages 0-4 years old; parents and guardians provided answers based on their observation of their children.
2) Children between the ages of 5- 11; parents and guardians where needed provided answers based on their observation.
3) Adolescents between the age 12 – 17,
4) Youth between the age of 18 -35,
5) Adults between the ages of 36 to 59,
6) Elderly – above the age of 60,

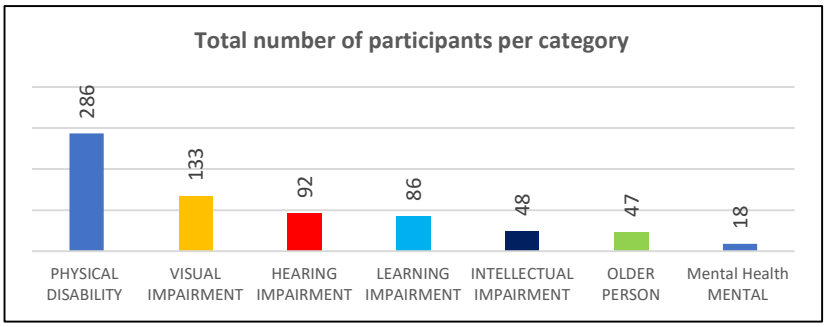
For those below the ages of 18, parental consent was obtained prior to the interview.

The following graphs provides a break-down of the age group for the participants and total number of registered disabilities in Azraq Camp:





Below is the detailed breakdown of different disabilities and older person who participated in the survey:



ii)Policy Brief, A Disability Inclusive Response to Covid 10, May 2020, United Nations. Accessed at: https://www.un.org/sites/un2.un.org/files/sg_policy_brief_on_persons_with_disabilities_final.pdf
iii)Disability Consideration during the Covid 19 Outbreak, March 2020, WHO. Accessed at: https://www.who.int/publications/i/item/WHO-2019-nCoV-Disability-2020-1

3: Direct impact of Covid 19

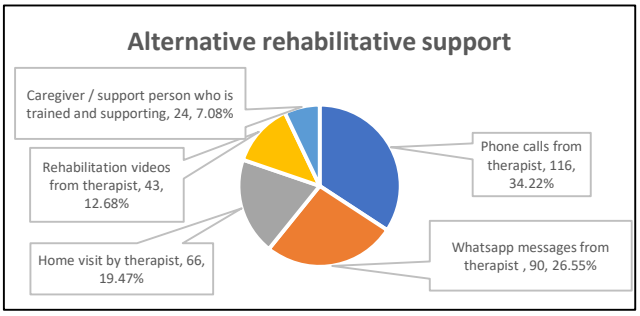
The survey for this report was designed to identify the following:

i) Access to rehabilitative services and alternatives,
ii) Participation and involvement within societal activities & potential barriers to leaving their homes,
iii) Identify sector-based challenges, if any.

A total of 438 individuals (80.51%) from 544 participants in the questionnaire stated yes to receiving rehabilitation services in the camp. 232 (52.9 %) from 438 individuals stated having higher frequency of visits: between once or twice a week. The number of individuals accessing services reveals high need for such services that is being met by humanitarian actors.

During the pandemic, from the 438 individuals only 168 individuals (38.3%) had access to alternative rehabilitation support. As such, 270 individuals who previously accessed rehabilitative services had discontinued as a direct result of the pandemic. This meant only a smaller number of cases were able to continue rehabilitation services based on reprioritization with urgent or severe criteria. The remainder were put on a waiting list.

Alternative rehabilitative support refers to online mechanisms and home visits. Through this method, targeted individuals were reached through multiple options as the graph below indicates.



It is worth noting majority of those who had alternative support stated the methods employed were easy and adaptable for them which stood at 152 individuals while only 16 stated the methods were difficult. Amongst the reasons cited for difficulties were linked to unavailability of suitable smart devices and internet connectivity, adapting to the online platform, e.g., individuals including children do not necessarily respond well thus posing challenge for online follow up, preference for in person guidance and illiteracy.

In times with reduced humanitarian staff presence, limited home visits were conducted through the NHF's community-based rehabilitation team which is a community network trained by rehabilitation specialist to assess and support basic rehabilitative services in the camp. Nevertheless, due to movement restrictions, these visits were extremely limited and dependent cases' severity. With regards to children with disability, Mercy Crops through its Shadow Teacher program similarly ensured its persons of concerned with priority cases received home visits to support their respective rehabilitation.

Those who did not have access to alternative rehabilitation support; 131 observe to be partially affected from the discontinuation and 36 stated to be seriously affected. The regression evaluation is based on personal assessment of individuals on their abilities to perform certain tasks or range of movement, progress or regression that one could identify for themselves.

Collectively, the technical experts on the rehabilitation team of DATF Azraq agree that those who did not receive alternative support have shown varying degree of regression in their recovery. Examples of such cases are children who underwent speech therapy, rehabilitative or physiotherapy. Without continuous rehabilitation, the muscles have weakened, leading to regression. Parents of children with physical disabilities who stop receiving physiotherapy sessions during lockdown mentioned that their children faced problem while walking and moving, when it was possible and achieved during the therapeutic exercise. As cited by the parent below:

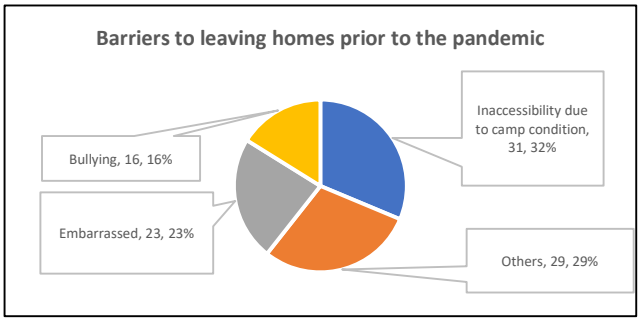
"My child has fallen down many times during his walking around the home, especially when his Ankle, Foot Orthosis were broken. Before, he was able to play when he used it".

This data speaks of common setup of rehabilitative service that is made available through medically trained personnel. However, the pandemic and the setup meant a significant number of individuals had to discontinue their sessions. The new normal relies heavily on online mode of communication and exchange of information. However, it is not without its own challenges. Firstly, access to smart phones that are not readily available within the camp added by sluggish network proves to be a challenge on its own. Secondly, in addition to illiteracy and preference to human interaction, certain physical conditions such as visual, speech and hearing impairment and mental disabilities create additional barriers for an individual to have meaningful engagement and understand the online content. This identifies the need for humanitarian partners to invest in online training materials and packages as deemed appropriate for specific caseloads.

While there exist restrains and challenges for rehabilitation services to convert entirely online, the lockdown has seen added value in community networks who are trained and able to perform home visits. Where possible, investing into primary caregivers to develop a degree of understanding and enabling support for the target population is also seen as important. Continuous rehabilitative support at home can decrease regression and potentially could reduce the number of visits to the rehabilitation centres that could in turn, lessen the waiting period for others to access the services. At a larger scale, this indirect investment builds the community's knowledge and ability to support each other when the need arises. Further, there is a need to have capacitated, empowered refugee network such as the community rehabilitation committee and Shadow Teachers that provide an answer to the gap when service providers are unable to be present.

Inclusion into social activities and barriers to leaving home.

The second component in the report seeks to identify if the targeted group were actively involved in any social activities and experienced barriers to leaving their homes prior to the pandemic. By assessing inclusion aspect, we can ascertain the degree of inclusion by humanitarian partners, their existing support system and access to their own community. On a positive note, a total of 476 (87.5%) from 544 interviewed, stated having no barriers to leaving their homes. The remaining 68 stated yes. The reasons varied as indicated in the graph below. The highest reason at 31.32% was linked to inaccessibility due to camp condition. Mobility has been a persistent challenge due to the nature of the camp set up and the absence of any transportation mechanism. The community itself coped with their own solutions by attaching carts to their bicycles for passengers.



Secondly, while the numbers for those who faced barriers are smaller in comparison to those who do not, it does not exclude the need for awareness raising by humanitarian actors to increase their acceptance of themselves as individuals with disabilities and amongst family and community members to accept these individuals in their daily life.

In terms of social interaction, 340 participants stated to being involved in social activities where else 204 were not involved in any social activities. From the 340:

-50.85% (240) interacted with neighbours and those in their immediate vicinity,
-40% (189) were involved in activities such as walking, football and games,
-9% (43) were involved in activities at community centres, Makani or at school.

From these figures, it can be understood that majority of those with disabilities and older persons rely on their immediate neighbours, friends or relatives for any social interaction and support network. While this is likely due to difficulties linked to physical movement, inconducive camp environment for movement with mobility aid equipment and the absence of transportation, it also demonstrates that community linkages are present and strong amongst the refuges in the camp. Secondly, individual or group activities that includes persons with disability is present albeit minimal, can be seen through team activities such as football and games.

The remainder participated in other activities conducted by humanitarian providers in Makani centres, kindergarten, or activities in schools. Due to this link, it is presumed the participants are toddlers or school going age. Finally, 28 individuals cited accessing vocational trainings such as handicraft, theatrical activities, sewing courses and embroidery.

Equally important to note that 204 individuals stated not participating in any activities due to limitations, unaware of activities and transportation challenges. This begets the question for us as humanitarians if we are sufficiently targeting these groups with activities? Are they receiving the appropriate information on the activities? and the need to identify factors that hinder further participation? We also need to critically examine by promoting inclusiveness if persons with disabilities require specific programming that would enrich their learning, social interaction and self-confidence.

In analysing the direct effects of the lockdown, 109 participants stated to being partially affected from not being able to perform their social activities and 58 participants stated to being serious affected. Naturally this is based on self-evaluation and due to cultural barriers, the individuals may not feel comfortable to acknowledge feeling a degree of anxiety. Those who did admit to being affected cited regression in education, increase in fear and anxiety due to isolation and reduced socialisation with relatives and neighbours, regression in progress achieved through rehabilitative session, losing income generating opportunities that has negatively impacted them.

The DATF technical team collective agree on the findings above stating those with disabilities experience more mental distress than those without disabilities[10]. In general, the situation created anxiety and lack of platform for persons with disability and older persons to interact and exchange left them feeling isolated as cited by student below:

'Because my situation is special, I used to gain skills through the sessions done by Mercy Crops in schools and interaction with my friends. But one day everything stopped, and I had to remain home with my problems by myself.'

Sector base challenges

The *Policy Brief on Inclusion*[11] provides four overarching areas of action that is applicable to all for the Covid 19 Response. The 4 areas are

i)Ensuring mainstreaming of disability in all Covid 19 response and recovery,
ii)Ensure accessibility of information, facilities, services and program,
iii)Meaningful consultation and active participation,
iv)Establish accountability mechanism to ensure disability inclusion in the Covid 19 response.

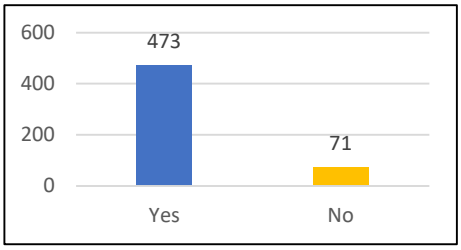
As an extension of this, access to different sectors were asked to establish inclusion and disability friendly services are made available during the lockdown. Overall, it is on a positive note that most of the services were accessible. Where challenges were identified such as queue for disabled and older persons in markets and hospitals, remedial actions were quickly undertaken by partners. Notwithstanding this should have been in place when the measures were

[10] …During the COVID-19 pandemic, isolation, disconnect, disrupted routines, and diminished health services have greatly impacted the lives and mental well-being of people with disabilities. Mental Health of People with Disabilities, Centers for Disease Control and Prevention. Accessed at: https://www.cdc.gov/ncbddd/disabilityandhealth/features/mental-health-for-all.html

[11] Policy Brief, A Disability Inclusive Response to Covid 19, May 2020, United Nations. Accessed at: https://www.un.org/sites/un2.un.org/files/sg_policy_brief_on_persons_with_disabilities_final.pdf

considered vis-à-vis Covid 19. Nevertheless, given the sudden implementation, the improvisation and adaptation prove flexibility and feedback mechanisms exist between the refugee community and humanitarian partners. When asked if in accessing any of these services, individuals felt unsafe, all the replies were related to fear of infection from Covid 19.

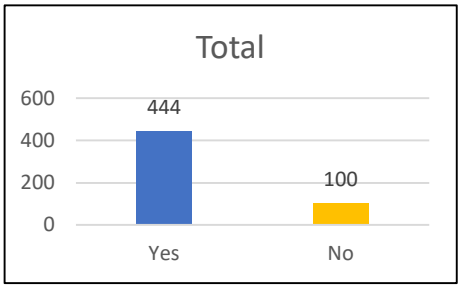
1) WASH & Hygiene Facilities



473 individuals stated having access to WASH & hygiene where else 71 individuals stated no. Those who stated no, it is possibly linked to provision of private latrines at shelter level and in instances of water collection from water points, it is reasonable to presume other family members and caregivers accessed the area. Additionally, in the event of identification of Covid 19 case, water tank was provided at plot level to ease access and to curb community transmission.

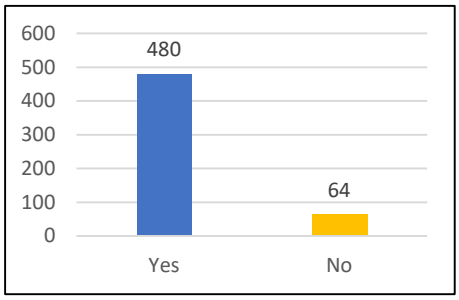
WASH partners also distributed hygiene kits consisting of face masks, sanitizers and cleaning materials alongside messaging on its usage to the community.

2) Food & Nutrition



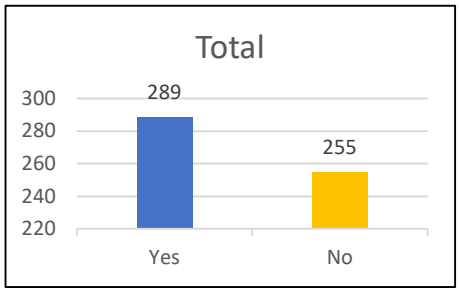
444 individuals stated yes to having access to food and nutrition services in the camp while 100 individuals stated no. An overwhelming majority of those who stated no were related to crowding at the malls and no services to facilitate older persons or those with disabilities. It is important to note WFP had continued monthly voucher distribution and food items were made available. UNHCR WFP collaboration ensured the malls created schedules based on different criteria to avoid overcrowding and physical distance, ensuring the application of personal protective equipment and the availability of sanitizers. Overcrowding at the initial stage was a result of panic within the community and fear there will be insufficient food items which settled with the consistent availability of supply. As stated earlier, following feedback on challenges faced by the older persons and persons with disability, a designated cashier and assistance were identified to smoothen the purchase experience.

3) Health Sector



480 individuals stated to having access to health care providers while 64 individuals stated no. During lockdown, the primary health care clinics had services limited to emergency, chronic illness and supply of medication. The secondary healthcare provided by hospital continued functioning for specialised services and emergency. Alternatively, healthcare providers activated hotlines to provide medical counselling and advise for non-emergency patients. However, referral for external healthcare had ceased and limited to life saving interventions.

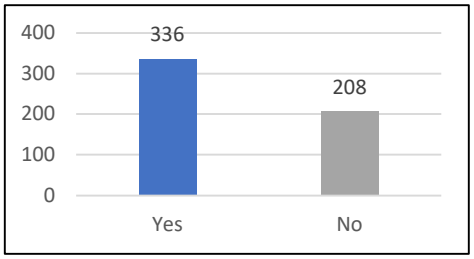
4) Protection



Access to protection services is managed by UNHCR and its protection partners. In the absence of in person appointments, UNHCR managed a hotline for which person of concern can reach for any protection related matters. A response plan was adapted with the relevant stakeholders including the Jordanian authorities. The response plan covered crucial areas such as registration of new births, deaths, marriage and divorce as well as specific guidance for SGBV, Child protection, detention and legal counselling.

From the persons interviewed, 289 stated having access to the protection services, where else from the 255 who stated no meant they did not have the need for the services.

5) Education sector



The largest impact of the lockdown and its subsequent restrictions impacted the education sector the most as it transpired during the scholastic semester. The adaptation to online mechanism for both formal and informal education was not without challenges that have been documented. The situation was fluid and adaptation such as technical errors on platforms were done progressively, distribution of smart devices to enable access, distribution of internet data for families, support in printing educational materials for students. Some challenges remained unchanged such as the quality of the internet and its barriers specific to persons with disability. As identified in the survey, the platforms were unable to consider situation of visual, hearing and speech impairment where visual or audio content were not sufficient or futile. Additionally, those who faced intellectual or learning disabilities require direct support using a variety of methodology found it challenging to follow and regressed in their education. Parents were also put in a position they were unprepared for such as those with illiteracy, unfamiliarity with smart devices which directly affected the children's learning abilities. As a mother stated in a focus group discussion:

"the children's education has regressed as they expect me to help them with their studies. Some of the topics I have no understanding and am not sure how best to help my child".

336 individuals stated to having access to the online platform for educational purposes, however to two subsequent questions that were asked i) *if they felt included in the platform and* ii) *if the platform took into account their special circumstances*, an overwhelming 290 students stated no. This drives the point that while the online mechanism was the quickest way to ensure education consistency was available to the population at large, this does not apply to students with disabilities. Often, due to their circumstances, many rely on more than one sense to formulate and

understand their environment. Some may even take longer to process and understand the information that is being conveyed resulting in delayed reactions, unable to grasp the topics and unable to voice or clarify the misunderstanding. While parents have inevitably assumed roles of teaching or providing guidance for children during the pandemic, we have to recognize the gap that they lack the knowledge or skills required for teaching children with disabilities.

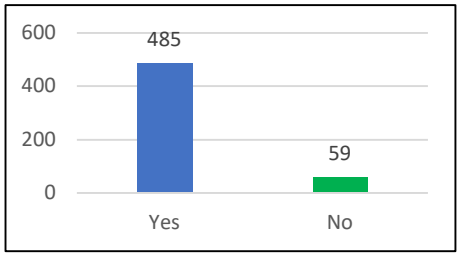
Another question asked was *pertaining to their involvement in in-person training prior to Covid* and *if not why*? This question seeks to establish the inclusion mainstreaming or the challenges for inclusion in the ongoing educational and vocational training sessions. 298 individuals said they would participate but did not do so for following reasons: Unavailability of the requested course mostly pertaining to caring for children with disabilities. It is clear as parents, they lack knowledge on how to care sufficiently for children with disabilities and often are at lost in helping their own child. Secondly, they would like to participate in ongoing trainings or educational opportunities as they recognise education as means to increase their skills, knowledge and marketability but were not able due to obstacles.

The obstacles were:

-Age group targeted for the activities does not cater for those above 30 years of age,
-Caring for family members with disabilities,
-Those with disabilities face challenge in accessing the premises for trainings,
-The trainings do not consider their challenges in learning,
-Unaware of such trainings or failed to receive information pertaining to such trainings.

This speaks to the inclusion criteria that is applied in programming, while organisations state those with disabilities are highly encouraged to participate, it does address the exiting barriers that prevents them from attending. This could potentially be services either from humanitarians or at a community level providing safe spaces that cares for children/ adults with disabilities and older persons while their parents or caregivers attend trainings or provision of transportation to enable them to attend in person. Further, humanitarian partners can work with specialise service providers in producing training content that is suitable for the target group. Also, inclusion efforts can be made by training existing trainers on how to interact with persons with disabilities and the modification methodology best suited for each impairment. Without addressing these barriers, inclusion remains a distant goal.

6) Information dissemination



Information dissemination in Azraq camp is done in collaboration between UNHCR and CARE which is achieved through different modalities such as the information gathering sessions, inter-agency community representative meetings, bulk SMS system, availability of announcements at various congregation points such as the mall and announcement boards in service centres.

At the onset of the pandemic, to ensure continuous flow of information with safety precaution measures, the Virtual Information Board (VIB) was established. It is an online platform containing all relevant information and announcements. Additionally, bulk SMS system continued to function and announcements through loudspeakers in the camp.

485 individuals stated yes to receiving all the relevant announcements through the VIB or communications sent via cellular services. Only 59 individuals stated to not receiving information due to internet connectivity accessing the VIB, VIB is not disabled friendly, lacking smart devices, family phone number is not updated, no valid mobile numbers and due to illiteracy. While the percentage of those who were unable to receive the information is relatively small partly

on refugees not updating their mobile number, these requests have also been identified through focus group discussions.

Challenges

Transportation or access to service was a common thread amongst all the sectors above. In various platforms, focus group discussions and in this survey, persons with disabilities and older persons have cited distance as a challenge to access services inside the camp. In the past, public transport licensed by the ministry of transportation were made available in the camp, however due to security concerns they were discontinued. The transport was nonetheless not disabled friendly. Efforts have been made from camp management to ensure those with disabilities, those with chronic illness and older persons are allocated shelters closer to service providers and facilitated building of ramps. The challenge remains that there are limited shelters with such proximity and unavailability of such shelters in the event of new admission or newly developed conditions.

Presently, there are community owned bicycle cart that provides transportation with a fee in the camp. These carts however are not suitable for those with wheelchairs or other forms of physical disabilities. Humanitarian partners such Mercy Corps has built a new model with trollies that can be used by families having children with physical and intellectual disabilities. The trolly was designed to hold children with their wheelchairs while the parent rode the bicycle. The newer model has the possibility of having 2 sets of passengers next to the rider.

Other challenges cited were the limited employment opportunities within the camp, the need for cash assistance for those having multiple disabilities amongst families members which increases the need for round the clock care, and in turn limits any feasibility of seeking income generating opportunities, reduced referral to external healthcare due to Covid 19, the need for continued rehabilitative sessions for those who require them, more support directed towards children with disabilities in their learning and a forum for the elderly to interact.

Conclusion

The objective of the document was to identify any potential challenges that persons with disability and older persons faced during the lockdown, identify any sector base challenges and analysis on gaps and recommendations.

As a direct impact of the lockdown, it is safe to say that majority of those who were undertaking rehabilitative sessions were affected and endured regression in their abilities. More needs to be invested into community owned and empowered networks that potentially be envisioned in providing the necessary support. This reduces heavy reliance on the service providers and allows space for continued improvement. Ultimately the regression does not only affect at an individual level but the family at large. The adaptation of online treatment plan which was implemented was well accepted and requires expansion in catering for different caseloads.

Insofar with barriers to leaving home, it is encouraging majority of the cases reported positively. Nonetheless, there is need for continued awareness on inclusion and self-acceptance. On inclusion, humanitarians should look beyond highly encouraging participations but actively identifying solutions to enable active and meaningful participation. Similarly, while inclusion into the mainstream is needed and encouraged, identifying specific programs within the general programming that caters to the understanding and skills of persons with disability is still needed. As an example of active involvement would be to have persons with disabilities who are trained as trainers and are able to train other community members while having the skills to communicate with persons with disabilities.

In accessing sector base services in the camp, it is highly encouraging the inclusion and adaptation rate along side feedback and improvisation is active within Azraq camp. However, challenges related to the education sector persists. In the event of a potential return to remote education, it is an area that requires urgent resources and attention in ensuring no one is left behind.

In conclusion, humanitarian actors in Azraq camp worked alongside persons of concern in identifying feasible solutions to endure the lockdown. The lessons learned and gaps identified provides a learning curve and guidance on areas to focus and build on moving forward not limited to in times of pandemic but identifying innovative ways to serve the population in need.