WOMEN'S COMMISSION
for refugee women & children

DISABILITIES AMONG REFUGEES AND CONFLICT-AFFECTED POPULATIONS

Women's Commission for Refugee Women and Children

June 2008

Cover photograph: Boy making a reed basket at the UNHCR-supported vocational training program for the blind and disabled at the Blind Association, Jalalabad, Afghanistan. (UNHCR/S. Schulman)

The Women's Commission for Refugee Women and Children works to improve the lives and defend the rights of refugee and internally displaced women and children.

The Women's Commission is legally part of the International Rescue Committee (IRC), a non-profit 501(c)(3) organization. It receives no direct financial support from the IRC.

www.womenscommission.org

June 2008

ISBN: 1-58030-072-3

TABLE OF CONTENTS

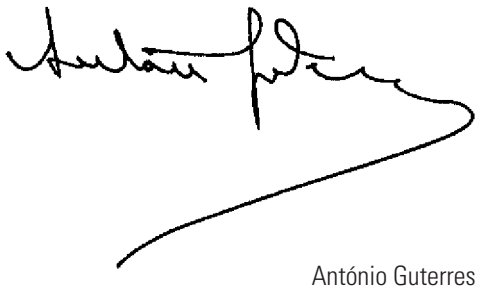
FOREWORD

Too often invisible, too often forgotten and too often overlooked, refugees with disabilities are among the most isolated, socially excluded and marginalized of all displaced populations. As this pioneering research by the Women's Commission for Refugee Women and Children reveals, those with disabilities are more limited by *our* actions than by their own physical and mental abilities. The way we design and construct camps can impede their access to vital services; the way we distribute food without taking their specific needs into account impacts their health and safety; the way we exclude them from vocational training and income generation programs promotes the view that they are helpless and dependent; and when we don't actively encourage their participation in refugee leadership structures, we give the impression that they are less able.

Yet, as this research also attests, refugees with disabilities possess valuable skills, knowledge and experience, and they wish and deserve to be given the opportunities to use them. They want equal access and opportunity. They need to be socially included and to participate fully. Like all of us, they want to contribute to their communities and have meaningful lives.

"Disabilities among Refugees and Conflict-affected Populations" highlights interesting and engaging examples of positive field practice—where those with disabilities have access to mainstream services as well as vital targeted services. The companion resource kit provides practical guidance for UNHCR and implementing partner field staff on ways to improve both protection and service delivery for these populations.

The Women's Commission sought to place refugees with disabilities higher on the international agenda and to provide tools and guidance for improving critical assistance. This research has accomplished just that. As the first undertaking of this kind, specifically focused on refugees, it has given both greater recognition and voice to those refugees with disabilities and provided us all with a way forward. Let us use this guidance to ensure improved protection, enhanced participation and equal opportunity for those with disabilities. Let us stop erecting—and start dismantling—those barriers that limit their access and potential.



António Guterres
United Nations High Commissioner for Refugees
June 2008

EXECUTIVE SUMMARY

The World Health Organization (WHO) estimates that between 7 and 10 percent of the world's population live with disabilities. As such, it can be assumed that between 2.5 and 3.5 million of the world's 35 million displaced persons also live with disabilities. Among displaced persons who have fled civil conflict, war or natural disasters, the number with disabilities may be even higher.

Yet persons with disabilities remain among the most hidden, neglected and socially excluded of all displaced people today. People with disabilities are often literally and programmatically "invisible" in refugee and internally displaced persons (IDP) assistance programs. They are not identified or counted in refugee registration and data collection exercises; they are excluded from or unable to access mainstream assistance programs as a result of attitudinal, physical and social barriers; they are forgotten in the establishment of specialized and targeted services; and they are ignored in the appointment of camp leadership and community management structures. Disabled persons' potential to contribute and participate is seldom recognized: they are more often seen as a problem than a resource. Moreover, traditional community coping mechanisms, including extended families, neighbors and other caregivers, often break down during displacement. The loss of caregivers can leave persons with disabilities extremely vulnerable and exposed to protection risks.

This report is the culmination of a six-month project commissioned by the Women's Commission for Refugee Women and Children and co-funded by the United Nations High Commissioner for Refugees (UNHCR) to address the rights and needs of displaced persons with disabilities, with a particular focus on women (including older women), children and youth. Based on field research in five refugee situations, as well as global desk research, the Women's Commission sought to map existing services for displaced persons with disabilities, identify gaps and good practices and make recommendations on how to improve services, protection and participation for displaced persons with disabilities. The objective of the project was to gather initial empirical data and produce a Resource Kit that would be of practical use to UN and nongovernmental organization (NGO) field staff working with displaced persons with disabilities.

While refugees and IDPs with disabilities face enormous challenges, the research was not wholly negative. The Women's Commission found examples of innovative and successful programs for refugees with disabilities, particularly in the areas of inclusive and special needs education, vocational and skills training, community health care and outreach programs and prosthetics and physical rehabilitation (especially for land mine survivors). We found situations where refugees with disabilities and their families were highly organized and had formed their own self-help support groups. The Women's Commission also found examples of positive disability awareness programs. Given an accessible physical environment, heightened disability awareness, both within their community and the local host community, and an inclusive approach by agencies assisting them, displaced persons with disabilities can live independent lives, participate fully in public affairs and make positive contributions to their communities.

The research found that, in general, services and opportunities for refugees with disabilities were better in refugee camps than in urban settings. Due to the more geographically and socially cohesive nature of refugee camps, it is easier to identify refugees with disabilities, adapt programs to be more inclusive and set up specialized services. It is also easier to effect attitudinal and programmatic change in refugee camps. Urban refugee communities are more dispersed and less physically cohesive. Many urban refugees are undocumented and lack any legal status. They are often afraid of the authorities and prefer to remain "hidden." This makes it much harder to identify persons with disabilities or to integrate them into mainstream or specialized services.

The study showed that less information and fewer services were available for people with mental disabilities than those with physical and sensory disabilities. Refugees with mental disabilities tended to be more "invisible" and "hidden" from public view than those with physical disabilities. They were less likely to be identified in registration and data collection exercises and tended to be more excluded from both mainstream and targeted assistance programs. They were less likely to be included in decision-making processes or in leadership and program management structures.

Collecting reliable and accurate data on the number and profile of displaced persons with disabilities was one of the weakest aspects

of all the programs surveyed for the report. In many cases, data on the number of displaced persons with disabilities was simply not available from the government, UNHCR or its implementing partners. Where data did exist, it was often inconsistent or inaccurate. One of the reasons for this was differences in the terminology and categories used to classify different types of disabilities and reasons for disabilities. In addition, concepts of "impairment" and "disability" can differ enormously among different cultures and societies. Data collection staff also lacked the technical expertise to identify and categorize different types of disabilities.

Almost all the countries surveyed identified problems with the physical layout and infrastructure of camps or settlements, and lack of physical access for persons with disabilities. Refugees with disabilities noted the physical inaccessibility of shelters, food distribution points, water points, latrines and bathing areas, schools, health centers, camp offices and other community facilities. Problems of physical accessibility were often worse for refugees living in urban areas, where the opportunities to adapt or modify physical infrastructure were much more limited, than in camps. Difficulties with physical access affected all aspects of disabled refugees' daily lives, especially those with physical and visual impairments. Unable to leave their homes, or move around easily, many refugees with disabilities faced greater levels of isolation than before their displacement.

Nearly all the field studies reported that refugees with disabilities did not receive additional or special food rations, nor were they prioritized in food distribution systems. In all the countries surveyed, participants pointed out that the food and nonfood distribution points were far from people's homes and the long, crowded lines made it difficult for many persons with disabilities to receive their rations.

All the field surveys cited the lack of specialized health care, psychosocial support and counseling services for persons with disabilities. There were no specialized doctors, no specialist therapy and a lack of specialized medicines and treatments. Moreover, there were generally no referrals to specialist services outside the camps. Nearly all the refugees surveyed said that health clinics were often physically inaccessible for persons with disabilities and that they had to line up for long periods and were not given priority treatment. Many disabled people and their families said that they were suffering from increased levels of isolation, depression and mental health problems since becoming refugees, but there were no or very limited psychosocial services available. A positive finding in all the countries' situations surveyed was that women with disabilities had access to reproductive health care. There were also positive examples of community health care and outreach programs (especially in refugee camps).

Access to education for children with disabilities was one of the most successful areas in all the countries surveyed. All the field studies showed that children with disabilities had access to schools and no cases were found of children with disabilities being actively excluded from school. The field surveys identified many successful examples of inclusive education programs for children with disabilities, including early childhood intervention programs; ongoing training of special needs support teachers and mainstream teachers in special needs education; the development of special teaching aids, appropriate curriculum and teaching resources; home support and liaison programs; parent support groups; and, where necessary, the establishment of separate schools, or learning environments, for children with particular needs (e.g., schools for blind or deaf children).

In some settings, although children with disabilities were not actively excluded from mainstream schools, they were not actively encouraged to attend either and dropout rates were high. This was due to various factors, including the lack of special needs support staff or training for mainstream teachers in special needs education; the lack of appropriate teaching aids or flexible curriculum; and the physical inaccessibility of school buildings and facilities. The field studies also found some incidents of gender disparity in school attendance rates for children with disabilities (more boys than girls with disabilities were attending school), although the reasons for this were not entirely clear from the research.

Access to vocational and skills training, income generation and employment opportunities for refugees with disabilities varied considerably. There were some examples of very successful vocational and skills training programs that were specially geared for persons with disabilities and had helped them to learn useful skills and subsequently either find employment or set up their own small business. In other settings, vocational training courses had

not been adapted to meet the needs of persons with disabilities and the teachers were not specially trained. Elsewhere, persons with disabilities were either actively excluded from vocational training or given no encouragement to attend. In all the countries surveyed, persons with disabilities said that they were keen to learn new skills and wanted to find jobs. However, they faced huge social, attitudinal and legal barriers in finding employment, not only because of their disability, but also because of their status as refugees and outsiders. The field research demonstrated that it was easier for refugees with disabilities in camps to find work or set up their own small businesses than it was for refugees in urban areas, where they were competing on the open market.

Nearly all the refugees with disabilities interviewed during the field studies said that they would like to be more involved in community affairs, camp management and decision-making processes. However, opportunities for *formal* participation of refugees with disabilities in camp management and program planning, implementation and management were very few, even in those situations where there were high levels of disability awareness. There were a few isolated examples of persons with disabilities being included in strategic planning processes and participatory assessments, and a few examples of NGOs with positive employment policies for persons with disabilities. In the absence of *formal* opportunities to participate in community management and decision-making, there were some positive examples of refugees with disabilities forming their own organizations and self-help groups.

Opportunities for community participation among refugees with disabilities in urban areas were even more limited. In all the countries surveyed, there was little to no contact between refugees with disabilities and local disabled persons' organizations (DPOs) and no attempts by local DPOs to integrate refugees with disabilities into their activities. A positive outcome of the field surveys, however, was a building of alliances between local disability service providers and local DPOs and refugees with disabilities in several countries. Involvement in the field research exposed local DPOs to the needs of refugees with disabilities and motivated them to include refugees in their programs. It also helped increase awareness of national disability services among refugee relief agencies.

In general, the quality of information on protection risks faced by refugees with disabilities was poor. Respondents in the field studies cited a range of protection problems, but gave few concrete examples. Almost without exception, everyone interviewed mentioned discrimination, stigmatization, harassment, neglect and exclusion of persons with disabilities as major protection concerns, both within their own communities and in the host communities. In several countries, the field studies found that women with disabilities were at risk of sexual violence, domestic abuse and physical assault, although again, few concrete examples were given. In one country, nearly all the respondents mentioned that older persons with disabilities were doubly discriminated against and were at risk of neglect and possible abandonment, especially when they became, or were perceived as having become, a burden for their families. The same country also highlighted physical abuse against children with disabilities.

The lack of available information about protection risks faced by persons with disabilities does not imply that refugees and IDPs with disabilities do not face protection risks, but rather highlights weaknesses in protection reporting and response and a general failure to address the protection needs of persons with disabilities during routine protection monitoring. The research also found that there were no clear policies or information about durable solution options for refugees with disabilities, in particular in third country resettlement.

Key Recommendations to All Humanitarian Actors

- **Make camp infrastructure and all facilities, services, shelter, organizations and information accessible to displaced persons with disabilities.** The needs of persons with disabilities should be addressed at the start of the emergency during the site selection, planning and design of camp infrastructure and services.
- **Set up a standard, centralized data collection system to collect disaggregated data on the number, age, gender and profile of displaced persons with disabilities in order to enhance their protection and assistance.** Attention should be paid to maintaining the confidentiality of information. Disability awareness training should be provided to all data collection officers.
- **Conduct community-based information- and awareness-raising campaigns to promote greater tolerance, respect and understanding of persons with disabilities.** Promote the inclusion of people with all types of disabilities in camp management structures, community decision-making processes and at all stages of the program cycle, ensuring age and gender diversity.
- **Promote full and equal access to mainstream services for persons with disabilities** (e.g., shelter, water and sanitation, food and nutrition, nonfood distributions, health and mental health services, education, vocational and skills training and adult education, income generation and employment opportunities, and psychosocial programs).
- **Provide targeted services, as needed, for persons with disabilities** (e.g., specialized health services, physical rehabilitation and prosthetics clinics, assistive devices, nutritionally appropriate food, special needs education, case management, protection monitoring and reporting mechanisms).
- **Ensure that displaced persons with disabilities have full access to all durable solution options** and to objective information regarding durable solutions in a format that is accessible and easy to understand.
- **Build alliances with local disability providers to support the integration of refugees and IDPs into local disability services.** Encourage local displaced persons' organizations (DPOs) to integrate disabled refugees and IDPs into their activities. Ensure that services provided to displaced persons with disabilities are also made available to persons with disabilities in the local community.

A complete list of recommendations can be found in Part 3 on page 36.

For a copy of the resource kit that accompanies this report, go to www.womenscommission.org or contact:

Women's Commission for Refugee Women and Children
122 East 42nd Street
New York, NY 10168-1289
1.212.551.3115
info@womenscommission.org

PART 1: INTRODUCTION AND BACKGROUND

Introduction

"In all wars and disasters, it is persons with disabilities that are first to die; persons with disabilities that are the first to get disease and infection; and it is persons with disabilities who are the last to get resources and medicines when they are handed out. They are treated as the bottom of the pile."[1]

The World Health Organization (WHO) estimates that there are more than 600 million persons with disabilities worldwide—between 7 and 10 percent of the world's population—80 percent of whom live in developing countries.[2] It can be assumed, therefore, that between 2.5 and 3.5 million of the world's 35 million displaced persons also live with disabilities. Indeed, the number of persons with disabilities among displaced populations may be even higher. Where displaced persons have fled civil conflict and war, a higher proportion of the population may have suffered serious injuries or trauma due to the fighting or land mine accidents, resulting in physical, mental or sensory impairments. According to the 1996 *United Nations Study of the Impact of Armed Conflict on Children,* armed conflicts in the previous decade caused more than a million deaths of children in poor countries. For every child killed, three were permanently impaired and many more psychologically damaged.[3] Similarly, where displacement is the result of a natural disaster, such as an earthquake or flood, large numbers of people may have suffered injuries resulting in a variety of impairments.

Health care and social support systems may be disrupted during civil conflicts and after a natural disaster, depriving the local population, especially children, of essential preventive or curative medical care and maternal and child health programs. This can mean that people with existing impairments do not receive the treatment they require and their conditions can worsen, while people with wounds and injuries resulting from the conflict or disaster may lack essential treatment, leading to permanent disabilities.[4] Lack of preventive health care (such as vaccination programs), poor nutrition and disruptions to maternal health programs can mean that children develop impairments during times of crisis that could otherwise have been prevented. Disruptions to schooling and other social support systems can mean that children with disabilities miss out on stimulation that is essential for their development.

The actual flight can also be fraught with dangers and difficulties for persons with disabilities. In some cases, families have to make agonizing decisions to leave behind less able family members who may not survive the flight. In Sierra Leone, for example, many children with disabilities were abandoned by their families when they fled the conflict.[5] Where communities have to escape immediately from a dangerous situation, those people with physical, mental or sensory impairments may be less able to flee, especially children and older people. At a residential home for persons with disabilities in Galle, Sri Lanka, for example, only 41 of the 102 residents managed to escape the building and survive the tsunami in December 2004.[6] Often, protection risks faced by displaced persons are greatest during flight, when they are the most vulnerable. People with disabilities may be more likely to face physical or sexual abuse and violence during flight because they are the least able to escape or defend themselves.

Unfortunately, the situation for persons with disabilities seldom improves greatly once they have crossed a border or reached a place of "safety." Sadako Ogata, former UN High Commissioner for Refugees, said "Disabled refugees face a double vulnerability—often the last to receive food, water and care…and, in many situations, viewed as a burden to be left behind."[7]

Among displaced populations, persons with disabilities are often the most hidden, marginalized, socially excluded and vulnerable. They can often be literally and programmatically "invisible" in refugee assistance programs. They are often not identified or counted in refugee registration and data collection exercises. They are excluded from or unable to access mainstream assistance programs through attitudinal, physical and social barriers. They are forgotten in the establishment of specialized and targeted services and ignored in the appointment of camp leadership and community management structures.[8] Disabled persons' potential to contribute and participate is seldom recognized: they are more often seen as a problem than a resource, and more often ignored than assisted.

Displaced persons with disabilities also face serious protection risks in camps and urban settings, including exploitation, physical and sexual abuse, harassment, ridicule, discrimination and neglect. Women, children and older persons with disabilities are often the most at risk. Displaced women with physical and mental disabilities

are triply marginalized by their status, disability and gender. They are more likely to be exposed to sexual exploitation and physical abuse. In general, women also tend to be the main caregivers for persons with disabilities in a community (as mothers, wives, grandmothers) and can face increased workloads, discrimination and abuse as a result of this role.

Children and youth with disabilities are also often subject to sexual and physical abuse, exploitation and neglect (including hiding children away, restricting them to the home and, in extreme circumstances, tying them up). They are often excluded from education and not provided with the support to help them develop to their full capacity.

Older persons with disabilities may find themselves abandoned by family members, whose resources are already depleted, so they can no longer care for dependent, older family members. They may face extreme isolation and vulnerability in displacement situations and may be unable to access the basic health care, food and shelter they need to survive. Loss of identity and status within their community and a sense of dislocation and isolation can put a huge strain on older persons with disabilities.

Where they existed, traditional community coping mechanisms, including extended families, neighbors and other caregivers, may have broken down either pre-flight, during flight or on arrival, and little attention is given to rebuilding them. Families may have been separated due to the conflict, or during flight, and neighbors who previously provided support find themselves settled in different locations. The loss of support mechanisms and previous caregivers can leave persons with disabilities even more exposed and vulnerable to protection risks.

While facing enormous challenges, the situation facing displaced persons with disabilities is not all negative. Conflicts and emergencies can often be catalysts for positive social, attitudinal and environmental change, and refugee or displacement camps can be conducive environments for introducing new approaches and improved services for persons with disabilities.[9] The research found examples of innovative and successful programs for refugees with disabilities, particularly in the areas of inclusive and special needs education, vocational and skills training, and prosthetics and physical rehabilitation, especially for land mine survivors. The Women's Commission encountered situations where refugees with disabilities and families of refugees with disabilities were highly organized and had formed their own self-help support groups. The Commission uncovered examples of creative disability awareness programs that had led to higher levels of awareness among the refugee community and relief agencies about the rights, needs and skills of persons with disabilities. The Commission also found NGOs that had positive employment policies, encouraging the employment of persons with disabilities.

In general, the Women's Commission found that many refugees with disabilities, depending on the severity of their impairment, had a large number of skills and talents to offer their community. Many people interviewed said that they wanted to be more involved in community affairs and decision-making, they wanted to contribute economically through finding employment and they wanted to attend school and gain valuable practical skills through vocational training. Given an accessible physical environment, heightened disability awareness, both within their community and the local host community, and an inclusive approach by agencies assisting them, displaced persons with disabilities can live independent lives, participate fully in public affairs and make positive contributions to their community.

Background

SCOPE AND OBJECTIVES OF PROJECT

While its primary focus is on improving conditions for refugee women, children and youth, the Women's Commission for Refugee Women and Children (Women's Commission) has, in recent years, begun to address the needs of other excluded and marginalized groups of refugees and displaced persons. Recognizing that refugees and internally displaced persons (IDPs) with disabilities are among some of the most excluded and marginalized of displaced persons in the world, the Women's Commission launched a project, co-funded by UNHCR, to address the rights and needs of displaced persons with disabilities in September 2007. The project addressed the needs of refugees and IDPs with both physical and mental disabilities, with a particular focus on the needs of women (including elderly women), youth and children.

The overall goals of the project were to enhance understanding of the challenges faced by refugees and displaced persons with disabilities, as well as their skills and potentials; to increase access to mainstream services for persons with disabilities, as well as to improve provision of specialized services; to promote greater inclusion and participation of persons with disabilities in community affairs, decision-making processes, project planning, implementation and management; and, finally, to ensure better protection for displaced persons with disabilities and to strengthen protection responses to the risks they face. The principal aim of the project was to produce a resource kit that would be of direct, practical use to UN and local and international NGO field staff working with displaced persons with mental, physical and sensory disabilities. The Resource Kit is available at www.womenscommission.org/special/disabilities.php.

The project sought to map existing services for displaced persons with disabilities in a range of countries and displacement situations, as well as identify examples of good practices and gaps. In addition to extensive desk research and liaison with relevant organizations engaged in this field, the project commissioned five field studies in select countries across different geographic regions and covering a broad range of displacement situations. (See Annex D, p. 50.) The field studies focused on conditions for displaced persons with disabilities in developing countries where, generally, there were fewer opportunities for refugees to be integrated into existing services than for persons with disabilities in industrialized countries. Due to a variety of reasons and constraints, the field studies focused exclusively on the situation facing refugees and asylum seekers with disabilities.[10] However, in reality both refugees and IDPs with disabilities face very similar challenges as a result of their displacement. The project therefore addresses the needs of *both* refugees and IDPs with disabilities in the Resource Kit.

The primary focus of the field studies was on services for persons with disabilities during refugee emergencies and protracted displacements rather than on disaster preparedness measures or post-conflict responses. While the field studies and Resource Kit address access to durable solutions for persons with disabilities, they do not deal in great detail with the actual implementation of return, reintegration and resettlement processes.[11]

DEFINITIONS, APPROACHES AND RESPONSES TO DISABILITY

Definitions

Disability. The UN Convention on the Rights of Persons with Disabilities (CRPD)[12] does not explicitly define the word "disability." Instead, the Convention treats disability as an evolving concept that can change over time and within and between different societies. Moreover, the Convention focuses on the negative social attitudes and physical barriers that prevent persons with disabilities from participating fully in society, rather than exclusively on individual impairments. The Preamble to the Convention recognizes that "disability is an evolving concept and that disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others."[13] Article 1 of the Convention states that persons with disabilities include "those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others."[14]

Adopting the "rights-based model" of disability promoted in the UN Convention, this project focuses on the physical, social, attitudinal and environmental barriers that prevent displaced persons with disabilities from participating in their society fully and on an equal basis with others in their community.

Impairment. An impairment is damage to an individual's physical, mental, intellectual or sensory condition. This project addresses the needs of displaced persons with a broad range of impairments. These include preexisting impairments resulting from childbirth, congenital diseases, infectious diseases, poor nutrition, poor maternal and child health care, accidental injuries, harmful traditional practices and trauma that occurred before displacement, as well as physical injuries and mental disabilities that result from the conflict, natural disaster or displacement itself.

For the purposes of this project, the Women's Commission interprets "mental disability" to mean people with long-term mental, intellectual and cognitive impairments that are congenital or arise from childbirth, illness, malnutrition or an accident or injury. In most cases, "mental disabilities" preceded the refugee emergency, unless they were acquired as a result of an injury or accident during the conflict or displacement. The Women's Commission distinguishes between people with "mental disabilities" and those with short- or long-term "mental illness," "mental disorders" or mental health problems.[15] There is, however, considerable confusion among organizations, service providers and data collectors regarding definitions of "mental disability" and "mental illness."

WHO International Classification of Functioning, Disabilities and Health. In May 2001, the 54th World Health Assembly endorsed the WHO's International Classification of Functioning, Disabilities and Health.[16] The aim of the classification is to provide a "unified and standard language and framework for the description of human functioning and disability as an important component of health."[17]

The new classification focuses both on how "body structures"[18] and "body functions"[19] impact on an individual's "activities"[20] and his/her "participation"[21] in society; and on how environmental and personal factors affect the lives of persons with disabilities. The five environmental factors that can limit activities or restrict participation are: products and technology; the natural environment and human-made changes to it; support and relationships; attitudes; and services, systems and policies.[22] The WHO classification has been accepted as one of the UN social classifications.[23]

A note of caution on definitions and data collection

The understanding of both "impairment" and "disability" can differ enormously among cultures and in different contexts. So, for example, a condition that may be considered a physical impairment or disability in some cultures may not be considered to have any impact on the abilities and activities of an individual in another society. Differences in definitions and conceptualizations of "impairments" and "disability," as well as differences in societal attitudes, can make it very difficult to arrive at a precise number of persons with disabilities within a community. Even where standardized definitions are used for the purpose of data collection, the way in which those definitions are interpreted can depend very much on the culture and society of the population.

Approaches to Disability

Not only do definitions and conceptions of disability differ among cultures and societies, but there are also differences in the way disability is approached by society, governments and service providers. Two main approaches to disability have emerged in recent years.

Medical/individual model. This is the more traditional approach to disability, which is still prevalent in many societies today and informs policies and services accordingly. This approach focuses on the individual and emphasizes the medical nature of the disability, which can be medically diagnosed and treated. The medical impairment is considered to be the primary cause of the disability and of the resulting exclusion or isolation that a disabled person experiences. Medical rehabilitation is seen as the most effective response, with the aim of treating or "correcting" the disability and enabling the individual to participate more fully in society. This approach requires specialized services and institutions, which are run by specialists (e.g., special schools or training centers), and often relies on expensive tools and equipment.[24]

Social model. This is a more recent approach to disability, now favored by many disability activists and organizations. It is also the approach the Women's Commission has taken in this study. The social model highlights the interaction between persons with impairments and their social environment. It is not so much the *impairment* that disables an individual, but the social, physical, environmental and attitudinal barriers that society erects that prevent his or her full and equal participation. Rehabilitation strategies are directed toward making the social environment more accessible for persons with disabilities, rather than solely toward medical rehabilitation of the individual. In other words, the perception is that the problem lies with the society, rather than with the individual. This model emphasizes the capacities of persons with disabilities and looks for strategies to make services, facilities, policies and practices more inclusive and accessible.[25]

Strategies and Responses

Rehabilitation. Rehabilitation is the process of removing—or reducing as far as possible—the factors that limit the activity and participation of a person with a disability, so that she/he can attain and maintain the highest possible level of independence and quality of life physically, psychologically, socially and economically. The aim of rehabilitation should be to provide an individual with equal opportunities for full and effective participation and inclusion in society, including opportunities to study, work and access services. To achieve full inclusion, many different interventions may be needed, including medical care, supply of assistive devices, therapy (physical and occupational), psychosocial services, social support, education (inclusive and special), job placement, support for economic self-reliance and eradication of physical, social and financial barriers.

Physical rehabilitation. Physical rehabilitation is an essential element in ensuring the full integration of persons with disabilities in society. The restoration of mobility is the first step toward enjoying such basic rights as access to food, shelter and education, getting a job and earning an income. Physical rehabilitation includes the provision of assistive devices such as prostheses, walking aids and wheelchairs, along with appropriate therapy. It also includes the maintenance, adjustment, repair and replacement of such devices.[26]

Community-based rehabilitation. Community-based rehabilitation (CBR) was developed by WHO in the 1970s as a community-based approach to provide rehabilitation, equal opportunities and social inclusion for all persons with disabilities within their own community.[27] CBR adopts a multilayered approach from the national to the community levels or vice versa. At the national level, a ministry is generally designated with the responsibility for coordinating CBR within the country and providing an organizational framework (usually

the social welfare, health or education ministry). At the district level, CBR managers, or district committees, are responsible for overall implementation, training and supervision of the CBR program. At the community level, CBR activities are implemented through a CBR committee consisting of different community representatives (such as teachers, health workers, community leaders, persons with disabilities and their families). They carry out house-to-house visits, provide information to persons with disabilities and their families and give help and advice in carrying out simple tasks of daily living. They also act as advocates for persons with disabilities with the local community to promote their accessibility and inclusion.[28]

CBR has evolved to become a multisectoral community development strategy. A joint International Labor Organization (ILO), United Nations Educational, Scientific and Cultural Organization (UNESCO) and WHO position paper published in 2004 described CBR as a strategy for rehabilitation, equalization of opportunity, poverty reduction and social inclusion of persons with disabilities.[29] As practiced today in more than 90 countries, CBR is a multisectoral approach implemented through the combined efforts of persons with disabilities themselves, their families, organizations and communities, and the relevant governmental and nongovernmental organizations working in the development sector. Involvement and participation of persons with disabilities is at the heart of CBR.

Inclusion. Rather than organizing "special" or segregated activities for persons with disabilities, inclusive policies promote the incorporation and equal participation of persons with disabilities in all mainstream activities. Promoting inclusion involves the removal of all physical, institutional, social, attitudinal and environmental barriers that prevent the full and equal inclusion of persons with disabilities in the activities enjoyed by other members of the society.[30]

Inclusive education. Inclusive education promotes the inclusion of *all* children in schools and learning environments, regardless of their particular needs or vulnerabilities. Inclusive education is now a well-established concept that has been endorsed by various international fora and educational policy frameworks. It is a policy that applies to *all* disadvantaged, marginalized and excluded children, not just children with disabilities.

As a follow-up to the 1990 World Conference on Education for All, governments, international organizations, NGOs and education specialists met in Salamanca, Spain in June 1994 to discuss special needs education and the concept of inclusive education. The conference adopted a Statement and Framework for Action that asserted that "schools should accommodate all children regardless of their physical, intellectual, social, emotional, linguistic or other conditions." Among the groups of children that should be included in schools were disabled children, street children, children from nomadic populations, children from linguistic, ethnic or cultural minorities and children from other disadvantaged or marginalized areas or groups.[31]

Inclusive education means actively identifying children who are not attending school because of their particular circumstances, marginalization or disadvantaged status and adapting learning environments to meet their needs and circumstances. It can be applied at all educational levels, from early childhood education to primary and secondary education, vocational training and adult education. Wherever possible, it means promoting the inclusion of children with disabilities in mainstream schools, rather than providing segregated or "special" education for children with special needs. It is argued that inclusive education not only improves educational opportunities for disadvantaged and marginalized children, it also helps combat discrimination and prejudice and improves the standard of teaching for *all* children as it results in improvements to the school environment and a teaching methodology and curriculum that are flexible and child centered.[32]

Early childhood intervention. This is a support system for children with disabilities and their families. The focus of early childhood intervention is on early diagnosis and identification of children with disabilities and learning difficulties and working with the child and their family from the earliest possible stage until they start school. It involves providing support, information and simple training to families to help them foster their child's development in areas such as communication, hygiene and mobility and helping children to be as independent and confident as possible.[33]

Universal design. Universal design means that all infrastructure and facilities should be designed to be usable by all people, to the greatest extent possible, without the need for adaptation or specialized design.[34]

Reasonable accommodation. Reasonable accommodation means making any necessary and appropriate modifications and adjustments to the physical environment and infrastructure to ensure that persons with disabilities can live independently and participate fully in all aspects of life.[35]

PART 2: MAIN FINDINGS

"The most important thing in an emergency is DIGNITY*. We have to treat persons with disabilities with dignity and respect their right to live in their own community with dignity."*[36]

The main findings from the field studies and accompanying global desk research are given below. Case studies are used to illustrate the findings. Most of the information comes from the five field studies, with additional information gathered from various disability programs elsewhere.

The Differences between Refugee Camps and Urban Settings

The field studies highlighted the differences between the situation faced by refugees with disabilities living in camps and settlements and those in urban areas.

REFUGEE CAMPS

"One thing that struck me when I looked back on the programs implemented…is that the 'glass house' nature of refugee programs, where people remain a captive audience and available on sight to take on board whatever is new and latest, affects developments. Attitudinal change—fundamental to developing inclusive education—appeared to be huge even in the short time we were there, but whether or not that has continued or has been sustained at any level would need to be examined."[37]

In general, there are better services and greater awareness about the needs of refugees with disabilities in refugee camps than in urban areas. Refugee camps are generally more geographically discrete, with a more physically cohesive community. It is easier to identify refugees with disabilities through standard registration and census operations in camps than it is in urban areas. The presence of a range of humanitarian agencies with technical expertise in a variety of areas (e.g., education/health/community services/vocational training) makes it easier to set up specialized programs for persons with disabilities.

Moreover, the "ready-made" community in a refugee camp makes it easier to effect both attitudinal and programmatic change. Refugees often have a surplus of time, especially in longer-term refugee situations. This makes them a "captive audience" for new ideas, attitudes and approaches. Refugees also often have a surplus of untapped capacity and skills. The research found that there is great potential for positive action and change in refugee camps if such time, skills and capacities are effectively employed.

URBAN SETTINGS

In contrast to refugee camps, urban refugee communities tend to be more dispersed and less physically cohesive. This makes it much harder to identify and register refugees in general, and refugees with disabilities in particular. Urban refugees are often undocumented and lack any legal status as refugees or asylum seekers. Their irregular status may mean that they do not wish to be identified and prefer to remain "hidden" from the authorities. Given their already low profile and the fact that many are confined to their homes due to lack of mobility and social attitudes, refugees with disabilities are even more likely to be "hidden" from public view and are even less likely to be identified, registered or integrated into mainstream or specialized services.

CASE STUDY Out of sight, out of mind: Iraqi refugees in Jordan

Iraqi refugees in Jordan are so frightened of deportation that they intentionally keep a low profile. They do not register with UNHCR, seek refugee status or try to access assistance from any of the humanitarian organizations in order to keep their location and background a secret. Many refugees do not exist on any official records. This made research into the living conditions for refugees with disabilities very difficult. In addition, refugees are dispersed throughout the urban areas, making it very difficult to locate them, and even when located, many are too afraid to speak to strangers. This situation is exacerbated for refugees with disabilities who, due to physical barriers and lack of mobility, discrimination, negative social attitudes and fear, are largely confined to their houses and rarely go out. They are among the most "invisible" and marginalized of all the refugees.

CASE STUDY Keeping a low profile: Colombian refugees in Ecuador

In Ecuador, many Colombians refugees do not register with UNHCR or officially apply for asylum, as they fear making themselves known to the armed groups operating in the border area between Ecuador and Colombia. Instead, they maintain a low profile and integrate into the local communities alongside economic migrants from Colombia.[38] UNHCR and the Government of Ecuador estimate that as many as 200,000 Colombians who have fled the violence in Colombia may be living throughout Ecuador. Most of these people are "invisible" to the authorities; they are undocumented, living without any legal status or protection and unable to access any of their basic rights as refugees.[39]

Urban refugees in general may be excluded from public services due to their lack of legal status, government restrictions, discrimination and lack of access to information. These difficulties are multiplied for urban refugees with disabilities, who also face physical, social and attitudinal barriers because of their disabilities. Difficulties in information dissemination in urban areas and the invisibility of refugees with disabilities means that urban refugees with disabilities often have no information about national services or facilities for persons with disabilities available locally, or about their rights both as refugees and as disabled persons in the country of asylum.

In general, it is harder for humanitarian agencies to implement refugee assistance programs in urban areas not only due to the dispersed and hidden nature of the community, but also because of government restrictions. With urgent needs in the community at large, restricted access and limited resources, the needs of refugees with disabilities are often neglected by humanitarian organizations in urban refugee programs, and there are few targeted programs for urban refugees with disabilities.

Many indigenous people in Colombia fall victims to land mines while trying to flee their homes in search of safety. (UNHCR/X. Creach)

Types of Disability

In general the study found that less information and fewer services were available for people with mental disabilities than those with physical and sensory disabilities. Refugees with mental disabilities tended to be even more "invisible" and "hidden" from public view than those with physical disabilities. There was often greater discrimination and stigmatization of people with mental disabilities, and family shame often led to the mentally disabled being hidden away, physically restrained and frequently neglected. Refugees with mental disabilities were less likely to be identified in registration and data collection exercises; they tended to be more excluded from both mainstream and targeted assistance programs, and they were less likely to be included in decision-making processes or in leadership and program management structures.

The majority of assistance programs in refugee settings tended to focus on people with physical and sensory disabilities. There was a lot more focus on physical rehabilitation programs, especially for land mine survivors. This focus included prosthetics clinics, provision of mobility devices and orthopedic and physical therapy, and special needs education for children with hearing and sight impairments. Far fewer organizations provided targeted services for refugees with mental disabilities and there were fewer attempts to integrate refugees with mental disabilities into mainstream programs, such as education, vocational training, income generation activities.

CASE STUDY The stigma of mental disabilities: Somali refugees in Kenya

UNHCR community services staff in Dadaab, Kenya acknowledged that despite the successful disability programs in the refugee camps, services for refugees with mental disabilities and mental health problems were severely lacking. In particular, there was only one technical adviser on mental disabilities and mental health for all three refugee camps. People with mental disabilities tended to be much more discriminated against and stigmatized within the predominantly Somali community in the camps than people with physical or sensory disabilities. Mothers of children with mental disabilities were often blamed for their child's disability and there was a common phenomenon of fathers abandoning mothers who gave birth to mentally disabled children, often taking the other children with him. Neighbors and extended family members also tended to ostracize families with mentally disabled members, leaving them isolated and alone. As a result, children and adults with mental disabilities tended to be hidden away and completely excluded from

A girl who was disabled by the war in Sierra Leone meets with the Women's Commission. (Jocelyn Cunningham)

community affairs and activities. Often mothers abandoned by their husbands and families and left alone with children with mental disabilities felt that they had no choice but to tie up their children if they wanted to leave their house for any reason. Although children with mental disabilities were able to attend school, they were much more likely to be ignored and neglected and not receive the support and assistance they needed. The priority, according to UNHCR, was to address negative attitudes toward people with mental disabilities through community awareness raising and public information programs.[40]

A notable exception to this trend is the Bhutanese refugee camps in Nepal, where a special program exists to provide mentally challenged young people with vocational skills training and income generation opportunities.

CASE STUDY Education for Bhutanese children and youth with mental disabilities

Children and youth with mental disabilities in the Bhutanese refugee camps in Nepal are encouraged to participate in mainstream education for as long as they are able (testing is provided). Occupational therapy is offered to children and youth with mental disabilities as an alternative to, or once they leave, mainstream schooling. This includes skills training in bamboo craft work, embroidery, painting, photo framing, musical therapy and making jute mats. In addition, young people are assisted with basic life skills and daily living tasks and young girls are helped with personal hygiene and other similar tasks. Training programs are tailored to suit the individual needs of each person and the aim is to enable mentally disabled young people to live as independently and with as much dignity as possible. Peer participation in the training programs by students in the mainstream schools is encouraged. Parents are also encouraged to participate in the training program to assist their children where necessary and to form their own support groups.

Meeting the needs of people with mental disabilities is often a low priority and is frequently overlooked in the midst of a major emergency. In Sri Lanka, however, a local NGO, MENCAFEP (Mentally Handicapped Children and Families Education Project), used the opportunity of increased funding and international attention following the 2004 Indian Ocean tsunami to expand its ongoing projects for children with mental disabilities and their families and include children affected by the tsunami.[41]

CASE STUDY Integrating children with mental disabilities into communities in post-tsunami Sri Lanka

MENCAFEP had been working in Sri Lanka for nearly 20 years at the time of the Indian Ocean tsunami, providing a wide range of community-based services for profoundly mentally disabled children and their families in the tea estates around Nuwara Eliya, in Sri Lanka's Hill Country. Two days after the tsunami on December 26, 2004, a team from MENCAFEP visited Batticaloa District on the

eastern coast of Sri Lanka to assess the tsunami damage and its impact on children with disabilities. According to MENCAFEP, not only had a lot of disabled children lost their lives in the tsunami, but many disabled units and centers attached to schools and pre-schools were also destroyed. MENCAFEP set about replicating its programs in the tsunami-affected areas in Batticaloa District. These services included a day care center and respite care center; an inclusive pre-school; a specialist disability center for profoundly disabled children; an education unit providing formal education and practical skills; a sheltered vocational training workshop and skills training in daily tasks for profoundly mentally disabled children and young people; physiotherapy and the provision of special aids (including special seats for severely disabled children). Through community outreach and home visits, MENCAFEP workers helped set up satellite centers in remote rural communities with local CBOs. The district hospital in Batticaloa also set up a special disability clinic with pediatricians and a psychiatrist for children with disabilities.

MENCAFEP's philosophy is to avoid the institutionalization of children with disabilities, which is very common in Sri Lanka. By providing support to families, they strive to enable children with disabilities to continue to live with their families. According to interviews with MENCAFEP, one of the major challenges faced in Batticaloa was negative attitudes and stigmatization of people with mental disabilities. Whereas MENCAFEP's long-established programs in the Hill Country had helped change attitudes toward children with mental disabilities, there was still a lot of superstition surrounding mental disabilities in Batticaloa, which it would take time to overcome. According to MENCAFEP, in Sri Lankan culture families of disabled children, especially the mother and the child, are seen to have done something wrong in a previous life that caused the disability. In some cases families of disabled children can be ostracized from their communities. MENCAFEP tried to change attitudes by integrating children with mental disabilities into existing community activities and providing disability training and awareness raising for local CBOs and community groups.

The destruction caused by the tsunami, plus 20 years of civil war that had ravaged Batticaloa District, had taken its toll on the community. Poverty levels were extremely high and social welfare indices very low. But paradoxically, the tsunami gave MENCAFEP the opportunity to expand its activities to include children with mental disabilities in Batticaloa District and to offer them new possibilities that they had previously been denied. It also provided an opportunity to challenge deeply held prejudices and stigmas about children with mental disabilities.[42]

Identification and Data Collection

Identifying and collecting data on the number of persons with disabilities and the types and causes of disability has proven to be one of the biggest challenges in refugee situations. In order to provide targeted services for refugees with disabilities and to adapt mainstream programs to ensure greater inclusion, systems must first be in place to identify persons with disabilities. In general, the greater the awareness and understanding of the needs and rights of persons with disabilities, the better the systems for identification and assessment, and the more accurate and comprehensive the data.

Methods of identification, registration and data collection vary from country to country. Refugee registration is usually the responsibility of the host government and/or UNHCR, although in some countries NGOs are also responsible for refugee data collection. Identification and data collection can take place through a variety of methods, including formal census operations, one-off or ongoing refugee registration exercises, participatory assessments,[43] community mapping and targeted surveys.

Identification of refugees with disabilities often takes place more informally. Information is shared among community outreach workers (such as traditional birth attendants, health workers, special needs support teachers, youth workers, social workers and camp management staff) and between different organizations and services (e.g., schools, health clinics, etc.). Refugee networks (e.g., camp committees, groups for women, the elderly, young people, parents, etc.) can also be a useful way to collect information about refugees with disabilities.

Numerous problems in data collection were encountered in the course of the field research. The first problem was that data collection staff often lacked the technical expertise and knowledge to identify and categorize different types of disabilities. This made it difficult to both detect and distinguish between different kinds of disabilities, which could lead to inconsistencies and inaccuracies in data. It was important, therefore, that data collection staff worked alongside trained disability workers, in order to accurately identify and record the number and profile of persons with disabilities within a refugee population.

Second, there was a lack of consistency in the way in which data was collected. The ideal is where data collection is centralized and is the responsibility of either the government or UNHCR, using a standardized methodology and definitions. However, there were many variants of this model. In some countries, there was no centralized system for refugee data collection at all, and thus no systems for the identification or registration of refugees with

disabilities. This was especially the case in urban refugee situations, where the refugee population was dispersed, and often hidden, as in Jordan and Ecuador, for example.

In other countries, there was a centralized system for data collection, but a lack of disability awareness meant that the system failed to include information on refugees with disabilities. This was the case in Yemen, where UNHCR has a comprehensive system for refugee registration, but does not collect information on refugees with disabilities or other special needs.

A third scenario was where the centralized data collection system was weak, and NGOs substituted with their own data collection. However, the drawback of this approach is that NGOs may only collect partial data on their own specific programs, rather than data on the entire refugee population. This was the case in Ecuador, for example, where NGOs keep data on their own programs, but there is a lack of comprehensive data about the entire refugee population.

A fourth scenario was where both UNHCR (or the government) and NGOs had their own comprehensive data collection systems, but the data was not consistent. This was the case in Nepal and Thailand, for example, where the data collected by the NGOs (Caritas Nepal and COERR, respectively) was not consistent with UNHCR's data. This may be due to the use of different data collection methodologies, different definitions and terminology or the involvement of staff with different skills and expertise in data collection.

In Nepal for example, Caritas excludes "mental illness" in its definition of "mental disability" and does not include individuals with mental health problems in its disability data. UNHCR, on the other hand, used the ProGres database categories for its 2007 census in the Bhutanese refugee camps, which includes "mental illness" in its definition of "mental disability." Given the high levels of mental health problems in the Bhutanese refugee camps, the inclusion of "mental illness" in UNHCR's definition of disability may help explain the significant discrepancy in overall disability numbers between Caritas and UNHCR (see also Nepal Country Profile, page 50).

In some countries, UNHCR, the government and partner organizations have coordinated effectively to gather data on the number and profile of refugees with disabilities in the camps. A comprehensive data collection exercise was carried out in the Dadaab refugee camps in September 2007, for example, providing very detailed information on the numbers and types of disabilities in the camps and on the immediate needs of people living with disabilities.[44]

A disabled Iraqi man entering a vocational training center funded by UNHCR in Damascus, Syria. (UNHCR/L. Boldrini)

Assessments

Once refugees with disabilities have been identified, it may be necessary to conduct more in-depth, community-based and individual assessments in order to ascertain their specific assistance and protection needs and refer them to appropriate services. The field research found that the quality and focus of assessments differed enormously. In some countries, there was no evidence of any kind of systematic assessments of persons with disabilities (in Ecuador and Yemen, for example). In other countries, there were partial assessments of refugees' medical, educational, physical or training needs. In none of the countries surveyed did refugees with disabilities receive individual, comprehensive assessments of all their physical, medical, psychological, educational, training and livelihood needs. This was an area in which UNHCR, in particular, was very weak.

CASE STUDY "Independent Living Plans" help refugees with disabilities live more independently

In Jordan, once Mercy Corps social workers had identified Iraqi refugees with disabilities living in Amman (through a variety of information sharing and referral networks), they conducted house

visits to help the refugees prepare "Independent Living Plans." The aim of these plans was to identify ways in which refugees with disabilities could become more self-sufficient and live more independently. Options included modifications to make houses more accessible (such as widening doors, installing ramps, etc.), provision of mobility or other assistive devices (such as wheelchairs, hearing aids, etc.) or providing durable medical equipment.

In Nepal, on the other hand, the disability program focused on medical assessments and certification for persons with disabilities. All persons with disabilities identified through the Caritas program were given the opportunity to attend a nearby hospital where they could be medically assessed and receive a medical certificate of disability, based on WHO standards (categories of disability). This has proven especially useful for refugees wishing to acquire mobility or other assistive devices, such as hearing aids, from the local hospitals.

In other cases, assessments were specifically geared to the type of program being offered. So, for example, in Thailand and Nepal, the educational skills and needs of children with disabilities were assessed in order to integrate them into mainstream schools, give them more specialized learning environments or provide them with vocational skills training.

Participatory assessments are an effective way of collecting comprehensive information about the needs, protection risks, capacities and resources of persons with disabilities and involving them in planning and decision-making processes using participatory and community-based approaches.

CASE STUDY Participatory assessment identifies key needs in Kenya

In Dadaab refugee camps in Kenya, UNHCR focused its 2007 participatory assessment on three thematic issues—education, sexual and gender-based violence, and people living with disabilities. A multifunctional team, consisting of representatives from UNHCR, other UN agencies, NGOs and the local community, held focus group discussions with refugees in the camps and the local population in Dadaab town to solicit their views. Focus group discussions were held with groups of people living with disabilities, as well as community and religious leaders, teachers, men, women, youth and children, and the elderly. The participatory assessment identified some of the key needs for people living with disabilities in the camps, such as the need for better medical services and more assistive and mobility devices, and the need for more specialist staff. It also identified the high levels of stigmatization and discrimination toward persons with disabilities and the lack of comprehensive data on the numbers and profile of persons with disabilities.[45]

Camp Layout/Infrastructure

Almost all the refugee situations surveyed identified problems with the physical layout and infrastructure of the refugee camps or settlements, and lack of physical access for persons with disabilities. In refugee camps, refugees with disabilities noted the physical inaccessibility of shelters, food distribution points, water points, latrines and bathing areas, schools, health centers, camp offices and

Refugees from Myanmar (Burma) at Umpien Refugee Camp, Thailand. (UNHCR/R. Arnold)

other community facilities. Buildings were either poorly designed for persons with disabilities and difficult to maneuver around or they were located far away from the homes of persons with disabilities or in locations that were physically inaccessible (e.g., on rough or raised ground). Difficulties with physical access affected all aspects of disabled refugees' daily lives, especially those with physical and visual impairments. Unable to leave their homes, or move around easily, refugees with disabilities faced greater levels of isolation than before their displacement.

Even in refugee situations where there were high levels of awareness of disability rights and well-established disability programs and services, the design and layout of the camps and the physical inaccessibility of many services were major impediments. In Nepal and Thailand, for example, where there are well-developed inclusive education and special needs education facilities, refugees repeatedly cited difficulties with physical access to schools, the poor design of school compounds, classrooms and latrines and the inaccessible location of school buildings as a problem for children with disabilities.

CASE STUDY Terrain and infrastructure limit access to services

In a recent study on inclusive education in six of the Karen refugee camps in Thailand, ZOA concluded that "the infrastructure of school compounds and buildings is not fully equipped to cater to the physical and learning needs of students with special education needs."[46] According to World Education, the camps are roughly laid out, often on mountains, with few services roads. Physical access to the classrooms is difficult for children with disabilities.[47] JRS, which provides special needs education in the Karenni refugee sites, writes that "The camps are quite basic, set in steep hills with no paved roads. The terrain is unsuitable for wheelchairs, so people with physical disabilities that prevent them from walking are often unable to leave home at all once they are too heavy to be carried by a parent/carer. These people suffer from isolation a lot. Of course, they also have difficulties accessing education, health and other services in the camps."[48]

A positive example of adapting the physical environment to make it more accessible for refugees with disabilities can be found in the refugee camps in Dadaab, Kenya.

CASE STUDY Adaptations improve lives

According to information from UNHCR, Dadaab is located in a river delta with very sandy ground. This makes it especially difficult for refugees with physical disabilities and those reliant on wheelchairs to move around the camps. In response to this challenge,

Disabled Iraqi veteran of the Iran/Iraq war in Amman, Jordan. (UNHCR/P. Sands)

wheelchairs with specially designed wheels have been created for use in Dadaab. Moreover, Handicap International—which took over responsibility from Care International for the disability CBR program in the refugee camps at the beginning of 2008—has also introduced disability mainstreaming in all construction projects in the camps. This involves sensitizing site planners and construction engineers to disability issues and ensuring that the construction of all community buildings is accessible and appropriate for persons with disabilities.[49]

Problems of physical accessibility are often worse for refugees living in urban areas. Unlike in refugee camps, where in theory it is possible for site planners to take into account the needs of disabled refugees when planning camp layout and infrastructure and make changes to accommodate their needs, such changes are not possible in urban areas, unless urban infrastructure for the population in general is made more accessible. Urban refugees usually have little choice when looking for housing and must take whatever they can find. For disabled refugees, housing may often be inaccessible (e.g., on high floors without elevators), cramped and difficult to maneuver about in with a wheelchair or physical disability. The few services that are available to refugees with disabilities may be located far from people's homes and

they may not have access to transport to reach them. This can result in disabled urban refugees living extremely isolated lives.

In Jordan, for example, Mercy Corps and researchers from the Landmines Survivors Network found that many Iraqi refugees with disabilities rarely left their homes. This was one of the reasons why Mercy Corps helped set up peer empowerment support groups for refugees with disabilities—to enable them to break their isolation by providing a space for people to meet, socialize and share experiences.

Food and Nutrition and Nonfood Items

Nearly all the field studies reported that refugees with disabilities did not receive additional or special food rations, nor were they prioritized in food distribution systems. In all the refugee camps, participants in the field studies pointed out that the food distribution systems were not suited to refugees with disabilities, especially those with physical and visual impairments. Food distribution points were frequently far from refugees' homes and they had to line up for long periods, or try to push their way through large crowds, to receive their food—which was difficult for many.

In Yemen, refugees said that people with visual impairments often lost some of their food ration as it was stolen by other (sighted) refugees. Refugees in Thailand and Yemen said that they thought persons with disabilities should be given priority in food distribution systems and should be given extra rations. In Nepal and Yemen, mothers of children with cerebral palsy pointed out the need for specially formulated food for their children, and mothers in Yemen said they needed milk for children with cerebral palsy and cleft palates.

There were some examples of refugees with disabilities receiving supplementary food. Until budget cuts, the Karen Women's Organization had been providing extra rations for disabled children either through the schools or through home visits by special education teachers in some of the refugee camps in Thailand. Some food aid is provided to extremely vulnerable urban refugees, including persons with disabilities, in Ecuador and Jordan through the humanitarian agencies.

Depending upon the severity of their impairment, most persons with disabilities were reliant on mothers, or other family members, to prepare their food. In Jordan, for example, 75 percent of refugees with disabilities interviewed for the field study said that they were unable to prepare food on their own.

A positive example of taking the needs of persons with disabilities into account in food and nonfood distribution systems can be found in Dadaab, Kenya, where UNHCR reached an agreement with WFP that

Disabled Angolan refugee in Nangweshi Camp, Zambia. (UNHCR/L. Taylor)

persons with disabilities will be given priority during food distributions. People with disabilities are served first during food distributions so they do not have to wait in long lines and members of the community have been mobilized to help persons with disabilities collect their food rations and transport them to their homes. People with disabilities do not, however, receive any special rations.[50]

Another positive example can be found in Nepal, where UNHCR distributed vitamin-enriched milk to children in the camp disability centers for nine months in 2007 and 2008. The signs of recovery and motor and sensory improvements among disabled children and youth were overwhelmingly positive and visible within a few months. Based on this experience, UNHCR decided to continue this practice in 2008.[51]

Lack of access to food and insufficient or inappropriate food can be particularly acute for older persons with disabilities. In assessments carried out among older people living in the IDP camps in Western Darfur, HelpAge International (HelpAge) identified nutrition and health as two of the most serious problems faced by older persons. Many older people lacked ration cards and did not know how to obtain one. They faced problems in accessing food because of restricted mobility and being unable to line up for long periods or

push their way through large and sometimes aggressive crowds. In a rapid nutrition survey carried out in May 2006, nearly 40 percent of older people were shown to be at risk of malnutrition due to clinical and social factors. HelpAge took several simple and immediate steps to ameliorate the situation.[52]

CASE STUDY Social center helps end isolation of older people in Darfur

In response to its assessment surveys, which highlighted that over 20 percent of older people in five IDP camps in West Darfur were not accessing WFP rations, HelpAge and WFP started to distribute supplementary food baskets to older people at risk of malnutrition. A "social nutrition center" was also piloted in Krinding IDP camp on the edge of El Geneina town. Older people were selected on the basis of both nutritional needs and social isolation and transported to the center three times a week to share a freshly cooked meal. While in the long run it was not feasible to continue to provide hot meals, the local community was keen to maintain the center as a social place where older people could meet. The center was therefore converted into a community-run tea canteen serving hot tea and high nutrition snacks. Not only did these steps improve the nutritional status of older people in the IDP camps, but the "social nutrition center" also helped give older people a greater sense of community and belonging, improve their mental and physical well-being, and break their isolation.[53]

In most of the countries surveyed, refugees reported that nonfood distribution systems were not accessible for persons with disabilities, especially those with physical and visual impairments. Distribution points were far from people's homes, they had to line up for long periods, or struggle through large crowds, and they were not given priority. In most countries, refugees said that they did not receive any additional or special nonfood items because of their disability (e.g., extra soap, clothes, cooking utensils, blankets, etc.), although refugees with disabilities did receive assistive devices and mobility aids in some countries. There were some exceptions. In Nepal, refugees said that they were sometimes prioritized in nonfood-item distributions, but this was usually when disability workers were involved in the distribution. In Dadaab, refugees with disabilities were often prioritized during nonfood-item distributions and received extra items such as clothing, kitchen and hygiene sets.

Health Services

Another problem cited in all the field surveys was the lack of specialized health care for refugees with disabilities. Health services in refugee camps did not cater to the specific needs of refugees with disabilities. There were no specialized doctors, no specialist therapy and a lack of specialized medicines and treatments for persons with disabilities (although it should be noted that such services may also not have been available in refugees' communities of origin).[54] Moreover, there were generally no referrals to specialist services outside the camps. Nearly all the field studies cited a lack of sufficient mental health services and specialist medical services for people with mental disabilities. Some field studies cited the lack of specialized hearing and/or eye clinics. Several studies mentioned communication difficulties for refugees with hearing problems, as the doctors and medical staff did not understand sign language (although this was probably also the case in refugees' communities of origin).[55] Nearly all the refugees surveyed said that health clinics were often physically inaccessible for persons with disabilities (far from their homes, on rough or raised ground). Mothers with disabled children often had to wait for a long time, with nowhere to sit down, before being able to see a doctor. Adults and children with disabilities were not given priority treatment. A positive finding in all the situations surveyed for the report was that women had access to reproductive health care.

CASE STUDY No special health services for persons with disabilities in Yemen camp

In Yemen, refugees at Kharaz camp have access to primary health care services in the camp, including primary health clinics, a mother and child health program, a program for TB and HIV/AIDS and, where necessary, referrals to local hospitals. But the field study found that persons with disabilities were not treated as a group with special needs and did not receive any specialized treatment in the camps. They had to line up with all the other refugees from 5:00 a.m. to register to see the doctor, and they were not given priority on waiting lists for referrals. Refugees with disabilities said that they could not obtain necessary medicines in the camps or referrals for treatment and operations outside the camp. They were not provided with assistive devices and there were no hearing or eye clinics in the camps. According to refugees interviewed, a high number of children in the camps had eye problems, due in part to the harsh climate, but they were not receiving any treatment and their conditions were deteriorating. The field study found that mental health services were not available in the camp and there were very limited referrals to specialized mental health services outside the camp. Treatment for people with epilepsy and mental illnesses was not always regular and was often interrupted. Although refugee women with disabilities benefited from the reproductive health services available in the camp, there were no special health programs for women with disabilities.

The situation is no better for refugees in urban areas. Of the Iraqi refugees with disabilities interviewed in Jordan, 41 percent said that health services were not at all accessible to them; only 23 percent said that they had access to treatment or health care specific to their disability. Those refugees who were able to visit private doctors or access free services at the Red Crescent Hospital and the Italian Hospital in Amman said that it was often difficult to see a doctor, there was a lack of specialists with knowledge of their particular condition, free clinics were often out of the medicines they needed and they could not afford medical equipment, such as hearing aids, wheelchairs or physiotherapy equipment.

In other countries, targeted health services and specialist support were available for the local population, but refugees with disabilities had difficulty accessing these services. This was due to a combination of lack of information, administrative barriers, discrimination and isolation.

CASE STUDY Refugees lack access to services in Ecuador

In Ecuador, the National Disability Council, CONADIS, in collaboration with implementing agencies, provides a variety of services to assist disabled Ecuadorians with access to specialized health care. These services include providing financial support to low-income persons with disabilities to help them acquire assistive medical devices or equipment, such as wheelchairs, hearing aids and equipment to help them live more independent lives at home and in the workplace. CONADIS also subsidizes medicines for people whose disabilities are a result of injuries to their spinal cords, psychiatric disorders and epilepsy, such as anti-convulsion and neurological medicines, and personal hygiene items. In order to qualify for this assistance, disabled people must have national identity cards or birth certificates and national disability identification cards; they must also have a doctor's certificate and evidence that they are not benefiting from other assistance or private insurance programs. As there is no reliable information about the number of refugees in Ecuador who possess a national disability card, there is also limited information about the number of refugees benefiting from these targeted services. Only one case of a refugee being able to access the CONADIS assistance program was found during the course of the field research.

Several field studies cited the lack of mobility and other assistive devices available to refugees through the health services (e.g., wheelchairs; crutches; prosthetics; hearing aids; eyeglasses) and the lack of rehabilitation for refugees with physical disabilities. In Dadaab, Kenya, for example, UNHCR reported that there was only sufficient budget to provide 50 wheelchairs for refugees in all three camps, which was not nearly enough to meet the need. Hearing aids are not provided at all in Dadaab and there is no prosthetics clinic in the camps, although some refugees with disabilities are referred to the rehabilitation ward at nearby Garissa Hospital and some children are referred to Bethany Kids International Hospital in Kijabe.[56]

In other countries, physical rehabilitation was the strongest component of the health care program for persons with disabilities.

CASE STUDY Successful prosthetics initiatives in Thailand benefit refugees

In the Thai/Burmese border camps, well-established medical, prosthetics and physical rehabilitation programs provide essential services to the large number of land mine survivors among the refugee population. According to the 2007 Landmine Monitor Report, at least 1,747 Burmese (refugees and migrants) with disabilities received services during 2006, including 286 land mine survivors.[57] Prosthetics clinics and rehabilitation services are provided by Handicap International and the Mae Tao Clinic. Handicap International has four prosthetics workshops in the camps and provides assistive mobility devices, prostheses and physical rehabilitation to refugees (mainly land mine victims and amputees). In 2005, Handicap International assisted 3,507 Burmese refugees through its rehabilitation activities.[58] The Mae Tao Clinic was set up in Mae Sot in 1989 by Dr. Cynthia Maung and provides free health care to Burmese refugees and migrant workers.[59] In 2001, the Mae Tao Clinic set up a prosthetics department to provide free surgical and postoperative care, prosthetics and rehabilitation to the large number of land mine survivors among the refugee population. The department, which is directed by a Burmese amputee, also runs a one-year training program for refugees to learn to make prostheses. In 2006, 174 people were provided with prostheses by the department (146 of whom were land mine survivors).[60] A new mobile prosthetic service was launched in mid-2005 through a joint venture between the Mae Tao Clinic and the Karen Handicap Welfare Association.[61] Both Handicap International's and the Mae Tao Clinic's programs were considered to be very successful by participants in the field study.

Another successful component of some health care programs has been the emphasis on community outreach, where disability workers visit refugees in their homes on a regular basis to provide physiotherapy, counseling, respite care and assistive devices.

CASE STUDY A model project: Regular visits by disability workers in Nepal

A very successful component of Caritas Nepal's disability program has been its community outreach work, funded by UNHCR. Disability

workers visit the homes of children with disabilities on a daily basis to provide physiotherapy, counseling and occupational therapy. The disability workers assess the physical needs of the children and provide cost-effective aids and appliances, such as special chairs, parallel bars and crutches. They provide materials to maintain the personal hygiene of children with mental disabilities and help teach children and their families about daily living skills.

In 2007, regular home visits were made to 116 refugees with disabilities in the camps.[62] In addition, community workers provide respite care for children with cerebral palsy in the camps for a fixed period of time to give their mothers, or other caregivers, a much-needed break. 54 children with spastic cerebral palsy were benefiting from this program in 2007 and it was considered one of the model programs in the refugee camps.

Older persons with disabilities can face particular challenges accessing health care in refugee and IDP camps. In particular, the focus on emergency health and primary health care can ignore the needs of older people and persons with disabilities who have chronic health problems. In rapid assessments carried out in six IDP camps in West Darfur in late 2005, during which more than 4,000 individuals aged 55 and over were interviewed, HelpAge identified health and nutrition as two of the most important needs facing older people.[63]

CASE STUDY Assisting older refugees in Darfur

HelpAge assessments repeatedly showed that the majority of older people were not accessing health services in the IDP camps in Darfur, despite the presence of international NGO clinics in all the camps surveyed. As an immediate step to address this situation, HelpAge established a network of community health workers who, with ongoing training in health and older people, were responsible for referring older people to health clinics in the camps and following up cases in their homes. A system of donkey-cart ambulances was also set up to assist in medical referrals of older people. As a result of this intervention, several medical agencies have allotted specific hours and days at their clinics during which older people are given priority for consultations and treatment. This has meant that older people no longer have to line up for long periods at the health clinics, one of the major barriers they had identified in accessing health services.

Another intervention by HelpAge was a mobile eye clinic set up in West Darfur. Nearly 2,000 people received surgical interventions or medicines through the eye clinic. Those patients who benefited from sight-restoring operations expressed a renewed sense of self-reliance and pride. They were able to carry out daily activities such as fetching water, collecting firewood, preparing food and cultivating a garden once again after the treatment.[64]

Psychosocial Services

In all the field studies, participants pointed out the lack of psychosocial support and counseling services for refugees with disabilities and their families. Although psychosocial programs existed in some countries, none of them provided specific support to refugees with disabilities.

The IASC *Guidelines on Mental Health and Psychosocial Support in Emergency Settings* provide a framework for understanding mental health and psychosocial problems in emergencies that is also useful when applied to persons with disabilities.[65] The guidelines state that mental health and psychosocial problems may be predominantly social or psychological in nature. Social problems may have existed before the emergency (e.g., poverty; preexisting discrimination and social exclusion). They may be emergency induced (e.g., family separation; disruption of social networks and community structures; gender-based violence) or humanitarian aid induced (e.g., undermining of community structures or traditional support mechanisms). Problems that are predominantly psychological follow the same model. They may be preexisting (e.g., severe mental disorder), emergency induced (e.g., depression and anxiety disorders, including post-traumatic stress disorder and grief) or humanitarian aid induced (e.g., anxiety due to lack of information about food distribution). The IASC *Guidelines on Mental Health and Psychosocial Support* identify people in the community with preexisting severe physical, neurological or mental disabilities or disorders as a subgroup that could be at increased risk of developing mental health problems in an emergency. Other at-risk groups include elderly people, especially those who have lost caregivers; people in

Local NGO CCBRS, Comprehensive Community Based Rehabilitation Somaliland, in partnership with UNHCR, provides physical therapy to the disabled as well as sexual and gender-based violence counseling in Hargeisa IDP settlement, Somalia. (UNHCR/A. Webster)

institutions; and people who experience severe social stigma, including people with severe mental disorders.[66]

Some persons with disabilities may have suffered severe anxiety and stress during their displacement and flight. Some people may have feared that they would be left behind or have been subjected to physical and sexual abuse and violence during the flight. Others may have lost their support networks. Family members, neighbors or other carers may have died or been separated during the flight and displacement, leaving persons with disabilities even more at risk and vulnerable to abuse.

For many persons with disabilities, life as a refugee or displaced person brings added strains and pressures that they may not have faced previously. Coping with a new physical and social environment where everything is different and nothing is predictable may add extra strains to the lives of persons with disabilities, especially at the beginning. The physical layout and inaccessibility of refugee camps and urban settlements and the lack of disability awareness in the planning of facilities, such as shelters or latrines, may make life more difficult for many refugees with disabilities and may increase levels of isolation for refugees who are unable to leave their homes or move around easily because of their disabilities.

The lack of essential support services and facilities, which refugees with disabilities may have benefited from before their displacement, such as specialized health services, special education and skills training programs, counseling or physiotherapy, may also contribute to feelings of isolation and despair. Similarly, the loss of essential medical equipment, mobility aids and other assistive devices, such as glasses, hearing aids, wheelchairs, crutches, may have a very negative impact on disabled refugees' daily lives. All of these factors can lead to increased levels of isolation, depression and mental health problems among persons with disabilities.

Older persons with disabilities suffer especially from a sense of isolation and loss of identity and status in refugee and displacement settings. They may be at greater risk of abandonment by families who feel they can no longer look after dependent family members. The disruption and dislocation of communities and social traditions may also result in older people feeling that they no longer have a role or status in their family or community.

At the same time, families and caregivers, especially women, can also suffer disproportionately in refugee settings. The added burden of looking after disabled family members, often in the absence of any other support networks, as well as trying to cope in a new environment—collect food, fetch water, deal with the camp bureaucracy—can put an enormous strain on families, especially women and single heads of households. They too may suffer from increased feelings of isolation and depression and, as a result, disabled family members may be shut away more than they would have been prior to displacement.

In several countries, disabled mothers and mothers of children with disabilities cited a particular need for psychosocial support and counseling programs.

CASE STUDY Mothers with disabilities struggle to raise their children

In Yemen, disabled women said that they were facing enormous pressures trying to raise their children in the harsh living conditions in the refugee camp. Single heads of household were particularly struggling. Some women with disabilities said that their children were very demanding and they resorted to beating them. Some disabled women were suffering from depression. Although ADRA provides counseling services for refugees with special needs, there was no special psychosocial program for persons with disabilities or their families in the camp. In a subsequent communication, UNHCR informed us that a psychiatrist joined UNHCR in September 2007 and pays regular visits to the camp to provide counseling to refugees, including those with disabilities.[67]

One psychosocial strategy that has worked successfully in many refugee and displacement settings has been providing the space and opportunity for persons with disabilities of all ages and their families and caregivers to meet and share experiences. There are several positive examples of refugees with disabilities and their families setting up their own self-help support groups to provide each other with emotional support and practical assistance.

CASE STUDY Training helps mothers of children with disabilities

In Nepal, Caritas assisted 55 mothers of children with disabilities from the Bhutanese refugee camps to attend one-month training and capacity-building courses in Kathmandu in 2007. The courses were particularly geared toward mothers of children with mental disabilities and cerebral palsy, but also included mothers of children with hearing, visual and physical disabilities. They were aimed at enhancing the mothers' self-confidence and self-esteem and developing specific skills to help them look after their disabled children (such as personal hygiene, nutrition and cooking, first aid, stress management, family planning and safer sex). The training program also organized visits to different skills training and support programs for children with disabilities and HIV/AIDS in Kathmandu.

This was very important in helping the mothers feel less isolated, helping them to realize that they were not alone and other children shared the same disabilities as their own, and in showing them the potential for children with disabilities to learn new skills and develop their capacities. The training courses were an opportunity for mothers to share experiences and feelings of fear, grief and loss. It enabled them to open up and express themselves in ways that many of them had never done before.

One of the most important initiatives to come out of the training courses was the formation of mothers' support groups in each of the refugee camps. The mothers visit the disability center every week and help support the children through stimulating activities and play materials that help develop their skills. The mothers have established a savings and credit plan, which they pay into each month for their disabled child. Members of the group in need of money can take a short-term loan from the savings program. Most importantly, though, the support groups have broken the isolation that many mothers were feeling and given them a space to express themselves and seek comfort and support.

Inclusive Education

Inclusive education was one of the more successful areas in all the camp-based refugee operations studied for this project. In all the countries surveyed, children with disabilities have access to schools and the field studies found no cases of children with disabilities being actively excluded from school. Rates of attendance by children with disabilities at mainstream schools were high in several of the countries studied.

Positive examples ranged from fully inclusive and integrated education programs, to more targeted, specialized teaching for children with special needs. The most successful programs included early childhood intervention programs; ongoing training of special needs support teachers and training for mainstream teachers in special needs education (including training in Braille and sign language); the development of special teaching aids, appropriate curriculum and teaching resources (e.g., textbooks in Braille, large print posters, etc.); home support and liaison programs; parent support groups; and, where necessary, the establishment of separate schools, or learning environments, for children with particular needs (e.g., schools for blind or deaf children).

In Dadaab refugee camps, for example, children with special needs are both integrated into the mainstream schools and also have the opportunity to attend special classes within the schools. National special needs education staff move within the three camps advising teachers on how to meet the educational needs of children with disabilities. In addition, some children with special needs (especially children who are blind or deaf) are placed in special boarding schools outside the refugee camps. The special needs education staff also conduct home visits to conduct educational assessments, prepare children with special needs for school and ensure appropriate placements, provide parental guidance and counseling and promote general awareness on disability issues.[68]

A common finding was that inclusive education programs can be a good entry point for developing other services for refugees with disabilities or helping them integrate into existing services (e.g., through early childhood intervention programs, refugee children with disabilities can be referred to appropriate rehabilitation or health care services; parent support groups can be a starting point for providing appropriate psychosocial support to parents of disabled children).

CASE STUDY A model education program on the Thai/Burmese border

Some of the most well-developed inclusive and special needs education programs can be found in the Burmese refugee camps in Thailand. In general, a high premium is placed on education within the refugee community. Preschool, primary and secondary schooling is provided in all nine refugee camps and general attendance is extremely high (between 93 and 99 percent in all camps).[69] The education programs are coordinated by the Karen Education Department in the seven Karen refugee camps and the Karenni Education Department in the two Karenni refugee camps, with assistance from CBOs and NGOs.

A variety of NGOs is responsible for implementing special education programs in the camps. Special education services are set up by the Karen Women's Organization in the seven Karen refugee camps, with the support of World Education. Programs include an early childhood intervention program where parents and teachers work together to identify children with disabilities as early as possible. Special education teachers work one-on-one with children through home visits to support them in becoming independent at home (e.g., through learning about hygiene and toileting), learning basic numeracy and language and learning to provide support and guidance to their parents. Children who are able to progress from the early childhood intervention program to mainstream schools are assigned an teacher who will assist them at school and tutor them at home.[70]

The Karen Women's Organization, with the support of World Education, also runs separate schools for children who are blind and deaf, where they are taught using Braille and sign language, with the

Deaf refugee children from Burma learn to sign in Thailand. (JRS Thailand)

goal of integrating students into mainstream schools at the secondary level. A significant development in the refugee camps has been the documentation of Karen sign language and the dissemination of Karen Braille, which had already been created in Myanmar (formerly, Burma).

The Karen Women's Organization and World Education also support inclusive education in mainstream schools. The Karen Women's Organization supports the integration of children with learning difficulties into mainstream primary schools and World Education provides ongoing training to special needs support teachers. Both organizations have provided awareness raising and orientation for schools, parents and the community to promote inclusive education. In December 2007, 548 children were enrolled in the special education program run by the Karen Women's Organization in the seven Karen refugee camps. Of these, 233 children were attending nursery and primary schools, 242 children were included in the early intervention program, 47 students were attending the school for the deaf and 26 students were attending the school for the blind.[71] Thirteen teachers for the hearing impaired, six teachers for blind students and 61 early intervention and inclusive education teachers were employed in the program.

The Jesuit Refugee Service (JRS), in conjunction with the Karenni Education Department, runs inclusive education programs in the two Karenni refugee sites (Ban Mai Nai Soi and Ban Mae Surin). Children from the ages of 3 to 18 (with a few older students) and with a wide range of special educational needs (from physical needs, hearing and visual impairments, to conditions such as Down syndrome and cerebral palsy) are given support to attend their local mainstream school. Special education assistants are placed in each grade of primary school and work with children who have been identified as having a special educational need. A special unit also exists in each primary school where special education assistants can work one-on-one with small groups of students. The program also offers support to students who are unable to attend mainstream school due to the severity of their disability. This includes "family friendship time" in two special education centers, where children and their families can come together to play, learn and support each other. Other services include home visits for educational purposes, special classes for blind and deaf students and monthly parent support groups. In November 2007, 239 students and their families were involved in the special education program. In addition, the special education program helps young persons with disabilities access short-term vocational training and informal education programs when they have completed, or can no longer cope in, mainstream schools.[72] Further, since 2005, the NGO WEAVE (Women's Education for Advancement and Empowerment) has been running an early childhood development program through nursery schools in the Karenni camps, in partnership with the Karenni Women's Organization.

In general the special education programs in the Karen and Karenni refugee camps have been very successful. Parents are happy that their children are able to attend school, or receive some kind of education; children feel empowered and less isolated as a result of the programs.[73] The perception of disabled children in the refugee community has changed due to the inclusive education programs and families with disabled children are less shunned and stigmatized than they used to be. Some drawbacks of both programs are difficulties in physical access to schools and educational facilities; overcrowded classrooms and lack of appropriate materials; the loss of trained staff, especially from the Karen Women's Organization, due to the resettlement program; and cuts in funding. In the Karen refugee camps, a major drawback has been the lack of support by the Karen Education Department, which sees inclusive and special needs education as expensive and not a priority.[74]

CASE STUDY Children with disabilities receive mainstream education in Nepal

Out of the 684 children with disabilities registered by Caritas Nepal, 550 (80 percent) were attending mainstream schools (291 boys and 259 girls)[75] and 371 hearing- and speech-impaired students had received sign language training in October 2007. The successful inclusive education program in the Bhutanese refugee camps includes ongoing training for special needs support teachers; classroom support for children with disabilities; home visits by special needs support teachers to encourage children with disabilities to attend schools and to liaise with parents and families; sign language training for the hearing impaired and for teachers and community workers; remedial classes for children who have learning difficulties; and skills training for children with mental disabilities. In addition, Caritas provides students with disabilities with learning accessories and teaching aids to help with their integration. These include rechargeable cells for hearing aids; eyeglasses, talking calculators, Braille books and teaching aids and cassette recorders for the visually impaired; and crutches, a tricycle, prostheses and other mobility aids for the physically impaired. As a result of their integration into mainstream education programs, some young persons with disabilities have been able to complete higher education.

Elsewhere, although children with disabilities were not actively excluded or discouraged from attending mainstream schools, they were not actively encouraged to attend and dropout rates were high. This was due to various factors, including the lack of special needs support staff or training for mainstream teachers in special needs education; the lack of appropriate teaching aids (e.g., schoolbooks in Braille) or flexible curriculum (e.g., for mentally challenged children); and the physical inaccessibility and poor design of school buildings and facilities, all of which made it difficult to support and sustain children with disabilities in mainstream schools.

Where special needs education was not available in mainstream schools, either in refugee camps or urban settings, refugee children with disabilities were usually excluded from local special needs schools, either due to the cost or because of their refugee status.

CASE STUDY Schools in Yemen lack services and supplies for children with disabilities

In Yemen, the CBR program run by Rädda Barnen encourages children with disabilities to attend school. Out of 77 children with disabilities identified by Rädda Barnen through its CBR program, 50 children (28 boys and 22 girls) were attending school in November 2007 (65 percent). Although children with disabilities are encouraged to attend mainstream schools, the schools are not inclusive for children with disabilities. There are no special education facilities, supplies, resources or curricula for children with disabilities and no special education teachers to take care of children with disabilities in the schools. Children with hearing and vision impairments face particular difficulties in the schools and there are no assistive devices, such as eyeglasses or hearing aids, to help children attend school. It is difficult for children with physical and visual impairments to reach the schools as they are far from their shelters and the roads are not paved. Despite these problems, the schoolteachers try to take care of children with disabilities even though they lack specialized training, resources and equipment.

CASE STUDY Disabled Iraqi children in Jordan need specialized education

Until 2007, the Jordanian government did not permit any Iraqi children to attend public schools, and the alternative, private schools were too expensive for the majority of refugees. In 2007, the government changed its policy and Iraqi children were allowed to attend Jordanian schools. However, school attendance among Iraqi children remains low due to regulations that prevent enrollment by children who have been out of formal school either in Iraq or Jordan for more than three years. Fears of disclosing illegal residency, severe overcrowding and a lack of sufficient books and school supplies have also contributed to low school attendance rates by refugee children.[76]

Among the disabled children aged 5 to 18 years old interviewed in the field study surveys, 60 percent (18 children) said that they were attending school. Thirteen children said that the school nearest them

was accessible given their disability, but few felt that the schools were inclusive. Most of the disabled children attending school had sensory impairments (six had visual impairments and three had hearing impairments). None of the children with physical disabilities interviewed for the study were attending school, and only five children with mental disabilities were in school. Many of the children surveyed identified the need for special education as one of their most immediate concerns in Jordan, or indicated the desire to be resettled to a country where there are more inclusive and accessible educational programs.

A final and important consideration is gender disparity in school attendance and dropout rates among children with disabilities. In all the refugee camp situations surveyed, more boys with disabilities were attending school than girls with disabilities (data is not available for the urban refugee situations). In Thailand, for example, the ZOA Education Survey (2005) found that 50.6 percent of children attending schools in the Karen camps were boys and 49.4 percent were girls. Data available from World Education and the Karen Women's Organization, however, shows that among disabled children attending schools in the same camps, 61 percent were male and only 39 percent were female. JRS Thailand writes that: "Refugees with disabilities tend to face more opposition than others to accessing education, from teachers, the wider community and even their own families. This is particularly true for girls (especially girls who are useful workers at home, e.g., girls with hearing impairments)."[77]

Similarly, in the Bhutanese refugee camps in Nepal, 53 percent of disabled children attending schools are boys and 47 percent are girls. This compares with a breakdown of 49 percent boys and 51 percent girls in the total school population. The lower attendance rates among disabled girls, compared with the overall school attendance rates for girls, suggests that disabled girls may be doubly discriminated against and even more disadvantaged when it comes to access to education. While the reasons for this are not entirely clear from the surveys, it is an issue that should be further researched and addressed in order to take remedial action.[78]

Disabled girls should be encouraged to attend school and participate in educational activities, and schools should stress to parents that it is important for *all* girls to attend school, including those with disabilities. In Dadaab, for example, considerable community awareness raising was needed to persuade the refugee community that *all* children with disabilities, including girls, had the right to education.

Vocational Training / Employment / Livelihoods

Access to vocational and skills training, income generation, and employment opportunities for refugees with disabilities varies. In some countries, very successful vocational and skills training programs have been set up that are specially geared for persons with disabilities. Refugees learn useful skills through the programs and are able to find employment or set up their own small business as a result.

In other countries, refugees with disabilities have access to vocational training, but it has not been adapted to meet their needs and skills and the teachers have not been specially trained to work with persons with disabilities. In some cases, courses are specially geared for persons with disabilities, but the choice of skills training is not appropriate for the people involved and it has not been successful. Elsewhere, vocational training courses exist for the general refugee population, but refugees with disabilities are either actively excluded or are given no encouragement to attend. And finally, there are situations where vocational training does not exist at all, either for the general population or for refugees with disabilities.

CASE STUDY Refugees with disabilities excluded from vocational training in Yemen

In Kharaz refugee camp in Yemen, training courses in sewing, weaving and production of straw products are offered to refugees. In addition, in 2007, 65 refugees attended vocational training in employable skills such as welding, plumbing and repair of home appliances in vocational training institutes in Aden. Nevertheless, the needs of persons with disabilities are not taken into account when planning these courses and persons with disabilities are not included. Only one refugee with a physical impairment joined the weaving workshop in the camp. Although some refugees with disabilities join the adult literacy classes, they usually drop out due to lack of support and the location of the classes, which is far from their homes. During focus group discussions, nearly all refugees with disabilities said that they had the ability and desire to work, but they did not have access to income generation activities in the camps. Although ADRA is running a self-reliance project, providing refugees with small credits to run their enterprises, refugees with disabilities were not included in this project.

Vocational training helps persons with disabilities to develop fine and gross motor skills and increases their sense of self-confidence and self-esteem.[79] It also gives persons with disabilities viable

Sudanese refugees in Kakuma Camp, Kenya, attend a class for deaf children using sign language. (UNHCR/B. Press)

opportunities to find employment or set up their own small businesses.

Nearly all the field studies showed that persons with disabilities are very keen to learn new skills—they want to receive vocational training and they want to be able to find jobs. The successful training programs show that there is huge potential, and capacity, for including persons with disabilities in vocational and skills training programs.

Youth vocational training is most effective where it is an extension of, or an alternative to, formal schooling for young persons with disabilities who have either completed, or reached their full capability, in the formal school system. Some special needs education programs also offer vocational skills training as part of their curriculum; for example, the deaf and blind schools in the Karen refugee camps.

Successful programs in different countries have included bicycle repair, radio mechanics, embroidery, painting, massage for the blind, handicrafts, music and auto mechanics. Other initiatives have been less successful, such as wristwatch repair and setting up musical bands.

One of the greatest problems facing persons with disabilities everywhere is the huge social, attitudinal and environmental barriers they still face in finding employment. Refugees with disabilities face double discrimination—not only because of their disability, but also because of their status as refugees and outsiders. In many countries, refugees are unable to legally work outside camps or refugee settlements, and even where they are, employers may be much less likely to employ them because they are refugees. For a refugee with a disability, the chance of finding employment in the open market may be close to zero.

There are some success stories. In Nepal and Thailand, for example, refugees with disabilities have been able to successfully set up small businesses in the camps using the skills they learned during vocational training programs. It is, however, generally much easier to start small businesses, or find employment, in refugee camp situations than it is in urban environments. There is less competition in camps to start small businesses, and NGOs and relief agencies are much more likely to have positive employment policies and be open to employing persons with disabilities than the open market outside the camps.

CASE STUDY Vocational training provides an alternative to formal education in Nepal

As well as providing inclusive education for children with disabilities, Caritas Nepal also runs vocational skills training courses for students who have mental, physical and sensory impairments when they reach a point that they can no longer cope in mainstream schools. Caritas believes that vocational training provides an alternative to formal education for young persons with disabilities and helps develop social and intellectual skills that will be useful in assisting them to live independent lives. In October 2007, 150 students (64 male and 86 female) were engaged in vocational training programs, while some 546 young people (292 male and 254

female) participated in vocational training courses between January 2001 and June 2007 in all seven Bhutanese refugee camps. Training courses have included carpentry, tailoring, electronics, bicycle repair, embroidery, painting, hairdressing, using a handloom, shoemaking, wristwatch repair, bamboo crafts, typing and computer training and playing in musical bands.

Training courses run for six months and a specially trained teacher is hired to run each course. Evaluation workshops held at the end of each training course highlight the successes and weaknesses of each course. So, for example, in 2007 courses rated highly (on the basis of attendance rates and progress made by the students) included bicycle repair, embroidery and bead-garland making. Wristwatch repair and the musical bands were less successful (lower attendance rates and the students made less progress than in other trades). Caritas decided to discontinue these courses and replace them with traditional weaving and jute-mat making in September 2007.

During focus groups discussions with refugees, participants were generally happy with vocational training opportunities for persons with disabilities available in the camps. They noted, however, that refugees with hearing impairments, refugees who were literate and those with mild forms of physical and mental impairments, were most likely to benefit from the vocational training programs. Participants said that some refugees with disabilities had set up small grocery shops, barber shops and spinning businesses in the refugee camps as a result of the training courses. However, they all stressed that while employment opportunities were available and refugees with disabilities had the capacity to work, very few refugees with disabilities benefited from these wage earning opportunities. It was noted that there was a lack of follow-up after the vocational training courses to provide participants with the necessary financial support, equipment and guidance to set up their own businesses or find employment.

Refugees with disabilities living in towns, as in Ecuador and Jordan, have far fewer opportunities to access vocational training programs or find a job with local employers. In Ecuador, for example, none of the refugees with disabilities interviewed for the field study were attending vocational training or income generation programs. Although vocational training programs for Ecuadorians exist, no refugees were able to access these opportunities.

Lack of employment is often cited as the biggest challenge facing refugees living outside camps who do not receive assistance and have to be self-reliant.

CASE STUDY Lack of income is debilitating for Iraqis in Jordan

In Jordan, Iraqi refugees cited lack of employment opportunities as the single biggest problem facing them. Without legal residency, no Iraqis can work in Jordan. In a recent study commissioned by Mercy Corps, the Sweileh Community Development Center found that 90 percent of Iraqis in Jordan identified themselves as "unemployed."[80] Unable to generate income to support even their most basic needs, many displaced Iraqis (especially men) feel extremely frustrated and helpless. For persons with disabilities, who have to pay for expensive medical treatment and/or equipment, the lack of income can be even more debilitating.

Among the 106 Iraqi refugees interviewed for the field study, only two said that they had access to income generating opportunities, although many had worked before becoming refugees. Fourteen individuals (20 percent of adults surveyed) said that they had access to vocational training or adult education programs, but only four of these attended courses specifically geared to persons with disabilities. Although vocational training opportunities exist for persons with disabilities in Jordan, for the most part these organizations do not include Iraqis in their programs. Over a quarter of refugees interviewed for the study said that they had applied to be included in Jordanian vocational training programs, but they were actively "excluded from participation."

One option for refugees with disabilities is to find employment with refugee relief agencies. In Nepal and Thailand, for example, refugees with disabilities are employed as special needs support teachers, rehabilitation workers and disability program managers. Some agencies, such as Caritas Nepal, have affirmative action policies that promote the employment of refugees with disabilities. ZOA Refugee Care in Thailand has a policy that 5 percent of its staff should be persons with disabilities.

Participation / Community Inclusion

Opportunities for participation and community inclusion differ considerably between refugee camp and urban refugee situations. In refugee camps, questions focused on the level of participation by persons with disabilities in camp management structures, such as camp committees, and in the planning, design, implementation and management of refugee assistance programs and protection strategies. In all the camp situations reviewed, it was found that there were limited *formal* opportunities for refugees with disabilities

Child being treated at International Rescue Committee Physical Therapy Unit, Kakuma Camp, Kenya. (Rebecca Hankin)

to be involved in camp management structures, even in those places where there were high levels of disability awareness.

Nearly all the refugees with disabilities interviewed said that they would like to be more involved in camp management, but they had never been asked. It appeared that camp committees themselves were not averse to the inclusion of refugees with disabilities, it was simply an issue they had not considered.

Similarly, nearly all the relief agencies (UN agencies, NGOs and CBOs) said that there were no reasons why persons with disabilities could not be included in the planning and management of assistance programs and they would be happy to involve them more. In reality, though, very few refugees with disabilities were actually involved in program planning or design and even fewer in implementation and management, especially at higher management levels.

In both Nepal and Thailand, the refugees are extremely well organized and have elaborate camp management and representation structures. Despite the high levels of disability awareness in both situations, however, there were few formal opportunities for refugees with disabilities to participate in camp management and community decision-making processes. No information was available from the field study in Thailand about the level of formal representation by refugees with disabilities on camp committees and in camp management structures, although according to the 2006 Landmine Monitor Report, 10 percent of section leaders in Mae La refugee camp were disabled (most of them land mine survivors).[81]

In Nepal, according to the field study, only one refugee camp management committee had a disabled member. Notably, community leaders who participated in focus group discussions for the field study in Nepal mentioned that persons with disabilities could participate more in community affairs if they were given the opportunity. Refugees with disabilities recommended that a certain number of seats on the camp committees should be reserved for persons with disabilities and they should not be discriminated against.

Interestingly, there was a difference in perceptions among refugees with disabilities and their families, and humanitarian organizations and service providers in the Bhutanese refugee camps regarding the levels of participation in program planning, design, implementation and management. Refugees with disabilities said that if given the chance, they could participate in the planning, design and implementation of assistance programs and protection strategies. However, they said that they had not been given the opportunity to participate and were often discriminated against. Humanitarian organizations, on the other hand, said that refugees with disabilities were actively consulted in program planning. They said that they were invited to attend meetings before the implementation of any program on disability issues and were fully involved in the World Disability Day celebrations and in extracurricular activities in the school. UNHCR Nepal, for example, said that it organized focus group discussions including refugees with disabilities in its planning exercise for the preparation of its Country Operation Plan in 2008.[82]

In Yemen, the field study noted that there were very few opportunities for persons with disabilities to participate in community affairs. People with disabilities in the camps said that they were "seen as a burden on the community." They were not included in any committees or sub-committees in the camp, and were not involved in any planning or programming. They noted, however, that for the first time in 2007, two small groups of men and women with disabilities had participated in the UNHCR participatory assessment. Refugees with disabilities said that if they were given the opportunity, they could be active participants in the planning and implementation of programs.

UNHCR has a dedicated registration center for Iraqi refugees located in Douma, 25 km from Damascus, Syria. A refugee injured in the war waiting at the registration center in order to receive an interview appointment. (UNHCR/R. Awabdeh)

CASE STUDY Greater awareness in the community benefits persons with disabilities in Kenya camps

A positive development in the refugee camps in Dadaab, Kenya, has been the drive to promote greater awareness and inclusion of persons with disabilities in community affairs. Since Handicap International took over the disability CBR program in January 2008, it has put great emphasis on community awareness raising to increase understanding of disability issues and combat negative attitudes toward persons with disabilities among community leaders, teachers, health workers and the community at large. The "disability center" has been renamed the "community center" and is now used for a range of different activities for the whole community, not just persons with disabilities. It is hoped that this will promote socialization and interaction between persons with disabilities and the wider community.

Handicap International has also promoted the representation of persons with disabilities in all decision-making and planning processes. At the end of 2007, for example, there was a multisectoral strategic planning exercise in all the camps. People with disabilities were represented in *each* of the sectoral planning meetings and invited to give their perspective. As a result of the strategic planning exercise, it was agreed that routine protection monitoring over the coming year would include a special focus on persons with disabilities. People with disabilities are also actively represented on Parent/Teacher Associations in the camps and there are some representatives of persons with disabilities on the camp committees. In addition, persons with disabilities have their own committees, which advocate for better services and representation.

Handicap International and UNHCR are also promoting community support networks for persons with disabilities and their families to help counter discrimination and stigmatization and break the isolation and exclusion that many persons with disabilities and their families experience. There have been attempts, for example, to involve youth groups in providing support to single mothers of disabled children, including women who have been abandoned by their husbands. The youth groups have been encouraging neighbors to come and look after a disabled child if the mother needs to leave the house for any reason, to avoid the mother tying up her child.[83] Handicap International has also supported the formation of livelihood groups, where persons with disabilities interact with others in the community. In addition, Handicap International has set up day care centers for children with disabilities that are run and managed by members of the community.

In the absence of *formal* opportunities to participate in community management and decision-making affairs, some refugees with disabilities have formed their own organizations and self-help groups. The level of self-organization among persons with disabilities is an indication of the level of disability awareness and inclusiveness in the community. Where persons with disabilities feel valued and included, they are more likely to have the self-confidence to form their own organizations than when they feel excluded and isolated.

In Nepal, refugees with disabilities have formed their own self-help groups in each of the refugee camps. Refugees with hearing impairments have also set up their own NGO—the Bhutanese Refugee Deaf Association. In addition, the mothers of children with disabilities have formed their own support groups.

CASE STUDY Self-help groups provide support in Nepal

Refugees with disabilities in Nepal have formed self-help groups in each of the refugee camps. The groups, of 10 to 15 adults (over 18 years of age), meet every week and provide a forum for persons with disabilities to share experiences, give each other mutual support and identify needs among persons with disabilities in the camp. It serves as a focal point for passing on information to disability workers in the camps and for consultation and cooperation between persons with disabilities and the disability workers. The self-help group is involved in practical activities such as taking people who are sick to the health center; assisting single disabled persons with repairs to their hut, collecting rations, etc.; and meeting with humanitarian organizations to raise awareness of the needs of persons with disabilities in the camps. The group encourages people with mental disabilities to participate in all its activities and stresses the importance of listening to their views and suggestions. Parents and siblings can also attend the group if their family member has a severe mental disability. Information about the self-help groups was provided by Caritas Nepal, which helps support the groups as part of the CBR approach. However, refugees with disabilities did not talk about the self-help groups during the focus group discussions in the camps.[84]

In the Karenni refugee camps in Mae Hong Son Province, Thailand, parents of children with disabilities have formed a monthly parent support group to share experience and provide mutual support. Through its special education program, JRS has also helped set up "Family Friendship Time" in two special education centers where children and their families can come together to learn, play and support each other. According to the information gathered in the field study, only one refugee DPO existed—the Karen Handicapped Welfare Association (KHWA) in Mae La camp. There was no information about refugees' involvement in local DPOs from the field study, although the 2006 Landmine Monitor Report stated that DPOs were active in Thailand.[85]

CASE STUDY Residential home is a lifeline for land mine survivors

The Karen Handicapped Welfare Association (KHWA) is a DPO set up and run by land mine survivors in Mae La Camp. In 2000, the KHWA set up Care Villa, a residential home for dependent land mine survivors in the camp. The founder of Care Villa, himself a land mine survivor, realized that there were land mine survivors in the camps with no one to take care of them. Sixteen residents (all men) were living in Care Villa in 2006, 13 of whom were land mine survivors.[86] Many of the residents had been blinded by their accident and lost one or more limbs.[87] Residents are provided with food, 24-hour caregivers (nurses), vocational training and moral support. In 2005, Care Villa provided its residents with training in radio mechanic work, crafts, musical instruments and English as a second language.[88] Only three of the survivors had family in the camp (in 2005), so the care and support provided by Care Villa was essential for their survival.[89]

In none of the countries surveyed were refugees with disabilities integrated or involved in the activities of local DPOs. There was generally a lack of awareness among both the refugee population and assisting agencies about the existence and activities of local DPOs and vice versa. One of the weaknesses of the research project was the insufficient focus on the activities of local DPOs.

Measuring levels of participation and inclusion was harder in urban refugee situations, as there were fewer opportunities for refugee participation. Due to the dispersed, often hidden, nature of urban refugee situations, refugees tend to be less organized than they are in camps and there are rarely any formal refugee management structures. Furthermore, the lack of assistance means that many urban refugees are simply struggling to survive and have little time for any other activities. Urban life for refugees with disabilities is often even more of a struggle and even more isolated than it is for the rest of the refugee population. Frequently confined to their homes, urban refugees with disabilities have even fewer opportunities to organize themselves.

In both Jordan and Ecuador, the study showed that there were no organizations for refugees with disabilities and few avenues for them to participate in any meaningful way in the design, implementation or management of refugee policy or assistance programs. In both countries, the researchers found that the refugee community in general was extremely economically and socially marginalized and excluded. The priority for *all* refugees, not just those with disabilities, was to improve their social, economic and legal status in order to participate more fully in the society (e.g., in Jordan this meant obtaining legal residency as a precursor to enjoyment of all other rights). Refugees with disabilities suffered a double discrimination and exclusion, due to their refugee status and their disability, which severely impeded their social integration and opportunities for community participation and inclusion.

In both countries, local DPOs existed (more in Jordan than in Ecuador), but in neither country were any refugees with disabilities involved or

included in local DPO activities. As a result of the research, however, a local DPO in the city of Ibarra, Imbabura Province, Ecuador, expressed an interest in including Colombian refugees in its activities. As noted earlier, the involvement of persons with disabilities affiliated with the Landmine Survivors Network Jordan as researchers in this project exposed them to the challenges faced by Iraqi refugees with disabilities. Consequently, the LSN Jordan has been exploring ways in which it can support Iraqis with disabilities. Encouragingly, as a result of the research, bridges have been built between local persons with disabilities and refugees with disabilities. For example, a house of Jordanian persons with disabilities living together as a support network has invited Iraqis with disabilities to join them. A few months after the completion of the research, Mercy Corps wrote: "A community by and for persons with disabilities of both nationalities is slowly developing, and we understand that some of the LSN surveyors are participating in that growing community, which is *good* news."[90]

Protection

In general, the quality of information on protection risks faced by refugees with disabilities was weak. Respondents in the field studies cited a range of protection problems, but gave few concrete examples. Almost without exception, all the refugees involved in the field studies mentioned discrimination, stigmatization, harassment, neglect and exclusion of persons with disabilities as major protection concerns, both within their own communities and in the host communities. In many countries, refugees with disabilities are doubly discriminated against, both because of their disabilities and because of their status as foreigners and refugees. They face exclusion from the employment market, health and public services, and educational opportunities both because they are disabled and because they are refugees.

The field study guidelines asked researchers to identify particular protection risks faced by women, girls and older persons with disabilities. In Nepal, nearly all respondents mentioned that older persons with disabilities faced discrimination, particularly in terms of access to nutritious food, warm clothing and medicine. They were at risk of neglect and possible abandonment, especially when they became, or were perceived as having become, a burden for their families. Respondents in Nepal also said that adolescent girls with disabilities should be provided extra protection from sexual assault.

In several countries, including Nepal, Thailand and Ecuador, the field studies cited sexual violence, domestic abuse and physical assault as protection risks facing refugee women with disabilities. Concrete examples of these abuses were difficult to find during the field research. In subsequent communication, however, UNHCR Nepal confirmed that in 2007 women with disabilities made up almost 8 percent of the survivors of all types of sexual and gender-based violence, and approximately 25 percent of rape survivors. In response to these trends, UNHCR launched a pilot project in November 2007 to train women with speech and hearing disabilities on sexual and gender-based violence and distributed whistles as a means of alarm. This project was conducted in cooperation with a local DPO, Kochi Deaf Association, and Caritas Nepal.[91]

Researchers in Jordan and Yemen said that there were no known cases of sexual violence and domestic abuse against refugee women with disabilities. In Jordan, the researchers explained that refugee women with disabilities rarely left their homes and said that they did not raise any specific protection concerns that were not also shared by male respondents. In Yemen, the number of reported cases of sexual and gender-based violence among the refugee population in general is very low. Data on incidents of sexual and gender-based violence against refugees in Yemen is kept by UNHCR, but there was no information about women with disabilities. The research team in Yemen noted that while women with disabilities did not report incidents of sexual violence in the refugee camp, some of them said that they had experienced violence and abuse during their flight from Somalia to Yemen and on arrival in Yemen at the hands of security personnel. Similarly, among Somali refugees in Dadaab, UNHCR reported very few cases of sexual and gender-based violence against women with disabilities.

It should be noted, however, that information on sexual and gender-based violence is very dependent on the context in which it is gathered. First, it depends on the gender of the interviewer, as women are less likely to talk openly about sexual and gender-based violence with men present. In Jordan, for example, although three of eight researchers were women, the researchers worked in pairs and there was nearly always a male researcher present at every interview. However, Mercy Corps Jordan also conducted separate focus group discussions with women on gender issues, and found no information about sexual and domestic violence.[92] Second, it depends on the level of trust and confidence between the researcher and interviewee. Third, it is affected by the format and setting for the interview (whether it was a group or individual discussion; whether it was in a public or private place; and who was present—e.g., other family members). Finally, it is influenced by the culture of the community and whether it is taboo to talk about sexual and gender-based violence, especially with outsiders.

A further protection problem raised during the field studies was refugees with disabilities going "missing" from camps. Again, little concrete information was available, but in countries like Nepal, there were indications that this may be linked to trafficking and may

Family members care for Ahmed, age 9. His father was killed in fighting near Baidoa, Somalia, during the war, after which his family fled to Galkayo. He has been paralyzed since birth. (UNHCR/B. Bannon)

especially affect refugee women with mental disabilities. More research should be carried out on this issue. Field research in Nepal also highlighted physical assault against refugees with disabilities (by "drunkard boys") and corporal punishment/beating of children with disabilities as protection risks. In Yemen, respondents said that single male heads of household with disabilities face particular challenges in looking after their children.

CASE STUDY Somali refugees with disabilities face discrimination and abuse

In Dadaab refugee camps, UNHCR reported that the greatest protection risk facing Somali refugees with disabilities was discrimination and stigmatization. People with disabilities, especially children, suffered frequent physical abuse. They were often beaten or tied up, had stones thrown at them or suffered verbal abuse from other people in the community. Mothers of children with disabilities also experienced harassment, stigmatization and abandonment.[93]

Refugees' perceptions of protection risks depended very much on their general living conditions. In Jordan, for example, where Iraqi refugees were struggling to survive, poor living conditions, lack of legal status, lack of employment opportunities and the need for durable solutions were cited as primary protection problems by *all* refugees, including those with disabilities. When pressed, Iraqi refugees with disabilities in Jordan cited material needs, such as blankets, heaters, batteries for hearing aids, medical equipment, hygienic items for the elderly and home improvements, as principal protection concerns, rather than physical risks. Similarly, in Yemen *all* refugees, including those with disabilities, cited the need for durable solutions, employment opportunities and access to basic needs as their primary protection concerns.

While not relevant in all countries, the field studies included questions on whether refugees with disabilities had equal access to refugee status determination (RSD) procedures and whether they faced discrimination because of their disability. In Jordan, 75 percent of respondents felt that the UNHCR RSD process was accessible for refugees with disabilities. Of the 25 percent who said it was not accessible, one quarter were people with physical disabilities. There was even less information available about whether RSD procedures were accessible for people with mental disabilities.

CASE STUDY Refugee status determination officers make efforts to reach Colombian refugees with disabilities

Colombian refugees in Ecuador said that they had access to the RSD processes, with some limitations depending on the type of disability they had. The field study found that there were no specific procedures in place for persons with disabilities, but that RSD officials tried to be flexible and meet the needs of individuals on a case-by-case basis. For example, RSD officials said that they would try to carry out interviews in locations that were physically accessible for refugees with physical disabilities. If a refugee had mental disabilities, RSD officials would try to interview the family of the person or a legal guardian.

Two-year-old Heba takes her first steps with prosthetic limbs, in Damascus. (UNHCR/J. Wreford)

The field studies also asked respondents the degree to which refugees with disabilities had access to information about their rights, services available to them and durable solutions. In general, persons with disabilities in refugee camps had better access to information, through heads of housing blocks and subsectors, disability workers, community health workers, special education teachers and self-help groups, than those living in urban areas. Refugees in urban areas had little information about their rights as refugees and as disabled persons, and little or no information about services available for persons with disabilities in the local community. It should be added that many refugee assisting agencies, including UNHCR, also lacked such information.

Similarly, in refugee camp settings there were more formal avenues for refugees with disabilities to report protection incidents than in urban areas. In Nepal and Yemen, the researchers asked respondents if they would know who to report a protection incident to, such as a missing disabled person. In both cases, refugees said that they would report the incident to the subsector head, camp management committee and the police (Nepal), or to the elders, police and UNHCR (Yemen).

Finally, some of the field studies asked refugees with disabilities how their general status and well-being had been affected by displacement. In Jordan, about half of the respondents said that their disability made their situation in exile much more difficult, because of the extra costs they had to bear and because they could not obtain training and education. The other half said that their disability was the *reason* for their displacement—they had come to Jordan because there were better medical specialists, health care and education than in Iraq. They also said that their disability increased their chances of resettlement to a third country. In Ecuador, the majority of refugees with disabilities said that they had suffered a decrease in access to health care and social benefits since becoming refugees.

Durable Solutions

Lack of information or clarity about durable solution options for refugees with disabilities was common in all the field studies. In particular, there was a lot of confusion about resettlement policies for refugees with disabilities, which was creating considerable concern. At the time of the field research, UNHCR was unable to give clear information about policies on durable solutions for refugees with disabilities in any of the countries surveyed, although UNHCR Nepal and Thailand did subsequently provide information.

Resettlement opportunities were available for refugees in all the countries surveyed. In Nepal and Thailand, after years of deadlock in finding durable solutions, third country resettlement was finally available to the refugees. The United States announced in 2006 that it would resettle 60,000 Bhutanese refugees over the next few years, and several other industrialized countries, including Australia, Canada, New Zealand, Denmark, the Netherlands and Norway, have since indicated their willingness to accept Bhutanese refugees for

resettlement. In Thailand, more than 24,000 refugees have been resettled since 2005 and UNHCR expects that a further 15,000 may be resettled by the end of 2008. The United States, Canada and Australia have all committed to accept large numbers of refugees from Thailand. Other resettlement countries are Finland, Great Britain, Ireland, the Netherlands, New Zealand, Norway and Sweden.

In Jordan, the legal situation for Iraqis improved in 2007 when UNHCR agreed to recognize them as refugees on a *prima facie* basis. This not only enabled Iraqis to avail themselves of UNHCR's protection, but also meant that they had the opportunity of resettlement to a third country. In reality, though, there are very few resettlement opportunities for Iraqi refugees.[94] Priority is given to extremely vulnerable cases and people who need specialized medical care, which is why some refugees believe that their disability may actually increase their chances of resettlement.

Researchers asked refugees with disabilities their views about resettlement.

CASE STUDY Confusion about resettlement in camps in Nepal

In Nepal, where resettlement has become a very politicized issue, there were mixed views. There were high levels of misinformation about resettlement within the refugee camps, and many refugees with disabilities who participated in the field study expressed fears about how they would be treated, attitudes toward persons with disabilities and whether their rights would be respected in resettlement countries. They had concerns about the language and culture, health care, education and other services for persons with disabilities and whether they could get a job in resettlement countries. Mothers of children with disabilities were worried about whether their children would be able to go to school in resettlement countries. Community leaders who took part in the field study said that "persons with disabilities should not be sent to third countries since this group is most vulnerable and dependent" and worried that their needs would not be met. In general, refugees with disabilities favored voluntary return or local integration over resettlement. Due to the levels of harassment and tensions surrounding resettlement in the Bhutanese refugee camps, however, it is difficult to know how representative these views are.

In subsequent communication with UNHCR Nepal, after the field research, UNHCR explained that a public information campaign on resettlement had been postponed until November 2007, due to a request from the Government of Nepal and the high levels of tension in the camps. UNHCR acknowledged that at the time of the research, refugees with disabilities may not have had sufficient information about resettlement options. Following the public announcement of resettlement by the Government of Nepal in November 2007, UNHCR held information sessions on resettlement at the disability centers in all the camps in December 2007. UNHCR noted that there had been a significant level of interest in resettlement among refugees with disabilities and that the organization would continue to provide more information sessions throughout 2008. UNHCR also noted that some of the first cases prepared and submitted for resettlement based on protection needs were refugees with physical and mental disabilities.[95]

During the field research in Thailand, there was a view that those refugees who were better educated, in good health and employed by NGOs would be prioritized over refugees with disabilities in resettlement programs. However, according to UNHCR data, 1,316 refugees with disabilities were resettled between January 2005 and March 2008. These included refugees with mental, physical and sensory impairments who could benefit from improved medical and other services in resettlement countries.[96] The field research in Thailand also found that resettlement had had an impact on services for refugees with disabilities in the Burmese refugee camps, such as health care and education programs, due to the loss of skilled and trained refugee staff.

In other countries, refugees with disabilities said that resettlement was their preferred durable solution. They said that they wanted to access better health services and medical care and that there would be more educational opportunities available for persons with disabilities in resettlement countries. For example, some Iraqis with disabilities actually came to Jordan in order to access resettlement opportunities.

There have also been a few positive examples of group resettlement programs actually targeting refugees with disabilities.

CASE STUDY Identifying refugees with disabilities in Kenya for resettlement

In late 2005, UNHCR launched a large-scale profiling exercise in Dadaab refugee camps, Kenya, called the "Disabled Refugees and Survivors of Violence Profiling Project." The aim of the project was to identify physically disabled refugees with legal and physical protection problems, as well as survivors of violence, who may be in need of resettlement. Some 5,500 individuals were screened through the project, of whom approximately 2,000 refugees with disabilities and their families were identified as meeting UNHCR's resettlement criteria. Most of the refugees were resettled in the United States.[97]

PART 3: RECOMMENDATIONS

Key Recommendations to All Humanitarian Actors

1. **The principles enshrined in the UN Convention on the Rights of Persons with Disabilities (CRPD) should underpin all refugee and IDP assistance programs.** Provide training to humanitarian workers, local government officials and refugee and IDP communities on the CRPD.
2. **Camp infrastructure and all facilities, services, shelter, organizations and information should be *accessible* to displaced persons with disabilities.** The needs of persons with disabilities should be addressed *at the start* of the emergency during the site selection, planning and design of camp infrastructure and services. Minimum accessibility standards should be established at the start of the emergency.
3. **A standard, centralized data collection system should be set up to collect disaggregated data on the number, age, gender and profile of displaced persons with disabilities** in order to help identify refugees and IDPs with disabilities and enhance their protection and assistance. Attention should be paid to maintaining the confidentiality of information. Disability awareness training should be provided to all data collection officers to assist them in identifying and registering persons with disabilities.
4. **Conduct community-based information and awareness-raising campaigns to promote greater tolerance, respect and understanding of persons with disabilities.**
5. **Promote the inclusion of people with all types of disabilities in camp management structures, community-based participatory assessment and strategic planning exercises, community decision-making processes** and at all stages of the program cycle, ensuring age and gender diversity.
6. **Provide transportation to persons with disabilities to enable them to access mainstream and targeted services.**
7. **Ensure that persons with disabilities have full and equal access to all food and nonfood distributions;** provide food that is appropriate, nutritionally adequate and easy to transport and safe, appropriate means to cook this food.
8. **Refugees and IDPs with disabilities should have full and equal access to health services**, including access to specialized health services, medicines and treatments, physical rehabilitation services and community health outreach programs, where necessary.
9. **Psychosocial support (in the form of counseling, community outreach programs and self-help groups) should be provided for displaced persons with disabilities and their families and caregivers.**
10. **Children with disabilities should have full and equal access to education.** Wherever possible, they should be included in mainstream schools. Ongoing training should be provided to mainstream teachers and special needs support teachers and appropriate curriculums, teaching aids and learning devices should be developed to support and sustain the inclusion of children with special needs. Where necessary, specialized teaching for children with specific disabilities (e.g., blind or deaf children) should be provided.
11. **Protection officers should receive training on the specific protection risks faced by persons with disabilities** and routinely include persons with disabilities in protection monitoring. Set up appropriate reporting mechanisms for persons with disabilities and their families to report protection problems.
12. **Ensure that displaced persons with disabilities have full access to all durable solution options** and full access to objective information regarding durable solutions in a format that is accessible and easy to understand. Ensure that refugees with disabilities are not separated from family members or caregivers when accessing durable solutions. Ensure that transportation is provided to persons with disabilities when accessing durable solution options.
13. **Promote greater understanding and awareness among UN and NGO workers of the national framework and services for persons with disabilities in the country of asylum or displacement area.** Ensure that services provided to displaced persons with disabilities are also made available to persons with disabilities in the local community.
14. **Build alliances with local disability providers to support the integration of refugees and IDPs into local disability services.** Encourage local disabled persons' organizations (DPOs) to integrate disabled refugees and IDPs into their activities.

Specific Recommendations to UNHCR and the International Community

1. **Promote attention to and services for persons with disabilities in all humanitarian emergencies through the development of IASC Guidelines** (such as the IASC Guidelines on Mental Health and Psychosocial Support and Gender-Based Violence) or other collaborative, interagency efforts to provide guidance and instruction to the field.
2. **The specific needs of displaced persons with disabilities should be addressed as a cross-cutting issue in all clusters** (protection, early recovery, camp management, etc.) within the UN-led IDP cluster approach.
3. **Minimum accessibility standards for persons with disabilities should be included in the Sphere Project Minimum Standards during the 2009/2010 revision of the Sphere Project Handbook** (e.g., 10 percent of latrines should be accessible for persons with disabilities).
4. **Revise and update the 1996 UNHCR Community Services Guidelines on Assisting Disabled Refugees to reflect current approaches to disability** within the international community and UNHCR's community-based approach to assisting refugees. Disseminate the guidelines widely and provide training on the guidelines for all UNHCR field staff.
5. **Revise UNHCR's 2004 Resettlement Handbook to provide adequate guidance on the resettlement of refugees with disabilities.**
6. **Revise and harmonize the disability definitions used in UNHCR's data collection system, ProGres, and in the UNHCR Heightened Risk Identification Tool.** Ensure the standard application of ProGres in all UNHCR operations.
7. **Include disability in all UNHCR age, gender and diversity mainstreaming exercises and participatory assessments.**
8. **Continue research into the needs of displaced persons with disabilities.** In particular, further research should be carried out on the conditions for refugees and IDPs with disabilities in urban areas.

PART 4: INTERNATIONAL RESPONSE

The following section provides a brief overview and analysis of some of the international policies and practices relating to issues of displacement and disability. It includes a review of UNHCR's policies on refugees and displaced persons with disabilities; an overview of other UN and international disability policies; and a summary of different organizational approaches to disability and displacement.

UNHCR Policies

UNHCR ASSISTING DISABLED REFUGEES: A COMMUNITY-BASED APPROACH

This is a manual developed by UNHCR's Community Services division in 1996 to provide practical guidance to UNHCR field staff on how to improve services for refugees with disabilities (hereafter referred to as *1996 Guidelines)*.[98] Written more than 10 years ago, the *1996 Guidelines* do not reflect the most current approaches and policies toward persons with disabilities. The guidelines adopt a more individualized/medical approach to disability, emphasizing early detection, medical screening, prevention, treatment and physical rehabilitation as the main strategies for assisting persons with disabilities. This contrasts with the social model adopted by this project, which stresses removing the physical, environmental, social, attitudinal and legal barriers that prevent persons with disabilities from enjoying full and equal participation in society.

The *1996 Guidelines* outline a two-stage approach to dealing with disability. Stage one includes identification of existing resources for persons with disabilities at the local, national, regional and international levels; identification and assessments of needs, with a strong focus on medical screening; and prevention and treatment. The guidelines specify three levels of prevention. Primary prevention includes primary health care measures to prevent children from developing impairments because of health factors such as malnutrition, the spread of communicable diseases and inadequate pre- and postnatal care. Secondary prevention includes early detection, curative care and early rehabilitation to prevent a preexisting impairment from becoming a long-term disability. Finally, tertiary prevention focuses on physical rehabilitation and the provision of appropriate aids aimed at "preventing disabilities from becoming a handicap."

The second stage focuses on rehabilitation and social integration for persons with disabilities, with a strong emphasis on CBR as an effective and appropriate method in refugee settings. The guidelines state that all UNHCR projects should be designed and implemented so as to maximize the *participation* of refugees with disabilities. They stress that refugees with disabilities should have *equal access and opportunities* in education, housing, transportation, health and social services, as well as all aspects of social, cultural and religious life. Special attention is paid to the needs of refugee women and children with disabilities, including information on promoting inclusive education in refugee settings.

The *1996 Guidelines* also focus on various strategies, including international medical evacuations and extra-regional resettlement of persons with disabilities, which were central tenets of UNHCR's policies toward refugees with disabilities in the 1980s and 1990s, but are now no longer in vogue.

It was unclear during the research for this project the extent to which the *1996 Guidelines* are still adhered to in refugee programs today. There was no evidence of any updated versions of the *1996 Guidelines* or ongoing training or promotion of the guidelines in UNHCR field operations. The guidelines are not available publicly on UNHCR's website. Indeed, most UNHCR personnel interviewed in the course of the project were unaware that the guidelines even existed.

Although the focus of the *1996 Guidelines* fits more into the individual/medical model of disability than the social model, aspects of the manual (in particular Part Three on rehabilitation and the emphasis on participation and equal access) are still relevant and applicable today. UNHCR should consider updating and revising the guidelines and reissuing them to its field staff with ongoing field training.

MEDICAL EVACUATION: UNHCR SPECIAL TRUST FUND FOR HANDICAPPED REFUGEES

One option for refugees with disabilities highlighted in the *1996 Guidelines* was international medical evacuation. In December 1981, the International Year of Disabled Persons, UNHCR announced the establishment of a Special Trust Fund for Handicapped Refugees, created with funds from the Nobel Peace Prize (which UNHCR won in 1981). Guidelines on how to administer the funds were issued in

1983 and revised in 1986.[99] The guidelines state that, in general, all refugees should be treated locally in public hospitals and facilities normally available to nationals, or in private hospitals where absolutely necessary. In exceptional cases, where adequate facilities are not available locally, a refugee patient may be referred for specialized treatment outside the country of asylum, usually within the same region. The program was set up specifically to "correct or minimize physical and mental disabilities."[100] In order to qualify for international medical evacuation, persons with disabilities required a medical referral from their doctor and a detailed social report prepared by UNHCR or the relevant implementing agency. Patients, and their escorts, could not apply for resettlement while abroad and had to agree in writing to return to their country of asylum after their medical treatment, or when requested to do so. Priority was given to children and young people who had a favorable prognosis for recovery and to heads of families, especially female heads of households, with dependent children. Assistance included medical, psychological and psychiatric treatment, surgical interventions, the purchase of prosthetic devices and procurement of medicines.

By the year 2000, the Special Trust Fund had run out of funds and its approach was no longer considered viable from a public health or administrative perspective. Refugees with disabilities were hence no longer evacuated for medical treatment.[101]

RESETTLEMENT: TEN OR MORE PLAN AND UNHCR RESETTLEMENT HANDBOOK

The *1996 Guidelines* also promoted third-country resettlement as a possible solution for refugees with disabilities.[102] The guidelines said that through the "Ten or More" and "Twenty or More" programs UNHCR was able to arrange for the annual resettlement of 200-300 disabled refugees and their families.[103] The Ten or More plan was established by UNHCR in 1973 for the resettlement of disabled refugees who had special medical needs that could not be met in their country of refuge. The aim of the program was for resettlement countries to accept 10 or more (or later, 20 or more) persons with disabilities, plus their families, annually who might otherwise not meet admissibility criteria in the resettlement country.[104] However, some countries have since suspended their Ten or More and Twenty or More resettlement programs.[105]

There are currently about 200 resettlement places worldwide for medical/disability cases in countries such as Norway, Finland, Netherlands, Denmark and New Zealand. These places are usually reserved for extremely urgent cases where immediate medical attention is required, such as a life-threatening illness or disability, rather than for chronic illnesses or long-term disabilities.[106] Some countries, such as the United Kingdom and Australia, have cost ceilings for the resettlement of individuals with serious illnesses or disabilities.[107] Australia, for example, makes no special provisions for the resettlement of refugees with medical needs, and on the contrary discourages it by setting rigid health criteria tied to public safety and undue cost considerations. Refugees will not meet health criteria if they have a medical condition that is "likely to result in a significant cost to health care and community services or prejudice Australians' access to health care or community services."[108] Such requirements are likely to exclude many refugees with disabilities from being eligible for resettlement in Australia and could be seen as actively discriminatory.

In 2004, UNHCR revised its 1997 Resettlement Handbook. Unlike the *1996 Guidelines,* the 2004 Resettlement Handbook gives scant attention to the resettlement of refugees with disabilities. The Handbook (like the *1996 Guidelines)* deals with the resettlement of refugees with disabilities only in the context of urgent medical needs. The Handbook stresses that where disabled refugees are "well-adjusted to their disability and are functioning at a satisfactory level" they are "generally not to be considered for resettlement."[109] It goes on to give the example of deaf refugees who have learned sign language and who are able to practice a profession, or who can benefit from training in the country of refuge, as a group that would not need resettlement. It says that wherever possible, treatment—such as the provision of hearing aids or prosthetics—should be provided in the country of refuge. "Only when such disabilities are untreatable locally, and when they seriously threaten the person's safety or quality of life, should resettlement be explored."[110]

Taken on its own, this guidance appears at best to treat the resettlement of refugees within an overly narrow remit, and at worst to actively advise *against* the resettlement of refugees with disabilities, in a way that could be interpreted as discriminatory. In subsequent e-mail correspondence with UNHCR resettlement staff, it was stressed that refugees with disabilities could fall within other profiles of people who are "at risk" or in need of a durable solution. "Disability is often used as an indicator of potential risk or past trauma. Resettlement staff are sensitive to this and will give particular attention to assessing the merits of resettlement for persons with disabilities, especially if no effective support is available in [the] country of refuge and where heightened risk to that individual may result because of the disability."[111]

Nevertheless, UNHCR's official resettlement policy currently fails to adequately deal with the issue of resettlement for refugees with disabilities. There is no guidance on family reunification for refugees with disabilities, or on how a disabled family member would impact a

family's opportunities for resettlement. This is especially important in group resettlement cases where there need to be clearer policies on resettlement opportunities for refugees with disabilities and their families. This includes information on special procedures for resettling refugees with disabilities, including pre-departure screening, counseling and travel arrangements; and on how to assist refugees with disabilities to access medical, educational, physical rehabilitation, training and employment services on arrival in the resettlement country.

UNHCR PROFILE GLOBAL REGISTRATION SYSTEM (PROGRES)

In 2004, UNHCR launched a new data collection software, ProGres (Profile Global Registration System), which is aimed at standardizing and improving refugee registration and data collection and at gathering more detailed and accurate information on refugee populations. ProGres allows for the collection of disaggregated data on the basis of age, gender, family composition, religion, ethnic group, area of origin and specific protection needs of the population. It also provides guidance on collecting data about groups of refugees with specific needs and protection risks, such as children and adolescents, women at risk, single parents, older people, people with specific medical needs, people with specific legal and physical protection needs and persons with disabilities. Since 2004, UNHCR staff across the world have been trained in ProGres, but it has not yet been implemented in all countries. ProGres has not been used in any IDP situations. One drawback is that the data collection staff often lack the technical expertise and knowledge to assess the nature of a disability and hence to categorize and record accurate data. Qualified professionals should be involved in data collection for all special needs categories.

The categories of disabilities listed under the Special Needs section of the database include sight impairment, hearing impairment, mental disability (moderate and severe), physical disability (moderate and severe) and speech impairment. [See Annex B, p. 63). Although these categories are generally useful in distinguishing between different types and levels of disability within a refugee population, the definition of "mental disability" in the ProGres database incorrectly uses the terms "mental disability" and "mental illness" interchangeably. Thus a moderate mental disability, for example, is defined as: "Having a mental *illness* resulting from childbirth, medical illness, injury or trauma…" (emphasis added).[112] However, mental health problems are also included separately under a category called "psychological condition" in the "Important Medical Condition" section of the Special Needs section of the database. Such confusion not only compromises the accuracy and quality of data collected, but can also affect the appropriateness of targeted responses.

Nevertheless, there is evidence that where ProGres has been properly implemented it significantly improves the quality and accuracy of data available about a refugee population, including information on disability. With improved training for data collection staff, some revisions to the Special Needs definitions and the standard application of ProGres in *all* UNHCR operations, UNHCR could vastly improve the quality of data available on refugees with disabilities worldwide.

UNHCR HEIGHTENED RISK IDENTIFICATION TOOL

An additional tool developed by UNHCR to identify groups of refugees at risk is the *Heightened Risk Identification Tool* (HRIT).[113] Like ProGres, the HRIT is a first line identification tool. Unlike ProGres, which aims to provide an overall profile of the refugee population (group-based information), the HRIT is aimed at providing detailed information about *individuals* at risk. It was initially developed as a tool to identify women at risk, and expanded to include other at-risk individuals in 2007.[114]

It is intended to be used by UNHCR protection and community services officers and NGO implementing partners to identify individuals at risk who require immediate intervention, ensure their referral to appropriate resources and plan for durable solutions, especially resettlement. The HRIT can be used as an interview tool, a checklist for case workers or a portable tool during visits to refugee communities.

The HRIT includes six heightened risk categories with different heightened risk indicators and checklists for determining the cause of the risk (whether past or present), the level of risk (high, medium or low) and the impact on both the individual and his/her family. Categories of people at heightened risk include women and girls, unaccompanied and separated children and adolescents, older persons, survivors of violence and torture, persons with health needs and persons with legal or physical protection needs. [See Annex C, p. 64.]

Unlike the ProGres database, where disability has its own separate category, disability is included as an indicator under the Health Needs category of the HRIT. Furthermore, the HRIT does not use the same definitions or terminology for disability as ProGres. Only two indicators are dedicated to disabilities—these are "physical disability" (with no further explanation) and "intellectual impairment from birth (e.g., Down syndrome, intellectual disability) or as a result of injury (e.g., acquired brain injury)." There is no

inclusion of other disabilities, such as sensory impairments, or mixed disabilities, and no indication of the severity of disability (i.e., severe/moderate as in ProGres).

Each of the six heightened risk categories includes an indicator called "impairment in daily functioning due to mental illness." The user guidelines list signs of mental illness that interviewing staff should look for. Unlike ProGres, where the terms "mental illness" and "mental disability" are incorrectly used interchangeably, the HRIT specifically states that "interviewers should note that mental illness does *not* include intellectual or congenital disabilities (e.g., Down syndrome, brain damage from birth or injury, physical disabilities, etc.). Daily functioning may be impaired in these instances, but is not caused by psychological factors."[115]

Although the distinction between "mental disability" and "mental illness" is helpful, in general the HRIT does not provide as detailed information on disability as ProGres. Disability is not included as an indicator under other heightened risk categories, for example, older persons, women at risk or children—even though living with a disability or supporting a family member with a disability can pose particular protection risks for all these groups. Moreover, the lack of specificity about the type and severity of disability in the HRIT means that it cannot accurately reflect the different protection risks faced by people with different disabilities.

A final comment on both the HRIT and ProGres is the danger of only viewing disability through a heightened risk, or special needs, lens during refugee profiling exercises. This can result in ignoring the skills and potential of persons with disabilities. Moreover, the tendency, especially in the HRIT, to see disability as a special health need means that there may be an overemphasis on medical responses, while ignoring disabled persons' other rights and needs and the social, physical and environmental barriers they face to participating fully in society.

Finally, it is important to recognize that identification of refugees with disabilities is just the first step. Knowing the number and profile of persons with disabilities in a community is only useful if action is then taken both to improve their individual situation and also to make the necessary social and environmental changes to enable them to participate on a full and equal basis in their community.

THE UNHCR TOOL FOR PARTICIPATORY ASSESSMENT IN OPERATIONS

Participatory assessments have become an established part of annual planning exercises in most UNHCR field operations. UNHCR defines participatory assessment as "a process of building partnerships with refugee women and men of all ages and backgrounds by promoting meaningful participation through structured dialogue."[116] It involves holding separate discussions with women, men, boys and girls, including adolescents, to gather "accurate information on the specific protection risks they face and the underlying causes, to understand their capacities and resources, and to hear their proposed solutions."[117] The aim of participatory assessments is to gather baseline data for age, gender and diversity analysis, to analyze protection risks and solutions together with refugees and to involve refugees at all stages of the program cycle. The participatory assessment tool provides guidance to staff on how to conduct participatory assessments using multifunctional teams and a variety of methodologies (such as observation and spot checks, semistructured discussions and focus group discussions).[118]

Participatory assessments are of particular relevance to refugees with disabilities as they are an effective method for ensuring that the views of *all* refugees are heard and that marginalized groups are not excluded during the design and delivery of goods and services. They can also lead to more detailed and disaggregated baseline data about a community, which in turn improves the planning and design of programs to meet the real needs of the community. If they are properly planned, participatory assessments can be an effective method of identifying persons with disabilities within a community, listening to their views and involving them fully in all stages of the planning, design, implementation and monitoring of assistance programs and protection responses. Where participatory assessments have fully involved refugees with disabilities, such as in the Dadaab refugee camps in Kenya, they have led to significant improvements in the design and delivery of services for persons with disabilities.

UNHCR AGE, GENDER AND DIVERSITY MAINSTREAMING STRATEGY

UNHCR's Age, Gender and Diversity Mainstreaming (AGDM) initiative aims to place refugees at the center of decision-making within UNHCR's operations and to promote the equal access and opportunity for all refugees regardless of age, gender, religion, ethnicity or ability. The approach uses UNHCR's participatory assessment tool to consult with refugees of all ages and backgrounds to identify the particular needs, concerns, priorities and proposed solutions for refugee women, men, girls and boys. The AGDM then uses this information to inform both policy and practice and synthesizes the findings into the program planning cycle, including the country operations plan and budget. This approach was piloted in 2004 and is now being mainstreamed through a roll-out strategy in all UNHCR field operations.

The strategy initially focused exclusively on age and gender. However, following an evaluation of the pilot projects in 2005, diversity was added, primarily to reflect the particular protection risks faced by different religious and ethnic groups. Although disability could also be included as an indicator of diversity, the focus of the AGDM strategy has been much more on age, gender and ethnic diversity. So while the AGDM could be an effective strategy for identifying the specific needs, skills and resources of disabled people in a community, it has not yet been fully used in this way.[119]

UNHCR COMMUNITY-BASED APPROACH

UNHCR's community-based approach encompasses the same values and some of the same methodologies as participatory assessments and the AGDM strategy. It places people of concern (those people under UNHCR's mandate—refugees, asylum seekers, Stateless persons, some internally displaced persons, and refugee returnees) at the center of all UNHCR operations and protection strategies. It is a participatory approach to working that is "based on an inclusive partnership with communities of persons of concern which recognizes their resilience, capacities and resources."[120] Several guiding principles underpin the community-based approach. These are a rights-based approach as a conceptual framework; meaningful participation of all members of the community in decision-making processes and community activities; age, gender and diversity analysis; empowerment; ownership and sustainability, whereby members of the community assume full responsibility for managing activities and services; and transparency and accountability. The community-based approach manual outlines different strategies for mobilizing community participation. These include situation analysis (including stakeholder analysis, participatory assessments and participatory planning) and community mobilization and empowerment (including community mapping, community-based action planning, monitoring and evaluation). Like the participatory assessments and AGDM strategy, the community-based approach provides great potential for including persons with disabilities in all aspects of decision-making, program planning, implementation and monitoring processes. However, the extent to which this has really been achieved has yet to be reviewed and analyzed.

ACTION FOR THE RIGHTS OF CHILDREN (ARC)

ARC is an interagency initiative begun by UNHCR and the International Save the Children Alliance in 1997 and later joined by several other UN agencies and NGOs.[121] ARC has produced 14 training resource packs for practitioners focusing on the rights and needs of refugee and displaced children. One of these resource packs is dedicated to addressing the needs of children with disabilities and reversing negative attitudes.[122] The resource pack provides comprehensive information on approaches to disability, relevant international legal standards relating to children with disabilities, the specific challenges for children with disabilities in situations of armed conflict and displacement and concrete strategies for encouraging the active participation and inclusion of children with disabilities in assistance programs, with particular attention given to inclusive education. This is an excellent resource for UN and NGO fieldworkers seeking to improve assistance and protection for displaced children with disabilities. The ARC disability resource pack is currently being updated and revised and a new edition will be available in mid-2008.

OTHER UNHCR POLICIES AND GUIDELINES

Other UNHCR policies and guidelines of relevance to refugees and IDPs with disabilities include:

- UNHCR. (2008). *Handbook for the protection of women and girls.* Geneva: UNHCR.
- UNHCR. (2003). *Sexual and gender-based violence against refugees, returnees and internally displaced persons: Guidelines for prevention and response.* Geneva: UNHCR.
- UNHCR. (2007). *Handbook for emergencies,* 3rd ed. Geneva: UNHCR.
- UNHCR. (1994). *Refugee children: Guidelines on protection and care.* Geneva: UNHCR.
- UNHCR. (2003). *Agenda for Protection,* 3rd ed. Geneva: UNHCR. http://www.unhcr.org/protect/PROTECTION/3e637b194.pdf.

Other UN and International Policies on Disability and Displacement

CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES, DECEMBER 2006

The Convention on the Rights of Persons with Disabilities (CRPD) was adopted by the UN General Assembly in December 2006. It was the fastest-ever negotiated human rights treaty and had a record number of state signatories when it opened for signature in March 2007. As of April 24, 2008, 127 countries had signed the Convention, with 24 ratifications, and 71 countries had signed the Optional Protocol, with 14 ratifications.[123] The Convention and Optional Protocol entered into force on May 3, 2008.

The CRPD is now the principal international human rights instrument to promote and protect the rights of persons with disabilities and as

such should guide all aspects of humanitarian response.[124] Article 11 of the CRPD specifically refers to situations of risk and humanitarian emergencies and calls on States Parties to take "all necessary measures to ensure the protection and safety of persons with disabilities in situations of risk, including situations of armed conflict, humanitarian emergencies and the occurrence of natural disasters."

Other relevant articles for refugees and displaced persons with disabilities include recognition of the specific rights of women and children with disabilities (Articles 6 & 7). The CRPD also emphasizes the importance of accessibility to enable persons with disabilities to "live independently and participate fully in all aspects of life." It obliges States Parties to take appropriate measures to ensure that persons with disabilities have access on an equal basis with others to the physical environment, transportation, information and communications and to other facilities and services in both urban and rural areas. It calls on States to identify and eliminate all obstacles and barriers to accessibility, including in buildings, roads, transportation, schools, housing, medical facilities, information, communication and other services (Article 9).

Article 16 calls on States Parties to protect persons with disabilities from exploitation, violence and abuse and to provide rehabilitation, reintegration and protection for those who are victims of violence and abuse. The Convention also guarantees the rights of persons with disabilities to freedom of expression and access to information in accessible formats (e.g., Braille and sign language) (Article 21). States Parties undertake to provide early and comprehensive information, services and support to children with disabilities and their families to prevent "concealment, abandonment, neglect and segregation of children with disabilities" (Article 23). The right of children to free and inclusive primary education is guaranteed in Article 24. States Parties are encouraged to promote the learning of Braille and sign language and to employ teachers qualified in sign language and Braille (Article 24). The Convention also calls on States to ensure that persons with disabilities have access to tertiary education, vocational training, adult education and lifelong learning on an equal basis with others (Article 24).

Similarly, the Convention guarantees the rights of persons with disabilities to health care, including sexual and reproductive and specialized health care (Article 25); habilitation and rehabilitation (Article 26); work and employment (Article 27); an adequate standard of living and social protection (Article 28); participation in political and public life (Article 29); and participation in cultural life, recreation, leisure and sport (Article 30). Article 31 obliges States to collect statistical data on disabilities and to comply with legislation on data protection to ensure confidentiality and respect for the privacy of persons with disabilities.[125]

The Convention was preceded by the 1993 UN Standard Rules on the Equalization of Opportunities for Persons with Disabilities, which were one of the major outcomes of the UN Decade of Disabled Persons from 1983 to 1992.[126]

THE SPHERE PROJECT HANDBOOK

The Sphere Project was launched in 1997 by a group of humanitarian NGOs and the Red Cross and Red Crescent movement. The aim of the Sphere Project was to establish an operational framework for accountability in disaster assistance efforts. The *Sphere Project Handbook* was published in 2000 (and revised in 2004) and consists of a Humanitarian Charter, which is based on the principles and provisions of international humanitarian, human rights and refugee law, and Minimum Standards for disaster assistance in five key sectors (water and sanitation, nutrition, food aid, shelter and health services).[127] Disability is dealt with as an issue throughout the *Sphere Project Handbook* that cuts across all sectors (other such issues include children, older people, gender protection, HIV/AIDS and the environment). People with disabilities are defined as having physical, sensory or emotional impairments or learning difficulties that make it more difficult for them to use standard disaster support services. The focus of the Sphere Project is on ensuring that standard facilities are as accessible as possible and that all vulnerable groups, including persons with disabilities, have full and equal access to assistance and information.

The strength of the Sphere Project is that it deals with disability as an integrated issue that cuts across all areas and considers the needs of persons with disabilities in all mainstream sectors. The weakness is that it is very general and lacks specific guidance. So under the food and nutrition section, for example, there are no guidelines for measuring malnutrition among individuals with physical disabilities; and under the health section there are no guidelines on the management of chronic diseases and disabilities during disasters, although it does contain a standard that discusses the needs of people with severely disabling mental illness. The *Sphere Project Handbook* is due to be revised in 2009, with the new edition available by the end of 2010. The issue of disability will be reviewed during the upcoming revision of the Handbook.

WHO/UNESCO/ILO: COMMUNITY-BASED REHABILITATION

Community-based rehabilitation (CBR) is a method that was developed by WHO in the 1970s as a community-based approach to assisting persons with disabilities within their local community. (See page 11 for a full description of the CBR approach.) Recent revisions of CBR strategies have emphasized the critical role that DPOs play in advocating and advising on behalf of persons with disabilities. They have also stressed the core human rights and poverty reduction components of CBR programs; the need to promote gender equality and the inclusion of all age groups, including middle-aged and older adults, in CBR programs; and the need for ongoing training for CBR workers, managers, DPOs and service providers.[128] New CBR guidelines developed by WHO, ILO and UNESCO, in collaboration with disability and development NGOs and DPOs, will be launched in 2008. Among other things, the guidelines address the relevance of CBR programs in situations of crisis, such as natural disasters, civil conflict and war, and complex chronic emergency situations.[129]

The CBR approach has been applied in numerous refugee and displacement situations. As a low-cost, community-based approach that relies on locally available resources and local skills and knowledge, it is well suited to a refugee or IDP setting. While increasing the visibility and integration of persons with disabilities, CBR has been criticized for not promoting their participation in decision-making processes at all levels, nor has it succeeded in mainstreaming disability issues.[130]

The new Guidelines on CBR and Crisis Situations attempt to address these criticisms.[131] The guidelines stress the importance of consultation, participation and representation of persons with disabilities in the crisis management process to ensure inclusive emergency planning and response. This includes disaster management planning, during the immediate emergency response and in the reconstruction and recovery phase. The guidelines state that the CBR approach is useful in ensuring that the needs of persons with disabilities are reflected in disaster preparedness planning; in ensuring that mainstream emergency assistance and support is accessible to persons with disabilities; and ensuring that persons with disabilities can benefit from reconstruction and development after the emergency.

IASC GUIDELINES ON MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT

In 2007, the Inter-Agency Standing Committee published *Guidelines on Mental Health and Psychosocial Support in Emergency Settings* to "enable humanitarian actors to plan, establish and coordinate a set of minimum multisectoral responses to protect and improve people's mental health and psychosocial well-being in the midst of an emergency."[132] The guidelines emphasize both emergency preparedness and minimum responses in the early phases of an emergency and comprehensive responses in the stabilized emergency phase and early reconstruction phases.

The guidelines highlight the mental health and psychosocial impact of emergencies on individuals, families and communities. They divide mental health and psychosocial problems into those that are predominantly social, including preexisting social problems, emergency-induced social problems and humanitarian aid-induced social problems; and those that are predominantly psychological, including preexisting mental health problems, emergency-induced problems and humanitarian aid-related problems. The guidelines identify groups of people at increased risk of mental health problems during an emergency. Included among these are people with preexisting, severe physical, neurological or mental disabilities or disorders. Also included are elderly people who have lost family members who were caregivers and people experiencing social stigma (including people with severe mental disorders). Mental health is viewed as a gradient from the short-term mental health impacts of an emergency to more acute distress and trauma to long-term, chronic mental illness and disability.

The IASC *Guidelines on Mental Health and Psychosocial Support* adopt a broad, holistic view of mental health and psychosocial well-being, avoiding an overemphasis on trauma and post-traumatic stress disorder. They suggest strategies for promoting mental health and well-being at all stages of programming and planning.

Although the IASC *Guidelines on Mental Health and Psychosocial Support* do not deal explicitly with mental disabilities (e.g., intellectual disability; long-term cognitive impairment; serious mental disorders; and congenital mental disability), the broad, holistic approach to mental health adopted by the guidelines is a useful framework for addressing disabilities in an emergency context. Furthermore, the core principles of human rights and equity: participation; do no harm; building on local resources and capacities; integrated support systems; and a multilayered approach (including basic services and security; strengthening community and family supports; nonspecialized support for people who need extra support; specialized services for people with severe mental disorders) that underpin the guidelines are all highly relevant when planning services and responses for people with all kinds of disabilities.

The IASC *Guidelines on Mental Health and Psychosocial Support* could be a useful model for developing similar interagency guidelines on meeting the needs of persons with disabilities during humanitarian emergencies.[133]

IASC GUIDELINES ON HUMAN RIGHTS AND NATURAL DISASTERS

In June 2006, the IASC published operational guidelines on *Protecting Persons Affected by Natural Disasters.* These guidelines mention persons with disabilities in a number of different contexts (e.g., camp security/safe and nondiscriminatory access to humanitarian assistance/inclusion in resettlement and reconstruction planning/inclusion in livelihood opportunities).[134]

BONN DECLARATION

The Bonn Declaration is the outcome of an international conference held in Bonn November 7-8, 2007 on the above topic. The declaration provides a set of recommendations for a more inclusive emergency response. These deal with inclusive pre-disaster preparedness and planning; an inclusive acute emergency response and immediate rehabilitation measures; and inclusive post-disaster reconstruction and development.[135]

International and Nongovernmental Organizations with Disability Policies

HELPAGE INTERNATIONAL

There is a significant overlap between the challenges faced by displaced older people and persons with disabilities who are displaced. Not only do many older people also have physical, mental and sensory impairments, but like persons with disabilities they are also often the most vulnerable, hidden and neglected group within a displaced population. HelpAge International (HelpAge) has more than 20 years of experience of working with older people in humanitarian crises and emergencies. Over this period HelpAge has documented many of its experiences and lessons learned in the form of policy papers, reports and guidelines for best practices. In 1999, HelpAge commissioned a major research project on how older people are affected by disasters and humanitarian emergencies, and how humanitarian agencies address their needs. The findings from this research, published in a report in 2000, are of direct relevance to humanitarian agencies working with displaced persons with disabilities.[136]

Like persons with disabilities, there is a glaring lack of reliable data on older people in humanitarian emergencies. UN and NGO relief agencies still fail to collect age- and gender-disaggregated data and older people, like persons with disabilities, continue to be systematically ignored in mainstream programming and decision-making processes. HelpAge reports that while there is a growing, and important, recognition of the specific protection and assistance needs of women and children in emergencies by a number of organizations with specific mandates, older people are frequently forgotten. Specific mandate organizations fail to adopt a cross-generational approach or to recognize the critical role that older people play as caregivers and advisers within the family and community; while mainstream agencies assume that older people will be able to access basic relief services like everyone else.[137]

The reality in humanitarian emergencies is not so straightforward. Like persons with disabilities, older people are often unable to access relief aid and services due to restricted mobility and inability to travel long distances or line up for long periods of time for relief aid. Health services focus almost exclusively on emergency and primary health care, with much less attention paid to addressing chronic health problems. The irony is, though, that, like persons with disabilities, if chronic health problems are ignored and untreated in an emergency, they can become acute and result in much more serious and long-term impairments. Older people, like persons with disabilities, are also ignored in income generation and livelihood projects, vocational training and adult education programs, and they lack access to basic information about their rights, relief services and durable solution options.

Older people also face many of the same protection problems as persons with disabilities. One of the greatest protection risks faced by older people in an emergency is isolation. The breakdown of family and community structures during an emergency and the separation of family members during flight can leave many older people alone and neglected. Like persons with disabilities, they may be separated from caregivers and lose the support of extended families and neighbors. The impact of chronic emergencies on households, in terms of the loss of income and the depletion of resources and coping strategies, can make it much harder to care for dependent family members, such as older or disabled people. This can result in neglect or abandonment of older people, particularly those who are disabled. [138]

Increased isolation makes older people, like persons with disabilities, more vulnerable to sexual and physical violence and abuse, theft and exploitation. Isolation and the loss of a meaningful role and status in the family and community can also lead to extreme loneliness, depression and mental health problems. While humanitarian organizations have put enormous effort into setting up support groups and safe spaces for women and children in refugee and IDP camps, similar effort has not been put into providing safe spaces for older people to meet and socialize.[139]

A lot of important lessons can be learned from HelpAge's experience and documentation of working with older people in emergencies, which can usefully be applied to displaced persons with disabilities.

Resources:

HelpAge International. (2004). Ageing and disability. *Ageways*, 64 (January 2004).

HelpAge International. (2000). *Older people in disasters and humanitarian crises: Guidelines for best practice.* London: HelpAge International.

HelpAge International. (2006). *Rebuilding lives in longer-term emergencies: Older people's experience in Darfur.* London: HelpAge International.

Wells, Jo. (2005). *Protecting and assisting older people in emergencies*. Network Paper Number 53 (December 2005). London: Humanitarian Practice Network.

HANDICAP INTERNATIONAL

One of the principal organizations involved in assisting refugees and displaced persons with disabilities is Handicap International. Indeed, Handicap International's activities began in the early 1980s in refugee camps in South East Asia—Thailand, Cambodia, Laos and Thailand—to assist refugees who had lost their limbs as a result of land mine accidents. Handicap International has continued to work with refugees and displaced persons with disabilities since that time. Although its main emphasis continues to be on orthopedic and physical rehabilitation for persons with disabilities and injuries in natural disasters, conflicts and situations of extreme poverty, it has also expanded its activities to promote the social inclusion of all persons with disabilities with a strong emphasis on community-based approaches. Handicap International is currently working in more than 60 countries.

Handicap International provides long-term development assistance in partnership with local disability organizations. It also has an emergency response unit and is involved in assisting refugees and displaced persons. Handicap International is currently collaborating with UNHCR to second technical staff for UNHCR operations to provide technical training and advice to UNHCR staff and the IASC Protection Cluster, and to help develop operational guidelines on assisting refugees and IDPs with disabilities based on analysis of good practices in the field.

Resources:

http://www.handicap-international.org/

WORLD VISION

World Vision is an international development and humanitarian aid agency dedicated to the relief of suffering and improvement in the quality of life of the world's poorest people. The World Vision Partnership is committed to mainstreaming and inclusion of people with disabilities across the organization and throughout all its development, humanitarian and advocacy programs.

World Vision seeks to support people with disabilities' participation in program planning, monitoring and evaluation; equipping humanitarian, development and advocacy staff on disability issues; and sharing best practice with other agencies, particularly through active membership of key disability coalitions. Through interagency collaboration, World Vision also actively seeks constructive policy changes, such as the inclusion of disabled children in education.

Resources:

http://www.worldvision.org.uk/

CHRISTIAN BLIND MISSION

Christian Blind Mission (CBM) is an international Christian development organization whose primary purpose is to improve the quality of life of the world's poorest persons with disabilities and those at risk of disability. CBM works with partner organizations in low-income countries to ensure that persons with disabilities and their families have ready access to affordable and comprehensive health care and rehabilitation programs, quality education programs and livelihood opportunities.

Working with persons with disabilities, CBM advocates for their inclusion in all aspects of society. In this context, CBM and its partners adopt the same approach toward refugees and IDPs with disabilities, providing them with services in camps and specialized referral facilities. CBM and its partners are active in refugee and IDP camps in Chad, Democratic Republic of Congo, Sri Lanka and elsewhere.

Resources:

http://www.cbm.org/

SAVE THE CHILDREN ALLIANCE

Save the Children has been working to further the rights of children with disabilities since its inception in 1919. Save the Children Alliance members work to address the rights of children with disabilities to inclusive education, play and leisure, family support and participation. They promote the full inclusion of children with disabilities in society, and advocate and lobby governments to implement laws and international treaties to enhance their full rights as citizens.

In an emergency, Alliance members ensure the inclusion of children with disabilities in their humanitarian response, including child-friendly spaces, education and other relief and rehabilitation activities. They also initiate specific interventions for children with disabilities to prevent discrimination and promote access to basic services.

Resources:

http://www.savethechildren.org.uk/

http://www.savethechildren.net/alliance/index.html

Lansdown, Gerison. Forthcoming. *Promoting the rights of children with disabilities: A guide to using the Convention on the Rights of Persons with Disabilities with the Convention on the Rights of the Child.* London: Save the Children Alliance.

Policy and Learning Team. (2005, January). *Working with the most vulnerable in emergencies.* London: Save the Children UK.

Richman, Naomi. (1993). *Communicating with children: Helping children in distress.* London: Save the Children UK.

Save the Children UK. (2005). *Making a difference: Training materials to promote diversity and tackle discrimination.* London: Save the Children UK.

Save the Children UK. (2008). *Making schools inclusive: How change can happen.* London: Save the Children UK.

THE INTERNATIONAL COMMITTEE OF THE RED CROSS (ICRC)

The International Committee of the Red Cross (ICRC) is an impartial, neutral and independent organization whose exclusively humanitarian mission is to protect the lives and dignity of victims of war and internal violence and to provide them with assistance. The ICRC works through 80 delegations and missions around the world. Its aim is to preserve or restore acceptable living conditions for civilians, the sick and wounded (both military and civilian) and people deprived of their freedom. Assistance includes ensuring access to food, water and other vital necessities, and restoring satisfactory hygiene conditions.

As part of its mandate, the ICRC supports the physical rehabilitation of victims of conflict and violence who have sustained physical injuries and disabilities through its physical rehabilitation programs and through the ICRC Special Fund for the Disabled, set up 25 years ago.

Resources:

International Committee of the Red Cross: http://www.icrc.org

ICRC Special Fund for the Disabled: http://www.icrc.org/fund-disabled

INTERNATIONAL CAMPAIGN TO BAN LANDMINES

The ICBL Working Group on Victim Assistance, comprising more than 25 international humanitarian and development organizations, has developed programmatic guidelines to help shape and promote comprehensive rehabilitation for landmine survivors worldwide.

Resources:

ICBL. (2004). *Guidelines for the care and rehabilitation of survivors.* http://www.icbl.org/problem/solution/survivors/guidelines

THE INTERNATIONAL DISABILITY AND DEVELOPMENT CONSORTIUM: TASK GROUP ON DISABILITY AND CONFLICT

The IDDC consists of 14 international NGOs involved in disability and development, including all those listed above. Disability and conflict were identified as a key issue by the IDDC and following an international seminar on the topic in June 2000, the task group was set up.

Resources:

IDDC. (2000, May 29-June 4). Disability and conflict. Report of an IDDC Seminar, London.

Kett, Maria, Sue Stubbs, and Rebecca Yeo. (2005). *Disability in conflict and emergency situations: Focus on tsunami-affected areas.* London: IDDC.

ANNEX A: Methodology, Field Studies, Field Research Methodology, Strengths and Constraints of Field Studies

Methodology

A four-pronged approach was used to conduct the research: 1) a review of existing UN, NGO, international and national policies on disability, with particular reference to displacement and disability; 2) global desk research into conditions for displaced persons in different refugee and IDP situations, primarily in developing countries; 3) telephone interviews with various organizations working in this field; and 4) field studies into specific conditions for refugees with disabilities in five different countries, carried out by local organizations.

The research was primarily qualitative rather than quantitative, and the objective was not to gather detailed demographic or sex- and age-disaggregated data on displaced persons with disabilities. The project served as a preliminary insight into the challenges faced by displaced persons with disabilities and was by no means an exhaustive study.

Field Studies

Different locally based NGOs working on disability issues were subcontracted to carry out the five field studies for the project. The reasons for this were varied. Not only did time and budget constraints prevent an international consultant from carrying out the research, but also, and more importantly, the Women's Commission believed that involving locally based organizations fully engaged in this issue, with an intimate understanding of the situation on the ground, would significantly improve the quality of the research. Wherever possible, the project tried to work through local disabled persons organizations (DPOs) and also to use persons with disabilities to carry out the research.

CHOICE OF COUNTRIES AND LOCAL ORGANIZATIONS

As mentioned above, for a variety of reasons, the countries selected for field studies focused exclusively on refugees and asylum seekers and not on IDP situations. In selecting countries and locally based organizations to conduct the field studies, the following criteria were used:

- a broad geographic range;
- a broad range of displacement situations (e.g., camp-based and urban refugees; emergency and long-term refugee crises);
- local organizations already engaged in working with persons with disabilities (either in the refugee or local community) and with an in-depth understanding of the local situation;
- wherever possible to engage local DPOs and persons with disabilities to conduct the research.

COUNTRY PROFILES

After much preliminary research and investigation, the following countries and local organizations were selected to carry out the field studies:

NEPAL

Location. Bhutanese Refugee Camps, Jhapa and Morang Districts, South East Nepal.

Background to refugee situation. Tens of thousands of refugees fled Bhutan in the early 1990s following a systematic policy of discrimination, denationalization and expulsion of ethnic Nepalis living in Southern Bhutan by the Bhutanese government.[140] The refugees, now numbering more than 107,000[141] (one-sixth of the total population of Bhutan), have been living in seven camps in South East Nepal for more than 16 years. This is one of the world's longest and most protracted refugee crises, although a solution for some of the refugees is now in sight.

Fifteen rounds of bilateral talks between the governments of Nepal and Bhutan between 1993 and 2003 failed to solve the refugee crisis, and the Government of Bhutan has refused to allow a single refugee to return. Given this *impasse,* in October 2006, the United States finally announced an offer to resettle 60,000 refugees.[142] Several other industrialized countries have since indicated their willingness to accept Bhutanese refugees for resettlement.[143] In January 2008, a refugee resettlement processing center was opened in Damak, Jhapa District. At the opening of the center, the U.S. ambassador announced that the U.S. government hoped to resettle 13,000 refugees in 2008 and a further 20,000 refugees by the end of 2009.[144]

Description of refugee camps. The Bhutanese refugee camps are renowned for their high levels of community organization and participation, as well as their excellent education programs and high literacy and school attendance rates. Refugees run many of the services in the camps themselves, including the schools, health services, vocational training and other community programs. There is a highly organized camp management structure in place in all the camps and broad levels of community representation. Women, youth and older people have active community-based organizations (CBOs) in the camps, and services for these groups are active and well organized.

UNHCR has overall responsibility for assisting the Government of Nepal to provide assistance and protection to refugees in the camps. The World Food Program (WFP) is responsible for providing food to the refugees. UNHCR's implementing partners provide additional services: the Lutheran World Federation (LWF), which has been working in the camps since they were set up in 1991, is responsible for camp infrastructure, water and sanitation and food and nonfood relief distribution. Caritas Nepal is responsible for formal and nonformal education and vocational training in the camps (see more below). AMDA (Association of Medical Doctors of Asia) provides primary health care services in the camps, including psychosocial services, an HIV/AIDS program and sexual and gender-based violence program.

For many years, services in the camps were of a very high standard. However, the protracted nature of the refugee crisis and accompanying donor fatigue have led to the departure of several implementing agencies and to a reduction in assistance. Budgetary constraints have resulted in cuts in essential services, including basic and supplementary food rations and nonfood items (such as plastic sheeting and clothing) and a switch in fuel from kerosene to coal dust briquettes, which are unpopular with the refugees.[145] Not only have cuts in assistance led to a general decline in living conditions in the camps, but the protracted nature of the refugee crisis has also contributed to a reported increase in depression and other mental health problems among the refugees and to growing levels of sexual and gender-based violence, especially domestic violence.[146]

Political unrest in Nepal and the violent Maoist (Communist Party of Nepal) insurgency that spread through the country from 1996 until a comprehensive peace agreement between the Maoists and the Government of Nepal was signed in 2006[147] also affected the refugee camps. Disaffected refugee youth formed their own Bhutanese Maoist organization, generating fear and insecurity in the camps. Violence and intimidation in the camps increased considerably in 2006, following the U.S. government's offer to resettle 60,000 refugees. Opposition to resettlement came from some of the refugee political leaders who continued to favor return to Bhutan as the only solution to the crisis, as well as from the Maoist youth operating in the camps.[148] Refugees who were perceived to support resettlement, especially the camp committee leaders, were threatened and in some cases forced to leave the camps and go into hiding. In May 2007, attacks by Maoist youths on refugees who supported resettlement resulted in the deaths of at least two refugees when the Nepalese police opened fire on the mob.[149]

Numbers of refugees with disabilities. Both UNHCR and Caritas Nepal collect data on the number and types of disability in the Bhutanese refugee camps. There is, however, significant discrepancy between the data collected by the two organizations. UNHCR estimates the total number of disabled persons to be 11,396 (10.6 percent of the total refugee population), while Caritas Nepal has recorded 3,388 disabled persons in the camps (3.2 percent of the total population).

The UNHCR data was collected in its 2007 census in the refugee camps, during which all refugees were met, including those who were restricted to their huts due to disability. Caritas Nepal's data was collected by disability staff in each camp using participatory rural appraisal tools at the start of the disability project in 1996 (see below for more details). According to Caritas, the data is regularly updated to include newly identified cases and newborn children with disabilities. One explanation for the discrepancy in data put forward by Caritas is that UNHCR's data collection may have been carried out by staff without technical expertise in diagnosing and classifying disabilities and may have included other groups, such as chronically sick and mentally ill persons, who are not included in the Caritas data collection.

Conversely, UNHCR suggests that during the 2007 census a decision was made to capture all persons with disabilities without categorization, so the UNHCR data also include persons with minor disabilities that do not significantly impair their daily life. UNHCR also argues that, as Caritas's disability program does not reach 100 percent of refugees with disabilities in the camps and the data may not be regularly updated, its figures may not be representative of the total number of persons with disabilities in the camps.[150] Whatever the reason, the discrepancy highlights the difficulties in obtaining accurate and consistent data on the number of persons with disabilities in a refugee situation.

According to both UNHCR and Caritas Nepal's data, the most prevalent form of disability is hearing impairment (35 percent of the total disabled population is hearing impaired according to UNHCR, while according to Caritas 49 percent of the disabled population is hearing *and* speech impaired). The second highest form of disability according to UNHCR is visual impairment (25 percent of total

disabled population) and according to Caritas is physical disability (23 percent of total disabled population). UNHCR ranks physical disability (moderate and severe) as the third most prevalent form of disability (19 percent of total disabled population), while Caritas ranks visual impairment as the third highest form of disability (12 percent of total disabled population).

According to UNHCR's census data, 0.1 percent of under-five-year-olds have a disability; 2.7 percent of 5- to 11-year-olds; 4.3 percent of 12- to 17-year-olds; 11.7 percent of 18- to 59-year-olds; and 42.1 percent of people over 59 years are disabled. Both UNHCR and Caritas conclude that in all age groups, more men than women live with disabilities.

Services for refugees with disabilities. A community-based disability program was started by Save the Children in 1995. It began with a home visiting pilot project targeting 20 children with disabilities and their families in two refugee camps. The program was extended in 1996 with the appointment of disability workers in all camps, and expanded to include CBR training for community leaders, schoolteachers and health workers. A community-based data collection exercise was organized in all the camps using participatory mapping tools to gather comprehensive information on the numbers and types of disability in the camps.[151]

In 2001, Caritas Nepal took over the disability program when Save the Children ceased its activities in the refugee camps. The main emphasis of the Caritas program has been on promoting inclusive education. Caritas provides training for special needs support teachers who serve as a vital bridge between the school and homes of children with disabilities. It runs training courses in sign language for refugees with hearing impairments, their families and caregivers, teachers and community leaders. Mobility devices, hearing aids and other aids and appliances are provided to persons with disabilities. There is a comprehensive vocational skills training program for youth who have completed school, or as an alternative to formal schooling, and for young people with mental disabilities. Disability community workers carry out home visits for counseling and physiotherapy, and respite care is given to children with cerebral palsy. There is an ongoing training and support group for mothers of children who are mentally disabled or suffer from cerebral palsy. All disabled refugees have the opportunity to receive medical certification of their disabilities (based on WHO classifications), which helps them to acquire assistive devices, including hearing aids. Finally, refugees with disabilities have been encouraged to set up their own self-help groups in the refugee camps with support from the disability workers.

Local organization. Field research for this project was carried out by Caritas Nepal. In collaboration with the Jesuit Refugee Service, Caritas has been involved in assisting the Bhutanese refugees since the start of the refugee crisis in 1991. Initially responsible for setting up and running primary and secondary schools in all the refugee camps (now providing education to more than 32,000 children),[152] Caritas Nepal's activities have expanded to include vocational training, play centers for preschool children, youth centers, counseling services for the students and a community-based disability project. Caritas programs are staffed almost entirely by refugees. Caritas encourages the employment of persons with disabilities in its programs.

Field research. The research was carried out by the coordinator of the disability project (a refugee) in six of the seven refugee camps November 12-28, 2007. The researcher conducted in-depth focus group discussions with 321 disabled refugees (disaggregated by age and gender), their families, caregivers and community/traditional leaders in five of the refugee camps. The researcher also conducted structured interviews with 28 NGO and UN service providers, including special needs support teachers, CBR workers, UNHCR staff and the physiotherapist. In addition, the researcher visited 55 households with disabled family members for informal discussions about their particular circumstances.

THAILAND

Location. Burmese refugee camps along the Thai/Burmese border.

Background to refugee situation. The first Thai/Burmese border camps were established in 1984 and, like the Bhutanese refugee camps, are some of the world's oldest and most long-term refugee camps. For more than four decades, Myanmar's (Burma's) four major ethnic opposition groups—the Karen National Union (KNU), Shan State Army-South (SSA-South), the Karenni National Progressive Party (KNPP) and the Chin National Front (CNF)—have been fighting with the country's ruling military junta (currently the State Peace and Development Council—SPDC) over demands by the ethnic groups for self-determination.[153] In 1984, a major offensive by the military into the KNU front lines triggered the first of many movements of refugees across the border into Thailand. Subsequent military offensives, as well as the military's "Four Cuts" policy, which aims to cut off food, funds, recruits and information to the opposition groups by terrorizing and abusing the civilian populations that are supporting them, have resulted in hundreds of thousands of refugees fleeing into neighboring Thailand. The fall of the KNU headquarters at Manerplaw in early 1995 caused enormous displacement and resulted in another major influx of refugees into Thailand. At the end of 2007 there were more than 130,435 registered refugees in the nine registered border camps.[154] Refugees are primarily from Myanmar's four main ethnic groups—the Karen, Karenni, Mon and Shan.[155]

Description of refugee camps. The camps are dispersed along 1,000 km of the Thai/Burmese border. Many of them are difficult to access due to their remote location. Set up more than 20 years ago, the camps are now well established with elaborate refugee camp management structures. The Karen and Karenni Refugee Committees are responsible for the overall management of the seven Karen camps and two Karenni camps. They oversee all activities in the camps and liaise with NGOs and UNHCR. The Karen Education Department is responsible for all the education programs in the seven Karen refugee camps, and the Karenni Education Department in the two Karenni refugee camps.

Camp committees coordinate the day-to-day running of the camps, in collaboration with local government officials. They consist of sectoral subcommittees responsible for areas such as supplies, health, education, camp affairs, security and judiciary, as well as central, zone and section-level committees. Community elders advisory boards, made up of senior refugees appointed by elders in the community, exist to provide guidance to refugee committees and camp committees. In addition, there are active women's and youth committees operating in all the camps, as well as other CBOs.[156]

The nine official refugee camps (seven Karen camps and two Karenni camps) are formally administered by the Government of Thailand, and most assistance is provided by NGOs. Shelter, food and nonfood items are provided through a consortium of NGOs known as the Thailand Burma Border Consortium (TBBC). Set up in 1984 when the first Burmese refugees arrived in Thailand, the TBBC now has 11 member organizations working in the Thai/Burmese border camps.[157] A variety of other NGOs are responsible for providing primary health care, water and sanitation, education, vocational training and adult literacy, income generation and employment programs and psychosocial programs in the camps. NGOs that form part of the Committee for the Coordination of Services to Displaced Persons in Thailand (CCSDPT) receive permission annually from the Ministry of Interior to work in the camps.

UNHCR has a more limited role in the Thai/Burmese border camps than it does in refugee operations in other countries. This is partly due to the fact that Thailand is not party to the 1951 UN Refugee Convention and/or its 1967 Protocol. UNHCR was only able to establish a presence in the border areas in 2000. UNHCR's primary role in the camps is to oversee protection activities that ensure that the refugees can live in safety and security within the camps. In 2007, UNHCR had 17 implementing partners responsible for different protection activities, including education, documentation, child protection and prevention of and response to sexual and gender-based violence. UNHCR continues to advocate for refugees to be given greater freedom of movement in and out of the camps, particularly in order to seek work in Thailand's labor-short economy. UNHCR works closely with some NGOs and CBOs as well as the CCSDPT and holds regular Protection Working Group meetings in Bangkok and at the provincial level.[158]

With little realistic prospect that Burmese refugees can soon go home, more refugees have expressed interest in resettlement to third countries. Since resettlement began in 2005, more than 24,000 Burmese refugees have been resettled from Thailand, and UNHCR expects that as many as 15,000 more could be resettled from all camps by the end of 2008. The United States, Canada and Australia have all committed to accept large numbers of refugees. Other resettlement countries are Finland, Great Britain, Ireland, the Netherlands, New Zealand, Norway and Sweden.[159] A report by the CCSDPT in 2007 found that the resettlement program was having a negative impact on education and health services in the camps, due to the loss of teachers and health workers.[160]

Numbers of refugees with disabilities. Until 2005, refugee data was collected by the Catholic Office for Emergency Relief and Refugees (COERR) on a monthly basis. In 2005, the Government of Thailand (Ministry of Interior), with the assistance of UNHCR, carried out a major re-registration exercise in the nine registered refugee camps using the ProGres registration software.[161] It was hoped that this exercise would provide a more detailed profile of the refugee population, which would be useful when planning durable solutions, such as repatriation or resettlement, and for improving protection and assistance in the camps.[162]

Since 2005, the Government and UNHCR have continued to update data on the refugee camps, including a detailed breakdown of persons with disabilities by age and gender using the ProGres disability definitions. [See Annex B, p.63.] COERR now collects data on extremely vulnerable individuals, unaccompanied and separated children only.

According to COERR, there were 2,949 refugees with disabilities in the seven Karen refugee camps that were surveyed for this project in November 2007. This represents 2.2 percent of the total population of those camps, of whom 66 percent were male and 34 percent were female. COERR's data distinguishes between three categories of disabilities (mentally disabled, physically disabled and mentally ill persons)[163] and between adults (18 years and over) and children (under 18 years). According to its data, the majority of disabled children and adults have physical disabilities (77 percent of disabled children and 85 percent of disabled adults). The data does not give a breakdown for sensory impairments (visual, hearing and speech).

According to data provided by UNHCR in March 2008, there were a total of 9,308 persons with disabilities in the nine registered refugee camps: 4,166 (45 percent) of whom were female and 5,143 (55 percent) of whom were male. This represents 7.1 percent of the total population of those camps, according to UNHCR's population data.[164]

Services for refugees with disabilities. Several NGOs have specialized programs for refugees with disabilities in the camps, with a particular emphasis on inclusive education, including teaching in Braille and sign language, income generation and vocational skills training and prosthetics clinics for the large number of land mine victims. Inclusive and special needs education programs are implemented by the Karen Women's Organization (with the support of World Education) in the seven Karen camps and by JRS in the two Karenni camps. The NGO ZOA is also responsible for vocational training, nonformal education and income generation for refugees with disabilities. The Karen Handicapped Welfare Association provides vocational training and runs a residential center for land mine victims in Mae La Camp. The Mae Tao Clinic runs a one-year training program to teach amputees to make prostheses and runs a prosthetics clinic, primarily for land mine victims. Handicap International provides refugees with disabilities with physical therapy and rehabilitation, assistive devices and prostheses in most of the camps. COERR is responsible for counseling and social work in the camps and for providing extremely vulnerable refugees, including persons with disabilities, with additional relief supplies, such as hygiene packs.

Local organizations. Research for the disability project was carried out by the NGO World Education and its local community-based implementing partner, the Karen Women's Organization. Since 2000, World Education has been supporting special needs and inclusive education programs in the Karen refugee camps. In 2003, World Education partnered with the Karen Women's Organization, which is now responsible for direct implementation of special education programs in all seven camps. The Karen Women's Organization has also organized parent workshops and community awareness days to promote understanding and awareness about disability issues in the refugee camps.

Field research. The research was carried out by a volunteer working with World Education, in close collaboration with staff from the Karen Women's Organization November 7-23, 2007. Research was conducted in Mae La refugee camp, near Mae Sot. Further information was gathered from organizations (NGOs and CBOs) working in the other six border camps under the supervision of the Karen Refugee Committee (Mae La Oon, Mae Ra Ma Lung, Umpiem Mai, Nu Po, Ban Don Yang, Tham Hin).

The researcher made several visits to Mae La camp where she carried out visits to the school, prosthetics clinic and vocational training and income generation programs. She held focus group discussions with the land mine victims group and parents of children with disabilities, as well as carrying out home visits to families of refugees with disabilities. She also interviewed camp leaders, NGO service providers, CBOs, camp school administrators and health providers in Mae La camp and the Mae Sot area.

Additional information about services for Karenni refugees with disabilities in Mae Hong Son Province (Ban Mai Nai Soi and Ban Mae Surin camps) was provided by JRS Thailand.

YEMEN

Location. Kharaz Camp, Lahej Governorate, Yemen.

Background to refugee situation. Due to its strategic location and generous asylum policies (the only country in the Arab Peninsula to have signed the 1951 Refugee Convention and its 1967 Protocol), Yemen has hosted thousands of refugees from the Horn of Africa for several decades. The outbreak of civil war in Somalia in 1991 led to a large-scale influx of Somali refugees into Yemen. Continuing civil unrest in Somalia and neighboring Ethiopia, as well as deteriorating socioeconomic conditions throughout the Horn of Africa, have contributed to a steady flow of refugees into Yemen.[165] A UNHCR registration exercise, completed in December 2006, estimated that there were more than 48,000 refugees in Yemen.[166] The Government of Yemen grants *prima facie* refugee status to all Somalis arriving in the country. Other refugees must go through a UNHCR refugee status determination to be awarded UNHCR Mandate refugee status.

Description of refugee camp. Research for the project was carried out in Kharaz refugee camp located in Lahej Governorate, some 150 km southwest of the capital, Aden. The site, a former military base, was chosen by the Government of Yemen as a permanent refugee camp in 1997. With support to its implementing partners, UNHCR helped construct basic infrastructure, family shelters and latrines in the camp, which was completed in early 2001. The government also constructed a road to facilitate access to the remote area. In June 2001, refugees were relocated from Jahin camp (135 km east of Aden) to Kharaz camp, where, according to the UNHCR registration exercise in December 2006, 8,691 refugees were living (8,040 Somalis and 651 Ethiopians).

The majority of refugees in Kharaz camp are women and children: 55 percent of the total population is under 18 years of age, 24 percent is women, 20 percent men and 1 percent elders. Kharaz is located in an isolated, semi-arid area with harsh climatic conditions and few

economic opportunities. Many male refugees choose to leave their wives, children and elderly relatives in the camps while they look for work elsewhere in Yemen, or in the Gulf States. There are consequently a high number of female-headed households and vulnerable individuals living in the camps, where they are reliant on UNHCR to provide assistance and protection. UNHCR estimates that as few as 5 percent of Somalis in Yemen are living in Kharaz refugee camp; the remainder choose to live in the towns and cities, where it is easier for them to find work.[167]

Kharaz refugee camp is a care and maintenance operation. UNHCR works through four implementing partners—the Adventist Development Relief Agency (ADRA), the Charitable Society for Social Welfare, Rädda Barnen (Save the Children, Sweden) and the Society for Humanitarian Solidarity—to provide refugees with shelter, water and sanitation, food and basic nonfood items, health services (including reproductive health services), primary education, vocational training, community services (including social counseling and a women's and men's community center) and income generation activities.

In general, self-organization and representation among the refugees appears to be weaker than in the camps in Thailand and Nepal. Although a Refugee Council exists, made up of 10 persons elected from the 86 block leaders, the field study found that its members needed training and awareness raising on their role and responsibilities in order to be more actively involved in meaningful planning and decision-making. There are very few CBOs in the refugee camps, and none for persons with disabilities.

Numbers of refugees with disabilities. UNHCR is responsible for assisting the Government of Yemen to register refugees in the country. In July 2005, UNHCR signed a memorandum of understanding (MOU) with the Government of Yemen to open six registration centers in six governorates to register new arrivals and renew expired refugee cards.[168] Although UNHCR collects data on the number of refugees in the country, this does not include information on the number or profile of refugees with disabilities. During interviews for the field study, UNHCR staff said that the office should start using the ProGres database and update its refugee data, especially data on refugees with special needs.[169]

Data on refugees with disabilities was provided by two of the implementing partners working with refugees with disabilities in the Kharaz camp, ADRA and Rädda Barnen. In June 2007, ADRA carried out a door-to-door survey to identify persons with disabilities and other persons with special needs in the camps. Rädda Barnen collects data on the number of children with disabilities who are reached through its CBR program (see below). According to information collected by both organizations a total of 167 refugees (2 percent of the total population) have disabilities. The highest number of refugees have physical disabilities (48.5 percent of the total disabled population), followed by visual impairment (28 percent of the total disabled population).

Services for refugees with disabilities. The only specialized program for refugees with disabilities is a CBR program for disabled children run by Rädda Barnen. The program is supervised by three CBR workers who carry out regular home visits, provide training to mothers of children with disabilities and help integrate refugee children with disabilities into the schools and other community services. None of the other organizations have specific services for refugees with disabilities.

Local organization. Research for the project was carried out by staff from the Center for Persons with Special Needs, established in 1990 by the Government of Yemen (Ministry of Social Affairs), in collaboration with UNDP and ILO, in Al Mansora, Aden. The Center provides services for Yemeni nationals with disabilities in four governates. These include: early intervention for children with disabilities and efforts to integrate them into mainstream schools; training to mothers of necessary skills to take care of their children with disabilities; vocational training for youth and young adults with disabilities (including carpentry, electricity, weaving, computer training, sewing, toy-making and leather work); microcredit and self-reliance projects; a physiotherapy center and a workshop to produce assistive devices and artificial limbs for persons with disabilities.

Field research. The research was carried out by 10 staff members from the Center for People with Special Needs, with the assistance of six refugee interpreters. The research team visited the camp from November 16-30, 2007. The team conducted discussions with 116 refugees with disabilities in focus groups disaggregated by nationality of the refugees, age and gender. In addition, focus group discussions were held with 20 mothers of children with disabilities. The research team visited four families of children with disabilities to observe their living conditions and carry out informal discussions (semistructured interviews). In addition, structured interviews were held with 22 NGO and UNHCR staff, including teachers, CBR workers, medical staff and UNHCR community services staff, as well as nine members of the Refugee Council.

At the time of the research, the Center was not involved in providing any services for refugees in Kharaz Camp, or for refugees residing elsewhere in Yemen. However, as a result of carrying out the research and finding out more about conditions for refugees with disabilities in the camp, the Center offered to provide assistive devices to disabled refugees free of charge. In February 2008, the

research team returned to Kharaz and agreed to provide 30 refugees with assistive devices. They also proposed providing capacity building to the CBR workers in the camp and visiting Kharaz Camp every three to four months to meet with the refugees with disabilities.

JORDAN

Location. Iraqi refugees, East Amman, Jordan.

Background to refugee situation. A recent study found that nearly half a million Iraqis have fled to Jordan since 2003 to escape the growing violence and unrest in Iraq.[170] In March 2007, UNHCR called the situation facing Iraqi refugees "the biggest displacement crisis in the Middle East" in nearly 60 years.[171] The displaced Iraqis are not recognized as refugees by the Jordanian government and do not have any kind of legal status. They are unable to legally work, find accommodation or access government services. The legal situation for Iraqis improved in 2007 when UNHCR agreed to recognize them as refugees on a *prima facie* basis, enabling Iraqis to avail themselves of UNHCR protection, including access to resettlement. However, the majority of Iraqis in Jordan have not applied for refugee status and remain unprotected and unassisted by the government or UNHCR.

Description of refugee situation. There are no refugee camps for Iraqis in Jordan and the majority of the refugees live in poor Iraqi neighborhoods in urban areas. A recent survey conducted by a Norwegian research foundation, FAFO and the Jordanian Ministry of Statistics found that nearly 80 percent of Iraqis in Jordan are living in Amman, most of them in East Amman.[172] Other cities with significant numbers of Iraqi refugees are Karak and Irbid.

Unable to obtain work permits in Jordan, the Iraqi population is highly dependent on money transfers from outside the country and savings from previous employment in Iraq. As funds begin to run out, many families are living in increasingly desperate conditions in cramped, semi-furnished apartments, often with several families sharing a single room that doubles as kitchen and bedroom. Most of the refugees receive no assistance and have to pay for their own food, electricity, water and health bills. With no legal status in Jordan, they are unable to access government services, including public health care. Barred from public hospitals, most of the refugees visit private doctors or attend free clinics at the Red Crescent Hospital and the Italian Hospital in Amman.

At the same time, the arrival of such a large number of Iraqi refugees has put an enormous strain on the Jordanian infrastructure and relations with the general public. The first Iraqi arrivals came with considerable resources, causing major rent and price hikes in Amman. More recently, refugees have arrived in a much poorer and more desperate condition, putting a strain on government services and infrastructure, including housing, water and sanitation, health care and education. Tensions are growing between the Iraqi refugees and the Jordanian public in a country traditionally known for its generosity and tolerance toward refugees.[173]

In the absence of government services, UN and NGO relief agencies have also found themselves severely restricted in the services they can provide to Iraqi refugees due to stringent government restrictions, close oversight and lengthy bureaucratic delays.

Numbers of refugees with disabilities. In general, there is a lack of reliable data regarding the number of Iraqi refugees in Jordan.[174] Even less information is available about the number of refugees with disabilities. UNHCR has data on the 50,000 registered refugees in Jordan. But these are only a fraction of the 500,000 Iraqis believed to be living there. UNHCR had registered 298 adults with disabilities (118 women and 180 men over 18 years of age) and 39 children with disabilities (13 girls and 26 boys under 18 years of age) in December 2007.

Among the 106 refugees with disabilities interviewed for the field study, 30 percent had a physical disability, 16 percent had a mental illness,[175] 13 percent were visually impaired; 1 percent had a hearing/speech impairment; 2 percent had a cognitive/learning disability; 17 percent were listed as "other";[176] and 12 percent had a combination. The primary cause of disabilities, according to the survey, were birth/hereditary (36 percent), war/violence (26 percent) and disease/illness (21 percent). In the absence of any other data, it is not possible to see how reflective this sample is of the general refugee population.

Services for refugees with disabilities. Although there is a well-established national disability strategy in Jordan, including special schools for the blind and hearing impaired, laws preventing discrimination on the basis of disability in schools and the workplace, and measures to develop a national inclusive education policy, refugees with disabilities are completely excluded from any of these services and protections. Similarly, refugees are excluded from the active network of national DPOs that exists in Jordan.

Very limited services and assistance are provided to refugees with disabilities by the relief agencies. Given the extent of government constraints on NGO activities and the scale of need of the Iraqi refugees in general, the needs of refugees with disabilities are frequently overlooked. Several international relief agencies and local NGOs are providing limited aid to refugees with disabilities through

their assistance programs for vulnerable Iraqis. Care International provides monthly cash assistance to extremely vulnerable families and helps them find housing; Caritas International provides medical assistance; and the local NGO, Tkiyet Um Al, runs a food assistance program for poor Jordanian and vulnerable Iraqi families. The Queen Zein Al Sharaf Institute for Development/Jordan Hashemite Fund for Human Development (hereafter referred to as "ZENID/JOHUD") runs 50 community development centers and a variety of specialized programs to enable persons with disabilities to become more active members of their communities. ZENID/JOHUD's kindergarten also has an inclusive policy for children with disabilities and encourages the involvement of parents in their children's early education activities. ZENID/JOHUD is one of the only Jordanian NGOs to integrate Iraqis into its programs.

Local organization. Research was carried out by Mercy Corps Jordan in collaboration with researchers affiliated with the national Landmine Survivors Network. In addition to ongoing development activities in Jordan, Mercy Corps is implementing projects to assist the most vulnerable Iraqi refugees, with funding support from UNHCR. Through its local partner, Tkiyet Um Ali, Mercy Corps provides food to hundreds of impoverished Iraqi families on a daily basis. Mercy Corps also provides relief items and educational opportunities to the most vulnerable Iraqi children and Jordanian children in East Amman, in an effort to minimize tensions between the two communities, and supports informal educational opportunities for Iraqi children and youth.[177]

Mercy Corps also supports the ZENID/JOHUD in its activities to help Iraqis and Jordanians with disabilities to live independent and integrated lives in their communities. These include house-to-house visits by trained Jordanian social workers to the homes of persons with disabilities, and independent living plans that identify ways in which Iraqis and Jordanians with disabilities can live more independently in their homes. Mercy Corps also supports two adult and two children's "peer empowerment support groups" that allow Iraqi refugees with disabilities to gather twice a month at the ZENID/JOHUD offices and share experiences, organize activities and form a cohesive network. Activities in the past have included picnics, visits to amusement parks for the children and dinners and theater outings for the adult groups.

The Jordan Landmine Survivors Network (LSN) was established in Amman in 1999 and is part of the international Landmine Survivors Network. It provides peer support to Jordanians who have lost limbs as a result of land mine and other accidents. The Jordan LSN has assisted more than 1,300 land mine survivors and others who have lost limbs. The Jordan LSN also works with other disability organizations to raise awareness among the general public and the government of the issues facing persons with disabilities, and to enforce local laws that will protect these rights.[178] At the time of conducting the research, the Jordan LSN was not providing any services or support to Iraqi refugees with disabilities.

Field research. All the interviews for the field study were carried out by eight researchers affiliated with the Jordan LSN, all of them persons with disabilities. Mercy Corps strongly supported the involvement of Jordanians with disabilities in carrying out the field study, as the organization believed it would enhance the quality and insights of the research. Their involvement in this project had a very positive impact on the researchers themselves and has helped bridge gaps between the Iraqi and Jordanian disabled communities.

Most of the researchers found their involvement in the study an enabling experience and were eager to have an opportunity to prove their capability in a professional capacity, as discrimination is still rife in Amman and many of them had been unable to find work. The researchers gained useful experience and bolstered their levels of self-confidence. They quickly gained the trust of the Iraqi refugees with disabilities and understood the complexities and sensitivities of the research, which undoubtedly improved its quality. At the same time, the researchers provided a positive role model to the Iraqi refugees with disabilities, most of whom rarely leave their homes.

Importantly, the field research also exposed the Jordanian researchers to the challenges faced by Iraqi refugees with disabilities and motivated them to seek ways to integrate Iraqis with disabilities into existing support networks for persons with disabilities in Jordan.

The field research took place November 19-29, 2007. The researchers were given a half-day training by Mercy Corps staff before beginning the survey. One hundred and six refugees with disabilities were given survey forms to complete and focus group discussions were held within the existing ZENID/JOHUD peer empowerment support groups. In addition, the eight researchers conducted 100 house-to-house visits in different geographic areas to gather information about the living conditions for refugees with disabilities.

One constraint cited by Mercy Corps and the researchers themselves was insufficient time for briefing and training. Lack of time for a thorough training and trial run meant that some of the researchers were unclear of the meaning of some of the questions, while others were so keen to be given a job opportunity that they did not properly read the briefing material given to them.

ECUADOR

Location. Colombian refugees in Esmeraldas, Sucumbíos, Carchi, Pichincha and Imbabura provinces, northern Ecuador, where there are the highest numbers of Colombian refugees and migrants.

Background to refugee situation. The vast majority of refugees in Ecuador are from neighboring Colombia. Civil conflict in Colombia between the two main left-wing guerilla movements—the FARC (Revolutionary Armed Forces of Colombia) and the ELN (National Liberation Army)—and right-wing paramilitary groups has caused widespread displacement, hardship and suffering for civilians since it began in the 1960s, with an escalation in fighting in the 1990s.[179] Most civilians affected by the war were previously displaced within Colombia itself; however, since 2000 an increasing number of Colombians have been forced to flee across the border into neighboring Ecuador and Venezuela.[180]

Description of refugee situation. Most of the Colombians flee into the three provinces in northern Ecuador bordering Colombia—Esmeraldas, Sucumbios and Carchi; high numbers of Colombian refugees and migrants are also living in Imbabura province.

Colombians fleeing to Ecuador must present an asylum claim to the General Directorate for Refugees (Ministry of Foreign Affairs) for a determination of their refugee status. Between 2000 and 2007, 52,337 Colombians applied for refugee status in Ecuador, of whom 15,563 people (nearly 30 percent) were recognized and 18,319 (35 percent) were rejected. A further 9,435 cases (18 percent) were submitted but either withdrawn or were not completed, and 1,062 (2 percent) of cases were resettled.[181] Colombians wishing to apply for asylum can also register with UNHCR, which conducts a preliminary interview, thus initiating the asylum process. However, many Colombians do not apply for asylum as they fear making themselves known to the armed groups operating in the border area between Ecuador and Colombia.[182] UNHCR and the government of Ecuador estimate that as many as 200,000 Colombians who have fled the violence may be living undocumented throughout Ecuador.

There are no refugee camps for Colombians in Ecuador. Instead, most refugees and asylum seekers choose to live in urban areas in dispersed family clusters. There are high concentrations of Colombian refugees in the cities of Quito, Santo Domingo de los Colorados, Ibarra and in Esmeraldas. There are high numbers of women and children among the refugees, as many of the men have either been killed in the violence, have stayed behind in Colombia or are working elsewhere.

Refugees and asylum seekers have limited access to national social assistance programs and services. Many are living in conditions of extreme poverty with high unemployment levels. They face racism, xenophobia, exclusion and discrimination on a daily basis. Asylum applicants receive assistance from UNHCR in the form of food, rent subsidies and nonfood items for the first three months of their asylum application. In practice, however, it can often take up to six months, or more, for their cases to be determined. One exception is health care, as refugees have generally been able to access public hospitals and receive the same health care as Ecuadorians. This is largely due to good contact between Hebrew Immigrant Aid Society (HIAS), the Red Cross and UNHCR and the social workers at public hospitals. In some places, refugees are even given a discount by the hospital social workers, according to the same system applicable to low-income Ecuadorian families, to help pay for medical services.

Asylum seekers are not legally allowed to work during the asylum application process. However, as the assistance provided by UNHCR is insufficient, many Colombians are forced to work in the informal economy, where they are often exploited and run the risk of not being paid for their labor. Even recognized refugees who are legally able to work find it difficult to find work due to discrimination, or face exploitation in the workplace.

The international response to assisting Colombian refugees and asylum seekers has been weak. UNHCR and a handful of humanitarian organizations assist the refugees with limited food, health care, education, income generation, vocational training, community development and psychosocial assistance. UNHCR has offices in Quito (Pichincha Province), Lago Agrio (Sucumbios Province) and Ibarra (Imbabura Province). The NGOs assisting Colombian refugees include the Red Cross Society in Sucumbios, Orellana and Azuay Provinces; FAS[183] in Pichincha Province; COOPI[184] in Carchi, Esmeraldas, Imbabura, Sucumbios and Orellana Provinces; and HIAS (see below for more details on HIAS).

Number of refugees with disabilities. There is no centralized system for collection of data on refugees with disabilities in Ecuador. Instead, different organizations have collected data for the population they are working with, but none of this data is complete and it does not give a reliable picture of the total number or profile of refugees with disabilities in Ecuador. The UNHCR branch office in Quito acknowledged that there is no systematic system for collecting data on refugees with special needs, including refugees with disabilities, and hence no reliable data is available. UNHCR's field office in Ibarra, on the northern border with Colombia, collects some data on refugees with special needs, including refugees with disabilities. But the data is not exact and is not broken down by age, gender or type of disability. UNHCR said that it was hoping to introduce the ProGres data collection system in early 2008, which is expected to fill these gaps.[185]

For the purposes of the research, a questionnaire was prepared to gather data on the number of refugees with disabilities, using the same categories the Ecuadorian National Council of Disabilities (CONADIS) uses to collect data on disability in Ecuador. The questionnaire was distributed to agencies working with refugees in different provinces in the country and they were asked to provide data on the number of refugees with disabilities that had used their services from January to November 2007.

According to HIAS, 86 of the 10,235 refugees who had used its services in 2007 were living with disabilities (0.8 percent). Of these, 37 refugees had physical disabilities, 19 had physical and mental disabilities, 13 had mental disabilities (intellectual and psychological), 11 had hearing/speech impairments and six had visual impairments. The data also distinguished between disabilities arising from birth, illness or malnutrition, conflict and war (e.g., injuries/land mines), trauma or torture and prolonged refugee situations.

Even less information was available from other UN organizations working with Colombian refugees in Ecuador. In September 2005, a joint UNICEF, WFP, UNHCR project was launched on the northern border of Ecuador to monitor the protection of Colombian refugees. In an interview with UNICEF about the project, the researcher was told that "during the implementation of the project, UNICEF did not detect disability problems among the refugee population."[186] Given that WHO estimates that in *any* population, 7-10 percent will have a disability, this statement reflects not so much the absence of disability among the Colombian refugees, but more the lack of disability awareness and sensitivity among UN staff implementing the project. Similarly, UNIFEM, which implements gender projects among Colombian women living on the northern border, also had no statistics or information about women with disabilities.

Services for refugees with disabilities. Ecuador is one of the leading South American countries in providing legal protection and inclusive policies and services for persons with disabilities. Ecuador ratified the UN Convention on the Rights of Persons with Disabilities on March 30, 2007. Moreover, the National Constitution prohibits discrimination on the basis of disability and guarantees the rights of children and adults with disabilities to education, rehabilitation, public services and transport and to participate in sporting and cultural events. The 2001 Disability Act established a National System for the prevention, care and integration of persons with disabilities and set up the National Council of Disabilities (CONADIS). It also guarantees the rights of persons with disabilities to education, health and rehabilitation, transport, physical accessibility, communication and employment. An amendment to the national Labor Code in 2006 (*Registro Oficial No. 198—January 30 2006*), stipulates that any public or private employer with more than 25 employees is obliged to employ at least one person with a disability for a permanent job.

CONADIS is the institution responsible for issuing national disability cards to all disabled persons and coordinating services for persons with disabilities. The national disability card entitles persons with disabilities to certain benefits, including health and transport rebates, and allows them to access special government programs for persons with disabilities (such as vocational training, income generation, employment and health care programs).

Despite these positive provisions, until 2004 refugees were unable to access any public services for persons with disabilities, or avail themselves of national legal protections. In 2004, the Ministry of Foreign Affairs declared that refugees with disabilities could also be issued with disability cards by CONADIS, entitling them to a range of public services. In reality, however, only a very few refugees have actually obtained national disability cards, and almost no refugees (even those possessing the cards) have access to the national disability services and programs. The reasons for this are varied and include a lack of information about refugee rights and the 2004 decision among government officials, social workers and refugees themselves; administrative obstacles and delays; racism and xenophobia; and a general mistrust by the refugees of national assistance programs. Although there are some private services (schools, health clinics, rehabilitation centers) for persons with disabilities, these tend to be too expensive and difficult for refugees to access.

None of the relief agencies providing assistance to Colombian refugees have any targeted programs specifically for refugees with disabilities, although some refugees with disabilities are benefiting from broader refugee assistance programs. Before the field research, there was very little collaboration between UNHCR or any of the refugee assisting agencies and organizations assisting persons with disabilities in Ecuador. As a result of the field research, however, HIAS made contact with several humanitarian organizations involved in providing services to Ecuadorian children with disabilities.

One of these, the Italian NGO OVCI,[187] runs health, education and rehabilitation projects for children with disabilities in Esmeraldas Province and in San Lorenzo. In San Lorenzo, HIAS has helped negotiate access for disabled refugee children to the Primero Pasos School, a school for children and adolescents with multiple disabilities, and to health care and rehabilitation programs run by OVCI and the National Institute for Children and Families (INNFA).[188] Similarly, in Esmeraldas Province it is hoped that refugees with disabilities can be integrated into OVCI's programs. This is a positive example of how refugees with disabilities can be integrated into national programs and also demonstrates one of the positive outcomes of the field research.

Local organization. The research was carried out by Hebrew Immigrant Aid Society (HIAS). HIAS has four programs addressing the needs of Colombian refugees in four provinces in Ecuador (Pichincha, Esmeraldas, Carchi and Imbabura). These include a psychosocial assistance program; CINOR (Orientation and Information Center for Refugees and Migrants)—a legal advice program; a humanitarian and social assistance and employment program; and administering a German government university scholarship program—DAFI. HIAS is working in eight Ecuadorian cities, and has offices in six of them.

Field research. A volunteer working with HIAS carried out the research November 1-30, 2007. The researcher visited six provinces in Ecuador. She met with government staff, including from the Ministry of Foreign Affairs and CONADIS, as well as staff from UNHCR and the four other humanitarian organizations (HIAS, Red Cross, COOPI and FAS) providing assistance to Colombian refugees. She conducted structured interviews with 24 staff from UNHCR, CONADIS and the four humanitarian organizations in six different provinces. She also visited 20 families in four provinces and held semistructured discussions with 24 refugees with disabilities and their families. Finally, she prepared and distributed a questionnaire to government agencies, UNHCR and other UN agencies, humanitarian organizations and DPOs in eight cities across Ecuador.

Field Research Methodology

The Women's Commission prepared a set of guidelines for carrying out the field studies outlining the information required and suggested research methodologies. [See Annex C, p.64.] A combination of different participatory research methodologies was used to collect information. These included:

FOCUS GROUP DISCUSSIONS

Where possible, researchers organized small, targeted focus group discussions with different sectors of the population regarding attitudes toward persons with disabilities, their needs and the challenges they faced as refugees; available mainstream and specialized services; gaps and good practices. The groups were organized by age and gender and included the following groups:

> disabled refugees (including women, men, girls, boys, youth and older persons with disabilities)

> families/caregivers of persons with disabilities

> community leaders (camp leaders/traditional community leaders/religious leaders/community workers)

In general, it was much easier to organize focus group discussions in refugee camp settings, where refugees were all living in the same place and communities tended to be more cohesive, than in urban areas.

SEMISTRUCTURED DISCUSSIONS

These were conducted with a small number of people in an informal and conversational way by using open-ended questions. Researchers used several techniques:

> house-to-house visits to meet with families with disabled members to discuss their specific needs and concerns

> visits to programs/services for persons with disabilities to meet project organizers and participants

House-to-house visits were favored by researchers in urban areas who found them to be an easier way to gather information and to meet with refugees with disabilities and their families.

QUESTIONNAIRES

Some researchers prepared questionnaires, which were distributed among refugees with disabilities and service providers. This approach was also favored in urban areas.

STRUCTURED INTERVIEWS

In both urban and camp settings, researchers held more formal discussions with service providers regarding services for refugees with disabilities. Those interviewed included:

> UNHCR and other UN agencies

> NGOs responsible for providing mainstream services to refugees and asylum seekers

> NGOs responsible for providing specialized services to refugees with disabilities

> National/local government agencies/departments responsible for providing national services to persons with disabilities

> Local organizations responsible for providing national services to persons with disabilities

> Local DPOs and CBOs

DATA COLLECTION

The researchers also collected disaggregated data on the refugee population and the number of refugees with disabilities. Data was collected from a variety of sources, including the government, UNHCR and other UN agencies and NGOs providing assistance to the refugees, as well as national NGOs, CBOs and DPOs. Where available, data was collected on the following issues:

- refugee population (disaggregated by age/gender and location)
- number of refugees with disabilities (disaggregated by age/gender and location)
- types of disabilities (e.g., physical/mental/visual/hearing, etc.)
- reasons for disabilities (e.g., from birth/due to illness/as a result of war, etc.)
- number of refugees with disabilities reached through targeted services

Nearly all the field studies reported difficulties in gathering data. Often data on the number of refugees with disabilities was simply not available from the government, UNHCR or its implementing partners. In other cases, data existed but there was conflicting data among the different organizations. A frequent problem was differences in the terminology and categories used to classify different types of disabilities and reasons for disabilities, which caused inconsistencies in data collection. Data collection staff often lacked the technical expertise to identify and categorize different types of disabilities. Finally, as discussed above, conceptions of "impairment" and "disability" can differ enormously between different cultures and societies. This can have a significant impact on the accuracy and comparability of data.

Strengths and Constraints of Field Studies

STRENGTHS/POSITIVE OUTCOMES

The field studies demonstrated the following positive outcomes or strengths in programs observed for persons with disabilities.

- The involvement of local organizations in carrying out the field research improved the quality of research, as the researchers already had an in-depth understanding of the local situation and could provide insights that an outsider may have missed.
- Using local disability service providers, DPOs and persons with disabilities as researchers had a very positive impact on the quality of research as they immediately understood the complexities and sensitivities of the issue and easily won the trust and confidence of the refugees with disabilities.
- Using persons with disabilities as researchers boosted the confidence and provided a positive role model for the refugees.
- The field studies exposed local DPOs and disability service providers to the needs of refugees with disabilities and motivated them to include refugees in their programs, with some positive results:
  - The Landmines Survivors Network in Jordan is exploring ways in which it can support Iraqi refugees with disabilities.
  - A household of Jordanian persons with disabilities in Amman, who live together to give each other support, has invited Iraqis with disabilities to join them.
  - A DPO in the city of Ibarra, Imbabura Province, Ecuador, has expressed an interest in including Colombian refugees in its activities as a result of the research.
- The field research has helped build alliances between refugee assisting agencies and organizations providing services to persons with disabilities. It has also increased awareness of national disability programs among refugee relief agencies:
  - The Center for Persons with Special Needs in Yemen has agreed to provide 30 refugees with disabilities in Kharaz camp with assistive devices, free of charge.
  - As a result of the research in Ecuador, HIAS is now collaborating with an Italian NGO, OVCI, to integrate refugee children into OCVI's project for Ecuadorian children with disabilities in Esmeraldas and San Lorenzo.
- Following meetings with UNHCR to discuss the findings of the report, UNHCR has agreed to revise its definitions of disability under the ProGres special needs codes and to harmonize these with the Heightened Risk Identification Tool definitions.
- UNHCR has also agreed to revise its criteria for resettlement of refugees with disabilities as a result of the research project.
- In general, the Women's Commission received very good cooperation and collaboration from the organizations it approached to participate in the project.
- Most organizations felt that this is a very neglected area and there is an urgent need for more resources, guidelines and research on the needs of refugees with disabilities. They welcomed the Women's Commission/UNHCR's initiative and were keen to remain involved in the development and implementation of the resource kit.

WEAKNESSES/CONSTRAINTS

The following areas of our field studies demonstrated where we could improve our efforts the next time out.

> Time frame: The time frame for the project was too short and did not allow for sufficiently in-depth field studies to deal with the scope and complexity of the issue (most countries only had two or three weeks to conduct their field research). The short time frame also inhibited the participation of some key NGOs in the field research, such as Handicap International. This was a drawback, given the important role they play in providing services to refugees with disabilities.

> Budget: The limited budget meant it was not possible to conduct field studies in a larger number of countries or variety of situations; the budget was not sufficient for longer field studies.

> Sample size: The sample size was too small to come to any quantitative conclusions (too few countries/too few people interviewed). The field studies tended to be snapshots, rather than exhaustive surveys.

> No field study in Africa: Due to time and budget limitations, as well as inability to identify a suitable local partner, there was no field study from the Africa region. The Women's Commission recognizes that this is a major constraint. However, case study material was available from refugee camps in Dadaab, Kenya (from UNHCR) and from IDP camps in West Darfur, Sudan (from HelpAge International).

> Training for researchers: There was insufficient time for proper training/briefing of researchers. This affected the quality of findings in some countries.

> DPOs: These groups were not sufficiently involved in carrying out the field studies; there was also not enough focus on the activities of local DPOs in the field study guidelines. Information on DPOs is therefore weak.

> Involvement of persons with disabilities: Although some field studies included persons with disabilities as researchers, this could have been more actively promoted in the planning of the project and drafting of field study guidelines, given the obvious benefits.

> National framework: In some countries, there was a need for more information about the national legal framework, and about provisions and services for persons with disabilities in order to understand how to better integrate refugees (especially urban refugees) and also to understand the rights of refugees with disabilities in the host country.

> Data collection: This was a very weak area. Data on refugees with disabilities was either nonexistent, incomplete or inconsistent. There was a lack of consistency in the categories/terminology used to collect data and lack of technical expertise in disability issues among staff responsible for data collection.

> Protection: This was one of the weaker areas of the field research. There was a general lack of understanding and/or information about specific protection risks facing refugees with disabilities.

ANNEX B: ProGres

Specific Need Definitions: Persons with Disabilities

The names and definitions that follow are specific to the ProGres database program used by UNHCR.[189]

Persons with Disabilities (DS)
An adult or child who is physically or mentally impaired by illness, injury or wounds that hinder the normal day-to-day activity and need to be addressed to allow the person to function normally.

Sight Impairment (Including Blindness) (DS-BD)
Having visual limitations resulting from illness, infection or injury that impact daily life and restrict independent movement; or an eye disease that requires ongoing treatment or regular monitoring.

Hearing Impairment (Including Deafness) (DS-DF)
Having restricted hearing ability that results from illness, infection or injury and impacts daily life and social interaction; *may* require regular treatment, monitoring or maintenance of an artificial hearing device.

Mental Disability—Moderate (DS-MM)
Having a mental illness resulting from childbirth, medical illness, injury or trauma that does not significantly limit ability to function independently and interact (but may require special education); condition requires some monitoring and *may* require modest medication.

Mental Disability—Severe (DS-MS)
Having a mental illness that requires assistance from a caregiver and medication; individual cannot function independently; inability to pursue an occupation because of mental impairment; *may* be receiving medical treatment (certified).

Physical Disability—Moderate (DS-PM)
Having a physical disability resulting from childbirth or injury that may be seriously disfiguring, but with reasonable treatment the person can function with a reasonable level of independence; may include mine victims and loss of fingers or limbs that do not limit their abilities or are corrected with a prosthetic device.

Physical Disability—Severe (DS-PS)
Physically incapacitated (severely restricted movement) caused by injury, illness or wounds; inability to pursue an occupation because of physical impairment; requires assistance from a caregiver and cannot easily function independently (may be confined to a wheelchair).

Speech Impairment/Disability (DS-SD)
Unable to speak clearly or to be easily understood as a result of injury, illness or malformation at birth; restricted or limited ability to function independently; may be able to communicate through sign language.

ANNEX C: Heightened Risk Identification Tool

Health Needs and Disability Definitions

The points below outline the primary issues the assessing staff should cover to gather the necessary input for HRIT.[190]

- Physical health problem
- Person with HIV/AIDS or other life-threatening disease or condition
- Physical disability
- Impairment in daily functioning due to mental illness:
  - Obviously confused thinking (such that responses are often incoherent)
  - Disorientation in time, place or persons or marked inattention (unable to identify where/who they are; unable to follow conversation/interview)
  - Obvious loss of contact with reality (e.g., has highly unrealistic or bizarre beliefs)
  - Clearly peculiar behavior (behavior that is regarded as nonsensical or bizarre by the person's own community)
  - Severe withdrawal, anxiety or depression such that daily functioning is greatly affected
  - Risk of harm to self or others

  (In making this assessment, it is critical that these mental illness cues also result in an impairment in daily functioning, as described by the individual or inferred by the assessing staff.)
- Intellectual impairment from birth (e.g., Down syndrome, intellectual disability) or as a result of injury (e.g., acquired brain injury)
- Drug/alcohol abuse/addiction
- Lack of access to adequate/specialized health care (including psychosocial support)
- Unable to care for self and no caregiver available
- Lack of access to adequate food, water and/or shelter
- Experiencing rejection or victimization by his/her own community
- Customary punishment and/or harmful cultural practices
- Detained/imprisoned in a place and denied freedom of movement (including for his/her protection)
- Engaging in survival sex
- Forced into begging
- Other

ANNEX D: Guidelines for Field Studies

DATA COLLECTION

Available data can be collected from the following sources:

> UNHCR data (registration data/community profiles)

> Government data (registration data/census data)

> Other UN agencies (WFP food distribution data/WHO health data/UNICEF—data on children; UNIFEM—data on women, etc.)

> NGOs (data used by implementing agencies and NGOs)

Where available, data should be collected on the following:

> Total number of refugees/asylum seekers in given situation, depending on focus of study (in-country/camp/city) and breakdown by location (by camp/city)

> Number of refugees with disabilities in given situation, depending on focus of study (in-country/camp/city) and breakdown by location (by camp/city)

> Age/gender breakdown of persons with disabilities

> Types of disabilities

> Number of persons with disabilities reached through targeted services (health/education/income generation/skills training, etc.)

BACKGROUND INFORMATION

The following background information should be collected:

> Description of population (country of origin; how many years as refugees; BRIEF reasons for flight)

> Description of living conditions (rural/urban/camp/village-type settlements)

> Description of situation (emergency; long-term care and maintenance; IDP; returnee population)

> Description of services available to *all* refugees (accommodation/shelter; food distribution; water and sanitation; health services; education; vocational training; income generation and employment opportunities; psychosocial services)

> Description of protection risks/problems facing *all* refugees (physical security—location of camps; legal security—documentation/registration; protection risks for women and girls; protection risks for children; protection risks for the elderly; protection risks for other at-risk/minority/marginalized groups)

TYPES OF DISABILITIES

A brief overview should include the types of disabilities among the population of concern (with age and gender breakdown if available) and the reasons for disabilities, for example:

> Physical disabilities—types and reasons (from birth; due to conflict/war—injuries/land mines; due to illness/malnutrition, etc.)

> Mental/psychological disabilities—types and reasons (from birth; due to conflict—injuries/trauma/torture; due to prolonged refugee situation—depression/trauma; due to illness)

> Blindness/visual impairment (from birth/due to illness/conflict-related (injury/land mine))

> Deaf/hearing impaired (from birth/due to illness/conflict-related (injury/land mine))

ACCESS TO AND APPROPRIATENESS OF MAINSTREAM SERVICES FOR REFUGEES WITH DISABILITIES

The following points should also be covered:

> Accommodation/shelter (is it accessible/appropriate for persons with disabilities?)

> Water and sanitation (are latrines/washing facilities/water points accessible/appropriate for persons with disabilities?)

> Food and nutrition (is food appropriate/adequate for persons with disabilities; are food distribution points/distribution mechanisms accessible for persons with disabilities; are disabled people able to prepare their food—i.e., do they have access to fuel/firewood/are they assisted with food preparation?)

> Nonfood items distribution (do disabled people have access to physical aids/equipment they require; are the special needs of persons with disabilities taken into account during distribution of nonfood items—clothing/blankets/cooking equipment, etc.; are nonfood-item distribution points and mechanisms accessible to persons with disabilities?)

> Health care services (are health facilities easily accessible for disabled persons/are there specialized health care services for persons with disabilities; are disabled persons provided with medicines, physical aids and other equipment they require; do disabled women have access to reproductive health services?)

- Education (do children with disabilities have access to schools; are schools inclusive for children with disabilities; are there any special education facilities/programs for children with special needs; are schools physically accessible for children with disabilities?)
- Vocational training and adult literacy programs (do disabled people have access to vocational training and adult education programs; are there special training programs for disabled persons?)
- Income generation and employment programs (do persons with disabilities have access to income generation/employment programs; are there special income generation/employment programs geared toward persons with disabilities; do persons with disabilities have a wage earning capacity?)
- Psychosocial programs (do persons with disabilities have access to psychosocial programs/counseling/mental health services; are there specialized psychosocial programs for persons with disabilities?)

OVERVIEW OF SPECIALIZED SERVICES FOR PERSONS WITH DISABILITIES

This set of questions needs to be answered when conducting field studies.

- What special programs/initiatives exist specifically for persons with disabilities? In what sectors (health/education/shelter/food/income generation, etc.)?
- Which groups of persons with disabilities are reached through these programs (people with physical disabilities; people with mental disabilities; hearing or sight impaired; children with disabilities; elderly with disabilities; women with disabilities, etc.)
- What percentage/sector of the disabled population do the programs reach?
- Short description of targeted programs for persons with disabilities (focus/target group/objectives/methodology)
- Which organizations are responsible for implementing these programs?
- Who provides funding for these programs?
- How involved are disabled persons themselves in the planning, design, implementation and management of these programs?
- Are disabled persons employed to run these programs?
- What impact have these programs had on the lives of disabled people?
- What has worked? What has not worked? Examples of good practices.
- What needs to be done to improve specialized services for persons with disabilities?
- What are gaps in services for persons with disabilities?

PROTECTION

Concerning protection, these questions should be answered.

1. What particular protection risks do persons with disabilities face?
    - Physical protection (camp security)
    - Domestic violence/abuse
    - Sexual and gender-based violence/abuse
    - Neglect and exclusion
    - Discrimination and stigmatization
    - Abusive treatment of persons with disabilities within community
    - Lack of access to documentation/registration
    - Access to asylum/refugee status determination (RSD) procedures
    - Discrimination in asylum interviews/RSD
    - Lack of access to information
    - Lack of access/discrimination in access to durable solutions (local integration/voluntary return/resettlement)
2. What protection risks do disabled women, girls and elderly persons face?
    - Physical protection (camp security)
    - Domestic violence/abuse
    - Sexual and gender-based violence/abuse
    - Neglect and exclusion
    - Discrimination and stigmatization
    - Abusive treatment of persons with disabilities within community
    - Lack of access to documentation/registration
    - Access to asylum/RSD procedures
    - Discrimination in asylum interviews/RSD
    - Lack of access to information
    - Lack of access/discrimination in access to durable solutions (local integration/voluntary return/resettlement)
3. What traditional community support mechanisms exist to assist and protect persons with disabilities?
4. How have traditional coping mechanisms been affected by displacement and dislocation?
5. What new community-based strategies exist to respond to protection risks faced by disabled refugees?
6. What strategies have been initiated by UNHCR, the local government and other humanitarian organizations to address the protection risks faced by persons with disabilities?

PARTICIPATION/COMMUNITY INCLUSION

Questions to be addressed in this area include the following:

1. Can persons with disabilities actively participate in the planning, design and implementation of assistance programs and protection strategies?
    - What strategies exist to identify persons with disabilities in refugee settlements?
    - Is disability included in registration/community mapping/participatory assessment exercises?
    - Is disability an integral part of the age, gender and diversity mainstreaming exercise (UNHCR initiative)?
    - What strategies exist to identify the needs, skills and resources of persons with disabilities in refugee settings?
    - What strategies exist to identify community support structures and traditional coping mechanisms for persons with disabilities?
    - What opportunities exist for persons with disabilities to be fully included in decision-making and community consultation processes?
    - Are persons with disabilities actively consulted in the planning and design of assistance programs and protection responses? What opportunities are there for their voices to be heard?
    - Can persons with disabilities participate in the implementation/management of assistance programs and protection strategies?
    - How are persons with disabilities represented in community leadership structures (both traditionally and in the refugee context)?
    - How is information transmitted to persons with disabilities (by community leaders; UNHCR; humanitarian agencies; local government)?
    - Are persons with disabilities active/visible participants in community affairs; or are they hidden and excluded?
2. What strategies are there to increase the participation and inclusion of persons with disabilities in community affairs/assistance programs and protection responses?
    - Have there been efforts to increase the visibility/representation of persons with disabilities in community affairs/consultation and decision-making processes?
    - Are there community action groups for persons with disabilities to increase their visibility and representation in refugee assistance and protection programs?

RESEARCH METHODOLOGY

The aim of the research is to make the information-gathering process as participatory as possible, using a variety of different participatory assessment tools and mapping techniques.

Focus Group Discussions

Set up targeted, small focus group discussions with the following sectors of the population regarding data/attitudes/needs/services/gaps and good practices:

> Refugees with disabilities (including women, girls, children and elderly persons with disabilities) (N.B.: It may be necessary to meet with men and women/boys and girls/children and adults separately, depending upon cultural practices and attitudes.)

> Families/caregivers for persons with disabilities

> Community leaders (camp leaders/traditional community leaders/religious leaders)

> NGOs/service providers working with persons with disabilities

> Meet with NGOs/refugees involved in providing services in different sectors (health sector; education sector; income generation sector)

> Host community (if relevant)

> Local government (if relevant)

Semistructured Discussions

These discussions are conducted with a small number of people in an informal and conversational way by using open-ended questions.

> Visit families/households with disabled members to discuss specific needs/resources and protection risks for persons with disabilities.

> Visit programs/services for persons with disabilities to meet project organizers/participants and discuss content/impact and effectiveness of projects.

Structured Interviews

These interviews should be with humanitarian organizations/service providers regarding data collection/policies and practices for persons with disabilities in camps:

> UNHCR (on data collection/implementation of age, gender and diversity mainstreaming/participatory assessments/protection risks and solutions, etc.)

> NGOs/service providers responsible for providing mainstream services to refugees/asylum seekers

> NGOs/service providers responsible for providing specialized services to persons with disabilities

> Local government/local institutions on national framework/legislation for persons with disabilities (if relevant)

NOTES

1 Telephone interview with Chris Stubbs, MENCAFEP (Mentally Handicapped Children and Families Education Project), Sri Lanka, October 25, 2007.
2 International Federation of Red Cross and Red Crescent Societies, *World Disaster Report 2007—Focus on Discrimination* (Geneva: IFRC, December 2007) chap. 4, *Disability and Disasters: Towards an Inclusive Approach*, http://www.ifrc.org/publicat/wdr2007/index.asp?gclid=CJS4iMDAIJICFSDMXgodlV4e7g.
3 See UNHCR and International Save the Children Alliance, Action for the Rights of Children Resource Pack: *Critical Issues: Disability* (London: International Save the Children Alliance, July 2001), http://www.savethechildren.net/arc/files/main.html, and WHO/ILO/UNESCO, CBR Guidelines: Supplement Chapters, *CBR and Crisis Situations,* Draft (Geneva: WHO, 2007), http://www.who.int/disabilities/publications/cbr/en/index.html, for more information.
4 UNHCR and International Save the Children Alliance, Action for the Rights of Children Resource Pack: *Critical Issues: Disability* (London: International Save the Children Alliance, July 2001), http://www.savethechildren.net/arc/files/main.html. See also note 2 and SHIA, Bonn Declaration (third draft), Draft declaration from the conference entitled, "Disasters Are Always Inclusive! Persons with Disabilities in Humanitarian Emergency Situations," held in Bonn, Germany, November 7-8, 2007, http://www.shia.se/files/Bonn%20Declaration-Draft.DOC.
5 See note 2.
6 Ibid.
7 See Refugees International, *Displaced and Disabled*, 02/03/2003, http://www.refintl.org/content/article/detail/1477/.
8 See note 2.
9 See UNHCR and International Save the Children Alliance, Action for the Rights of Children Resource Pack: *Critical Issues: Disability* (London: International Save the Children Alliance, July 2001), http://www.savethechildren.net/arc/files/main.html, and note 2.
10 As well as time and budget constraints that limited the number of field studies, the Women's Commission also reached an agreement with UNHCR to focus exclusively on refugees in its field research in order to avoid overlap with a similar project of Handicap International that is addressing the needs of IDPs with disabilities.
11 For more information on pre-emergency prevention, disaster preparedness measures and post-conflict return and reconstruction phases see the IASC, *Guidelines on Mental Health and Psychosocial Support in Emergency Settings*, (Geneva: IASC, 2007), http://www.humanitarianinfo.org/iasc/content/subsidi/tf_mhps/default.asp?bodyID=5&publish=0; The Sphere Project, *Humanitarian Charter and Minimum Standards in Disaster Response* (London: Oxfam Publishing, 2004), http://www.sphereproject.org/content/view/27/84; and IASC, *IASC Operational Guidelines on Human Rights and Natural Disasters: Protecting Persons Affected by Natural Disasters* (Geneva: IASC, June 2006), www.humanitarianinfo.org/iasc/content/documents/working/OtherDocs/2006_IASC_NaturalDisasterGuidelines.pdf.
12 Ad Hoc Committee on a Comprehensive and Integral International Convention on the Protection and Promotion of the Rights and Dignity of Persons with Disabilities, *Convention on Rights of Persons with Disabilities,* Final report, distributed December 6, 2006, http://www.un.org/disabilities/convention/conventionfull.shtml.
13 Ibid, Preamble, paragraph (e).
14 See note 12, Article 1.
15 The IASC *Guidelines on Mental Health and Psychosocial Support* (Geneva: IASC, 2007) provide comprehensive guidance on mental health and psychosocial support during emergencies. The guidelines make a distinction between people with preexisting mental disorders and people who may suffer mostly short-term mental health problems and disorders as a result of the emergency or the nature of humanitarian aid (but with the potential for becoming chronic disorders, especially without necessary intervention and support). The guidelines state that an estimated average baseline of 2-3 percent of the general population have a severe mental disorder. This is believed to increase by 1 percent in emergencies. People with mild to moderate mental disorders (e.g., mood and anxiety disorder, including post-traumatic stress disorder) are estimated to increase, on average, by 5-10 percent in emergencies above a base line of 10 percent of the population.
16 This was previously called the International Classification of Impairments, Disabilities and Handicaps (ICIDH). In 2001, the World Health Assembly endorsed the second edition of the ICIDH (ICIDH-2).
17 See UNHCR and International Save the Children Alliance, Action for the Rights of Children Resource Pack: *Critical Issues: Disability* (London: International Save the Children Alliance, July 2001), http://www.savethechildren.net/arc/files/main.html.
18 Ibid. Anatomical parts of the body such as organs, limbs and their components.
19 Ibid. Physiological functions of body systems (including psychological functions).
20 Ibid. Activity limitations are difficulties an individual may have in executing activities.
21 Ibid. Participation restrictions are problems an individual may experience in involvement in life situations.
22 See WHO, ILO and UNESCO, *CBR: A Strategy for Rehabilitation, Equalization of Opportunities, Poverty Reduction and Social Inclusion of People with Disabilities,* joint position paper (Geneva: WHO, ILO, UNESCO, 2004).
23 See note 17.
24 Ibid.
25 Ibid. See also, Kett, Maria, Sue Stubbs, and Rebecca Yeo. *Disability in Conflict and Emergency Situations: Focus on Tsunami-affected Areas.* London: IDDC, 2005 for further discussion of Social Model approach to disability; and International Federation of Red Cross and Red Crescent Societies, *World Disaster Report 2007—Focus on Discrimination* (Geneva: IFRC, December 2007) chap. 4, *Disability and Disasters: Towards an Inclusive Approach*, http://www.ifrc.org/publicat/wdr2007/index.asp?gclid=CJS4iMDAIJICFSDMXgodlV4e7g.
26 See note 17.
27 See Helander, Einar and A. Goerdt. *Training in the Community for People with Disabilities* (Geneva: WHO, 1989).
28 See note 17.
29 See note 22.
30 See note 17; see also, ZOA Refugee Care Thailand, *Having Their Say: Refugee Camp Residents and Inclusive Education,* position paper (Maesot, Thailand: ZOA, May 2007), http://burmalibrary.org/docs4/ZOAPosition_Paper-Having_Their_Say.pdf.
31 See UNESCO, *Salamanca Statement and Framework for Action on Special Needs Education*, Salamanca (Paris: UNESCO,1994), http://www.unesco.org/education/pdf/SALAMA_E.PDF; see also UNESCO, *Overcoming Exclusion through Inclusive Approaches in Education: A Challenge and a Vision* (Paris: UNESCO, 2003); and INEE, *Minimum Standards for Education in Emergencies, Chronic Crises and Early Reconstruction* (New York: INEE, 2004), http://ineesite.org/page.asp?pid=1240.
32 See note 30.
33 See VSO, *Inclusive Education for Children with Special Needs in the Thai-Burma Border Refugee Camps,* VSO Thai-Burma Border Program, July 2006.
34 Ad Hoc Committee on a Comprehensive and Integral International Convention on the Protection and Promotion of the Rights and Dignity of Persons with Disabilities, *Convention on Rights of Persons with Disabilities* (Article 2) (New York: UN, 2006), http://www.un.org/disabilities/convention/conventionfull.shtml.
35 Ibid.
36 See note 1.
37 E-mail correspondence with Deirdre Walshe (lecturer in special educational needs at C.I.C.E. (Church of Ireland College of Education), Dublin, and one of the founders of the inclusive education program in the Bhutanese refugee camps, where she was working as a resource teacher with Caritas Nepal from 1994 to 1996), October 16, 2007.
38 See Refugees International, *Ecuador: International Support Needed for Colombian Refugee* (Washington, D.C.: Refugees International, 2004), http://www.refugeesinternational.org/content/article/detail/958/.
39 UNHCR press release, January 16, 2008, Quito, http://www.reliefweb.int/rw/rwb.nsf/db900sid/YSAR-7AWP54?OpenDocument.
40 Telephone interview with UNHCR community services officer, Dadaab Sub-Office, Kenya, March 6, 2008; see also, UNHCR Community Services Sub-Office Dadaab Monthly Newsletter *People Living with Disabilities* Issue No. 2, October 2007.
41 See note 1; see also, http://www.mencafepsrilanka.com/bati.html.
42 Ibid.
43 See UNHCR, *The UNHCR Tool for Participatory Assessment in Operations* (Geneva: UNHCR, 2006), for more information about participatory assessments.
44 In follow-up e-mail communication with UNHCR community services officer, Dadaab, Kenya, April 23, 2008, the Women's Commission learned that there was a significant increase in the number of new arrivals from Somalia in the first quarter of 2008 due to the worsening conflict in Somalia (between 600 and 1,000 new arrivals per week). Among these new asylum seekers there were a large number of people with disabilities, especially visual impairment. UNHCR was working in cooperation with Handicap International to immediately integrate new arrivals with disabilities into the camps and ensure that they had full and equal access to all services.
45 See UNHCR, *The UNHCR Tool for Participatory Assessment in Operations* (Geneva: UNHCR, 2006), for more information about UNHCR participatory assessments.
46 See ZOA Refugee Care Thailand, *Having Their Say: Refugee Camp Residents and Inclusive Education,* position paper (Maesot, Thailand: ZOA, May 2007), http://burmalibrary.org/docs4/ZOAPosition_Paper-Having_Their_Say.pdf.
47 E-mail communication with Fred Ligon (director, World Education), October 15, 2007.
48 Information compiled by JRS special education coordinator and camp-based staff, November 30, 2007.

49 Telephone interview with UNHCR community services officer, Dadaab Sub-Office, Kenya, March 6, 2008.
50 Ibid. See also, UNHCR Community Services Sub-Office Dadaab Monthly Newsletter *People Living with Disabilities* Issue No. 2, October 2007.
51 Information provided by UNHCR Nepal, April 21, 2008.
52 See HelpAge International, *Rebuilding Lives in Longer-term Emergencies: Older People's Experience in Darfur* (London: HelpAge International, 2006).
53 Ibid.
54 E-mail communication with Valérie Scherrer (Emergency Coordinator, Christian Blind Mission (CBM)), April 23, 2008.
55 Ibid.
56 Telephone interview with UNHCR community services officer, Dadaab Sub-Office, Kenya, March 6, 2008. See also UNHCR Community Services Sub-Office Dadaab Monthly Newsletter, *People Living with Disabilities*, Issue No. 2, October 2007.
57 See Human Rights Watch, *Thailand Landmine Monitor Report 2007,* http://www.icbl.org/lm/2007/thailand.
58 Ibid.
59 See the Mae Tao Clinic website, http://www.maetaoclinic.org/.
60 See note 57.
61 See Human Rights Watch, *Thailand Landmine Monitor Report 2006*, http://www.icbl.org/lm/2006/thailand.
62 Caritas Nepal Disability Program data.
63 See HelpAge International, *Rebuilding Lives in Longer-term Emergencies: Older People's Experience in Darfur* (London: HelpAge International, 2006), and telephone interview with Susan Erb (HelpAge International), September 27, 2007.
64 See note 52.
65 See IASC, *Guidelines on Mental Health and Psychosocial Support in Emergency Settings,* http://www.icn.ch/IASC_MHPSS_guidelines.pdf.
66 Ibid.
67 E-mail communication with UNHCR Yemen, April 13, 2008.
68 See UNHCR Community Services Sub-Office Dadaab Monthly Newsletter, *People Living with Disabilities*, Issue No. 2, October 2007.
69 E-mail communication with UNHCR Thailand, May 7, 2008; see, VSO, *Inclusive Education for Children with Special Needs in the Thai-Burma Border Refugee Camps*, VSO Thai-Burma Border Program, July 2006; however, according to information provided by UNHCR Thailand, dropout rates among school students are high (over 10 percent) due to the large number of adolescents who drop out to find work outside the camps.
70 VSO, *Inclusive Education for Children with Special Needs in the Thai-Burma Border Refugee Camps*,VSO Thai-Burma Border Program, July 2006.
71 According to data collected by COERR in November 2007, there were a total of 874 children with disabilities (below 18 years of age) in the seven Karen refugee camps.
72 Information provided by JRS Thailand in report prepared by JRS special education coordinator and camp-based staff, November 30, 2007.
73 See note 70.
74 Ibid.
75 This represents 2 percent of the total school population of 32,035 students.
76 See Mercy Corps Jordan, http://www.mercycorps.org/countries/jordan/614.
77 Information provided by JRS Thailand in report prepared by JRS special education coordinator and camp-based staff, November 30, 2007.
78 E-mail communication with Maria Kett (assistant director, Leonard Cheshire Disability and Inclusive Development Center, University College London), April 29, 2008. One explanation for lower school attendance rates among disabled girls is that in general, according to the field surveys, there were more boys with disabilities than girls in any given population. According to the Action for the Rights of Children (ARC), however, this may be because boys with disabilities survive longer. Girls with disabilities are more likely to be abandoned, discriminated against and excluded from education and general participation in society. Another reason may be that prevailing family/societal attitudes keep girls at home to help with household chores.
79 Caritas Nepal Bhutanese Refugee Education Program, *Interim Narrative Report,* September 20, 2007.
80 Information supplied by Mercy Corps Jordan.
81 See Human Rights Watch, *Thailand Landmine Monitor Report 2006*, http://www.icbl.org/lm/2006/thailand.
82 E-mail communication with UNHCR Nepal, April 21, 2008.
83 Telephone interview with UNHCR community services officer, Dadaab Sub-Office, Kenya, March 6, 2008. See also UNHCR Community Services Sub-Office Dadaab Monthly Newsletter, *People Living with Disabilities*, Issue No. 2, October 2007.
84 The self-help groups were preceded by a Forum for People with Disabilities (FoPewD), which received funding from the Abilis Foundation, a foundation set up by people with disabilities in Finland in 1998 to provide small grants to projects initiated and run by people with disabilities in developing countries. Funding for the Forum ended in December 2004 and, according to Caritas Nepal, the Forum has since ceased its activities due to lack of funding and has been replaced by self-help groups.
85 See note 81.
86 See Human Rights Watch, *Thailand Landmine Monitor Report 2007,* http://www.icbl.org/lm/2007/thailand.
87 See Clear Path International, which helps fund KHWA, http://www.cpi.org/cpiblog/archives/000321.php, and Mae Tao Clinic, http://maic.jmu.edu/journal/9.2/focus/matthee/matthee.htm.
88 See note 81.
89 See Clear Path International, http://www.cpi.org/cpiblog/archives/000321.php.
90 E-mail correspondence with Mercy Corps Jordan, February 26, 2008.
91 E-mail communication with UNHCR Nepal, April 21, 2008.
92 Follow-up telephone conversation with Mercy Corps Jordan, December 12, 2007.
93 Telephone interview with UNHCR community services officer, Dadaab Sub-Office, Kenya, March 6, 2008. See also UNHCR Community Services Sub-Office Dadaab Monthly Newsletter *People Living with Disabilities* Issue No. 2, October 2007.
94 The United States, however, is giving priority for resettlement to those Iraqis who have previously worked as translators, etc., for the U.S. government or as contractors in Iraq.
95 E-mail communication with UNHCR Nepal, April 21, 2008.
96 UNHCR Thailand: Camp Disabled Population Resettlement Statistics from January 1, 2005 to March 10, 2008, and e-mail communication with UNHCR Thailand, May 7, 2008.
97 Information provided by UNHCR Senior Resettlement Officer, UNHCR Geneva, February 25, 2008.
98 See UNHCR, *Community Services Guidelines: Assisting Disabled Refugees: A Community-based Approach,* 2nd ed., rev. (Geneva: UNHCR, May 1996).
99 Ibid., Annex 5 (IOM/FOM/15/18/86, March 13, 1986).
100 Ibid., point 1.5.
101 E-mail communication with Head of UNHCR Resettlement Section, UNHCR Geneva, March 6, 2008.
102 See note 98.
103 Ibid., 9.
104 See United Kingdom Country Chapter (September 2007) in UNHCR, *Resettlement Handbook* (Geneva: UNHCR, November 2004), http://www.unhcr.org/cgi-bin/texis/vtx/protect?id=3d4545984. The United Kingdom used to resettle approximately 70 persons a year under the Ten or More and Mandate Program. Currently the Ten or More program has been suspended and is under review in the United Kingdom.
105 For more information on individual countries' specific resettlement programs see the Country Chapters in UNHCR, *Resettlement Handbook* (Geneva: UNHCR, 2004), http://www.unhcr.org/cgi-bin/texis/vtx/protect?id=3d4545984.
106 E-mail communication with senior resettlement operations coordinator, UNHCR Geneva, April 27, 2008.
107 In Australia, medical costs must currently be under Aus $250,000, calculated over a lifetime.
108 See Australia Country Chapter in UNHCR, *Resettlement Handbook* (Geneva: UNHCR, 2004), http://www.unhcr.org/cgi-bin/texis/vtx/protect?id=3d4545984.
109 UNHCR, *Resettlement Handbook* (Geneva: UNHCR, November 2004), http://www.unhcr.org/cgi-bin/texis/vtx/protect?id=3d4545984.
110 Ibid., Section 4.4.4.
111 E-mail communication with UNHCR Senior Resettlement Officer, February 25, 2008.
112 See UNHCR Division of International Protection Services/Division of Operational Services, *Guidance on the Use of Standardized Specific Needs Codes* (IOM/028/FOM/030) (Geneva: UNHCR, 2007).
113 See UNHCR, *Heightened Risk Identification Tool (HRIT)* (Geneva: UNHCR, 2007).
114 The HRIT was developed by the University of New South Wales, the Victorian Foundation for Survivors of Torture and UNHCR and piloted in Bangladesh in early 2007.
115 See User Guide in UNHCR, *Heightened Risk Identification Tool* (Geneva: UNHCR, 2007).
116 See UNHCR, *The UNHCR Tool for Participatory Assessment in Operations* (Geneva: UNHCR, 2006).
117 Ibid.
118 Ibid.
119 Discussion with UNHCR staff, Geneva, January 9, 2008. See also UNHCR, *Mainstreaming Age, Gender and Diversity Summary Report* (Geneva: UNHCR, 2006).
120 UNHCR, *A Community-based Approach in UNHCR Operations* (Geneva: UNHCR, January 2008). [Note that Bibliography lists 2008 version of this document, and, needless to say, it is not provisional.]
121 UNICEF and the Office of the High Commissioner for Human Rights joined ARC in 1999 and the International Rescue Committee and Terre des Hommes joined the ARC steering committee in 2006.
122 See UNHCR and International Save the Children Alliance, Action for the Rights of Children Resource Pack: *Critical Issues: Disability* (London: International Save the Children Alliance, 2001), http://www.savethechildren.net/arc/files/main.html.

123 See http://www.un.org/disabilities/.
124 See http://www.un.org/disabilities/default.asp?id=182 for full text of the Convention.
125 For more detailed analysis of the content and application of the CRPD, see United Nation, OHCHR and IPU, *From Exclusion to Equality: Realizing the Rights of Persons with Disabilities, Handbook for Parliamentarians on the Convention on the Rights of Persons with Disabilities and Its Optional Protocol* (Geneva: United Nations, 2007), http://www.un.org/disabilities/.
126 See http://www.un.org/disabilities/default.asp?id=182 for full text.
127 See The Sphere Project, http://www.sphereproject.org/content/view/27/84.
128 See WHO, ILO, UNESCO, *CBR: A Strategy for Rehabilitation, Equalization of Opportunities, Poverty Reduction and Social Inclusion of People with Disabilities,* Joint Position Paper, 2004.
129 See Ibid. fn 188 and Draft WHO/ILO/UNESCO, CBR Guidelines: Supplement Chapters, *CBR and Crisis Situations*, 2007.
130 See note 122.
131 See WHO/ILO/UNESCO, CBR Guidelines: Supplement Chapters, *CBR and Crisis Situations*, Draft (Geneva: WHO 2007), http://www.who.int/disabilities/publications/cbr/en/index.html.
132 IASC, *Guidelines on Mental Health and Psychosocial Support in Emergency Settings* (Geneva: IASC, 2007), http://www.humanitarianinfo.org/iasc/content/subsidi/tf_mhps/default.asp?bodyID=5&publish=0.
133 Ibid.
134 See Inter-Agency Standing Committee, *Protecting Persons Affected by Natural Disasters: IASC Operational Guidelines on Human Rights and Natural Disasters* (Geneva: IASC, June 2006), http://www.humanitarianinfo.org/iasc/content/documents/working/OtherDocs/2006_IASC_NaturalDisasterGuidelines.pdf.
135 See SHIA, Bonn Declaration, Draft declaration from the conference entitled, *Disasters Are Always Inclusive! Persons with Disabilities in Humanitarian Emergency Situations,* held in Bonn, Germany November 7-8, 2007, 3rd draft, November 23, 2007, http://www.shia.se/files/Bonn%20Declaration-Draft.DOC.
136 See HelpAge International, *Older People in Disasters and Humanitarian Crises: Guidelines for Best Practice* (London: HelpAge International, 2000).
137 See HelpAge International, *Rebuilding Lives in Longer-term Emergencies: Older People's Experience in Darfur* (London: HelpAge International, 2006).
138 Ibid. and telephone interview with Susan Erb, HelpAge International, September 27, 2007.
139 See note 137.
140 See Human Rights Watch, *Last Hope: The Need for Durable Solutions for Bhutanese Refugees in Nepal and India,* Volume 19, No. 7(C) (New York: Human Rights Watch, May 2007), http://hrw.org/reports/2007/bhutan0507/ and Amnesty International, *Bhutan: Nationality, Expulsion, Statelessness and the Right to Return,* AI Index: ASA 14/01/00, September 2000, http://www.amnesty.org/en/library/ for more information about background to Bhutanese refugee crisis.
141 According to the UNHCR census data, in October 2007, there were a total of 107,341 refugees living in all seven refugee camps.
142 Human Rights Watch press release, May 17, 2007, http://hrw.org/english/docs/2007/05/17/bhutan15936.htm.
143 IRIN report. February 14, 2008. http://www.irinnews.org/Report.aspx?ReportId=76563.
144 JRS Dispatches, No. 229, January 18, 2008, http://www.jrs.net/dispatch/index.php?lang=en&sid=2981.
145 See Human Rights Watch, *Last Hope: The Need for Durable Solutions for Bhutanese Refugees in Nepal and India,* Volume 19, No. 7(C) (New York: Human Rights Watch, May 2007), http://hrw.org/reports/2007/bhutan0507/. However, in an e-mail communication with UNHCR Nepal, April 21, 2008, UNHCR reports that standards of assistance have been maintained between 2006 and 2008, and the budget for Bhutanese refugees increased by almost 20 percent between 2006 and 2008. Notably, the High Commissioner's initiative Health/Nutrition to Bhutanese Refugees in Nepal brought approximately $1 million in additional funding to the program in 2007.
146 See Human Rights Watch, *Last Hope: The Need for Durable Solutions for Bhutanese Refugees in Nepal and India,* Volume 19, No. 7(C) (New York: Human Rights Watch, May 2007), http://hrw.org/reports/2007/bhutan0507/.
147 See International Crisis Group, *Nepal's Peace Agreement: Making It Work*, Asia Report No. 126, December 15, 2006, for more information, http://www.crisisgroup.org/home/index.cfm?id=2929&l=1
148 See note 146.
149 See Human Rights Watch Press Release, *Nepal: Bhutanese Refugee Tensions Erupt into Violence: Nepali Police Need to Protect Refugees' Freedom of Expression*, May 31, 2007, http://hrw.org/english/docs/2007/05/31/bhutan16034.htm.
150 E-mail communication with UNHCR Nepal, April 21, 2008.
151 Sue Stubbs, Save the Children Overseas Disability Advisor, *Nepal Trip Report,* November 1-7, 1996 (internal document provided by Caritas Nepal).
152 Caritas Nepal data, December 2007.
153 See Thailand Burma Border Consortium, http://www.tbbc.org/camps/history.htm.
154 UNHCR data, December 26, 2007, http://www.tbbc.org/camps/populations.htm.
155 See http://www.tbbc.org/camps/populations.htm.
156 See http://www.tbbc.org/camps/management.htm.
157 See http://www.tbbc.org/aboutus/aboutus.htm.
158 Information provided by UNHCR Thailand by e-mail communication, May 7, 2008.
159 Ibid.
160 Susan Banki and Hazel Lang. *Planning for the Future: The Impact of Resettlement on the Remaining Camp Population.* Bangkok: CCSDPT, 2007. http://www.ccsdpt.org/resources.htm. In a subsequent e-mail communication with UNHCR Thailand May 7, 2008, however, the office stated that it had investigated reports that resettlement was favoring educated refugees and had found that this was not the case.
161 ProGres (Profile Global Registration System) was launched by UNHCR in 2005. It is aimed at standardizing and improving refugee registration and data collection and gathering more detailed and accurate information on refugee populations. It uses standard definitions and codes for collecting data, including data about refugees with special needs, such as disabilities.
162 See UNHCR Press Release, December 16, 2004, http://www.unhcr.org/cgi-bin/texis/vtx/news/opendoc.htm?tbl=NEWS&id=41c19a994.
163 There is considerable confusion in terminology and definitions. In some countries, organizations include people with mental illness and mental health problems in disability statistics; in other countries data on mental health problems is not included in disability statistics.
164 UNHCR Thailand, Camp Disabilities—Breakdown by Age and Gender (as of March 10, 2008).
165 See BBC report July 5, 2006, http://news.bbc.co.uk/2/hi/middle_east/5151518.stm for more information.
166 See UNHCR press release, March 3, 2006 for more information. http://www.unhcr.org/cgi-bin/texis/vtx/news/opendoc.htm?tbl=NEWS&id=44081d924.
167 Ibid.
168 Ibid.
169 Interview with UNHCR Senior Community Services Assistant, November 21, 2007.
170 See FAFO, *Iraqis in Jordan 2007: Their Numbers and Characteristics* (Oslo: FAFO, May 2007), http://www.fafo.no/ais/middeast/jordan/Iraqis_in_Jordan.htm. The study was carried out by the Norwegian research institute FAFO, in collaboration with the Jordanian Government Department of Statistics, with support from UNFPA. Funding for the study came from the Norwegian Ministry of Foreign Affairs.
171 Mercy Corps Jordan, http://www.mercycorps.org/countries/jordan/614.
172 See FAFO study, http://www.fafo.no/ais/middeast/jordan/Iraqis_in_Jordan.htm.
173 Ibid., note 75.
174 The FAFO study was the first attempt to try to tabulate the number of Iraqi refugees in Jordan.
175 There is some confusion in terminology and definitions. In some countries, researchers included mental illness and mental health problems as a mental disability; in other countries they were treated separately and data on mental health problems was not included in disability statistics.
176 According to the survey, the majority of individuals listed as "other" had conditions associated with chronic illness or age.
177 See Mercy Corps Jordan, http://www.mercycorps.org/countries/jordan/614.
178 See Landmines Survivors Network, http://www.landminesurvivors.org/where_jordan.php.
179 See BBC, Q & A: *Colombia's Civil Conflict*, November 22, 2007, http://news.bbc.co.uk/1/hi/world/americas/1738963.stm.
180 Refugees International, *Ecuador, International Support Needed for Colombian Refugees*, http://www.refugeesinternational.org/content/article/detail/958/.
181 Source: Ministry of Foreign Affairs, Quito, October 8, 2007.
182 See Refugees International, http://www.refugeesinternational.org/content/article/detail/958/.
183 Fundacion Ambiente y Sociedad (Environment and Society Foundation).
184 *Organismo de Voluntariado para la Cooperación Internacional—la Nostra Famiglia.* OCVI provides services to disabled children around the world and has been working in Ecuador since 1994.
185 Interview with UNHCR community services officer, UNHCR Quito, November 16, 2007.
186 Interview with UNICEF project assistant, UNICEF Quito, November 15, 2007.
187 See note 184.
188 The INNFA runs a scholarship program for young people with disabilities.
189 See UNHCR, *Guidance on the Use of Standardized Specific Needs Codes* (IOM/028/FOM/030) (Geneva: UNHCR, 2007).
190 UNHCR, *Heightened Risk Identification Tool* (Geneva: UNHCR, June 20, 2007).

BIBLIOGRAPHY

General Information on Disability and Displacement

Ad Hoc Committee on a Comprehensive and Integral International Convention on the Protection and Promotion of the Rights and Dignity of Persons with Disabilities. *Convention on Rights of Persons with Disabilities.* Final report, distributed December 6, 2006. http://www.un.org/disabilities/convention/conventionfull.shtml.

Harris, Alison with Sue Enfield. *Disability, Equality and Human Rights: A Training Manual for Development and Humanitarian Organisations.* London: Oxfam Publishing, 2003.

Helander, Einar and A. Goerdt. *Training in the Community for People with Disabilities.* Geneva: WHO, 1989.

HelpAge International. *Ageways,* 64 ("Ageing and Disability" issue) (January 2004).

———. *Older People in Disasters and Humanitarian Crises: Guidelines for Best Practice.* London: HelpAge International, 2000.

———. *Rebuilding Lives in Longer-term Emergencies: Older People's Experience in Darfur.* London: HelpAge International, 2006.

IASC. *Guidelines for Gender-Based Violence Interventions in Humanitarian Settings.* Geneva: Inter-Agency Standing Committee, 2005.

———. *Guidelines on Mental Health and Psychosocial Support in Emergency Settings.* Geneva: Inter-Agency Standing Committee, 2007.

———. *IASC Operational Guidelines on Human Rights and Natural Disasters: Protecting Persons Affected by Natural Disasters.* Geneva: Inter-Agency Standing Committee, 2006.

IDDC. *Disability and Conflict.* Report of an IDDC Seminar. London, May 29-June 4, 2000. http://www.iddc.org.uk.

Inter-Agency Network for Education in Emergencies. Good Practice Guides: *Inclusive Education of Children At Risk.* http://ineesite.org/page.asp?pid=1060.

———. *Minimum Standards for Education in Emergencies, Chronic Crises and Early Reconstruction.* New York: INEE, 2004. http://ineesite.org/page.asp?pid=1240.

International Campaign to Ban Landmines. *Guidelines for the Care and Rehabilitation of Survivors.* http://www.icbl.org/problem/solution/survivors/guidelines.

International Federation of Red Cross and Red Crescent Societies (IFRC). *World Disaster Report 2007—Focus on Discrimination.* Geneva: IFRC, 2007.

Jones, H. and R. A. Reed. *Water and Sanitation for Disabled People and Other Vulnerable Groups.* Leicestershire, UK: WEDC, 2005.

Kett, Maria, Sue Stubbs, and Rebecca Yeo. *Disability in Conflict and Emergency Situations: Focus on Tsunami-affected Areas.* London: IDDC, 2005.

Landmine Survivors Network. *Prosthetics and Orthotics Programme Guide: Implementing P&O Services in Low-Income Settings: A Guide for Planners and Providers of Services for Persons in Need of Orthopaedic Devices.* http://www.landminesurvivors.org/what_PO_Guides.php

———. *Prosthetics and Orthotics Project Guide: Supporting P&O Services in Low-Income Settings: A Common Approach for Organizations Implementing Aid Projects.* http://www.landminesurvivors.org/what_PO_Guides.php.

Lansdown, Gerison. *Promoting the Rights of Children with Disabilities: A Guide to Using the Convention on the Rights of Persons with Disabilities with the Convention on the Rights of the Child.* London: Save the Children Alliance, forthcoming.

Norwegian Refugee Council (NRC). *Camp Management Toolkit.* Oslo: NRC, 2004.

Oxfam Technical Brief No. 1. *Excreta Disposal for People with Physical Disabilities in Emergencies.* London: Oxfam Publishing, 2007.

Oxfam Technical Brief No. 2, *Vulnerability and Socio-cultural Considerations for PHE in Emergencies.* London: Oxfam Publishing, 2007.

Policy and Learning Team. *Working with the Most Vulnerable in Emergencies.* London: Save the Children UK, 2005.

Richman, Naomi. *Communicating with Children: Helping Children in Distress.* London: Save the Children UK, 1993.

Save the Children UK. *Making a Difference: Training Materials to Promote Diversity and Tackle Discrimination.* London: Save the Children UK, 2005.

———. *Making Schools Inclusive: How Change Can Happen.* London: Save the Children UK, 2008.

SHIA. Bonn Declaration (third draft). Draft declaration from the conference entitled, Disasters Are Always Inclusive! Persons with Disabilities in Humanitarian Emergency Situations, held in Bonn, Germany, November 7-8, 2007. http://www.shia.se/files/Bonn%20Declaration-Draft.DOC.

The Sphere Project. *The Sphere Project: Humanitarian Charter and Minimum Standards in Disaster Response.* London: Oxfam Publishing, 2004. http://www.sphereproject.org/content/view/27/84.

UNESCO. *Overcoming Exclusion through Inclusive Approaches in Education: A Challenge and a Vision.* Paris: UNESCO, 2003.

———. *Salamanca Statement and Framework for Action on Special Needs Education.* Paris: UNESCO, 1994. http://www.unesco.org/education/pdf/SALAMA_E.PDF.

UNHCR and International Save the Children Alliance. Action for the Rights of Children Resource Pack: *Critical Issues: Disability.* London: International Save the Children Alliance, 2001. http://www.savethechildren.net/arc/files/main.html.

United Nations, OHCHR and IPU. *From Exclusion to Equality: Realizing the Rights of Persons with Disabilities: Handbook for Parliamentarians on the Convention on the Rights of Persons with Disabilities and Its Optional Protocol.* Geneva: United Nations, 2007.

Wells, Jo. *Protecting and Assisting Older People in Emergencies.* Network Paper Number 53. London: Humanitarian Practice Network, 2005.

WHO, ILO and UNESCO. *CBR: A Strategy for Rehabilitation, Equalization of Opportunities, Poverty Reduction and Social Inclusion of People with Disabilities,* Joint position paper. Geneva: WHO, ILO, UNESCO, 2004.

———. CBR Guidelines: Supplement Chapters, *CBR and Crisis Situations.* Draft. Geneva: WHO, 2007. http://www.who.int/disabilities/publications/cbr/en/index.html.

World Programme of Action. *The Standard Rules on the Equalization of Opportunities for Persons with Disabilities.* Adopted by the UN General Assembly, December 20, 1993. http://www.un.org/esa/socdev/enable/dissre00.htm.

UNHCR

UNHRC. Executive Committee of the High Commissioner's Programme, Standing Committee. *The Protection of Older Persons and Persons with Disabilities.* Paper submitted to high-level meeting on the regional review of MIPAA. Macao, China: United Nations ESCAP, 2007.

———. *A Community-based Approach in UNHCR Operations.* Geneva: UNHCR, 2008.

———. *Agenda for Protection,* 3rd ed. Geneva: UNHCR, 2003. http://www.unhcr.org/protect/PROTECTION/3e637b194.pdf

———. *Assisting Disabled Refugees: A Community-based Approach,* 2nd ed. Geneva: UNHCR, 1996.

———. *Handbook for Emergencies,* 3rd ed. Geneva: UNHCR, 2007.

———. *Handbook for the Protection of Women and Girls.* Geneva: UNHCR, 2008.

———. *Handbook on Voluntary Repatriation: International Protection.* Geneva: UNHCR, 1996.

———. *Heightened Risk Identification Tool.* Geneva: UNHCR, 2007.

———. *Refugee Children: Guidelines on Protection and Care.* Geneva: UNHCR, 1994.

———. *Resettlement Handbook.* Geneva: UNHCR, 2004.

———. *Sexual and Gender-based Violence against Refugees, Returnees and Internally Displaced Persons: Guidelines for Prevention and Response.* Geneva: UNHCR, 2003.

———. *The Reach Out Training Kit: Module 8—Vulnerable Groups.* Geneva: UNHCR, 2005. http://www.icva.ch/doc00001528.html.

———. *The UNHCR Tool for Participatory Assessment in Operations.* Geneva: UNHCR, 2006.

Nepal

Amnesty International. *Bhutan: Nationality, Expulsion, Statelessness and the Right to Return.* AI Index: ASA 14/01/00, September 2000. http://www.amnesty.org/en/library/.

Human Rights Watch. *Last Hope: The Need for Durable Solutions for Bhutanese Refugees in Nepal and India,* Volume 19, No. 7(C). New York: Human Rights Watch, 2007. http://www.hrw.org/reports/2007/bhutan0507/.

———. *Nepal: Bhutanese Refugee Tensions Erupt into Violence: Nepali Police Need to Protect Refugees' Freedom of Expression.* Press release: May 31, 2007. http://hrw.org/english/docs/2007/05/31/bhutan16034.htm.

Thailand

Banki, Susan and Hazel Lang. *Planning for the Future: The Impact of Resettlement on the Remaining Camp Population.* Bangkok: CCSDPT, 2007. http://www.ccsdpt.org/resources.htm.

Human Rights Watch. *Thailand Landmine Monitor Report 2006.* New York: Human Rights Watch, 2006. http://www.icbl.org/lm/2006/thailand.

———. *Thailand Landmine Monitor Report 2007.* New York: Human Rights Watch, 2007. http://www.icbl.org/lm/2007/thailand.

UNHCR. *First Karen Refugees Swap Tropical Forest of Thailand for U.S. Concrete Jungle.* Press release: August 18, 2006, http://www.unhcr.org/cgi-bin/texis/vtx/news/opendoc.htm?tbl=NEWS&id=44e5bdf72.

ZOA Refugee Care Thailand. *Having Their Say: Refugee Camp Residents and Inclusive Education.* Position paper. Maesot, Thailand: ZOA, 2007. http://www.burmalibrary.org/docs4/ZOAPosition_Paper-Having_Their_Say.pdf.

Jordan

FAFO. *Iraqis in Jordan 2007: Their Numbers and Characteristics.* Oslo: FAFO, 2007. http://www.fafo.no/ais/middeast/jordan/Iraqis_in_Jordan.htm.

Ecuador

BBC. Q & A: Colombia's Civil Conflict, November 22, 2007. http://news.bbc.co.uk/1/hi/world/americas/1738963.stm.

Refugees International. *Ecuador: International Support Needed for Colombian Refugees.* Washington, D.C.: Refugees International, 2004. http://www.refugeesinternational.org/content/article/detail/958/.

ACRONYMS AND ABBREVIATIONS

ADRA	Adventist Development Relief Agency
AGDM	Age, gender and diversity mainstreaming
ARC	Action for the Rights of Children
CBM	Christian Blind Mission
CBO	Community-based organization
CBR	Community-based rehabilitation
CCSPDT	Committee for the Coordination of Services to Displaced Persons in Thailand
COERR	Catholic Office for Emergency Relief and Refugees
CONADIS	National Council of Disabilities (Ecuador)
COOPI	Cooperazione Internazionale (International Cooperation)
CRPD	UN Convention on the Rights of Persons with Disabilities
DPO	Disabled persons' organization
FAFO	The Fafo Research Foundation (Norwegian research foundation)
FAS	Fundacion Ambiente y Sociedad (Environment and Society Foundation, Ecuador)
HIAS	Hebrew Immigrant Aid Society
HRIT	Heightened Risk Identification Tool
IASC	Inter-Agency Standing Committee
ICBL	International Campaign to Ban Landmines
ICRC	International Committee of the Red Cross
IDDC	International Disability and Development Consortium
IDP	Internally displaced person
IFRC	International Federation of Red Cross and Red Crescent Societies
ILO	International Labor Organization
INEE	Interagency Network for Education in Emergencies
JRS	Jesuit Refugee Service
KHWA	Karen Handicapped Welfare Association
KNU	Karen National Union
LSN	Landmine Survivors Network
MENCAFEP	Mentally Handicapped Children and Families Education Project (Sri Lanka)
NGO	Nongovernmental organization
OCVI	Organismo de Voluntariado para la Cooperación Internacional—la Nostra Famiglia (Italian NGO)
ProGres	Profile Global Registration System
RSD	Refugee status determination
SGBV	Sexual and gender-based violence
TBBC	Thailand Burma Border Consortium
UN	United Nations
UNDP	United Nations Development Program
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNIFEM	United Nations Development Fund for Women
VSO	Voluntary Service Overseas
WEAVE	Women's Education for Advancement and Empowerment (Thailand)
WFP	World Food Program
WHO	World Health Organization
ZENID/JOHUD	The Queen Zein Al Sharaf Institute for Development/Jordan Hashemite Fund for Human Development
ZOA	ZOA Refugee Care

ACKNOWLEDGMENTS

This report was written by Rachael Reilly, consultant to the Women's Commission for Refugee Women and Children. Field research for the report was carried out by Ravi Sharma Chapagain, Caritas Nepal; Ann McAllen, World Education, Thailand; Chiara Buono, HIAS, Ecuador; Laila Abubaker Bashumaila (Director), Faiza Ali Hunaishi, Khadra Adem, Mohamed Ben Mohamed, Abdulaziz Mohamed Mahmood, Fuad Abdulkareem, Abdullah Al-Duhaimi, Basel Ahmed Abdullah, Anwer Abdulrahim and Ahmed Saeed Saleh, Center for Persons with Special Needs, Al-Mansora, Aden, Republic of Yemen; and Mohamad Abu Qtesh, Omar Mahmoud Fares Al-Mashareh, Heba Mansour Essa, Ahmad Arabiyat, Mohammad Abdulraheem Abu Fares, Ahmad Musalam, Zinat Mohamad and Mohamad Mansour, researchers affiliated with the Landmine Survivors Network, Jordan.

The Women's Commission would especially like to thank Fr. Varkey Perekkatt S.J., Bhutanese Refugee Education Program, Caritas Nepal; Fred Ligon, World Education, Thailand and the Karen Women's Organization; HIAS, Ecuador; the Center for Persons with Special Needs, Al-Mansora, Aden, Republic of Yemen and Aisha Saeed, UNHCR Yemen; and Karen Saba and Kelsey Noonan, Mercy Corps Jordan, for their assistance and support in organizing the field research for the report and for providing comments on the final drafts. Without the collaboration of these organizations, this report would not have been possible. We would also like to thank Francesca Bonelli, UNHCR Dadaab, Kenya; Chris Stubbs, MENCAFEP, Sri Lanka; Susan Erb, HelpAge International; and Kelle Rivers, JRS Thailand for the additional case study information they provided for the report and for their comments on the final drafts.

Special thanks also to Maria Kett, Leonard Cheshire Disability and Inclusive Development Center, University College, London; Valérie Scherrer, Christian Blind Mission (CBM); Tina Hyder, Save the Children UK; Jane Betts, World Vision UK; Mark Van Ommeren, Alana Officer and Mr. Chapal Khasnabis, World Health Organization; Simon Walker, Office of the High Commissioner for Human Rights; Sarah Lumsdon, Oxfam GB; Hani Eskandar and Alison Joyner, Sphere Project; Claude Tardif, ICRC and Theo Verhoeff, ICRC Special Fund for the Disabled; Luciano Loïacono-Clouet, Handicap International; Cindy Dubble; and Deirdre Walshe for their valuable time and input to the report and for providing comments on the final drafts.

The Women's Commission is grateful to UNHCR for providing funding for this project, and especially to Terry Morel, former Chief, Community Development, Gender Equality and Children Section; Aminata Gueye, Senior Community Services Coordinator; Jennifer Ashton, Senior Resettlement Operations Coordinator; Sean Henderson, Senior Resettlement Officer (Global Policy) and Susanne Butscher, Registration Officer, Field Information & Coordination Support Section; and to UNHCR Yemen, UNHCR Nepal, UNHCR Dadaab, UNHCR Ecuador and UNHCR Thailand for their input and assistance to the project, including comments on the final draft.

This project would not have been possible without the participation of the many refugees with disabilities—young, old, women, men, girls and boys—and their families who provided invaluable insights into their daily lives and the challenges they face as refugees and as persons with disabilities. This report is a tribute to their strength and courage, even in the face of great difficulties and obstacles. We hope that it will go a small way toward improving their lives and ensuring that they can live in dignity and hope.

The Women's Commission thanks UNHCR, The StarFish Foundation, Natasha Boissier, Beth Daniels and Dina Dublon for their support of this project.

Women's Commission for Refugee Women and Children
122 East 42nd Street
New York, NY 10168-1289
+1.212.551.3115
info@womenscommission.org
womenscommission.org