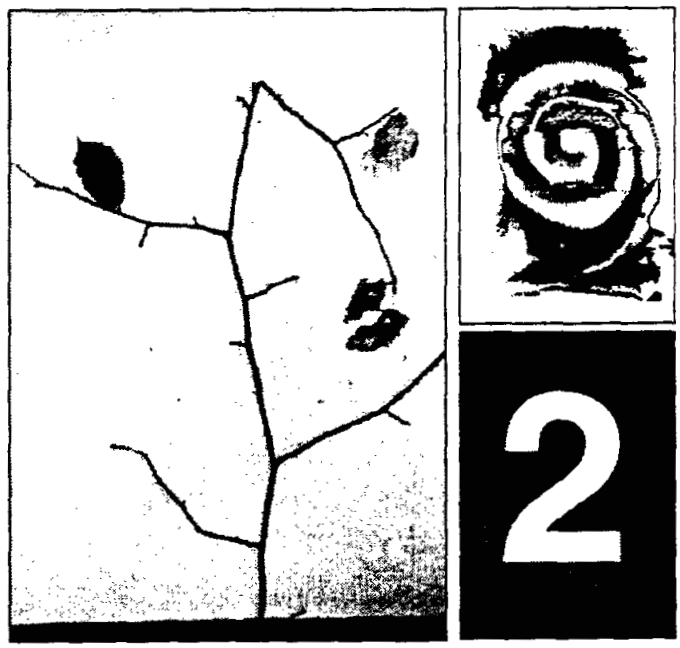
Assisting Disabled Refugees

A Community-based Approach



COMMUNITY
SERVICES
GUIDELINES

Revised May 1996
Second Edition

Additional copies of these guidelines may be obtained from:

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Design and Layout: LN Crossing
Photographs: A. Hollmann/UNHCR, pp. 64 and 69

This manual is a revision of the guidelines published in 1992 under the title "UNHCR Guidelines on Assistance to Disabled Refugees".

FOREWORD

Despite the hopes at the start of this decade, massive displacements of populations as a result of conflict, civil strife and atrocities continue. Displacement has been the objective of gross violations of human rights as well as a consequence of actions with other primary aims.

Much attention has been focused on improving emergency response to the needs of refugees. Whether for large groups or for individual victims of persecution, it is recognised that this response must go beyond the provision of material relief. The response must also address their social, human and emotional needs, and help to heal psychological wounds.

Helping people to help themselves and to help others in need is at the heart of the community services approach advocated herein. This support must start at the earliest possible opportunity and continue in a structured and well-planned manner, reaching and giving priority to those who need it most.

These revised manuals seek to strengthen community services by providing practical guidance to those closest to the refugees. The manuals cover refugee emergencies, assistance to disabled refugees, urban refugees and working with unaccompanied minors. They reflect experiences and lessons learnt since the preparation of the original version.

Comments and suggestions for improvements are most welcome and should be addressed to Community Services (TS00), UNHCR Headquarters, C.P. 2500, CH-1211 Geneva 2 depot., Geneva.

With best wishes for your work.

Nicholas Morris

Nicholas Morris, Director
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United Nations High Commissioner for Refugees

Refugees are persons who are often exposed to violence, hardship, deprivation and poor medical care which results in disabling conditions. The purpose of this manual is to enable those working with refugees to understand the causes and effects of disability on refugees and to look for solutions to make life more meaningful and manageable under often impossible conditions. To this end the manual provides practical guidance to UNHCR offices in the field and others working with refugees, on steps that should be taken to prevent and to provide treatment for disabling conditions, and to promote the rehabilitation of refugees who are handicapped because of a physical or mental disability.

Part One • Current Practice
Provides an overview of disabled populations, defines terms in current use, outlines UNHCR's activities relating to disabled refugees and
delineates the policies determining action to be taken.

Part Two • First Steps
Discusses resources.Outlines procedures for identification and assessment of disabled refugees. Provides information on preventive measures.

Part Three • Rehabilitation
Covers various aspects of the rehabilitation process.

The value of this manual will be measured solely in the resulting impact on the lives of disabled refugees. It is intended to promote and direct action. Offices in the field are encouraged to share with Community Services (PTSS) Headquarters their experiences in applying the policies and guidelines presented.

CONTENTS


Labels
are the
Handicap

part 1

Current Practice

Overview

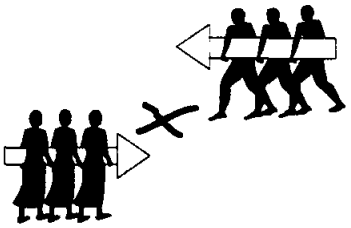
Action by UNHCR

Overview

- The pattern of disability among refugees is likely to be similar to that in their country of origin, but with an increased risk of mental disturbance resulting from their refugee experience. Physical handicaps resulting from injuries incurred through armed conflict, violence and the presence of landmines, may also be more prevalent
- Recognized strategy on disability is two-pronged, with the emphasis on prevention and rehabilitation through a community-based approach.
- Many of these disabilities can be prevented or remedied.
- **Assistance to the disabled should be provided from the very outset of a refugee emergency. Later can be too late.**

Action by UNHCR

- UNHCR assists disabled refugee men, women and children in their country of asylum, or by evacuating them abroad to neighbouring countries for the necessary treatment when local facilities are inadequate.
- Measures for disabled refugees are based on the concept of community-level care and are incorporated into the overall Care and Maintenance Programme.
- In the development, implementation and review of their respective programmes of protection and assistance, offices in the field are expected to seek actively the implementation of the policies outlined on pages 10 and 11.
- Field offices should assess existing projects in relation to the policies outlined in this section and ensure that priority needs have been targeted and that they are being addressed appropriately.



"We do not want charity or special favours and privileges; only the same basic rights and freedoms as others.
We wish to be treated as equal human beings—to be able to participate in the common life to the extent of our capabilities, without having to face unnecessary barriers to our involvement.
We have the same *needs and desires as anyone* else—to be self-sufficient—self-determining—to have a measure of dignity and self-respect—to be contributing and responsible members of society—to enjoy the same basic freedoms, rights and responsibilites as anyone else..." *

Incidence: The World Health Organization (WHO) estimates that 10% of the world's population is disabled. Among refugees the incidence tends to be lower because the disabled, who are unable to cope with the demands of the flight into exile, are often left behind. (The incidence of disability in repatriated populations however tends to be higher.) Nevertheless, the pattern of disability among refugees is likely to be similar to that in their country of origin, but with increased risk of mental disturbance resulting from their refugee experience. Physical handicaps due to injuries incurred through armed conflict, violence and the presence of mines, may also be more prevalent.

Causes: WHO also calculates that about 70% of the disabling impairments in developing countries (where most refugee populations are to be found) are caused by malnutrition, communicable diseases, low quality pre- and post-natal care and accidents. Other conditions which commonly cause disability in refugee populations in developing countries include: vitamin deficiences, polio, leprosy, epilepsy, mental retardation, severe ear and eye infections, burns, injuries caused by violence (war, torture) and other severe trauma. Many of these disabilities can be prevented or remedied.

Approach: In accordance with the principles of primary health care, recognized strategy on disability adopts a two-pronged approach:

a) Prevention through all types of measures, within and without the health sector, that contribute to a reduction in the incidence of impairment. (For example, in cases of armed conflict, provide **immediate** medical care for

* Source: "Obstacles", Report of the Special Committee on the Disabled and the Handicapped, Canada House of Commons, Ottawa, 1981, also quotes appearing on pages 8, 26, 32, 52 and 76.

Overview

wounded refugees to reduce impairment and initiate measures for eventual rehabilitation.) If impairment is already present, measures should be taken to reduce the severity or to postpone the occurrence of disability and handicap. Early diagnosis and assessment of a refugee population for the presence of disabling conditions is therefore essential.

b) Rehabilitation through community-based rehabilitation services (with an appropriate system of supervision and referral), with the aim of total coverage of all populations. These services deliver at least the most essential care, and form an integral part of the national socio-economic development programmes. (1)

Types of Interventions: The possible interventions that can be undertaken in favour of disabled people can be divided into roughly two categories:

General interventions, including those aimed at:

- building awareness of disability, of the abilities of disabled people, and of the possibility to provide rehabilitation in the family and the community;
- providing more equitable opportunities, better access to the general systems of society , general interventions in the environment, and so on;
- increasing the representation of disabled people and their families on all formal and informal bodies with authority to decide on plans, services, etc., for disabled people;
- promoting and protecting disabled people's human rights;

Specific interventions, including:

- functional training in self-care, mobility, behaviour and communication, including provision of appliances and technical equipment to facilitate training and/or to alleviate the consequences of disability. Also included are environmental interventions in respect of individuals, such as removal of physical barriers for a disabled person, informing and sensitising the family and the community with a view of creating more positive attitudes and less discriminatory behaviour;
- special education calling for resources not available, or not properly used, in regular schools;
- vocational measures, including assessment, formal or informal vocational training, job placement, assistance in setting up small enterprises, etc. (2)

Defining Terms: A clear understanding of certain basic concepts is necessary to appropriate planning and action on the behalf of the disabled. The terms and their definitions used here are based on the WHO publication, International *Classification of Impairments, Disabilities and Handicaps*, (Geneva, 1980)

Impairment

"... any loss or abnormality of psychological, physiological or anatomical structure or function."

Disability

"... any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal for a human being."

Appropriate action can prevent one stage from leading to the next.

The process can be reversed if early interventions are made in time.

An amputee fitted with an artificial leg and trained to use it is then neither disabled nor impaired in most activities. If, however, he cannot do the work he did previously as a rice farmer, he is still handicapped. Training in a new vocation can also remove the handicap concerning work.

Handicap

"... a disadvantage for a given individual, resulting from an impairment or disability, that limits or prevents the fulfilment of a role that is normal, depending on age, sex, social and cultural factors, for that individual."

Prevention:

Prevention takes place at different levels.

- Primary: includes measures taken to eliminate or reduce the occurrence of mental, physical or sensory impairment. Preventive strategies at this level would involve water and sanitation, physical planning, health, social and educational services.
- Secondary: involves the early identification and treatment of a condition so that it does not result in a disability. Preventive strategies at this level would involve preventive and curative health services.
- Tertiary: aims at preventing the impairment from becoming a disability or handicap. Measures taken at this level include screening, parent education and provision of appropriate aids. An accompanying programme of public education at all levels is essential, so that groups who are at risk, and their families, are not only informed but motivated to participate in the implementation of preventive measures.

Rehabilitation:

Rehabilitation has been defined as including all measures used to reduce the impact of disabilities and handicaps and to enable the persons affected to achieve social integration. (3)

Equalisation of Opportunities:

This means the process through which the general system of society, such as the physical and cultural environment, housing and transportation, social and health services, educational and work opportunities, cultural and social life, including sports and recreational facilities, are made accessible to all. (4)

Social Integration:

Social integration is viewed as active participation of disabled and handicapped persons in the mainstream of community life. In order to achieve this aim, it is necessary to provide adequate rehabilitation for all disabled and handicapped persons and to reduce to a minimum all handicapping conditions in all aspects of their environment. (5)

example

Definition of Terms: A 40 year old woman has had leprosy for several years.

Disease/injury	• **leprosy**
Impairments	• **loss of feeling in feet and hands** • **loss of tissue from these areas** • **disfigurement**
Disability	• **decreased ability to use her hands and feet**
Handicaps	• **difficulty with movement** • **difficulty doing household and other work** • **difficulty having normal social relationships due to rejection by her community**

"Handicap International"

Classification of Handicaps

According to medical criteria, handicaps are classified in four categories.

Category 1
People having discomfort because of old wounds.

Finger or toe amputee
Club foot treated
Blind in one eye, dumb, deaf
or vision problems

Category 2
People with wound or fracture sequelae. They can almost lead a normal life but cannot support intense effort or daily work.

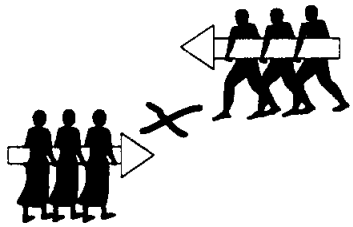
Legs with different length
Slightly limited joint
Peripheral nerve paralysis
Hand or fore-arm amputee
Club foot partially reducible

Category 3
People who can move alone with difficulty or with an appliance.

One leg amputee
Slight poliomyelitis or fitted with an orthopaedic device
Hemiplegia (able to walk)
Adult club foot
Severe joint stiffness
Upper arm amputee

Category 4
People who cannot walk by themselves and must move with a wheelchair.

Elderly
Blind
Paraplegia
Double amputee
Hemiplegia
Cerebal palsy



"Disabled people are constantly adjusting to difficulties that many people face only in a crisis."

Disabled refugees have even greater hurdles to self-help.

The Current Situation: As far as the refugee community is concerned, disabled refugees fall within the existing legislation of the countries in which they are seeking asylum. In countries where they are not granted refugee status, but are being assisted by UNHCR as 'mandate refugees', field offices attempt to ensure, through liaison with local facilities (government and NGO), that these refugees benefit from the assistance being offered to local citizens. This is usually done on a case-by-case basis.

Where national resources are already meagre and assisting refugees would deprive nationals of their own services, UNHCR covers the cost of providing assistance to the refugees. Also, when facilities do not exist or access is denied to refugees, UNHCR pays for the provision of necessary assistance (e.g., medical treatment, rehabilitative measures). In some cases, where local resources are inadequate, refugees can be medically evacuated for treatment then returned to the country of asylum. In other cases, resettlement will be the only solution.

Measures for disabled refugees are based on the concept of community-level care and are incorporated into the overall Care and Maintenance Programme. Such measures aim to supplement the family's and the community's resources to enable them to cope with their disabled members and become self-reliant. Exceptionally, programmes can be organized for those refugees without family or other support.

Action by UNHCR

UNHCR is directly addressing disability issues in four areas:

1. Many activities in the health sector of UNHCR projects help to **prevent impairments** and, through treatment, prevent impairments from causing disabilities and handicaps.
2. Some projects and some sectors within projects **support rehabilitation** for groups of refugees.
3. Through a project administered by the Programme and Technical Support Section at Headquarters, a limited number of individual refugees with extraordinary medical problems receive treatment through **international medical referrals**, normally within the region where they have asylum.
4. Through the "Ten or More" and "Twenty or More" plans, UNHCR is able to arrange annually for the **resettlement of 200-300 handicapped refugees and their families.** (6)

While current UNHCR-supported action on behalf of the disabled is positive and, in some cases, truly outstanding, there is no overall coherence to these interventions. The needs of some disabled refugees are addressed in certain situations but not in others. While measures such as immunisation, medical treatment and adequate nutrition are generally priorities in UNHCR's programmes, only limited efforts have been made so far to provide disabled refugees with such services as physical rehabilitation, vocational training, opportunities to earn income, psychological assistance and the active promotion of social integration. When such provisions have been made, they have tended to be at a high per capita cost and available only to a very small proportion of the population in need.

A more systematic approach is needed. To this end, the practical measures advocated and the policies presented in this document have been drawn up as a guide to taking effective action in the field.

International Medical Evacuation: A project is established at Headquarters each year to cover assistance to disabled refugees throughout the world for treatment and rehabilitation of individuals and groups with special needs.

Assistance is provided mainly for medical, psychological and psychiatric treatment, surgical interventions, the purchase of prosthetic devices and procurement of medicine.

UNHCR assists disabled men, women and children in their country of asylum or by evacuating them abroad to neighbouring countries for the necessary treatment when local facilities are inadequate. Some patients have to be transferred immediately for life-saving treatment. Efforts have been made to obtain treatment free of charge in certain countries for severely handicapped refugees for whom treatment costs are high.

The main objective of this project is to extend all necessary assistance to disabled refugees, enabling them to attain self-sufficiency and thereby promoting durable solutions to their problems. Guidelines for medical evacuation of disabled refugees have been spelled out in IOM/FOM/15/18/86 dated 13 March 1986 (see annex no. 5).

General Policies

In the development, implementation and review of their respective programmes of protection and assistance, offices in the field are expected to seek actively the implementation of the following policies:

1 Concrete efforts are to be made to **prevent the incidence of potentially disabling impairments** and particular attention is to be given to the following causes:
- inadequate nutrition
  - including micronutrient deficiencies,
  - as well as insufficient or improperly balanced diets
- infectious diseases
  - particularly those covered by an Expanded Programme of Immunisation (EPI)
  - as well as tuberculosis
  - and ear and eye infections
- problems surrounding pregnancy and birth
- safety hazards
  - particularly those placing children at risk.
- provision of medical care to wounded and outreach to those who are immobilized at the time of an emergency, to prevent death, minimize impairments and initiate rehabilitation procedures.

2 UNHCR-assisted health, education and social services are to be designed and implemented with specific attention to the **early detection** and, as appropriate, **treatment** of disabling conditions.

3 UNHCR projects in all sectors are to be designed and implemented so as to maximise the **participation** of, and the benefit to disabled refugees, be they male, female, children or adults.

4 Offices in the field are to seek to ensure that disabled refugees have **equal access** to, and opportunities in, education, work, housing, transportation, health and social services, as well as all aspects of the social, cultural and religious life accessible to the population at large.

5 As concerns disabilities generally, field offices are to seek to ensure that disabled refugees have access to the same **rehabilitation services** as nationals, and where this is not possible, to services equal to those available to nationals.

6 Where individuals suffer physical, mental or sensory **disabilities related to their situation as refugees**, (e.g. injuries or trauma related to war, persecution, torture or the hazards of the flight into exile) appropriate rehabilitation services are to be provided as **basic components** of UNHCR's assistance programme.

7 Support for rehabilitation is to be provided at the earliest time possible in the development of a refugee situation, with a view to **promoting** the **self-reliance** of disabled refugees and their families.

8 **Disabled refugees and their families** are to be the **focus** of the rehabilitation process. Thus appropriate support should be provided to encourage their active and direct participation in the processes of prevention, treatment and rehabilitation.

9 In developing and assisting rehabilitation measures for refugees, field offices and Headquarters are to give **priority** to:
- disabilities resulting from the refugee situation, victims of war/ mines
- measures with broad coverage within the refugee population
- measures that will facilitate integration and self-reliance
- technologies and measures appropriate to the country where refugees are living and that have a low per capita cost.

10 With regard to all aspects of prevention, treatment and rehabilitation, field offices are to take all possible steps to ensure that the relevant **services are appropriate to the needs** of, and accessible to, refugee children and to both women and men.

Field offices should assess existing projects in relation to the policies listed above and ensure that priority needs have been targeted and that they are being addressed appropriately.

Where needs are identified that fall within this policy framework, but which cannot be met through existing local or UNHCR resources, field offices are expected to make these known to Headquarters.

Levels and Possible Types of Assistance Provided

to Disabled Refugees through UNHCR

PHASE I

Screening for Special Assistance (as per defined criteria):

1. disability condition
2. long-term treatment
3. chronic illness

PHASE II

Treatment

- referral to hospital
- liaison with hospital staff
- arrangement for investigation and surgery
- hospitalization procedures
- interpreters to facilitate communication between patient and hospital staff

Counselling

- individual and family counselling
- home visits explaining nature of disease and treatment
- improve environmental conditions
- refer to rehabilitation centres
- refer to vocational centres

Material Aid

- prosthetic appliances
- aids to daily living
- accommodation
- other tangible requirements for effective management

Community Support

- arrange donors for blood transfusion
- volunteer attendant
- temporary accommodation
- language classes
- local community support

Financial Assistance

- medical reimbursement
- supplementary diet
- conveyance

PHASE III

Follow-Up in the Community

PHASE IV

Resettlement in cases where repatriation and local integration are not politically feasible

Setting priorities for action: Once the needs assessment has been carried out it should be clear what actions are needed. Priorities for action will then need to be decided. Criteria for setting priorities will also need to be established. These will depend upon the situation.

For example:

a) the action addresses a problem or need identified by disabled people and/or their families;

b) the action can be carried out with the present resources or resources can be obtained.

For each priority, numerous activities may need to be carried out to bring about the desired result. Consequently, it may be wise initially to restrict the number of priorities. (7)

Other Criteria that could be used in planning assistance/services:

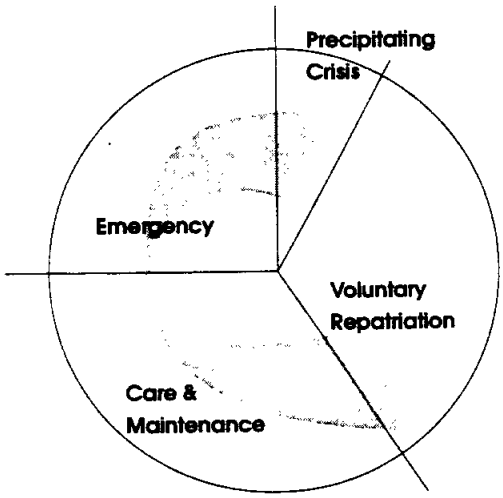
1. Magnitude of the problem
   - incidence/prevalence
   - severity
   - duration
   - degree of distress caused to those afflicted and among family members
2. Technological aspects
   - availability of technical solution
   - effectiveness of technical solution
   - possibility of quickly training technical and management personnel
3. General concern
   - public concern
   - likelihood of achieving community involvement
   - requirements of personnel
   - requirements of budget. (8)

example

Planning Action (9)

Situation of People with Disabilities	Current Action (or lack of it)	Community and District Actions that could be taken
People believe that disabilities are the result of wrong doing.	No public education is available on causes of disabilities.	Provide education to the community and counselling to families of disabled people.
Disabilities in children are not identified until they are two to three years old.	Screening for disabilities is not provided for infants and young children.	Incorporate screening for disabilities into growth monitoring programme(s)
Most disabled children do not attend school.	Local schools accommodate only children who have no disabilities or who have mild to moderate difficulty walking.	Facilitate acceptance of disabled children by local schools.
Most disabled adults do not have income-producing work.	Disabled adults lack opportunities to learn income-producing skills.	Explore community resources for income-generating (before looking outside the community).

The incidence of disability in refugee populations tends to be lower than that in the country of origin, because the disabled are often left behind, die during the exodus or during the emergency phase. Very few survive for long in refugee situation unless they are provided with aids to daily living, nutrition and medical care.

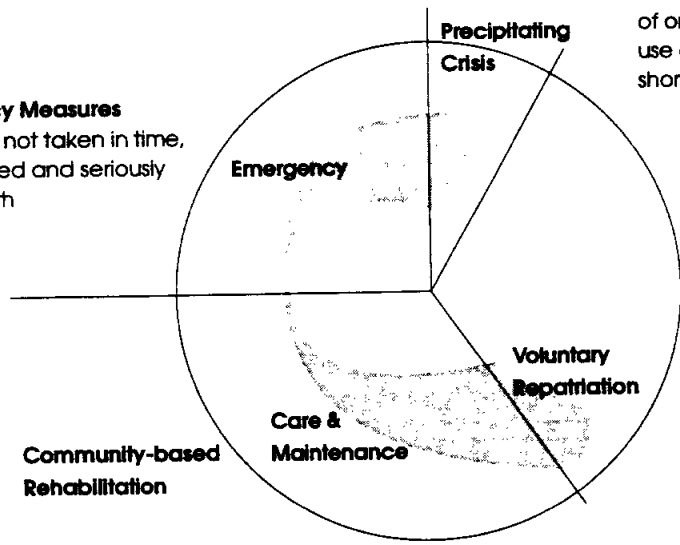


The incidence of disability in repatriating populations tends to be higher than during the emergency phase.

The incidence of disability in the refugee population will change over time because of illness, accidents, deaths, successful rehabilitation.

Preparedness
- data on incidence in country of origin
- information about situation in country of origin: (fighting, use of torture, food shortages, etc.)

Emergency Measures
if action is not taken in time, the disabled and seriously ill risk death



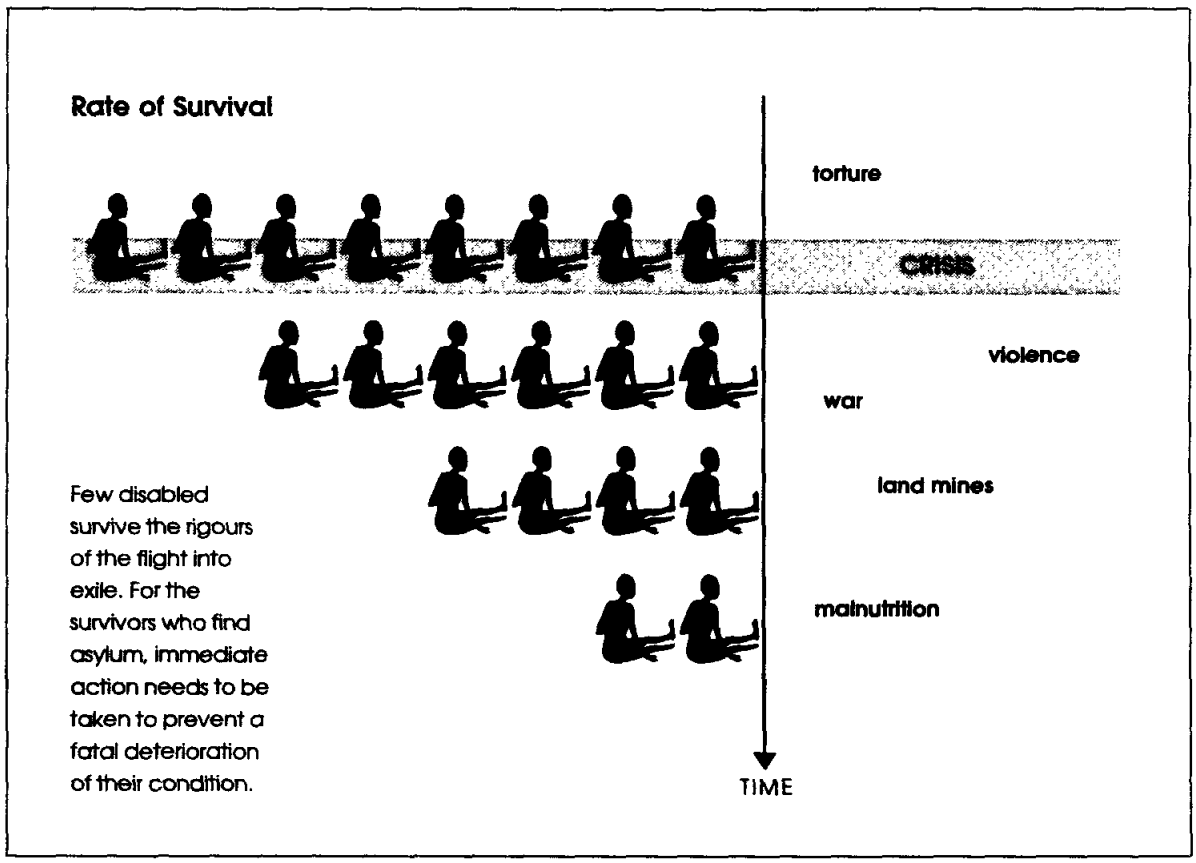
Preparedness: Repatriation
- identification and medical screening
- counselling
- organizing continuity of support (family, community, services)

Key: **Incidence of disability in refugee and returnee populations.**

Refugee Emergencies: responding to the needs of the disabled.

Principle Actions

- Needs assessment (carried out with the participation of a professional in Community/ Social Services).
- General screening for all cases in which the disability represents a serious obstacle to leading a normal life and achieving self-sufficiency.
- Medical screening to identify cases requiring immediate health care to prevent deterioration of condition.
- Implementation of preventive health care measures (which may include essential first initiatives such as measles vaccination, oral rehydration therapy (ORT), therapeutic feeding, prevention of vitamin deficiencies (Vitamins A and C), guidance, advice and education on health matters/practices).
- Mobilize the community (including disabled) to help plan and implement services for disabled.
- Organize family-based care (reunification where families have been dispersed; "foster" care arrangements for disabled people without family support).
- Train refugee community workers for outreach and other activities.
- Set up monitoring, reporting, coordinating and referral mechanisms.
- Organize outreach to those who are unable to come forward to make their needs known or use services.



Repatriation of Disabled Refugees: The types of services provided in the country of asylum must take into account the eventual return of the disabled refugee to the country of origin where services and facilities, if they exist, are likely to be inadequate. Where repatriation is the preferred solution, the best interests of the disabled are likely to be served through family and community-based care in both the country of asylum and the country of origin. Preparation for repatriation therefore should promote community development and provide sufficient assistance to ensure that families with disabled members can stay together.

Preparing the refugee prior to departure

- Establish the voluntary nature of the return
- Provide information, guidance and counselling to avoid unreal expectations
- Where applicable – organize mine awareness training
- Individual assessment of needs and capacities

Preparing the ground in the country of origin

- Locate family, friends
- Initiate community development activities in areas of return
- Make an assessment of services – what is available, what is lacking
- Ensure sufficient and appropriate infrastructure is in place to receive disabled returnees (NGOs operating in the country of asylum should be encouraged to extend programmes/services to the country of origin. Do not wait for the government which is likely to have other priorities.)
- Collaborate and coordinate with NGOs and government agencies

Travel

- Provide appropriate transport (e.g. buses rather than trucks).
- Keep disabled with families.
- According to needs, the disabled should be accompanied by paramedical personnel or refugees with first aid skills.
- Provide, appropriate accommodation and facilities at rest stops.

On arrival in country of origin

a) Strategies for assisting returnees:
   - Individual and family counselling
   - Support groups/volunteers
   - Group counselling and therapy
   - Community awareness and support
   - Self-help groups
   - Networking (formal and informal)

b) Short- and Long-term assistance: In the case of the disabled for whom short-term assistance would be inappropriate, additional assistance may be provided in the form of a one-time assistance grant from UNHCR. However, in planning for the long-term, provision should be made for assistance by governmental or non-governmental institutions. In this context a good referral network is vital.

Resettlement: Resettlement of disabled refugees should be the last option. It is more advisable to help the integration of the disabled in their own communities. However, there may be situations where this is impossible because the local resources are very meagre and the need for daily physical care is beyond the reach of the community or the kind of care is not available. Cases such as these need to be carefully scrutinized before steps are taken for their resettlement.

The criteria for the resettlement of refugees who are medically-at-risk are:

1. Recognized refugees (Mandate, 1951 Convention or other regional instruments).
2. Severe medical condition justifying treatment with positive prognosis for total/partial recovery.
3. Treatment/care/rehabilitation not available locally.
4. Local/regional options/solutions explored (including medical evacuation within country or region).
5. Regional settlement
6. Extra-regional resettlement.

Planned Voluntary Repatriation
Identification of Extremely Vulnerable Individuals (EVIs) and Medical Screening:

Identification of extremely vulnerable individuals should be undertaken at the time of registration to plan the assistance required during the movement and reintegration phases of the repatriation. Medical cases would include:

- chronically ill with diseases that require continuation of long-term treatments (e.g. tuberculosis, leprosy, diabetes, etc).
- disabled/physically handicapped
- children who are moderately malnourished (between 70%-80% weight for height)
- pregnant women
- mentally ill.

Identification is carried out by a medical team working with the registration team. Care should be taken not to overlook those who might not be able to walk to the registration sites because of acute disease or physical disability.

Counselling should be provided regarding the arrangements made for assistance during the movement and the reintegration phase. Special emphasis should be put on seeking assistance and support from close relatives and other refugees travelling to the same destination. Where support of close relatives cannot be ensured for unaccompanied children, authorities in the country of origin should identify a reliable alternative support system.

Priority should be given to seeking family reunion on both sides of the border as a solution to EVI problems. Outside assistance should not replace support by the family. This is particularly important for refugees with mental health problems.

Updating Medical Records: Preventive and chronic disease medical records should be updated and sent with the returnees for continuation of the services in the country of origin. Preventive records include immunization, particularly measles, antenatal sevices, family planning and other MCH records.

Medical Screening and Escort: It is essential to ensure that refugees should not unduly suffer in the process of repatriation. In this regard, it is necessary to conduct screening in health and nutrition for all repatriants prior to their departure.

The objectives of the medical screening are to:

- ensure that repatriation of refugees with acute life threatening conditions will be postponed while they are undergoing treatment;
- make adequate provisions for attending to emergencies during the movement phase;
- prevent transmission of an internationally notifiable disease across the border;
- postpone pregnant women who might deliver on the way (as assessed by a qualified medical doctor/midwife);
- ensure that families with severely malnourished children (i.e. less than 70% weight/height) are not moved until the child recovers (> 75% weight/height);
- make a final check of the medical records and provide measles vaccine on the spot if required;
- provide medicines required for continuation of treatments of chronic diseases till access to similar services in the country of origin is assured.

A mobile medical escort (comprising medical doctor/TBA/Community Health Worker(s) as required) should accompany each convoy. Each medical escort should have a first aid kit in addition to medicines such as ORS, chloroquine, paracetamol, aluminium hydroxide, ampicillin, promethazine injection and egotamine injection (with the necessary needles and syringes).

Assessment of Medically-at-Risk Cases: All medically-at-risk cases should be supported by a report from a qualified medical doctor and contain an up-dated UNHCR medical form attached which will report on:

a) the refugee's medical condition, i.e. history and diagnosis;
b) treatment and rehabilitation received in country of asylum;
c) prognosis: deterioration/improvement including potential for recovery;
d) treatment and/or rehabilitation recommended and if available in country of asylum or region.

Refugees who are well-adjusted to their disability and who are able to function adequately in their present environment should not be submitted for resettlement on the basis of their medical condition alone. Similarly, refugees with an illness which can be easily controlled with medication made available in the country of asylum should not be considered for resettlement.

Survivors of Torture or Violence in Need of Resettlement: Refugee populations may include those who are the victims of torture or deliberate and systematic violence. Some survivors will require coordinated medical care, counselling, protection and special assistance, which may best be provided in the country of asylum. Where resettlement is deemed to be the most appropriate durable solution, torture victims should be submitted either within the protection category, or within the medical category.

Needs will include the recording by a qualified (and sensitized) medical professional of the refugee's injuries. Observations and comments on the refugee's psychological state of mind will also be useful. Not all torture victims develop medical conditions which are easily identifiable. If not symptoms or injuries are evident, it is particularly important to ensure that the Resettlement Registration Form (RRF) is properly documented so that the receiving country will have all the relevant information on the refugee's background. Such cases should be submitted within the protection criteria. Refugees with symptoms should be submitted within the medical category.

It is important to remember that the families of the survivors may be haroring complex feelings of guilt and helplessness and may in turn need special care and attention. Information on how the refugee community reacted to trauma, loss, grief and mental illness prior to exile is also important, and could be included in the resettlement file.

Refugees Who are HIV Positive: Refugees with the HIV/AIDS virus may be diagnosed through HIV testing under a resettlement country's mandatory medical screening. They may in turn be denied resettlement, if they are found to be positive. For the refugee who is rejected because of his HIV status, the consequences could include refoulement indefinite detention, denial of access to care and treatment and devastating personal and family stress. UNHCR and IOM (Intergovernmental Organization for Migration) have issued a joint policy position against testing for AIDS.

UNHCR HIV Guidelines: UNHCR has developed comprehensive guidelines which aim to provide maximum protection and assistance for HIV positive refugees. Resettlement countries have expressed a reluctance to accept refugees who are diagnosed HIV positive or with AIDS, when the medical condition alone is the reason for resettlement and there are no obvious protection or family reunification concerns. We would, therefore, not advocate the resettlement of this group. For other refugees, however, who are in need of resettlement for their protection (or for reasons of family reunion) and who are diagnosed with HIV/AIDS, every effort should be made to pursue resettlement. UNHCR's policy and Guidelines regarding refugee protection and assistance for refugees diagnosed with HIV/AIDS state:

1. Confidentiality – on the part of all persons involved in the screeing process, from pre-test

counselling, notification of results and post-test counselling and contact tracing.

2. If the medical condition excludes the refugee from resettlement admission, the refugee should be granted an automatic waiver, or at least the opportunity to apply for a waiver of excludability. It is the position of both UNHCR and IOM that resettlement countries requiring HIV screening should be prepared systematically to grant waivers of excludability to a refugee who tests positive. The IOM officer, or embassy or consular officer responsible for the testing and post-testing counselling should ensure the refugee is put in contact with the UNHCR Field Officer to apply for a waiver of excludability. The waiver application should then be prepared and filed by the UNHCR Protection Officer.

3. The UNHCR Field Officer will then inform UNHCR Headquarters and provide a complete case file. UNHCR Headquarters will immediately assign a specific code number to the refugee case, which is then transmitted to the field to preserve confidentiality. The code number will be used instead of the name in all subsequent internal and external exchanges concerning the refugees, until the time when it is obligatory for his name to be used, i.e. for the submission to the competent authority to grant the waiver.

4. UNHCR Headquarters will coordinate the application for a waiver by advising the legal officer in the Field Office who is representing the refugee. Waiver applications to Australia, Canada and USA are prepared and monitored by the Field Offices in the above-mentioned countries. The refugee's file will be forwarded by the Field Office in the country of asylum to UNHCR Headquarters where it will be reviewed, before being forwarded to Australia, Canada or the USA for preparation.

5. UNHCR will, with the refugee's consent, provide full information in order to assist the case.

6. If a guarantee of sponsorship for future medical costs is required, every effort should be made by the UNHCR Office inthe resettlement country to identify and find financial sponsors. The sponsor must be informed of the refugee's condition, and be able to confirm in writing that he can cover the costs.

Check List: Information required for waiver request of HIV/AIDS Refugee who is HIV positive or has AIDS.

1. Completed RRF.
2. Copies of submission and rejection letters.
3. Copies of other relevant correspondence.
4. Copies of sponsorship commitment, or name/address of the sponsor or sponsoring agency.
5. File number provided by the embassy.
6. Whether the refugee has taken a confirmatory test (two Eilsa Tests and one WesternBlot or other tests such as P24 antigen or Lavagen tests).
7. The refugee's source of infection and current medical condition.
8. Details of AIDS counselling and its transmission provided to the refugee.
9. Medical and social support structure available to the refugee in the potential resettlement country (e.g. family, friends, health facilities, volunteer support, self-help groups, etc).
10. Medical and social support structures otherwise available to the refugee in the country of asylum.
11. Refugee's employment skills or prospects for employment in the country of resettlement.
12. Legal status and situation of the refugee in the country of asylum.
13. What are the options for the refugee if the waiver is denied.

Women-at-risk: In every refugee population there may be specific groups of refugee women, who

are particularly vulnerable and susceptible to protection problems. These will include unaccompanied or unsupported adolescent girls and women, elderly women and disabled women. All efforts will have been made to address their special needs locally, through improving their security and safety by, for example, providing separate living conditions which are in close proximity to camp services. Female interpreters should also be used and trained on protection issues and needs which are specific to women. There may, however, be women refugees whose safety cannot be guaranteed for whom resettlement offers the only form of protection.

Medical Needs: A women refugee who is facing serious protection problems may also have medical needs. In the classification of her case, the protection needs to be the reason for seeking resettlement, with her medical needs fully documented for the resettlement submission. If she is facing protection problems and a life-threatening medical illness, the case will require urgent processing.

A women refugee who is not facing protection problems, but has medical problems which cannot be addressed locally should be submitted within the defined medical category.

Women Rape Victims: There is often particular resettlement interest in women refugees who have been the victims of rape or other sexual violence. It is important that these women be protected from any further risk, and provided with culturally appropriate care and counselling in the first asylum setting. There may be circumstances where a rape victim will be resettled after consideration of all the components; such as the security situation in the first asylum country, and her mental and physical condition. Her resettlement to a safe third country should be sought when it is the only means of guaranteeing her protection.

It should also be remembered that refugee men and boys are vulnerable to rape and sexual violence and suffer physical and psychological trauma. UNHCR believes that preventive measures involving the refugee community through the implementation of support programs will benefit and provide further protection for the group as a whole. The host government should also be made aware of its duty to investigate, prosecute and punish perpetrators of sexual violence.

Exploring Solutions for Medically-at-Risk Cases: Every effort should, in the first instance, be made to fully explore the possibility of local solutions in the country of first asylum. As far as possible, all refugee patients should be treated locally in public hospitals and medical facilities, which are normally available to the national population. Treatment in private hospitals and clinics is usually only justified when it offers the only means of essential medical treatment.

Possible local solutions:

- What health and social service resources are available at community level, which could be made available to the refugees?
- If none are available, can the Field Office initiate a local project with the involvement of the national or local authorities to meet needs?
- Can the response also be shown to benefit the local host population?
- Is there a local NGO which could assist?
- What resources are available within the refugee community (i.e. health and social service professionals, community workers) and is there a means of strengthening these resources to meet the needs?
- What solutions are possible within the region?
- Is medical evacuation a possibility, either inside the country, or within the region?

Medical Evacuation: In exceptional circumstances, where medical facilities are not available locally, a refugee patient may be referred for specialized treatment outside the country of first asylum. It should, however, be noted that the medical evacuation of a refugee is not the same as his resettlement and that the patient is ex-

pected to return to his country of first asylum upon completion of treatment. Referrals should normally be to medical facilities within the same region of asylum. A patient should be counselled not to apply for asylum while undergoing medical treatment abroad.

Procedures for medical evacuation should include:

- a detailed medical recommendation from the patient's doctor;
- a second medical opinion in support of the recommendation;
- a detailed social assessment report on the case;
- referral, with all relevant medical documentation to UNHCR Headquarters which must authorize all medical evacuations.

Extra-regional Resettlement: Refugees with serious medical needs, which cannot be addressed either locally or regionally, should be submitted to the Resettlement Section at UNHCR Headquarters, which after consultation with UNHCR and IOM medical staff, will take appropriate action on the case.

The submission of a case with serious medical needs does not guarantee automatic resettlement. This should be clearly explained to the refugee at the time of submission. Many resettlement receiving countries have long waiting lists for their nationals requiring specific medical and health treatment from their health services (for example, kidney transplants). Resettlement does not, therefore, guarantee that the necessary medical treatment will be available. Headquarters decision to proceed with a medical case will, therefore, depend on an assessment of whether or not treatment is available abroad.

Resettlement countries have in the past experienced difficulties in meeting the needs of certain categories of medical cases. Such cases include severe mental health and HIV positive cases when resettlement is pursued to provide for their health needs alone and there are no protection concerns. It sould therefore be noted that the chances of such cases being accepted by receiving countries are limited.

Medically-at-risk refugees and their families will have special needs which should be clearly addressed through the documentation (medical report and social assessment report). They may also require priority resettlement processing, and in particular for those with no links, may benefit from submission to special annual programmes for medical or disabled cases. These programmes are referred to as the Ten or More, or Twenty or More Plan, and offer quota places for non-linked vulnerable medical cases, who might otherwise not meet the resettlement countries admissability criteria. Other resettlement countries accept medically-at-risk refugees within their overall quotas for programmes.

All medically-at-risk cases forwarded to Headquarters require the following documentation:

1. completed and updated RRF
2. completed and updated UNHCR medical form, signed by the designated medical doctor and patient
3. completed Social Assessment Report
4. other medical reports and documentation.

When new projects are proposed ...

... some questions that should be asked are:

Approach

Will the intervention tend to increase the dignity of the people affected?

Will it encourage the development of refugee human resources?

Is it in keeping with refugees' cultural and religious beliefs?

Will it result in the better integration and acceptance of the individual?

What

What strategies will be used?

What materials/equipment are needed -locally devised and prepared?

What existing channels will be used?

Will efforts be made to make people independent?

Where

Where will the programme/project be mainly conducted?

In the refugee camp/settlement?

In the home?

In a small local centre?

In a central city location?

Who

Who will be the major category of direct care workers? Parents, disabled persons, primary level personnel or professionals?

How comprehensive is the coverage?

Who will be the major target group?

- a single category of disabled persons?
- a single age group? or
- all disabled or all age groups?

How many will be served?

Are existing organizations being involved?

Cost

Per disabled person. Is there a multiplier effect?

What about continuity/sustainability?

Can indigenous measures be used?

What is the most cost effective?

Would it be feasible to train local/refugees? (6)

part 2

First Steps

Resources

Identification

Prevention

Resources

- One of the major roles of the field office must be to identify and mobilize all relevant existing resources at the local, national, regional and international levels.
- In planning, every effort should be made to integrate disability prevention and rehabilitation for refugees into the existing community services, particularly primary health care services.
- Resources at the local level should not be neglected, especially those to be found within the refugee population. Disabled refugees and their families should not be forgotten and their potential contribution should not be underestimated.
- The success of a community-based programme of prevention and rehabilitation for disabled refugees will depend on the understanding and participation of the whole community, not just those immediately affected.

Identification

- Before action can be taken for treatment and rehabilitation, disabled refugees and others who may be at risk must be identified and their needs assessed.
- Once handicapped and disabled refugees have been identified, it is strongly advised that they be medically screened as soon as possible.
- In trying to identify disabled refugees and evaluate the impact disability has on their lives, it must be remembered that different societies view disability in different ways. Cultural inhibitions should be understood and every effort made to encourage the community to collaborate in the process of identification by explaining the practical benefits in terms of prevention, cure and rehabilitation.

Prevention

- Initial preventive measures must often specifically target the special needs of infants and children, who are particularly vulnerable to disabling impairments arising from their situation as refugees.
- Where impairment has already occurred, prompt action must be taken to prevent long-term disability.
- While health services may play a major role in prevention and rehabilitation of disabilities, it is important to remember that the real determinants of the health status of refugees are elements not usually classified as part of the health sector (e.g. water, sanitation, nutrition).
- Every refugee is potentially "at risk" in terms of their mental health.

"There is a real joy in being responsible for yourself."

Various factors have contributed to the limited availability of services for disabled refugees. Such services are often thought, wrongly, to require sophisticated technology and large sums of money. The model of residential institutions has been seen by some, again erroneously, as the norm for rehabilitation services. Hence families, health workers and teachers have not seen the relevance of integrating disabled refugees into normal patterns of activity, thus marginalizing a person or groups because of a physical and/or mental condition.

UNHCR does not have sufficient resources to address fully the prevention and rehabilitation needs of all disabled refugees. Therefore, one of the major roles of the field office must be to identify and mobilize all relevant existing resources (e.g., information and expertise, personnel, finance and infrastructure) at the local, national, regional and international levels. The community of refugees is the biggest resource that is often left untapped.

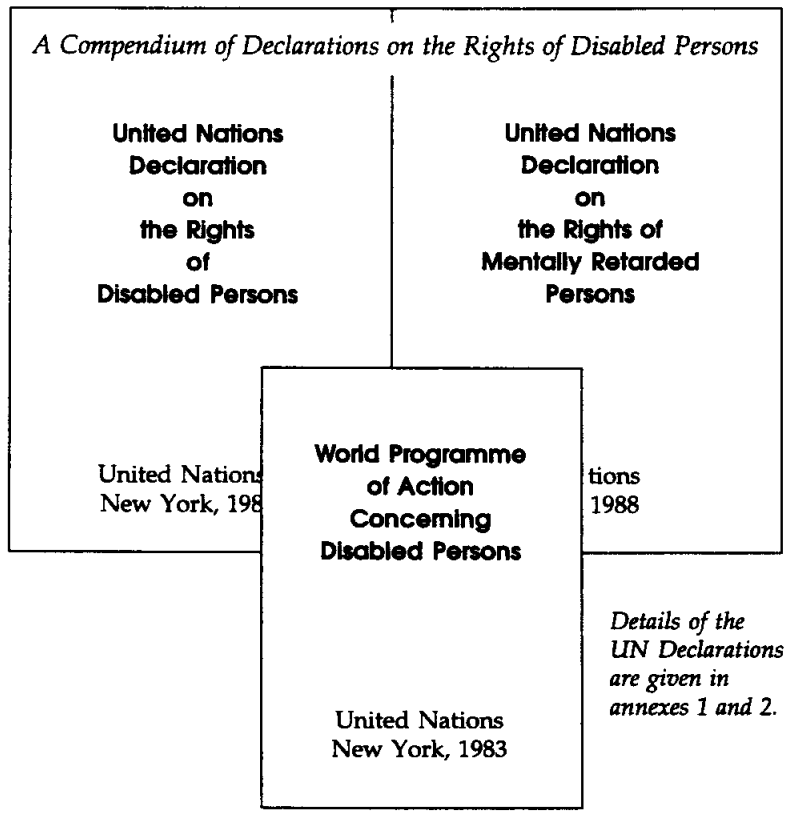
Planning and Policy-making: An examination of national policies should reveal what policies, if any, exist concerning disability services. If there is no policy, it is possible that aspects of care, treatment or rehabilitation of disabled people may be the written or unwritten responsibility of any or all of the ministries of social services, health, education and labour or split between all of these with no coordination. There may be a specific coordinating body in another ministry or non-governmental agency. Even where there is a policy, the commitment to develop services may not have been made or implemented.

Resources

Government policy-makers should be encouraged to develop and promote public policies and plans that incorporate the needs of disabled refugees. To guide this process reference can be made to UN policies and resolutions concerning disabled persons. These are formulated in a variety of documents, as shown below.

Policy-making and planning for disabled refugees should involve not only decision-makers in the various ministries and other offices of government concerned with disability, but also members of organizations working with the disabled, including disabled representatives if possible, and professionals working in the sector. Partners in the planning process may wish to seek advice from other members of the United Nations family (e.g., UNICEF, UNESCO) or other specialized agencies (e.g., WHO, ILO) as well as NGOs.

In planning, every effort should be made to integrate disability prevention and rehabilitation for refugees into the existing community services, particularly primary health care services. Creation of a special organization, independent of other services, should be discouraged.



Complete integration into regular services may result in loss of visibility but this can be rectified by having an advisory and coordinating body that directs policy and monitors activities.

At the mid-term review of the UN Decade of Disabled Persons, it was concluded that:

> **"Each concerned body or agency should review its disability-related programmes with a view to expanding them or making them more effective;"**
>
> **"Each body or agency should ensure that the needs of disabled persons are integrated into regular projects, in addition to the specific project designed to benefit them;"**
>
> **"Regional and country offices should promote a better understanding of disability issues, thereby encouraging governments to give higher priority to disability-related programmes;"**

Almost all developing countries have some rehabilitation services, yet it is estimated that such services, which are provided within institutions mostly situated in a capital or other big cities, can only cater for a very small proportion of the total number of disabled in need of rehabilitation. In addition to their limited geographical coverage, such institutions usually specialize in one disability and in specific types of care or training.

Non-governmental organizations often run many of the institutions providing rehabilitation services. If they are financed through external contributions they may be dependent on expatriate staff or on staff trained abroad. As such institutions originate independently from the government system, and from each other, there may be poor co-ordination of services and resources may not used to the best effect.

The implementation of a rehabilitation programme at the community level, integrated into the health service infrastructure, solves some of these problems. However, such programmes require an already widely developed health infrastructure.

Community-based rehabilitation programmes may be started in a number of ways, by an existing institution for the disabled, or by a non-governmental organization for example. While such programmes need not be dependent on governmental intervention, integration into the health service infrastructure has the added advantage of the involvement of various other community-based services such as rural development teams, agricultural extension groups, local social services groups and primary schools.

Community-level Resources: Coordination and cooperation between sectors are essential to the successful integration of services for disabled refugees into existing programmes and infrastructures. Resources at the local level should not be neglected, especially those to be found within the refugee population.

Host Community: Personnel working in existing specialized rehabilitation services (most probably these will be located in urban areas) may be willing to become involved in broader-based community activities, and may also be able to assist in the training of refugee community workers.

Cross-sectoral networks of people whose work brings them into contact with disabled people could assist by sharing information, planning and initiating action. The skills of local artisans could also be put to use in making simple rehabilitation aids or in training refugees.

Organized groups of disabled and other concerned members of the host community (service clubs or groups, religious organizations), given encouragement and training, can provide invaluable support for disabled refugees and their families. If locals and refugees share similar problems, a joint project could be developed for both groups, thereby promoting positive interactions and encouraging acceptance of refugees by their hosts.

Refugee Community: The success of a community-based programme of prevention and rehabilitation for disabled refugees will depend on the understanding and participation of the whole community, not just those immediately affected. Thus community and religious leaders, teachers, health and social service professionals and other health workers (including midwives and traditional birth attendants) within the refugee population should be identified, trained and mobilized. Refugee community workers must also be recruited and trained as they will play a major role in screening, surveys and outreach services. Disabled refugees and their families should not be forgotten and their potential contribution should not be underestimated

Some Ideas on How to Use Existing Institutions for Referral Services (11)

The disabled need access to a variety of services; ensuring their access to these services is a first step.

1. The first step in planning for referrals is to make an inventory of the existing referral services in the country. These should include both government- and NGO-operated services, as illustrated in the example below:

   a) health care facilities that can provide diagnostic and curative services, in particular orthopaedic surgery, ophthalmology, audiology, ear-nose and throat diseases, psychiatry. Services may include both specialists and generalists (e.g. district health personnel);

   b) health care facilities that offer a rehabilitation programme, such as national centres (set up mostly for physically disabled only), orthopaedic workshops, physiotherapy, occupational therapy and speech therapy services, mental health programmes; including training courses for health sector rehabilitation personnel;

   c) educational facilities providing special education, non-specialised schools able to receive disabled children and adolescents; including training courses for special educators;

   d) vocational facilities. Review the informal and formal training sectors and their capacity to absorb disabled adolescents and youth; special vocational training centres; sheltered workshops; including training courses/facilities for specialised vocational training; if vocational assessment does not exist, such a service may be created within an existing facility, the objective being to determine whether or not disabled people can be referred to vocational training set up for the able-bodied and later on be placed in employment in the open labour market;

   e) legal structures and procedures for protecting human rights, including mediators (ombudsmen) at the central and local levels.

continues...

2. The next step consists in identifying and evaluating professionals and facilities capable of receiving referrals. Their number may turn out to be small and their capacities limited. Also, they will tend to be located mainly in the capital, making them inaccessible to a large proportion of the population. As a rule, the personnel need upgrading of their training to include CBR. In the medium-term perspective, this can be done at special seminars/courses. In the long-term, CBR should become an integral part of their professional training.

3. At this point, and in co-operation with the existing professionals/facilities, one could start negotiating a number of co-ordinated activities. The questions to be asked in this context are the following:

   a) can the referral services receive disabled people (and if so, how many), provide the desired services, and then send these persons back to the district and community with a follow-up programme?

   b) is there a possibility of decentralising the referral services, e.g. by creating smaller units at the provincial level?

   c) can the referral services become mobile, e.g. can visits to the province, district or camp levels be undertaken, should this prove suitable and cost-effective (also taking into account the transport costs)?

4. After a period of 3-4 years of such co-operation, one could evaluate its outcome. At the same time one should estimate met as well as unmet community needs.

5. The referral services should then be reoriented to provide better for unmet community needs. Plans should be made to expand their responsibilities to larger parts of the country. These centres should help with teaching/training programmes and with continuous evaluation and research.

Check List

- ❑ Is there in the country of asylum a generally accepted concept of prevention, early detection of impairment and disability, and rehabilitation as part of the general pattern of human services for all citizens?
- ❑ To what extent have the policy statements of human rights, the Rights of the Mentally Retarded and the Rights of Disabled Persons been accepted in the country?
- ❑ Has the World Programme of Action for Disabled People been incorporated into the planning of services?
- ❑ Have any national development plans been made for either:
  a) inclusion of disabled persons into regular and generic services; or
  b) specific services for disabled persons?

- Are specific policies formulated by the Government concerning disability and disabled persons? If so, does the responsibility for their implementation lie with a particular ministry, Government agency or NGO, or is it shared by several ministries and Government agencies?
- Is there a national coordinating committee (or similar body) on disability?
- Is there any national umbrella organization of non-governmental organizations concerning disabled persons, operating alongside or instead of a national coordinating committee?
- Are there any internationally sponsored programmes (by United Nations organizations and agencies, bilateral aid agencies or NGOs) in which disability issues in general and as affecting refugees are included, or could be included? What is their coverage? Where are they sited (urban/rural distribution)? What disabilities are covered? What age range? Are facilities being used to best advantage?
- Can the local health/social services infrastructure be used to provide personnel for services for disabled refugees? What kind of training do they have? What additional skills would they need to become competent in prevention and rehabilitation tasks? Are there people in the area who could teach those skills?
- What organizations of disabled persons are established – on a local, regional or national basis? Can disabled refugees join, participate?
- What government support (financial and organizational) is given to such organizations? What activities do organizations of disabled persons take part in (self-advocacy, self-help, mutual support, service provision, income-generating activities)? How can refugees benefit or participate?
- Is there a system of primary health care teams or centres?
- What facilities are there at the district level for the training and supervision of staff in primary health teams or back up treatment (e.g., provision of drugs, professional advice, rehabilitation training).
- Are there general hospitals at the regional or district levels? To what extent are these equipped to deal with the treatment of different types of disabilities (motor, sensory, mental, internal)?
- What specialised medical facilities are there for the treatment of special conditions? How accessible are they?
- What facilities exist for psychiatric treatment?
- Have health professionals, teachers, refugee leaders and others with appropriate skills/training been identified, recruited and mobilized?
- Are the services equally accessible for men and women?
- Are there female staff to attend female patients?

"From the start I could not accept being treated any differently than before my accident simply because I was now disabled. I was still the same person. I am still the same person."

Prompt Action in Assessing Needs: Before action can be taken for treatment and rehabilitation, disabled refugees and others who may be at risk must be identified and their needs assessed. When workers are in place before refugees arrive, identification can be done by screening all new arrivals, for those who need immediate assistance and those who should be followed up later.

Outreach: A combination of house-to-house visits and information from refugee leaders can be used to identify those who have already settled. In both instances trained refugee community workers can play a major role. This avoids the barriers of culture and language faced by outsiders.

Medical Screening: Some disabled refugees will have impairments that are likely to become worse, some may even result in death, if proper medical care is not provided promptly. Once handicapped and disabled refugees have been identified, it is **strongly advised** that they be medically screened as soon as possible. (See UNHCR Disabled/Medically-at-Risk form, annex no. 3)

At the earliest possible stage, health workers and others working with refugees should be given simple guidelines developed by the senior health officers to help them identify disabilities in the population, particularly in the youngest age groups. A register can then be established and used to provide basic information necessary to establish priorities for service development.

For example, in populations affected by war, physical rehabilitation may be a priority. The first service response would be to establish a

Identification

workshop producing simple mobility aids and artificial lower limbs. In a population affected by long-term famine, infants are particularly vulnerable. The child's overall development is likely to be inhibited and individual potential significantly reduced. A simple developmental screening process can be used and a structured pre-school stimulation programme introduced. Both services could be developed as low-cost systems.

Immediate Requirements: Disabled and handicapped refugees sometimes require immediate help to meet the requirements of daily living.

If the refugee is having difficulties in carrying out any of the activities listed here, then an immediate response will be necessary.

- obtaining food, water, fuel
- preparing food
- eating food
- washing himself/herself
- dressing
- washing clothes
- cleaning his/her house
- preventing injuries to parts of his/her body that have no feeling
- moving around inside his/her house and immediate surroundings
- moving around outside his/her living area
- going to the toilet or latrine
- working
- going to school
- understanding what is said to him/her
- expressing thoughts, needs and feelings
- taking part in family activities
- taking part in community activities.

(See assessment form for a person who is disabled or chronically ill, annex no. 4)

Cross-cultural Considerations: In trying to identify disabled refugees and evaluate the impact disability has on their lives, it must be remembered that different societies view disability in different ways. Minor impairments and disabilities (e.g., moderate mental retardation or minor mobility disturbances) may not be recognized as a handicap.

However, most families and groups know whether they have a disabled member, though for cultural reasons, they may be reluctant to bring that disability to public attention. This is particularly so in relation to mental handicap where early recognition is essential. These cultural inhibitions should be understood and every effort made to encourage the community to collaborate in the process of identification by explaining the practical benefits in terms of prevention, cure and rehabilitation.

For anyone intending to study the needs of disabled people, it is essential to have an understanding of the social structures, the cultural traditions, the organisation and the lines of authority prevailing in the communities where they live. This knowledge can only be acquired from people who have been living in the particular community for a long time, who share the culture, and who are familiar with the local conditions. (12)

General Screening:

The questions listed here are examples. Resources, priorities and other factors vary among situations, consequently the questions appropriate for a check list will also vary.

Sample Check List:

- ❑ Is there anyone in the family, or do you know anyone who has an illness or injury that needs treatment?
- ❑ Is anyone having trouble taking care of himself or herself?
- ❑ Is anyone having trouble getting enough: food/water/ cooking fuel?
- ❑ Is there anyone who does not have the things needed for daily living, such as: cooking utensils/enough clothes/ blankets?
- ❑ Do you know anyone who does not have an adequate place to live?
- ❑ Do you know of any children who are separated from their parents?
- ❑ Do you know anyone who has difficulty: walking/using his or her arms or legs/seeing/ hearing/speaking/learning?
- ❑ Do you know anyone who sometimes has seizures?
- ❑ Do you know anyone who has problems because of sometimes acting in strange ways?
- ❑ Does anyone in this family need help with: contacting any members of your family in another place/finding any family members who have become separated?

Guidelines:

In order not to raise undue expectations it is necessary to conduct the screening and assessment in a sensitive and professional manner. The following guidelines concern screening and assessment by refugee community workers:

Wording:
All questions must be worded simply and clearly in the language of the refugees.

Training:
Train workers beforehand on how to use any check-lists they are given. Role-playing is useful for helping workers practise and understand all questions.

Presentation:
Questions must be asked respectfully, not in a demanding or authoritarian way.

Cultural factors:
Discuss with workers what considerations are necessary concerning such factors as:

- the sex and age of workers in relation to the sex and age of those whose needs are to be assessed
- the role, if any, of refugee leaders.

Observations:
When making an assessment, a worker looks for evidence that confirms or contradicts the information given.

Follow up Questions:
Information given may require follow-up questions. For clarification, or more information, a question commonly used when someone indicates they have a problem is: "How have you been able to cope with this problem up to now?"

Community Involvement:
Respond immediately to at least some of the problems by involving refugees in the process of assistance.

Publicize and explain to to those interviewed:
a) the purpose of the survey, and
b) the action that can be expected in response.

Check List

- ❑ Have refugees who may be medically at-risk (e.g. the disabled, the sick, the elderly, unaccompanied children, pregnant women and nursing mothers, etc) been identified and their needs assessed?
- ❑ Are any special measures necessary to meet their basic needs?
- ❑ What measures are necessary to meet special needs?
- ❑ Among the disabled, what types of disability exist, and what age ranges are affected?
- ❑ How have the needs of disabled refugees been assessed? What is the source of this information? Have the disabled themselves been consulted?
- ❑ Have priorities for treatment and services been established?
- ❑ Do criteria used for classifying disabilities take into account cultural and other factors?
- ❑ What is the refugee community's attitude to disability?
- ❑ Is there consensus on who is disabled and on ways in which these refugees can be assisted?

Notes:

"It isn't so much the disability that paralyses, but the thousandfold handicaps caused by society." *

Primary Prevention: In developing countries, infants and children are particularly vulnerable to disabling impairments arising from their situation as refugees – where precarious food supplies lead to malnutrition, where overcrowding facilitates the spread of communicable diseases and inadequate prenatal care leads to an increased incidence of birth trauma. Thus, initial preventive measures must often specifically target the special needs of this group.

Secondary Prevention: Where impairment has already occurred, action must be taken to prevent long-term disability. This requires early detection (screening) and curative care through provision of appropriate drugs (e.g., for tuberculosis, ear infections, trachoma, leprosy), provision of essential surgery (for cataracts, injuries, etc.) and early action for rehabilitation.

Tertiary Prevention: At this level, measures are aimed at preventing disabilities from becoming a handicap, with rehabilitation being a major component. Other preventive action, however, would include screening, public health education and provision of appropriate aids.

Emergency Measures: Essential first initiatives established in the emergency phase may include:

- measles vaccination for all children nine months to five years of age and for those up to 12 years old, if there is evidence of the disease in older children.
- oral rehydration therapy (ORT), with the establishment, as needed, of ORT centres for early treatment of dehydration cases.

* Source: Women and Disability, ed. E. Boylan, Women and World Development Series, Zed Books Ltd, London, 1981, p.7

Prevention

- support for breastfeeding mothers and infants; and therapeutic feeding for all severely malnourished children.
- prevention of Vitamin A deficiency for all children under five years (e.g. mass distribution of Vitamin A every three to four months), and early detection and treatment of cases.
- prevention of Vitamin C deficiency through ensuring an adequate source in the diet.
- advice on health practices for refugees in cross-cultural situations.
- health education, practical guidance and support during pregnancy and post-natal period for young mothers who do not have older relatives to assist them.

The principles of primary health care with their emphasis on preventive and promotive practices should form a key element in refugee health programmes, which, in addition to the interventions listed above, should include:

- mother and child health services including monitoring of children's health and development/growth.
- basic treatment of common diseases, particularly ear infections, control of diarrhoea (and use of ORT) and respiratory infections.
- immunization coordinated with the national "Expanded Programme of Immunization" (EPI). Full immunization should be implemented for at least 80 percent of children under five years for DPT, measles, poliomyelitis and tuberculosis (BCG).
- training of community health workers and traditional birth attendants with attention to reducing and responding to birth trauma, including recognition of asphyxia.
- hygiene and sanitation including monitoring and support for clean water, latrines, vector control and garbage disposal.
- child spacing where culturally appropriate.
- health education to be conducted through clinics, feeding centres and/or in mass campaigns.
- individual treatment of chronic diseases (e.g., tuberculosis and leprosy).
- eye ointment for mass treatment of trachoma and treatment of individual cases of cataract.
- prevention of deafness and hearing impairments by treating individual cases of otitis media.

While health services may play a major role in prevention and rehabilitation of disabilities, it is important to remember that the real determinants of the health status of refugees are elements not usually classified as part of the health sector (e.g. accident prevention, nutrition, safe water and sanitation, adequate clothing and shelter).

Accident Prevention: Concrete measures can be taken in refugee camps to reduce the likelihood of fatal or disabling accidents. When sites are being planned, the design of dwellings and other structures and the spaces between them need to be considered with a view to reducing the risks of fire. Elevated cooking facilities can help reduce the risk of burns to children. The safe storage of pesticides, cooking fuel and other poisonous substances is necessary both at the camp and dwelling unit levels. Public health education on the reduction of safety hazards should be a responsibility of community health workers.

Landmines

Demining and mine awareness programmes are essential to the prevention of disabilities among refugees repatriated to areas where land mines and unexploded shells present a danger. Physicians for Human Rights cite the following statistics on landmine injuries. (13)

Country	Ratio of Amputations resulting from injuries caused by a mine explosion	Remarks
Cambodia	1 in 236 people	300-700 amputations/month were carried out because of mine injuries in 1991
Angola	1 in 470 people	
N. Somalia	1 in 1000 people	
Vietnam	1 in 2500 people	
USA	1 in 22 000 people*	*ratio of amputations resulting from **all traumatic injuries**. Amputations resulting from injuries caused by landmines is almost nil.

Nutrition: The provision of an adequate (to meet caloric levels required by all sectors of the population) and balanced food ration is essential to maintaining good health and reducing vulnerability to disease. Micro-nutrient requirements must be met through the basic ration or from supplementary sources.

Breastfeeding is the safest and nutritionally most adequate source of food for children under 6 months. Mothers should be supported to exclusively breastfeed their infant up to 6 months. To mothers of infants 6 months and above, counselling on how to prepare and use safe and nutritionally adequate complementary foods should also be provided routinely. Where whole grains are distributed as part of a food ration, it is essential that grinding facilities be readily available so that mothers can prepare food that is easily digested by children who are being weaned.

Nursing mothers, pregnant women and diagnosed malnourished children may often need to supplement their diet in order to prevent irreversible impairments. Such supplements may be given in kind, or as financial assistance based on an assessment. A periodic evaluation of the beneficiaries is essential to ensure that those in need are being properly assisted. It should be remembered however, that the aim of nutritional assistance is to provide a balanced food ration for the whole refugee population, and that supplementary food programmes should not be used to support an inadequate system of rationing.

Other Preventive Measures Include:

- provision of adequate shelter avoiding overcrowding and unhealthy locations
- control of pests that spread disease
- safe working conditions
- fire fighting measures
- ready access to clean water and provision of adequate sanitation
- provision of adequate clothing and necessary material items

Preventable and Non-preventable Causes of Disabilities (14)

Disability	Preventable Causes	Non-preventable Causes
Moving difficulty	Poliomyelitis Cerebal Palsy Accidents Tuberculosis Stroke Landmines	Arthritis Osteo-arthritis Diabetes Muscular dystrophy Genetic diseases
Seeing difficulty	Trachoma and other eye infections Xerophthalmia Onchocerciasis Accidents Glaucoma	Cateract Diabetes Degenerative eye diseases Genetic diseases
Hearing and/or speech difficulty	Cerebal palsy Ear infections Infective diseases during pregnancy (e.g. rubella) Goitre Meningitis Use of ototoxic drugs	Neurogenic deafness Genetic diseases
Learning difficulty	Cerebal palsy Goitre	Idopathic mental retardation Genetic diseases
Behavioural difficulties	Drug abuse Alcoholism	Cognitive, affective or behavioural impairments

Common Diseases Affecting Refugees: Causes and Prevention

Disease	Major contributing factors	Preventive measures*
Diarrhoeal Diseases	Overcrowding, contamination of water and food.	Adequate living space, public health education, good personal and food hygiene, safe water supply and sanitation. Exclusive breastfeeding.
Measles	Overcrowding	Adequate living space (not below minimum recommended standards (15)). Immunization of children nine months to five years of age.
Respiratory Diseases	Poor housing, lack of blankets and clothing.	Minimum living space standards, proper shelter, adequate clothing, sufficient blankets. Exclusive breastfeeding.
Malaria	New environment with a strain to which the refugees are not immune. Stagnant water which becomes a breeding area for mosquitoes.	Destroying mosquito breeding places, larva and adult mosquitoes by spraying. However the success of vector control is dependent on particular mosquito habits and local experts must be consulted. Provision of mosquito nets. Drug prophylaxis only for those (e.g. young children) who otherwise might die on first attack, rather than start to develop immunity.
Meningococcal Meningitis	Overcrowding in areas where the disease is endemic (often has local seasonal pattern).	Minimum living space standards. Immunization only after expert advice when surveys suggest necessity. Immunization is only achieved after a week.
Tuberculosis	Overcrowding.	Minimum living space standards but where endemic will remain a problem.
Worms (especially hookworms)	Overcrowding. Poor sanitation.	Minimum living space standards, proper sanitation. Good personal hygiene. The wearing of shoes.

Common Diseases Affecting Refugees: Causes and Prevention

Disease	Major contributing factors	Preventive measures*
Scabies (skin disease caused by burrowing mites)	Overcrowding. Poor personal hygiene.	Minimum living space standards, enough water and soap for washing.
Xerophthalmia	Vitamin A deficiency. (Xerophthalmia is often precipitated by measles or other acute infections.)	Adequate dietary intake of vitamin A. If not available, provide vitamin A fortified food. If this is not possible, vitamin A capsules. Immunization against measles. Breastfeeding.
Anaemia	Malaria, hookworm, poor absorption or insufficient intake of iron and folate.	Prevention/treatment of contributory disease. Correction of diet including food fortification. Breastfeeding.
Tetanus	Injuries to unimmunized population. Poor obstetrical practice causes neo-natal tetanus.	Good first aid, immunization of pregnant women and subsequent general immunization within EPI. Training of midwives and clean ligatures, scissors, razors, etc.
Typhoid and Cholera	Overcrowding. Poor personal hygiene, contaminated water supply, inadequate sanitation.	Minimum living space standards, safe water, proper sanitation. WHO does **not** recommend vaccination; it offers only low, short-term individual or no protection aginst the spread of the disease. Good personal hygiene, food and public hygiene and public health education are the most effective measures. Exclusive breastfeeding.

* Malnutrition increases vulnerability to serious attacks of all these illnesses; a proper diet is thus effectively a preventive measure.

Community Health Workers:
At the first level of refugee health care is the community health worker, responsible for a section of the refugees and working among them, home visiting, case finding and following up, and responsible for the basic community-wide preventive measures, including public health education. The community health worker, who should be a refugee with the appropriate training, identifies health and nutritional (and often social) problems, and if simple on-the-spot treatment is not possible, refers patients to the appropriate service.

Mental Health: Every refugee is potentially "at risk" in terms of his or her mental health, as practically every refugee has suffered severe losses of family, friends, and material possessions, not to mention the loss of nationality and identity. Added stresses of adaptation and other trauma predispose him or her to mental breakdown.

As much as possible, refugees should have the opportunity to control their own lives. In camps, refugee participation in planning, implementation, management and evaluation of all assistance measures should be as extensive as possible. Freedom of movement and the right to employment or other forms of self-support are basic.

Efforts to restore "normality" through re-establishing community social structures and institutions, normal cultural and religious life should also be supported. This is of particular importance for children, whose mental health and psycho-social development is to a large extent dependent upon the restoration of daily routines and activities, as well as the resumption of educational, recreational and cultural activities. (16)

example

A 30 year old mother from a rural area flees to a city in a neighbouring country after her husband is killed. She begins to act strangely and seems out of touch with reality. Although she has had no such problems for several years, she had previously experienced similar but less severe psychological disturbances.

Possible Causes:
- tauma from loss of husband;
- loss of support from her community;
- disorientation in a new environment;
- tendency toward psychological disturbance.

Impairments:
- hallucinations;
- talks to people who are not there;
- absence of normal motivation and interests;
- disturbed thought processes.

Disabilities:
- inability to concentrate on daily tasks;
- difficulty receiving and understanding new information; inconsistent contact with reality.

Handicaps:
- failure to take care of her children adequately;
- inability to work;
- inability to maintain normal relationships.

Check List

- ❑ Has a commitment to primary health care been made in the country? If so, to what extent has it been implemented?
- ❑ Are there any particular disease, nutritional or cultural problems which should be addressed by specific action?
- ❑ What is the concern of the target groups and the community in general about the specific problem?
- ❑ Are any "road to health" or "child health passports" or other country developmental screening devices being used in the country? If so, is such a programme followed by intervention? Can these services be extended to refugees?
- ❑ What early childhood developmental programmes are there? Do they have instruments or tests that have been found reliable? Can these be adapted for use by refugees?
- ❑ Is support for breastfeeding mothers and infants available as a routine service? Are efforts made to help mothers to re-establish breastfeeding? Is infant feeding monitored as part of child care services.
- ❑ Are there any parent organizations in the host community which would be willing to take part in parent-to-parent outreach activities involving refugees?
- ❑ Are there any parent or other education programmes for refugees onto which disability information and guidance could be grafted?
- ❑ In clinics for, or attended by refugees, could information that is made available about child development also cover the early signs of disability?
- ❑ Are simple leaflets or booklets with relevant information on impairment and disability available in the language(s) of the refugees in places where refugee women and children congregate.
- ❑ Are there any groups of parents of disabled people who could be mobilized and involved in refugee education on a person-to-group basis?
- ❑ Is there a resource centre able to provide accurate and relevant information to refugees about disability?
- ❑ Are there any appropriate early identification and treatment programmes for young disabled people?

part 3

Rehabilitation

Promoting Social Integration

Refugee Women

Children and Education

Special Health Problems

Community-based Rehabilitation

Ten Basic Rules for Integrated Living*

1. **Family life:**
   Persons with a disability, should have the freedom to find a partner, have children, and set up a family. They should live with their family and be part of their community.

2. **Shelter:**
   Disabled persons should have shelter and be able to move about freely at home and in their surroundings.

3. **Food:**
   As infants, the disabled should be breastfed. As children and as adults, disabled persons should have a fair share of their family's food.

4. **Schooling:**
   Children with a disability, should go to school with the non-disabled. Teachers should have learned how to take care of the special needs of their disabled pupils and to include them in all school activities.

5. **Education and Training:**
   Disabled persons should get the opportunities for education and training that they need in order to prepare themselves for work and to live independently.

6. **Leisure Time:**
   Disabled persons should be free to join others on social, cultural and religious occasions.

7. **Public Services:**
   Disabled persons should have access to all public services and all public buildings. Roads and public transport should be designed in such a way as to let them move and mix freely and independently in society.

8. **Association:**
   Disabled persons should not be denied membership of any associations or organizations open to all, and they should be free to form or join an association of disabled people, should they so wish.

9. **Economic Opportunities:**
   Disabled persons should have the same opportunities to work as other people; any loss of income caused by their disability should be compensated.

10. **Political Participation:**
    Disabled persons should be allowed to vote and to participate in government as other citizens do. Their voice should be heard in matters of concern to them and regarding services provided for them.

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* Adapted from: Prejudice and Dignity, An Introduction to Community-based Rehabilitation, E. Helander, UNDP, New York, 1983, p. 90

Some practical tips on working with disabled people....

- Remember that a person who has a disability is a person, like everyone else.
- Relax, if you don't know what to do or say, allow the person who has a disability to help put you at ease.
- Explore your mutual interests in as friendly way: the person likely has many interests besides those connected with the disability.
- Remember that difficulties the person may be facing may stem more from society's attitudes and barriers than from the disability itself.
- Offer assistance if asked or if the need seems obvious, but don't overdo it or insist on it. Respect the person's right to indicate the kind of help needed.
- Talk about the disability if it comes up naturally, without prying. Be guided by the wishes of the person with the disability.
- Be considerate of the extra time it might take for a person with a disability to get things said or done. Let the person set the pace in walking and talking.
- Speak directly to a person who has a disability. Don't consider a companion to be a conversational go-between.
- Don't move a wheelchair or crutches out of reach of a person who uses them.
- Never start to push a wheelchair without first asking the occupant if you may do so.
- When pushing a wheelchair up or down steps, ramps, curbs, or other obstructions, ask the person how he or she wants to proceed.
- When meeting a person who is blind or visually impaired, identify yourself and let the person know you are addressing them by using their name or touching their shoulder or arm. Be sure to tell them when you are leaving.
- Give whole unhurried attention to the person who has difficulty speaking. Ask questions that require short answers or a nod or shake of the head.
- Speak clearly and distinctly to a person with a hearing impairment or other difficulty understanding. When full understanding is doubtful, write notes.
- When dining with a person who has trouble cutting his/her food, offer to help if needed. (It may be easier to ask if the person would prefer to have the food cut up in the kitchen.) Explain to a person who has a visual problem where dishes, utensils, and condiments are located on the table.
- Be alert to possible existence of architectural barriers in places you may want to enter with a person who has a disability; watch for inadequate lighting, which inhibits communication by persons who have hearing problems.

Adapted from notes published by the Awareness, Publication and News section of the Afghan Disabled Society.

Promoting Social Integration, Women, Children and Education

- The goal of rehabilitation is re-integrating the disabled into the mainstream of the community's activities.
- Negative attitudes and ignorance are serious obstacles to the attainment of self-sufficiency by disabled refugees.
- For refugee women their own disability or that of a member of the family is likely to be a major handicap. Disabled women heading households need special help.
- When medical or paramedical intervention is being planned, the capacity, needs, aspirations and prospects of the individual should be borne in mind as well as his/her family context.
- Access and mobility do not depend only on medical interventions, but also on planning, organization, management and cooperation.
- Teachers should be encouraged to include disabled children in their classes whenever possible. Disabled refugee children should be encouraged and helped to complete as much of their schooling as possible.
- Efforts should be made to incorporate the disabled in existing or planned vocational training and income-generating activities for the general refugee population.
- Action to promote the social (and economic) integration of disabled refugees need not be delayed pending medical or specialised rehabilitation measures.
- Under no circumstances should action be taken which might identify or establish disabled refugees as a separate or isolated population.

Community-based Rehabilitation

- Community-based rehabilitation involves measures taken at the community level to use and build on the resources of the community, including the impaired, disabled and handicapped persons themselves, their families and their community as a whole.
- **The objectives of CBR ought to be the "empowerment" of the disabled person; or the family of the disabled child; and full social integration of the disabled.**
- CBR emphasizes local construction or rehabilitation aids using low-cost designs and local materials.
- A well-coordinated referral system will be essential.

"One of the most challenging powers against which the disabled constantly strives is that of attitudes. The image of the physical perfection portrayed by the media; society's emphasis of the work ethic as a criteria for usefulness to society; and the public's concentration on disability rather than the ability are destructive."

Rehabilitation is not the automatic result of medical treatment or physical therapy. It also means achieving the maximum level of physical, mental and social functioning of which a disabled person is potentially capable. This can range from completely normal functioning for some, to doing such basic tasks as eating and dressing for others. The goal of rehabilitation work is to restore the disabled to the community in an effort at re-integrating them into the mainstream of the community's activities.

Disabled refugees can contribute to their communities when given the chance. Rehabilitation includes removing barriers to their full participation, ensuring equal access to housing, transportation, social and health services, education and information, work opportunities, cultural and recreational activities, social interaction. They should not be denied opportunities to meet people, to make friends, to marry and to have a family.

Removing such barriers is dependent as much on attitudes as on mobility. An understanding and motivated community can ensure the active participation of disabled refugees in all spheres of communal life. Families play a major role in helping (or preventing) disabled refugees to achieve this social integration. Programmes should therefore be designed to keep the disabled in the family. Families must be encouraged to take part in rehabilitation and receive the necessary support and training to fulfill this responsibility.

Action in favour of handicapped refugees should be quick, simple, cost-effective and cause minimal disruption to the normal social relations of the handicapped vis-a-vis the rest of the refugee community.

Promoting Social Integration

Having identified the disabled within the community, the next step is to involve them, together with refugee leaders, health professionals, community health workers, teachers, religious leaders, traditional healers, and non-refugees working in the situation in a process of identifying:

- attitudes towards particular disabilities within the population;
- barriers to the full participation and social integration of disabled refugees;
- relevant resources in the refugee and host communities;
- measures that can be taken to overcome barriers in existing health and social services, education and training programmes, income generating activities and other areas of community life.

On the basis of this information appropriate rehabilitation activities can be planned.

Action to promote the social (and economic) integration of disabled refugees need not be delayed pending medical or specialised rehabilitation measures. These can come later, as and when necessary. Nor should a lack of specialist resources, skills or knowledge on the part of the field personnel inhibit them from taking initial action in favour of the handicapped refugees within the general caseload. Keeping in mind the principal and ultimate goal of social and economic integration of the handicapped, simple common sense may be used to find appropriate immediate action.

The achievement of full participation and equality depends on positive and constructive attitudes on the part of the disabled person as much as on the part of his/her family and community. The pre-existence or sudden occurrence of the disability will have ramifications for the individual refugee. For example, a refugee disabled early in life may have resolved the issues of body image, a unique means of completing tasks of daily living, personal coping mechanisms and social interaction... (although these may again be complicated by new living conditions as a refugee). The recently-disabled refugee's feelings about his or her new status will depend on his or her self-image, support system, social and physical environment and the creative coping abilities that he/she can mobilise to adjust psychologically and physically. Thus individual counselling of the disabled and their families may be necessary.

There are many ways that disabled persons can contribute to their family and community. However, it is important that the rehabilitation programme have a broad view of how this can be done – helping with daily activities in the home, leading or participating in community action, making goods for sale, teaching and so on. Thus a programme of rehabilitation is not just about providing for skills or career training, but should aim to make available as wide a range of opportunities for the disabled as possible.

A Disabled Person's Expectations of Rehabilitation (17)

1. Like any other individual or citizen of a country, the disabled person expects and hopes to get good education, suitable vocational training leading to eventual socio-economic rehabilitation so that he/she can lead an independent satisfactory life.
2. To be provided with regular medical care to improve the functioning as far as possible as well as prevent the disability from deteriorating any further.
3. To be helped and guided in his/her orientation and readjustment in the family, community and society with full participation.
4. To participate actively in his/her own rehabilitation, deciding for him/herself the goals that he/she wishes to achieve, it is essential that he/she is trained in accordance with his/her potential and inclination.
5. To be provided with suitable aids and appliances that help to bring his/her mental and physical potential to the maximum.
6. To be provided with easy access to physical environment including rehabilitation services through removal of structural barriers and communication problems.
7. To be placed in a suitable job after training where facilities and safeguards are provided for the basic adjustment of his/her disability in order to enable him/her to function to his/her maximum capacity.
8. To receive evaluation and follow-up services till such time that he/she is fully settled with success in his/her job. This evaluation and follow-up is a combined and cooperative process between the disabled employee, the placement officer and employer."

Medical Interventions: When medical or paramedical intervention is being planned in favour of handicapped refugees, the following points should be borne in mind:

- the particular capacities of the individuals concerned
- the actual needs of each individual, bearing in mind his/her family context
- the long-term integrative goals (e.g. will the treatment facilitate the individual's access to existing employment possibilities)

Attitudes: Negative attitudes based on religious and cultural beliefs, as well as a prevailing ignorance about disability, in most parts of the world and at all levels of society, are serious obstacles to the achievement of self-sufficiency by the disabled.

Negative attitudes often arise from the general conception of disabled people as helpless and objects of pity. Even if it is admitted that disabled people can achieve independence, they will still be regarded as passive performers in social interaction. Even in countries where efforts to promote independence are being made, laws and regulations may have been so framed and the disabled so categorised that they are still severely handicapped. In less developed countries it is more likely that knowledge about the nature and cause of disability will be based on superstitions, or religious and cultural beliefs. Efforts to dispel these sorts of misconceptions will need to be presented in a relevant and appropriate fashion according to the target audience, bearing in mind that perceptions of what constitutes a disability may also be a social or cultural variable.

To help refugees to accept disabled persons and to integrate them into their communities, they must be made aware of the causes of disabilities, of the ways and means to prevent impairments and the benefits of rehabilitation. Thus, information and education will be the background to all interventions and the key to successful rehabilitation and integration.

Information/education campaigns can be aimed at a variety of audiences:

- disabled individuals
- parents and family members
- teachers
- employers
- community, health and social welfare workers
- refugee communities at large
- the host community

They can be reached in a variety of ways individually, in the home (community out reach) or wherever groups gather:

- clinics
- feeding centres
- schools
- religious meeting places

Increased knowledge alone will not bring about an immediate change in practices. To be effective the information provided will have to be relevant and advice and techniques simple to implement.

Some Myths about the Disabled...

They are being punished by God.

They are not human any more.

They cannot help themselves and need to be taken care of.

They cost a lot of money.

They are useless.

They are_____

(What can you add to this list?)

OPEN THE DOORS TO THE DISABLED

public transport inaccessible

abandoned by family

cannot grasp handle to open door

START

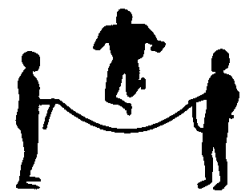
An intersectoral approach is needed to facilitate:

- access to services, education, information, employment;
- physical access to buildings and transport;
- acceptance and integration into the community.

family takes part in rehabilitation training

shunned by neighbours

transport organized for children who have difficulty walking to school



doorways widened to improve access

latrines inaccessible

refused employment because of hearing impairment

children with mild handicaps excluded from local schools

disabled participate in planning community activities

commmunity-run workshop provides rehabilitation aids, vocational training and employment for disabled

neighbours offer to help with daily tasks

FINISH

ramps replace steps

children throw stones

women organize support groups for families coping with disability

it all becomes too hard; frustration gives way to depression

steps make UNHCR office inaccessible

Understanding and Changing Attitudes (18)

Probably one of the most effective ways of changing attitudes is by involving the community in positive interactions with disabled people who have been successfully rehabilitated.

The way disabled people are treated differs from family to family, community to community, country to country, and is a reflection of cultural beliefs and attitudes, as well as the influence of religion and economic and social pressures.

Local beliefs and customs:
The birth of disabled or deformed children may be attributed to bad actions by the parents or to actions displeasing to the gods. Thus corrective measures may be viewed negatively as a further provocation of the fates.

Lack of correct information:
It is sometimes believed that paralysis caused by polio or cerebal palsy is contagious. Children who have fits or mental illness are sometimes believed to be possessed by the devil or by evil spirits. Such children may be feared, locked up or beaten.

Failure to recognize their value and potential:
Negative and erroneous attitudes about their capacities may lead to disabled people being neglected or abandoned.

Fear of what is strange, different or not understood:
In communities where polio is common, a child who limps may be well accepted. However in a community where few children have physical disabilities (or where most who do are kept hidden), the child with a limp may be teased cruelly or avoided by other children.

The degree of disability:
The severity of the disability often influences whether or not the family or community gives the child a fair chance. In some societies, mobility may determine acceptance into society. A certain level of impairment may be acceptable, (e.g., walking with braces, crutches), but those who never manage to walk at all will probably die in childhood, from hunger or neglect.

Relative values:
Where poverty is extreme, a child's disability may seem of small importance. **Only when the basic needs of food and shelter are met can a family give attention to a child's disability.**

Family Support: It must be remembered that refugee families subsisting under the strained conditions that typify many refugee situations (e.g., few opportunities to work or earn income, unaware of, or unable to claim their rights to services and assistance, lacking resources of the most basic kind and dependent for their survival on outside support) will probably be ill equipped to provide adequately for those in their care. Thus the family must be supported and strengthened. Support will range from providing for initial basic survival needs of shelter and clothing, water, food and health care, to ensuring access, *inter alia,* to health and social welfare services, training and work opportunities, schools and child care.

For disabled refugees who do not have family or relatives to turn to for help, special measures may need to be taken to meet their particular needs – assistance with the activities of daily living, aids to increase their mobility and access to facilities and services for example. Wherever possible such refugees should be cared for by and in the community (e.g. through foster families, assistance in the home) and not isolated from it by placement in institutions or special centres. If family members can be traced, early reunification should be attempted.

Training: Training of people at all levels is vital to the successful implementation of an approach to rehabilitation based on community participation.

All staff and other non-refugees providing assistance, including health professionals, should be made aware of the principles of the approach adopted. For those with no experience of working with disabled people, training, in addition to covering practical aspects of assistance, should also cover the physical and psychological effects of disabling diseases and disabilities, and the socio-cultural implications of disease, disability and rehabilitation.

In-service training is essential to ensure that training is relevant to the specific aspects of the actual refugee situation.

At the community level, training should be based on the skills and knowledge the person will need to carry out the tasks required of him or her. For example, refugee community workers employed in house-to-house surveys and community outreach services will need to be trained in identifying disabilities, counselling and communication. Teachers will need clinical (e.g. detecting impairments in hearing) and counselling skills, while health workers will need teaching skills. Cross-cultural differences may necessitate re-education in health practices for mothers and other refugee women.

Training inputs need to be made at regular, periodic intervals to take advantage of lessons learned from problems faced by staff and to encourage them to share their experiences in dealing with the actual situation.

Disabled Refugees as Leaders and Workers in Rehabilitation Activities: The importance of assistance which actively supports and respects the capacity of individuals and groups of disabled refugees to take decisions about their own requirements must be stressed. They should be consulted about their needs and given a voice in the community. Thus active participation by the disabled in general community affairs, as well as matters of immediate concern to them, should be encouraged.

Disabled refugees recruited to manage or take part in rehabilitation activities are more likely to work with commitment. Drawing on their personal experience they have a better understanding of the problems, needs and potential of disabled persons. Their weakness contributes to their strength.

Leaders and workers who are disabled may prove to be excellent role models, especially for disabled children and their parents. A group of disabled persons seen to be working together productively as a team, helping other people and enjoying themselves in the process, is an inspiration to families, giving them a new hope and a new vision of the future. This alone is a big first step toward rehabilitation. (19)

Volunteers: The term volunteer should not be taken to indicate a person working without any reward. All volunteers need compensation or recognition for what they do, something that counts in their society. Locally recruited volunteers are usually better motivated, if they have a disabled family member or if they are themselves disabled and have benefitted from the CBR programme. Such compensation or recognition could take the following form:

- appreciation or esteem by other people
- official recognition of his/her work, e.g. in the local press, presentation of an award at an official ceremony, or a written recognition by an important person
- a modest salary
- a contribution in kind, such as some extra food, disposition of a piece of land to cultivate, a uniform, clothes, a horse, etc.
- a signed diploma showing the competence required
- a good training that is useful for the person
- travel to a seminar or participation in a workshop
- career prospects – unfortunately most such rewards consist in moving centrally – promotion and career need to be possible locally
- in tightly controlled societies, working as a volunteer sometimes for example, provides a women with a legitimate reason for leaving the house and meeting other people
- for family members the knowledge that their efforts will diminish the degree of dependency of a disabled family member is important; the disabled person will later on need less help and may contribute economically to the family. (20)

Vocational Training and Income-Generating Activities: Early attempts at training the disabled favoured sheltered workshops which operate under controlled and "safe" conditions for the disabled. However, over a period of time experience has shown that the objective of integration is not achieved. Some criticisms of sheltered workshops are that they often actually hold back the development and crush the spirit of the participants who are not involved in the planning, organization or running of their programme and who are often treated as children or sweated labour. For these reasons, such special facilities for training handicapped refugees should be viewed carefully.

Ideally, separate training and/or job creation facilities for handicapped refugees should be replaced by efforts to incorporate them into existing or planned vocational training and income-generating activities for the general refugee population. As and when necessary, help should be given to assist the handicapped refugee to fit in with existing facilities (i.e. by encouraging training instructors and possible employers to give the disabled an equal chance; by improving physical access to the work-place; or by providing the refugee with simple tools to facilitate their work in view of the particular handicap involved.)

example

Daily Activities:

Access and mobility, which are key factors in the rehabilitation process, do not depend only on medical interventions, but also on planning, organization, management and cooperation.

The tasks of daily living as described below are often the common lot of the refugee in rural areas. For many of the disabled most of these tasks are beyond their capacity or can be managed only with difficulty.

Some of the tasks of daily living....

- A food ration consists of maize and beans. The maize must be ground but the only mills available are privately owned and situated at a distance of half a day's walk from the refugee site. Milling costs the equivalent of half a kilo of whole maize.
- The monotony of the food ration can be varied by bartering at the local market (2 km away), but only by using a portion of the already limited ration. Small plots, where available, are used to grow vegetables.
- Water points are situated a long way away from many refugee homes.
- Wood and grass used for building and cooking fires can only be found at increasing distances from the site.
- To women fall the tasks of collecting firewood and grass for thatching, grinding the maize, fetching the water, cooking, caring for children, the sick and the elderly and entertaining visitors.

Many of these problems could be resolved or minimized:

- by better planning of the location of water points or by organizing other means of transport and distribution (e.g. provision of a wheeled carts), or by relocating disabled refugees closer to services, water points, etc).
- by cooperation among community members in the formation of local co-operatives for milling the maize and of mutual support groups for women (child minding, etc).
- by better management of scarce resources by finding alternative materials for building and/or fuel.

Check List

Medical Interventions

- ❑ To what extent are health services run by the Government and to what extent on a private basis?
- ❑ Do refugees have access to government health services?
- ❑ Does the primary health care system include measures for prevention of impairment, detection and diagnosis of impairments, simple rehabilitation techniques, as well as necessary referrals?
- ❑ Is there a system of primary health care teams and centres? Can these reach refugee camps/settlements?
- ❑ Are comprehensive rehabilitation services available through special centres which may serve as a referral point to and from integrated health and other services systems?
- ❑ Are disabled persons and their families encouraged to participate in decisions regarding their own rehabilitation process? Are health staff trained to understand the importance of such participation?
- ❑ Do social welfare, health or education services have personnel responsible for counselling and referral services for persons with disabilities and their families? Are there private agencies which offer advice?

Promoting Social Integration

- ❑ Within the different religious groupings, are there any beliefs that would be indicative of particular attitudes towards disabled persons?
- ❑ Are there any religious bodies or organizations involved in issues concerning disabled persons, either by providing facilities, or by influencing public attitudes towards disabled persons which could be mobilized to extend services to refugees?
- ❑ What opportunities are there for disabled refugees to take part in religious worship and ceremonies? Are there any barriers to such participation?
- ❑ Are any sports or other recreational activities organized for disabled refugees. Do these activities permit participation by persons with different degrees of ability?
- ❑ Are recreational, cultural and social associations open to refugees with disabilities?
- ❑ Do activities for specific groups (for example young people and women) take into account the needs of persons with disabilities?
- ❑ Do places of public entertainment and other meeting places provide access for disabled persons?
- ❑ Are there any organizations of or for the disabled active in the country of asylum? Can refugees join/participate in or benefit from their services?

- Are refugees active in the running of the services for disabled? Are they involved in planning, management and evaluation?
- Do disabled refugees participate as individuals or as part of a group? Are the views of disabled refugees given additional weight in decision-making?
- What role do family members of disabled persons play?
- Have barriers to mobility and access been identified and overcome?
- To what extent are technical aids to mobility-impaired and visually and hearing impaired persons available in the country? How are these aids distributed and how are costs met? What are the arrangements for servicing? Are aids imported or produced locally? What adaptions have to be made to local conditions?
- Have provisions for transport of disabled refugees been made? How is this transport organized and financed? Is its availability limited to certain situations, for example for access to medical treatment, education or work, or is it more generally available?
- What are the criteria for access to special transport facilities?
- Have provisions been made for building or adapting accommodation/camp environment according to the needs of the mobility impaired?
- Can arrangements be made for assistance in the home for severely disabled refugees without family or other support?
- What residential provisions are available for disabled persons unable to live with their family?

Vocational Training and Employment

- Are there any laws or regulations that bar disabled persons (including refugees) from employment?
- Alternatively, do any specific measures exist that secure the right of disabled persons (including refugees) to work?
- What are the possibilities for vocational training for disabled refugees?
- Do refugees with disabilities, particularly young people, have access to ordinary vocational training programmes? If not, what modifications are necessary in order to include disabled refugees in these programmes?
- Are there separate centres for vocational rehabilitation? Do refugees with disabilities have access?
- Are vocational training/rehabilitation programmes run by government or private agencies? On a national or regional basis? Do they include people with different types of disabilities, or do they concentrate on one category? Do the skills taught reflect possibilites for employment or income-generating activities within the local community?
- Are there placement services for disabled refugees?

A sense of self worth, self-respect and dignity, are the qualities that are at the core of the disabled woman's capacity to improve her own life

Equality of opportunity and treatment of women has yet to be achieved in most societies. A woman with a physical or mental disability faces a double handicap. (21)

According to findings by the International Labour Organization (ILO), in general women in rural areas of developing countries work from 12 to 16 hours a day doing the bulk of agricultural work and the marketing and processing of produce, after which they remain exclusively responsible for all domestic chores and the care of children and dependants.

"It is not surprising then, that millions of these women are: ... permanently in poor health, not from specific illness, but from general maternal depletion caused by too much work and too little food combined with too many pregnancies too close together. From girlhood to womenhood, females in many societies are fed last and least ... Under these conditions, major causes of impairment and disability among children – infectious diseases, malnutrition of pregnant mother and child, injuries before or at birth, accidents and other sources of trauma - are the least controlled". (22)

Refugee Women

For refugee women, many of whom are heads of households, their own disability or that of a member of the family is likely to be a major handicap through:

- **stigma and loss of status:** resulting in neglect and isolation, exclusion from participation in community affairs, abandonment by husband, loss of opportunities to marry,and to have children.
- **being housebound:** loss of opportunities for education and employment outside the home, loss of opportunities to participate in social and leisure activities.
- **overprotectiveness of family:** loss of rehabilitation opportunities.

Traditional practices that inflict disability:

- female genital mutilation
- early childhood marriage and early pregnancy
- skin burning
- Complications resulting from female genital mutilation:
  - haemorrhage
  - infection
  - tetanus
  - keloid formation
  - fistula cases (causing incontinence)
  - obstructed labour
  - death.

The reasons advanced for the existence and persistence of this practice include: to ensure chastity; to conform with religious beliefs; initiation rites and aesthetic considerations. Both the World Health Organization and the Commission on Human Rights have appealed for an end to the practice of female genital mutilation. The Commission concluded that such practice "should be construed as a definite form of violence against women which cannot be overlooked nor be justified on the grounds of tradition, culture or social conformity".

The Effects of Discrimination: When planning interventions for the prevention and rehabilitation of disability, the implications of the dependent and subjugate status of women in many countries must be taken into account.

For example:

- in many societies, from girlhood to womanhood, females are fed last and least.
- families in rural areas do not send even able-bodied girls to school once they attain puberty.
- education and training are seen as an investment in breadwinners (i.e. men).
- most rehabilitation services are male-oriented.
- disabled women have fewer options for employment.
- disabled women are likely to have lower aspirations than disabled men and accept a greater degree of dependency than their disability requires.
- the majority of single-parent households will be headed by females, including those who are disabled.
- the frequency of disability is notably higher among illiterate women than among those who have received even a basic education.
- women are likely to be excluded from or under-represented in leadership structures.

case study

Some of the worst discrimination against disabled women is directed at the mentally retarded and the blind. Objects of false pity and mindless charity, blind women are often relegated to the lowest status in the community - they are isolated from society and confined to a corner of the house and live in obscurity, silent misery and total social and economic dependency.

Name: Anna
Age: 25
Sex: Female
Education: Illiterate
Status: Single
Disability: Blind from disease which affected her eyesight when a girl

Background
Lives with brother and his family, plus numerous other cousins and their families (total of 40 people in the household). She has stayed in the house for the past 10 years in the camp.

Rehabilitation Plan
Once Anna's case was brought to the attention of the Community Services office a female field worker started an orientation and mobility programme with her, followed by daily living skills. The family was very supportive, especially Anna's sister-in-law and cousins who were involved in the training. Training took place three times a week. It was made easier because Anna was highly motivated. The training period was completed in six months. Discussions were held as to income-generating activities and Anna opted for goat rearing. A goat and 2 kids were purchased after she and her family made a pen for them. UNHCR contributed to the purchase price.

Problems encountered
Anna speaks a dialect and is not able to communicate in any of the major languages which the field worker is familiar with. Throughout each training session the sister-in-law acted as the interpreter and this was not only time-consuming but also hampered the smooth flow of the teaching process.

The only place where training could take place was within the compound of the house and there were always lots of children around who never seemed to disappear despite efforts at chasing them out. This was a constant source of distraction and interruption.

Results
Being highly motivated, Anna had plans. From the sale of milk she was able to accumulate her savings and purchase some chickens. Now together with selling milk, she is also selling eggs. One of her first projects was to build a room for herself and she managed to do this with some basic furnishings. It is a luxury to have a room to oneself in the camps but that was her first priority in view of the noise and crowded situation. This was also made possible by the support and encouragement of her family. She is esteemed highly by those living in her area as even the men in this traditionally male dominated society are not in as economically viable a position as she is.

She is in complete charge of her animals, looking after them and keeping all the accounts. This has also made her more mobile. She is also participating fully in the household chores, from drawing water from the well to cooking.

Check List

- ❑ Do educational provisions meet the special needs of refugee girls and young women with disabilities?
- ❑ Could training programmes be made more relevant to women's needs?
- ❑ Do women with disabilities have access to appropriate health services?
- ❑ Is any support being given to single-parent households headed by women caring for persons with severe disabilities?
- ❑ Are there any day-care and respite facilities for children and adults with disabilities? How are these organized? What are the criteria for admission?

Notes:

A disabled child growing up has the same needs as other children for:

- **play**
- **respect, friendship and love**
- **helping (work)**
- **adventure and testing limits**
- **school and other forms of group learning**
- **taking part in community activities**

In the developing countries, it is common to find children sick over long periods of time, in particular in the age group under five. Infectious diseases, malnutrition, asthma, diarrhoea and intestinal parasitosis, alone or in combination, have the effect of making the child weak and feverish for weeks or months. Such a child often lags behind in his or her development milestones such as ability to walk, to communicate and self-care. This delay may be accentuated by behaviour problems.

Thus it is not at all rare for a disbled child to be primarily perceived as sick and for the family to wait for its condition to improve. If there is no improvement in sight, the family will gather together to discuss what is to be done and will also consult any outsider believed to have some experience. In the end, a "diagnosis" may be established, and an appropriate remedy may be sought. The latter may consist of giving the child some herbs or in fetching medicines from the local pharmacy. Should these fail to relieve the child, the family might consult a local healer or a religious leader. If this too gives no result, the family might next approach a more specialised healer or have resort to modern medicine, if available. The latter is normally costly and may require travelling long distances, which explains why such action is often delayed.

It may be that the disabled child is none the better for all these interventions, upon which the family may conclude that a spell or a curse is the cause of the child's disability. To remove it, somebody with magic power has to be consulted, but such a person may not be easy to find, and the costs could be heavy. So, again, the consultation may be delayed for a long time.

Children and Education

Meeting such a family as an outsider, one often has the impression that what the family is looking for is a magic cure – some sort of intervention that will make the disability disappear.

At first contact, the family may therefore express its expectations of a cure for the disabled child, and it might be quite some time before they get back to the initial problems and a description of their initially "felt needs". What one may hear then is, for example: "the problem is that my child does not walk at all," "... does not eat or drink" "...needs help with everything, occupying an adult full time", "... cannot go to school", or "... has a behaviour problem". (23)

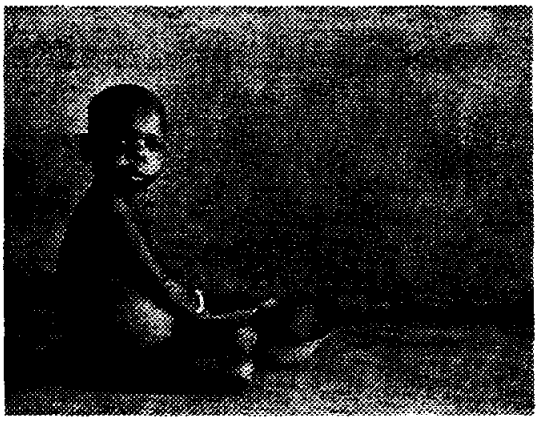
Gender Issues: Many studies show that more boys are disabled than girls. It is sometimes argued that this is because boys are more exposed to physical stress and danger, or because of sex-linked "genetic" factors

But there may also be other reasons why reports show so many more disabled boys than girls:

- **of those who are disabled, more of the boys than the girls are taken to medical centers where their disabilities are recorded;**
- **disabled girls often are not cared for as well as disabled boys; therefore more of the girls die when they are babies or small children.**

In short, disabled boys often receive better attention than do disabled girls. This, of course, is not surprising: in most countries non-disabled boys also get better treatment, more food and more opportunities than do non-disabled girls. (24)

Co-ordinated Team Approach between Health Workers and Social Services Staff: Inadequate nutrition and lack of stimulation for infants can cause developmental delay, and if prolonged, permanent retardation of mental development. Breastfeeding is important to ensure optimal physical and mental development of infants. It is a way of caring that ensures contact between the mother and child and enhances bonding. Children of about 10 months, who are just about to develop speech, crawling and walking, are particularly vulnerable to a lack of interaction with a care giver. Clearly in famine situations these are serious risks and infant stimulation groups should be an integral part of the response to such an emergency. Screening is needed to identify children who are particularly at risk. Both supplementary feeding and teaching mothers how and why to stimulate their children are needed as well as health and nutrition instruction and monitoring the weight, height and development of infants.



Education: Teachers in schools attended by refugee children should be encouraged to include disabled children in their classes whenever possible. A positive attitude to disability should be encouraged at all times. Teachers should be helped to understand that even children whose disabilities may prevent them from making normal educational progress can benefit socially and psychologically from school attendance by virtue of being with their peers.

Simple guidelines should be given to teachers on management techniques for children with hearing or visual problems. Field offices should ensure that any teacher training conducted for those who will teach refugee children includes instruction on how to identify pupils with sensory and intellectual problems and how to accommodate disabled children in their classrooms.

For a physically disabled child in a rural area, schooling may be especially important – more so, perhaps, than for able-bodied children. If they are unable to do hard physical tasks, they will need to learn other skills, using their minds, that will allow them to find suitable work and to take part in community activities. Such children should be encouraged and helped to complete as much of their schooling as possible.

Not only teachers, but parents and school authorities will need to cooperate, while distance and other problems in getting to school will need to be taken into account and overcome (e.g. providing/sharing transport, or setting up a local school).

If special arrangements cannot be made for more severely disabled children to attend school, parents may be able to organize and form their own special school or arrange for lessons at home.

Notes

Common causes of impairment and disability in refugee children:

- polio
- ear and eye infections
- mental retardation
- vitamin deficiencies
- burns
- amputations
- tuberculosis
- leprosy
- measles
- malnutrition
- poor reproductive health care
- lack of basic health and rehabilitation services
- poor sanitation and crowded living conditions

Behaviour Problems:
Some disabled children develop serious behaviour problems. This is often because they find their bad behaviour brings them more attention and "rewards" than their good behaviour.

Work and Training:
Rehabilitation programmes and families should encourage the disabled child to make his/her own choices and should make available as wide a range of opportunities as possible.

Making sure rehabilitation aids and procedures do more good than harm:
Before deciding if a child needs special aids, braces, surgery or equipment, and what kind, carefully consider the needs of the whole child within her family and community.

case study

Name: Kim
Age: 8 years
Sex: male
Education: nil

Kim lived in a town that previously housed about 60,000 people. Chemical weapons were used to bomb the town. All the houses and other buildings were destroyed. Most of the people fled, but 5,000 died.

Description of disabilities:
Kim survived with severe chemical burns to his face and other parts of the body. He has also developed severe respiratory complications.

Kim and his mother came to UNHCR seeking to be sent abroad for facial surgery. He was completely wrapped in a cloth, clinging to his mother and hiding from sight.

Strategies adopted and rehabilitation plan:
It was not possible to send Kim abroad for surgery. After several visits and lengthy friendly talks Kim slowly started to show his face.
He also started to respond to questions and smile. He explained that he felt that people were always laughing at him. He wanted to play football and start school but he felt too ashamed. After long counselling through his mother who acted as interpreter we built confidence. He then agreed to play football if the other children would accept him.

Later a local women's group was approached for help. The women's group organized a play group and bought a ball and guernseys for a team of twenty children. Kim was slowly persuaded to join in and play with the other children. The children had been asked to show compassion, to be patient and not to laugh at him. After six months Kim no longer felt the need to hide his face and could sit by himself.
He will be attending school next year.

Child-to-Child Programme: School children can be encouraged to understand and accept those who are disabled through the Child-to-Child Programme. This is a non-formal educational programme in which the activities that relate to the disabled help children to:

- gain awareness of different disabilities and what it might be like to be disabled
- learn that although a disabled person may have difficulty doing some things, she may be able to do other things extra well
- think of ways that they can help disabled children feel welcome, take part in their play, schooling, and other activities, and manage to do things better
- become the friends and defenders of any child who is different or has special needs.

Three Models for an "Inclusive School"(25)

The approach of **Model I** is to send as many disabled children as possible to the local school. The experience is that, with sufficient preparation of the teachers and some simple arrangements, around 80% of the children with "special educational needs" can benefit from schooling in an ordinary class. But for some of them, there will be problems, e.g:

a) to come to school and to move inside it;
b) to do normal school work;
c) to behave normally;
d) disabled children may be badly treated by others.

Some of these problems can be solved, others not. Here are a few examples:

a) some children with moving difficulties could be helped to come to school and to return home (trolley, carried, using an animal, etc.), and also helped inside the school, e.g. in using toilet facilities. Some children with mental retardation or with vision impairment could be accompanied to school by other children.

b) it should be recognised that problems to do normal school work by disabled children will lead to either repeating of classes or to dropouts. This is common among non-disabled children as well. The school performance can be improved by better preparation of the teachers, by curriculum adaptation, and by assistance provided through special education.

c) Some disabled children do have behavioural problems. Here increased efforts on the part of the family to correct the situation as soon as these problems become apparent may be useful. Integrating these children in pre-school activities often has beneficial effects on behaviour disturbances.

d) In order to diminish discriminatory behaviour by classmates, the teacher needs to carefully prepare all the non-disabled children and their parents for the arrival of a disabled classmate, monitor the situation at all times, and take immediate corrective measures whenever there is a problem.

The proposal for **Model II** is to start training and employing a multi-disability resource teacher. The teacher should probably be someone who graduated from a teachers' college and who has some years of experience. [A post-graduate training course in special education] should allow him or her to acquire sufficient competence for primary school education for children with severe vision impairment, with severe hearing/speech impairment, and with mental retardation.

[...]

It is proposed to provide the mobile teacher with transportation, if needed, and to ask him or her to provide special education at local schools with a view to integrating the disabled children in a "normal" class at an appropriate time.

In **Model III**, a national system to provide resources for all special educational needs should be developed. This would include the establishment of courses, so that multiple-disability resource teachers can be provided everywhere. Special resource centres in the provinces/districts could follow. The training of single-disability resource teachers for children with severe or otherwise complex educational needs should continue. Most likely fewer such teachers will be needed than foreseen, as many of the tasks can be carried out by the multiple-disability teachers.

A referral system should be built up, the most useful idea being perhaps to create a system of mobile consultants.

For all these models, special technology should be provided. This has to fit into the requirements of the national school curriculum, as well as with the local CBR system. A number of functional training tasks often carried out in special education institutions should preferably be transferred back to the home or community. An individualised approach to the teaching of disabled children in an "inclusive school" is likely to give better results, and the family should be involved, supporting the school's efforts.

Advantages of Attendance at Local Schools:

Schooling and education will help the children to learn about the world around them and to become useful members of the community.

Even if these children cannot learn to read, write and count like other children, there are other reasons for schooling, for instance: it helps them to become independent adults; it prepares them for work; the learn to get along, how to behave and work with others; it develops their abilities; they learn to accept rules and responsibility; it helps to form friendships and creates the feeling of belonging to a group; it teaches them activities that will stand them in good stead in the future.

Identification of School Children
with Special Educational Needs (26)

UNESCO proposes that each school teacher will go through the following questionnaire and make a class list indicating the difficulties identified among the children. The overall difficulties of each child will then be rated as severe, moderate, or mild.

"THIS CHILD...

1. has problems in understanding what you are saying.
2. has difficulties in doing things by him/herself, like eating, dressing, bathing and grooming.
3. is a repeater.
4. has difficulty in seeing.
5. has difficulty in hearing.
6. has speech that is difficult to understand.
7. sometimes has fits
8. appears dull or slow compared with other children of his age.
9. often bumps into things
10. often rubs his eyes.
11. can't move around without assistance.
12. can't fully take part in sport.
13. often turns his head in order to hear.
14. often scratches his ear and complains of pain and discharges.
15. often asks the teacher to repeat what has been said.
16. takes much more time than most of the others in learning anything new.
17. can't carry out two simple directives in a row.
18. has trouble paying attention.
19. does not answer when called.
20. is extremely bright.
21. frequently gives the wrong answers to questions.
22. is often sick.
23. finds school work boring.
24. avoids people, plays alone.
25. is extremely shy.
26. has short attention span — daydreams.
27. places head close to book or desk when drawing, reading or writing.
28. closes or covers one eye.
29. is easily frustrated and has difficulties getting along with other children.
30. has difficulty in understanding concepts like left, right, up, down, over, under
31. has poor balance.
32. has difficulties in learning to do things like other children of his age.
33. Additional observations."

Check List

- ❑ Does legislation on education in the country of asylum include disabled persons?
- ❑ Is there a universal right to primary education? Is this extended to refugees?
- ❑ Are children and adolescents with disabilities taught within the ordinary school system? Can disabled refugee children particpate?
- ❑ Is integrated education a deliberate policy or "accidental"?
- ❑ What types of support services (e.g. resource classrooms, teachers' aids, etc.) are available within schools open to refugees? What provisions are there for use of special teaching methods or special equipment? Is training given in special skills, such as sign language, Braille, mobility?
- ❑ Does the education programme attend to the social skills needed to cope with ordinary life situations?
- ❑ How do school authorities approach physical access by the disabled to schools? Is special transport provided which could be made available to, or shared by disabled refugees?
- ❑ Are there any specially designated places or specially adapted courses for disabled persons within higher and vocational education? Are these open to refugees?
- ❑ Are other vocational and technical centres open to the disabled and to disabled refugees?
- ❑ What special schools or classes exist at primary and secondary level for the disabled? Are they funded by the public or private sector? Are these open to refugees with disabilities? Are pupils referred through ordinary schools, health or social services, or otherwise? Are special schools residential or not? Do the schools provide transport? Is support given through parent-teacher contact? Are special schools administratively and organizationally separate from the ordinary school system, or is there a common administrative framework?
- ❑ Are special education methods included in teacher training courses for teachers in general and for teachers of refugees in particular?
- ❑ Do adult education programmes open to refugees take account of the needs of adults with disabilities?

"... they are always doing things for you, but never with you. I have a very basic premise, and that is that we all have a basic human right to be wrong, to make mistakes. Which means that we all have a basic human right to make decisions for ourselves. When people prevent you from making decisions, as is done with the disabled, they are depriving you of a key activity of being human."

Mental Health: Violence is part of many refugee situations and its victims should have access to co-ordinated medical, counselling, material and legal assistance. Furthermore, in addition to ***immediate access*** to treatment, field offices should ensure that these refugees are given priority attention for recovery and long-term rehabilitation. In such matters, field staff will need the guidance of qualified experts.

Depending upon a person's coping mechanisms, not all will want or need to avail themselves of all these services. However, those working with refugees must be alert to the mechanisms of avoidance and denial, and be sensitive to complaints and the hidden problems behind them. Feelings of rage, despondency, insufficiency, etc. are very often not admitted, or are repressed.

The process may be further complicated by the suspicions of such refugees of representatives of authority, doctors, compatriots they do not know well (e.g. interpreters) and the fear of betrayal engendered by their experiences. Medical, social and psychological examinations thus may be regarded by some refugees as a threat.

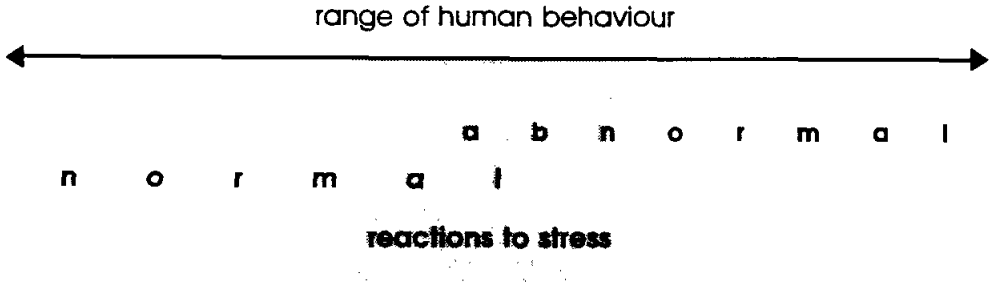
Characteristic symptoms of distress are the re-experiencing of traumatic events and a numbed responsiveness to the external world, as well as a variety of other symptoms such as pains, dizziness, insomnia, or moodiness. Emotional instability and irritability can result in explosions of aggressive behaviour with little or no provocation. Depression is a common phenomenon in refugees – at its most extreme, it can lead refugees to suicide. Lighter forms of depression may lead refugees to complain of restlessness, sleep disturbances

or inertia, as well as psychosomatic complaints such as headaches, dyspepsia or heart symptoms.

Severe symptoms of distress are fright, haziness, restlessness and re-living of traumatic events through recurrent recollections or nightmares and sudden feelings as if the violence is happening again. These "flash backs" can be triggered by situations or sensations related to the trauma (e.g. questioning by a civil servant, a physical examination, hearing shouts, cries, etc.)

In the light of the above, it can be seen that those working with refugees who have been victims of torture and other violence must combine sensitivity with tact and patience. Care must be taken that measures used to assist these people do not contribute to the distress of individuals who are already under psychological pressure as a result of their experiences as refugees. Moreover, given the highly specialized and confidential character of such interventions, the development of treatment and rehabilitation projects by field offices should be done in consultation with Headquarters. Funding may be arranged, as appropriate, through a project administered by Headquarters or through a country project.

Resources may also be made available through the United Nations Voluntary Fund for Victims of Torture. UNHCR coordinates with the fund to implement treatment and rehabilitation services.



What is seen as normal human behaviour, including "normal reactions to stress", depends on perceptions which are determined by our physical appearance, health, personality, age, culture, religion, education, socio-economic status, and circumstances. Each individual has a different threshold of tolerance to stress.

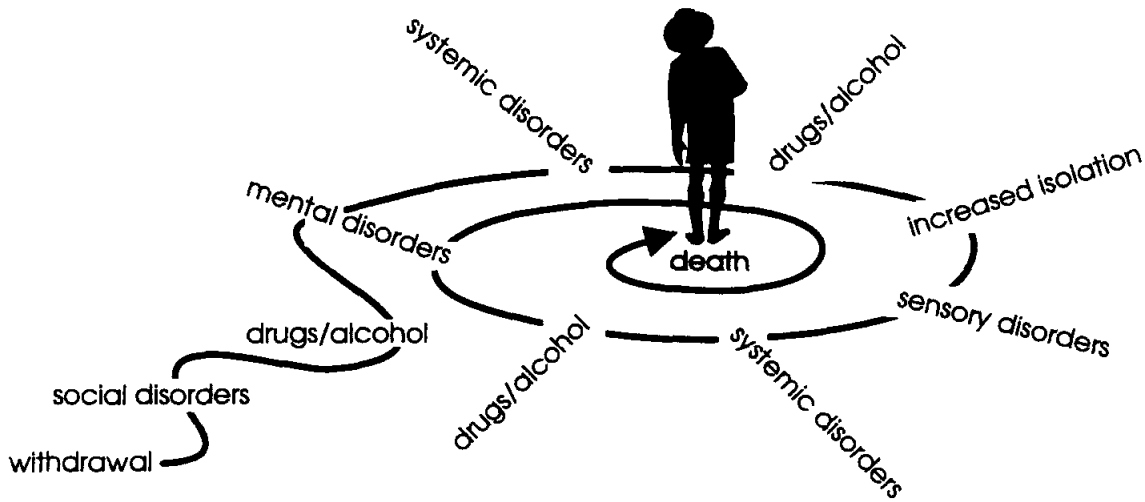
Inappropriate Coping Behaviour

Substance Abuse: Some refugees who are unable to face the stresses and frustrations of their situation may resort to alcohol and drugs as a way of coping. The consumption of drugs and alcohol can have serious consequences for the health of the refugee and can lead eventually to death. Substance abuse not only creates problems for the user but also for his/her family and will have an adverse impact on the morale and discipline of the larger refugee community.

Substance abuse is an individual problem that concerns the whole community.

Preventive activities at the community level should support and reinforce traditional coping mechanisms:

- family reunification
- counselling
- access to employment (or other income-generating activities), educational, health and other services
- mutual support groups
- religious practices
- participation and leadership in activites of direct concern to refugee community
- recreational activities.



AIDS Victims: The need to promote sexual health is increasingly more urgent in the world of today. Refugees are likely, as are all other people, to be affected to a certain extent by the AIDS epidemic, and ways must be sought, particularly in an urban situation, to target assistance programmes which afford preventive and supportive facilities commensurate with those available to nationals.

HIV, or human immunodeficiency virus, has now been recognized as the cause of AIDS. The risk of exposure to HIV confronts individuals at every level in society. The virus is transmitted by three main routes: blood and blood products, perinatal transmission and sexual intercourse. AIDS and HIV infection are unlike other diseases, in that there is no cure, little chance of stabilization and no vaccine. The modes of transmission are, however, limited, and susceptible to responsible control, provided education is given and resources are made available. National and international efforts aim at combating the spread of AIDS initially through public education.

Insofar as they have an impact on refugees, national and other measures taken to combat AIDS and to prevent the spread of HIV infection must be related to the overall objectives of international protection. ***The principle that must underlie every decision and action concerning AIDS is that refugees should not be singled out as a group at special risk.***

People in general, and this includes refugees, are often more concerned about Sexually Transmitted Disease (STD) with visible symptoms than they are about HIV. Discussing how to treat and prevent STD can provide the opportunity to talk about HIV.

HIV/AIDS counselling is a process with the objectives of:

a) preventing HIV infection, and

b) providing psycho-social support to those already affected.

The need for continued help and problem-solving is a common feature of most HIV-related situations and should be a key aspect of most counselling relationships.

Being diagnosed with, or suspecting the possibility of personal HIV infection brings with it profound emotional, social, behavioural and medical consequences. Adjustment to HIV infection is a lifelong process that exerts new demands on individuals, their families and the immediate communities in which they reside. These strains may threaten the loss of identity, independence, privacy and social status. They can also involve fears of loneliness, of dying and death, guilt and anger. Much of the stress experienced by people infected with HIV may also reflect underlying anxiety about family obligations.

HIV/AIDS and Breastfeeding (27)
In developing countries vertical transmission of the HIV virus from mother to infant is estimated at 25-30%, and 15-30% in industrialized countries. A proportion of this transmission will be through breastfeeding. To date, and in relation to HIV transmission through breastfeeding, current research data indicate that, where the causes of infant deaths are infectious diseases and malnutrition, infants who are not breastfed run a particularly high risk of dying from these conditions. In such situations, breastfeeding should remain the standard advice to pregnant women.

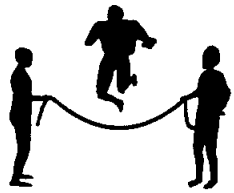
Counselling therefore has to take into account not only the immediate social and medical environment but also social relationships and attitudes and beliefs about HIV/AIDS. Factual information and education should be provided in a way that is truly relevant to the day-to-day life of the person concerned. Families with AIDS victims need special help: children who may be orphaned, as well as the elderly who are left alone, would need support and active assistance to cope with the demands of daily living.

Assistance

- All refugees should have access to adequate and appropriate health promotional information.
- Material assistance to individual cases may be necessary in order to afford refugees suffering from AIDS the same level of care available to nationals.
- Community services staff should draw up inventories of treatment resources available in local hospitals and health centres with a view to identifying a systematic referral system for HIV-infected persons.
- The principles of confidentiality and informed consent must be enforced and the handling of individual case files must be the object of special precaution.
- Advocacy of the rights of AIDS patients and HIV-seropositive persons is all-important, to ensure that they are not subjected to discriminatory practices.
- Outreach to families in the community is essential to identify persons suffering from debilitating diseases and assistance to their families needs to be organized.

Check List

- ❑ Is there any reluctance to treat certain categories of disabled persons within the general health services (e.g., mentally retarded)?
- ❑ What facilities exist for psychiatric treatment exist? Are they based mainly on out-patient or on institutionalized treatment? Is there an emphasis on early discharge from psychiatric wards? To what extent are general health-care personnel trained to deal with mentally ill patients?
- ❑ Are the needs of mentally retarded persons understood to be different from those of mentally ill?
- ❑ Was violence or physical injury involved during the flight?
- ❑ Was he/she involved personally in the violence (e.g. torture, imprisonment, rape) in the place of origin?
- ❑ Was he/she a witness to violence and were members of the family involved?
- ❑ Could important rituals for burying the dead be carried out prior to flight, during flight and presently?
- ❑ Is information on the situation in the country of origin and on asylum status being shared? The hardest thing to live with is not knowing.
- ❑ Is he/she consulted whenever possible on current/future plans?
- ❑ Do the conditions under which the person is living allow for self-respect? Are there culturally appropriate measures to determine space and privacy?
- ❑ Is self-reliance being encouraged? Are goals for self-reliance realistic?
- ❑ Are cultural factors being respected, i.e., food habits, traditional child-rearing methods?
- ❑ Has a mental health programme been incorporated into the basic health services provided to refugees at various levels?



"Community-based rehabilitation involves measures taken at the community level to use and build on the resources of the community, including the impaired, disabled and handicapped persons themselves, their families and their community as a whole." (28)

In recent years what amounts to a revolution has taken place in the rehabilitation field in both developed and developing countries. The emphasis has shifted away from special institutions, to families and communities as the critical locations for rehabilitation with specialized treatment and training.

These developments, which have specific implications for action to assist disabled refugees, have been based on the premise that sophisticated treatment and rehabilitation aids are of little value unless they actually enable disabled people to integrate more fully where they live and have practical benefits in their daily life. The result has been a shift toward "community-based rehabilitation" (CBR), of which the World Health Organization is a leading advocate.

"Community-based rehabilitation involves measures taken at the community level to use and build on the resources of the community, including the impaired, disabled and handicapped persons themselves, their families and their community as a whole." (28)

The objectives of CBR ought to be:

- the "empowerment" of the disabled person; or the family of the disabled child – and the style of intervention must reflect this. (i.e., not a service imposed from the outside and delivered by experts)
- full social integration of the disabled. In order to achieve this aim, it is necessary to provide adequate rehabilitation for all the disabled and handicapped and to reduce to a minimum all handicapping conditions in all aspects of their environment.

The WHO concept of CBR is closely related to

Community-based Rehabilitation

primary health care and forms an integral part of the programme "Health for All by the Year 2000". It has three fundamental features:

1) its focus on community involvement
2) its use of simplified, culturally-relevant rehabilitation technology
3) its service delivery system

CBR as defined by WHO covers all disabilities and all age groups. It places the responsibility for service delivery on the family and is administered by a health infrastructure. (29)

(It should be noted however, that other models for CBR exist and that they can be developed outside the health system.)

Where CBR services are provided or are being developed for nationals, they can be expanded to benefit refugees. Conversely, where relief agencies are in a position to provide such services for refugees, field offices should encourage them to include nationals as well, in consultation with local health authorities.

No matter how CBR is approached, a well-coordinated referral system will be essential.

While it is estimated by the WHO that approximately 70% of the disabled persons within a population will benefit from the CBR methods described in their manual (see next page), others may require referral for more specialized treatment, where this is possible. Such referrals should be made, however, in the context of the family and community support system. Where an individual must leave his or her community for treatment, there should be preparation beforehand so that the refugee and family members understand what is to be done and what result can be expected. It will also be necessary to assist those who are referred for treatment to re-integrate in their communities and to make use of any rehabilitation aids they may have received.

Rehabilitation and Human Rights: Rehabilitation includes not only the training of disabled people but also interventions in the general systems of society, adaptations of the environment and protection of human rights.

Protection of human rights is an obligation for the authorities of each country, for its communities and for every citizen. Disabled people shall have the same rights to a life in dignity as others, and there must be no exceptions. Special attention may be needed to ensure the access to the following:

- health and social services;
- educational and work opportunities;
- housing, transportation and to buildings;
- information;
- cultural and social life, including sports and recreational facilities;
- representation and full political involvement in all matters of concern to them. (30)

Major Strategies for Rehabilitation (31)

Institution-based rehabilitation services may be provided in a residential setting, or in a hospital where disabled people receive special treatment or short-term intensive therapy. The institution-based approach focuses on the person's disability and gives little attention to the person's family and community, or to other relevant social factors. The major shortcomings of institution-based care are its high cost and its location, usually in urban centres, making it inaccessible to those living in outlying areas. In addition, specialized institutions often lack qualified personnel. Competent institution-based care, however, is an important part of the rehabilitation referral system for the provision of special assessments, surgical interventions, other skilled treatment and specialized equipment.

Outreach rehabilitation services are typically provided by health care personnel based in institutions. Such a programme provides for visits by rehabilitation personnel to the homes of people with disabilities. The focus is on the disabled person, and perhaps the person's family. Education and vocational training are generally not included. Community involvement in these services is usually limited, with the result that they evoke little social change. The cost per person treated is high. Outreach services can be a valid part of the referral system, however, when used in special situations, such as the delivery of services to extremely remote areas.

Approaches to Service Delivery (32)

Conventional	Community-based
Supply-generated	Needs-generated
Delivered by outsiders	Participatory
Single level	Multiple levels
Centralised services in institutions or as outreach programmes	Starting-point in the community, referral services seen as complementary
Single sector	Multiple sector
Separate from other community development programmes	Integrated in other community development programmes

Community-based rehabilitation (CBR) is characterized by the active role of people with disabilities, their families, and the community in the rehabilitation process. In CBR, knowledge and skills for basic training of disabled people are transferred to disabled adults themselves, to their families, and to community members. A community committee promotes the removal of physical and attitudinal barriers and ensures opportunities for people with disabilities to participate in school, work, leisure, social and political activities within the community. A person is available in the community to work with disabled people and their families in rehabilitation activities. Disabled children attend the local school. Community members provide local job training for disabled adults. Community groups assist the families of disabled people by providing care for their disabled children or adults, transportation, or loans to initiate income-generating activities. Community-resources are supported by referral services within the health, education, labour and social service systems. Personnel skilled in rehabilitation technology train and support community workers, and provide skilled intervention, as necessary.

Community-based rehabilitation implies involving the disabled, their families, the local community including the various local institutions, in a process of self-help, using what is available to make life meaningful for those with special needs.

The Scope of a National CBR Programme:
Rehabilitation for people with disabilities cannot be accomplished by only one sector or one type of service. Health, education, vocational and social services all contribute to the rehabilitation process, although usually one ministry is designated responsible for management of the rehabilitation programme at the community level.

In countries where the Ministry of Health is in charge, the community health worker (CHW) provides the link with the community and takes responsibility for rehabilitation activities at the community level. When the Ministry of Social Affairs is in charge, there may not be a contact person in every community, so volunteers are identified to become community rehabilitation workers (CRWs). Alternatively, a community development worker, where such a cadre exists, is designated responsible for rehabilitation.

Some countries have a national coordination committee for rehabilitation, composed of representatives of the various sectors providing rehabilitation services, of non-governmental organisations (NGOs) of disabled people, and of NGOs providing rehabilitation services. A representative of the ministry concerned with local government may also be included, since this ministry works to promote disability-related issues as part of community development activities.

In addition to participating in the national coordination committee, each sector and organisation has its specific plans for the delivery of services or for activities to promote rehabilitation. Mechansims for the coordination of these services and activities may be stated in general terms at the national level, but will be more defined at the peripheral levels, where referrals actually take place and where all sectors are involved with the commmunity.

National administrations vary in their degree of decentralisation. It is easier to coordinate services as part of CBR when authority has been decentralized to the local level. If decision-making is carried out primarily at the national level, it is imperative that plans for coordination of services and NGO activities be conveyed to the district and community levels.

To provide the variety of services necessary for rehabilitation is not an easy task in any country. The health care sector will be called upon to provide specialized rehabilitation personnel. The education sector will find that many disabled children can be integrated into local schools, but that the teachers will require training in order to be able to assist them. The social services sector will find that some disabled people can recieve job training along with the able-bodied. Others, however, will require special training and specially adapted work places. Very often, ministries simply do not have the resources to provide for these.

To distribute services to all parts of the country is another difficult task. Most rehabilitation services are based in large cities. These services are rarely adequate to meet the need in urban, much less rural, ares. Here NGOs can make a significant contribution to a national plan by coordinating their activities with the government to ensure that rehabilitation personnel and services are distributed throughout the country.

The development and distribution of services is best done in response to needs identified at the community level. CBR provides a framework to facilitate this process. Services at other levels relay information from the community and back again. But the beginning and end of the action is always in the community.

Community Level: In a CBR programme, a local committee takes responsibility for the comprehensive rehabilitation process. This committee may be the community development (village) committee, the community health committee, or a specially formed rehabilitation committee. Its job is to facilitate the rehabilitation of disabled community members.

The community alone cannot meet all the needs of people with disabilities. Certain referral services should therefore be available in a region before a community programme is initiated. The extent of these will vary from country to country. However, the following preconditions will make it easier to begin CBR in any country:

- community leaders and organizations who agree to support and participate in the programme
- community rehabilitation workers who will be available
- personnel who will train and support the community workers
- rehabilitation personnel who will be available within the referral services
- referral services that will provide basic appliances and equipment.

The way in which community activities are initiated will vary from country to country. It is generally neither a top-down nor a bottom-up process. It is unrealistic, however, to wait for each community to develop the idea of community involvement in rehabilitation. It is also unrealistic to expect community members to take part in the rehabilitation process if they have not participated in the initiation of the rehabilitation activities. Hence a CBR programme begins with a stimulus external to the community, but develops within the community.

Other Levels - Composition and Services
First referral (or district level): includes a CBR committee to respond to community needs and to coordinate services; it will be a key point in the delivery of rehabilitation services (district hospital or rehabilitation centre); provides technical supervision; mid-level rehabilitation workers

Second referral (or provincial level): includes a CBR committee; staff provide training and supervision of rehabilitation workers at district and community levels; within medical services, rehabilitation procedures are carried out by physicians, therapists and prosthetists/ orthotists; location of some special schools and vocational training centres.

Third referral (or central level): such as specialty hospitals in major urban areas, which serve as national referral centres.

CBR DELIVERY SYSTEM (33)

Community Rehabilitation Workers: In primary health care, the community health care worker facilitates community action to improve the health of all members of the community. In community-based rehabilitation, the community rehabilitation worker facilitates community action to improve the physical, psychological and social status of people with disabilities. The CRW is a resource for disabled people and their families, and for other community members who wish to contribute to the rehabilitation process. Since the roles of the CHW and of the CRW are closely related, it can be helpful to have the same person fill both.

When the CRW is a volunteer, the community may select the individual. The community also decides on the tasks to be performed by the CRW, the amount of time the volunteer should devote to rehabilitation, and the remuneration that the community will provide. If the volunteer is provided by an NGO that is active in the CBR programme, the NGO and the community together may select the volunteer.

The responsibilities of the CRW include:

- identifying people with disabilities
- undertaking basic assessment of the disabled person's capabilities
- providing information to disabled people and their families on appropriate training
- referring disabled people to district level as necessary
- maintaining records of training and progress of disabled people
- providing information to the community on the causes and prevention of specific disabilities
- working with community leaders and organizations to assist people with disabilities or their families, as necessary, and to facilitate the integration of disabled people in family and community life
- assisting people with disabilities to establish or strengthen their own organizations, which can participate in the CBR programme
- participating in the community committee for CBR.

Mid-level Rehabilitation Workers: The recommended responsibilities of the MLRW include:

- identifying disabilities and the specific rehabilitation needs of individuals
- providing mid-level therapeutic interventions
- referring individuals to higher levels or other sectors, as necessary
- assisting community rehabilitation committees to plan and implement CBR programmes
- supporting and monitoring rehabilitation activities of CHWs
- supervising record-keeping and reporting by CHWs
- training CRWs and providing information to the community in support of CBR activities.

Prosthetists and Orthotists: Most countries have prosthetists/orthotists in at least one central facility. Their task is to fabricate and fit artificial limbs and braces. In many developing countries, the number of prosthetic/orthotic personnel is minimal, as is the number of disabled people who have access to these services. This service is considered costly because it involves not only the training and posting of prosthetists/orthotists, but also the establishment of workshops and a regular supply of materials. Despite the cost of establishing and maintaining orthopaedic workshops, this service is vital for disabled people who need specialized appliances in order to move around.

In many countries, it is customary to train personnel in both prosthetics and orthotics. Most countries, however, cannot field sufficient staff to meet the needs. One approach to this situation is to train personnel selectively, depending upon specific needs. Personnel could be trained in either lower limb orthotics or lower limb prosthetics, for example. The former would be appropriate where there are many children with disabilities caused by polio, and the latter where a natural disaster or war has left many people with amputations.

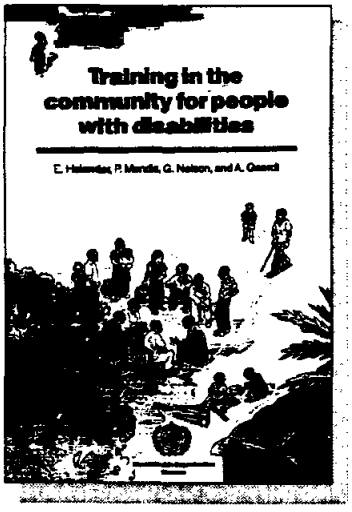
Staffing for prosthetic/orthotic services includes technicians. These may be craftsmen skilled in wood, metal or leather working; or they may be workers trained on the job to prepare specific components of the appliances. This second group of workers can undertake much of the manual labour, while the prosthetists/orthotists focus on the fitting and alignment of the appliances.

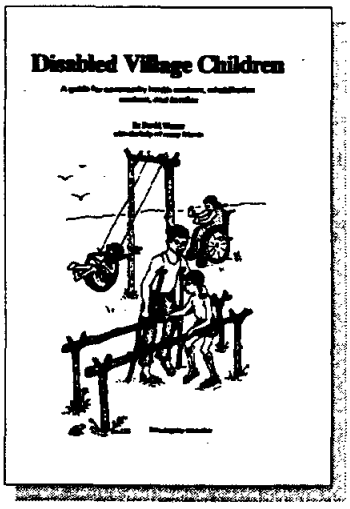
In countries where it is not possible to have prosthetic/orthotic workshops in each district, prosthetic/orthotic staff must travel to outlying areas to provide services, or disabled people who need appliances must travel to the workshops. In either case, a CBR programme should provide follow-up for individuals who receive appliances. This consists of periodic checks to ensure that the person is using the appliance and that the appliance fits comfortably and is in good repair.

Manuals for Working with Disabled People

The WHO has developed a detailed manual for implementing its approach, *Training in the Community for People with Disabilities.*

The basic objective of the WHO programme is to enable disabled persons, together with their family members, to be trained so that the rehabilitation process can be carried out within the home. In order to achieve this aim, advice, guidelines and instructions are made available to three key persons or groups of persons: the local supervisor; community leaders; and school teachers. The supervisor is likely to be a professional health worker, recruited and trained to identify disabled persons within the community. The supervisor's tasks are to select participants for community-based rehabilitation, to instruct and supervise trainers, and to evaluate results. The second group is composed of community leaders, who are advised on how to recognize the important role that disabled persons can play in their community, and how to provide them with full access to all opportunities. The third group is composed of school teachers, who will be instructed on methods of integrating disabled children into ordinary schools. (15)





Complementary to this is, *Disabled Village Children: A Guide to Community Health Workers, Rehabilitation Workers and Families* by D. Werner. The guidelines presented in both texts can be adapted to meet local needs in refugee camps and settlements.

Community-run Rehabilitation Centres: The emphasis of community-based rehabilitation is on family-based care, in the home, with the family members as primary rehabilitation workers. For home-based rehabilitation to be effective, however, parents need carefully prepared and selected information, friendly encouragement and assistance. At times they will also need back-up services of rehabilitation and medical workers with different kinds and amounts of skills. These might be best provided through a local community-run rehabilitation centre.

While referral to hospitals or other arrangements may be needed for some individuals, there are strong arguments in favour of developing a small community-based rehabilitation centre run by refugees and/or local concerned persons:

1. It is a visible, practical, low-cost base for coordinating rehabilitation activities in the home and for providing back-up services outside the home.
2. It can produce a wide range of rehabilitation equipment and aids quickly and cheaply, using local resources, with participation of families, school children and local craftspersons, when possible.
3. It can include a 'playground for all children' and organize activities to encourage understanding and interaction with the disabled.
4. It can provide meaningful work and training experience for local, otherwise often untrained and unemployed disabled persons. It gives the families of disabled children and others the chance to see what a useful, helpful and rewarding role disabled persons can have in a community.
5. Although the best place for day-to-day rehabilitation is often the home, there are families for whom this may be very difficult. In many homes the family does the best it can, but the extra work of trying to care for a severely disabled person may simply be too much for the family that has to work long hours just to survive. Under these circumstances, special care at a community centre may be of enormous benefit to both the disabled person and the family. (34)

Possible Activities and Functions of the Community-run Rehabilitation Centre (35)

- Parent meetings, mutual assistance and shared child care between families of disabled.
- Playground for all children (disabled and non-disabled).
- Group action to get disabled children into school
- Special group activities for children who cannot attend normal school
- Community awareness activities, involving community in improving environment (accessibility).
- Educational and preventive activities
- Rehabilitation assistants to help with basic therapy.
- Family and small group training in basic care, therapy and development of disabled children (guidelines and advice)
- Workshop for making and repairing (and teaching families how to make and repair) orthopaedic and rehabilitation aids.
- Non surgical orthopaedic procedures (e.g., straightening joints with series of casts, etc).
- Workshops and/or agricultural projects where disabled youths can learn income-producing skills to bring in some income to the programme or family.
- Prevention campaigns.
- Activities to involve and include as much of the community as possible (adults and children) in the programme, possibly: help with therapy, help with play and entertainment, accompany disabled children on outings, help them get to school,support committee, toy-making workshop for children, outreach.

Appropriate Simplified Rehabilitation Technology: CBR emphasizes local construction of rehabilitation aids to increase the mobility and productive capacity of people who are handicapped. The making of a wheelchair or corner seat, for example, would be contracted to the person in the community with the appropriate carpentry skills. Much work has been done in recent years in developing low-cost designs for such rehabilitation aids. In addition, some organizations have developed expertise in the production of artificial limbs and braces from locally available materials (e.g. bamboo, rattan, leather and wool). This avoids depending on costly imported products which are often inappropriate for use under difficult conditions, especially when their repair may require spare parts or professional skills that are unavailable locally or too expensive. Headquarters can assist with contacting these organizations.

A rehabilitation workshop can draw on the skills of local craftsmen (refugees or members of the host population), carpenters, welders and shoemakers, to make low cost aids with local materials. The workshop could also serve as a training centre in a variety of skills.

A rehabilitation workshop might include areas and equipment the following activities:

- **plaster casting** for correcting contractures and club feet
- **game and toy making** (or this can be done in a separate 'children's workshop')
- **artificial limb making** for making simple bamboo or leather limbs and perhaps more complex ones of wood, aluminium, or resin
- **welding and metalwork** for making and repairing wheelchairs and other metal aids
- **brace (caliper) making** using metal, plastic or both
- **leatherwork** for making brace straps, adaptations for shoes and sandals, and knee pieces
- **woodworking** for making crutches, walkers, lying and standing frames, special seating, wooden wheelchairs
- **sewing** (with machine if possible) for wheelchair seats, straps, special clothes and other articles

Approaches to Technology (36)

Conventional	Community-based
Medicalised; profession oriented; imported procedures.	Problem-solving; people-oriented; use of spontaneous technology built on resources at hand.
Dominance of formal highly structured training systems.	Emphasis on informal training systems.
Introduction of legislation to give positive discrimination	Protection of existing human rights at all levels and elimination of negative discrimination

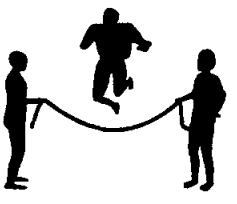
Factors to Consider in the Evaluation of CBR (37)

Factor	What to look for	Comment
Relevance	Does the programme meet the needs of the disabled people, their families and communities, and does its purpose remain valid and pertinent?	As long as we have disabled people in our societies, a rehabilitation programme will be needed and should remain relevant, provided the needs have been properly identified and met in an individualised way.
Effectiveness	Did the programme achieve its objectives both in terms of benefits for disabled people and population coverage?	The programme objective should be formulated beforehand. It should specify the dimunition of the degree of disability (quality) and the population coverage (quantity) to be achieved. Targets should be realistic, taking into account both the available resources and the constraints.
Efficiency	Were the resources made available used in the most efficient way?	This relates to the management of personnel, training programmes, means of transport, budget provisions, and so forth.
Sustainability	Will the programme continue once external assistance is withdrawn?	Where a CBR programme has grass-roots, where the community feels that it owns the programme and that it is responsible for it, where the government continues providing its part of the support, the CBR programme should take care to not introduce components that cannot be maintained by national means.
Impact	What effects has the programme had on its institutional, technical, economic and social settings?	A CBR programme may have an impact on the attitudes and behaviour among non-disabled. For example, disabled people may be better accepted and given more equitable opportunities and representation. It may bring about removal or reduction of physical barriers.

Check List

- ❑ Are policy-makers in health or any other sector aware of the concept of CBR?
- ❑ If so, have any efforts been made to implement it?
- ❑ Are there any projects or services in the government or private sector that could be described as "community-based rehabilitation" as defined by WHO?
- ❑ What rehabilitation aids are produced in the country?
- ❑ Could prostheses and other rehabilitation aids be produced locally?
- ❑ If needed, could special training be provided for production of aids by local crafstmen?
- ❑ Are there any CBR projects being implemented in the country based on models other than that proposed by WHO?
- ❑ Is there an effective referral system already in place?

Notes:



1 Disability, Prevention and Rehabilitation, Technical Report Series No. 668, WHO, Geneva, 1981, p. 13

2 Prejudice and Dignity, An Introduction to Community-based Rehabilitation, E. Helander, UNDP, New York, USA, 1992, pp. 42-43

3 as for (1) p. 9

4 World Programme of Action Concerning Disabled Persons, UN Decade of Disabled Persons 1983-1992, UN New York, 1983, p.3.

5 as for (1), p. 9

6 The "Ten or More" Plan is a programme under which certain refugees are resettled in Belgium, New Zealand and the United Kingdom. The "Twenty or More" Plan concerns Denmark, the Netherlands and Norway. Other special programmes involve Finland, Sweden and Switzerland.

7 Disability prevention and rehabilitation in primary health care. A guide for district health and rehabilitation managers. WHO, Geneva, 1995, pp. 16-20

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13 Landmines, A Deadly Legacy, The Arms Project of Human Rights Watch & *Physicians for Human Rights, Human Rights Watch*, USA, 1993, pp. 125-127.

14 Community-based rehabilitation and the health care referral services. A guide for programme managers, WHO, 1994, p. 32

15 WHO recommends 30 square metres per person, plus the necessary land for communal and agricultural activities and livestock, as a minimum overall calculating figure. Of this, 3.5 square metres is the absolute minimum floor space per person in emergency shelter.

16 Paragraphs 78-91 of UNHCR's Guidelines on Refugee Children provide further recommendations.

17 Prejudice and Dignity, An Introduction to Community-based Rehabilitation, E. Helander, UNDP, New York, USA, 1992, p. 38

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34 Adapted from, Disabled Village Children – A guide for community health workers, rehabilitation workers and families, D. Werner, The Hesperian Foundation, Palo Alto, USA, 1987.

35 as for (31)

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annexes

Declaration on the Rights of Disabled Persons*

The General Assembly

Mindful of the pledge made by Member States, under the Charter of the United Nations, to take joint and separate action in cooperation with the Organization to promote higher standards of living, full employment and conditions of economic and social progress and development,

Reaffirming its faith in human rights and fundamental freedoms and in the principles of peace, of the dignity and worth of the human person and of social justice proclaimed in the Charter,

Recalling the principles of the Universal Declaration of Human Rights, the International Covenants on Human Rights, the Declaration of the Rights of the Child and the Declaration on the Rights of Mentally Retarded Persons, as well as the standards already set for social progress in the constitutions, conventions, recommendations and resolutions of the International Labour Organisation, the United Nations Educational, Scientific and Cultural Organization, the World Health Organization, the United Nations Children's Fund and other organizations concerned,

Recalling also Economic and Social Council resolution 1921 (LVIII) of 6 May 1975 on the prevention of disability and the rehabilitation of disabled persons,

Emphasizing that the Declaration on Social Progress and Development has proclaimed the necessity of protecting the rights and assuring the welfare and rehabilitation of the physically and mentally disadvantaged,

Bearing in mind the necessity of preventing physical and mental disabilities and of assisting disabled persons to develop their abilities in the most varied fields of activities and of promoting their integration as far as possible in normal life,

Aware that certain countries, at their present stage of development, can devote only limited efforts to this end,

Proclaims this Declaration on the Rights of Disabled Persons and calls for national and international action to ensure that it will be used as a common basis and frame of reference for the protection of these rights:

1 The term "disabled person" means any person unable to ensure by himself or herself, wholly or partly, the necessities of a normal individual and/or social life, as a result of a deficiency, either congenital or not, in his or her physical or mental capabilities.

2 Disabled persons shall enjoy all the rights set forth in this Declaration. These rights shall be granted to all disabled persons without any exception whatsoever and without distinction or discrimination on the basis of race, colour, sex, language, religion, political or other opinions, national or social origin, state of wealth, birth or any other situation applying either to the disabled person himself or herself or to his or her family.

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*(3447 SWXXX)

3 Disabled persons have the inherent right to respect for their human dignity. Disabled persons, whatever the origin, nature and seriousness of their handicaps and disabilities, have the same fundamental rights as their fellow-citizens of the same age, which implies first and foremost the right to enjoy a decent life, as normal and full as possible.

4 Disabled persons have the same civil and political rights as other human beings; paragraph 7 of the Declaration of the Rights of Mentally Retarded Persons applies to any possible limitation or suppression of those rights for mentally disabled persons.

5 Disabled persons are entitled to the measures designed to enable them to become as self-reliant as possible.

6 Disabled persons have the right to medical, psychological and functional treatment, including prosthetic and orthetic appliances, to medical and social rehabilitation, education, vocational training and rehabilitation, aid, counselling, placement services and other services which will enable them to develop their capabilities and skills to the maximum and will hasten the process of their social integration or reintegration.

7 Disabled persons have the right to economic and social security and to a decent level of living. They have the right, according to their capabilities, to secure and retain employment or to engage in a useful, productive and remunerative occupation and to join trade unions.

8 Disabled persons are entitled to have their special needs take into consideration at all stages of economic and social planning.

9 Disabled persons have the right to live with their families or with foster parents and to participate in all social, creative or recreational activities. No disabled person shall be subjected, as far as his or her residence is concerned, to differential treatment other than that required by his or her condition or by the improvement which he or she may derive therefrom. If the stay of a disabled person in a specialized establishment is indispensable, the environment and living conditions therein shall be as close as possible to those of the normal life of a person of his or her age.

10 Disabled persons shall be protected against all exploitation, all regulations and all treatment of a discriminatory, abusive or degrading nature.

11 Disabled persons shall be able to avail themselves of qualified legal aid when such aid proves indispensable for the protection of their persons and property. If judicial proceedings are instituted against them, the legal procedure applied shall take their physical and mental condition fully into account.

12 Organizations of disabled persons may be usefully consulted in all matters regarding the rights of disabled persons.

13 Disabled persons, their families and communities shall be fully informed, by all appropriate means, of the rights contained in this Declaration.

2433rd plenary meeting
9 December 1975

Declaration on the Rights of Mentally Retarded Persons*

The General Assembly

Mindful of the pledge of the States Members of the United Nations under the Charter to take joint and separate action in co-operation with the Organization to promote higher standards of living, full employment and conditions of economic and social progress and development,

Reaffirming faith in human rights and fundamental freedoms and in the principles of peace, of the dignity and worth of the human person and of social justice proclaimed in the Charter,

Recalling the principles of the Universal Declaration of Human Rights, the International Covenants on Human Rights, the Declaration of the Rights of the Child and the standards already set for social progress in the constitutions, conventions, recommendations and resolutions of the International Labour Organisation, the United Nations Educational, Scientific and Cultural Organization, the World Health Organization, the United Nations Children's Fund and other organizations concerned,

Emphasizing that the Declaration on Social Progress and Development has proclaimed the necessity of protecting the rights and assuring the welfare and rehabilitation of the physically and mentally disadvantaged.

Bearing in mind the necessity of assisting mentally retarded persons to develop their abilities in various fields of activities and of promoting their integration as far as possible in normal life,

Aware that certain countries, at their present stage of development, can devote only limited efforts to this end,

Proclaims this Declaration on the Rights of Mentally Retarded Persons and calls for national and international action to ensure that it will be used as a common basis and frame of reference for the protection of these rights:

1 The mentally retarded person has, to the maximum degree of feasibility, the same rights as other human beings.

2 The mentally retarded person has a right to proper medical care and physical therapy and to such education, training, rehabilitation and guidance as will enable him to develop his ability and maximum potential.

3 The mentally retarded person has a right to economic security and to a decent standard of living. He has a right to perform productive work or to engage in any other meaningfuloccupation to the fullest possible extent of his capabilities.

4 Whenever possible, the mentally retarded person should live with his own family or withfoster parents and participate in different forms of community life. The family withwhich he lives should receive assistance. If care in an institution becomes necessary,it should be provided in surroundings and other circumstances as close as possible tothose of normal life.

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*(2856 XXVI)

5 The mentally retarded person has a right to a qualified guardian when this is required to protect his personal well-being and interests.

6 The mentally retarded person has a right to protection from exploitation, abuse anddegrading treatment. If prosecuted for any offence, he shall have a right to dueprocess of law with full recognition being given to his degree of mental responsibility.

7 Whenever mentally retarded persons are unable, because of the severity of their handicap,to exercise all their rights in a meaningful way or it should become necessary to restrictor deny some or all of these rights, the procedure used for that restriction or denial of rightsmust contain proper legal safeguards against every form of abuse. This procedure mustbe based on an evaluation of the social capability of the mentally retarded person byqualified experts and must be subject to periodic review and to the right of appeal to higherauthorities.

2027th plenary meeting
20 December 1971

UNHCR Disabled/Medically-at-Risk Form

Resettlement of Disabled/Medically-at-Risk and Victims of Torture

Only for completion for those refugees considered in need of health services available in a resettlement country. To be completed by examining physician.

1. Recommended for priority action:

   ☐ E = Emergency
   P = High Priority
   L = Low Priority

2. Name: _____

   Sex: _____ Date of Birth: _____ UNHCR Reg. No: _____

   Camp: _____

   Current address: _____

   _____

   Date of examination: _____

3. Summary Statement: _____

   _____

4. Medical History: _____

   _____

   4.1 *Pertinent Results of Investigation/Evaluations:*
   (i.e. if any blood or urine analysis, ECG, EEG, X-rays, scanner, etc)

   _____

5. Health Evaluation:

   5.1 *Examination Findings:* _____

   _____

   5.2 *Diagnosis* _____

   _____

6. Recommended Treatment Management Plan

   6.1 *With Access to Current Services:* _____

   _____

6.2 *With Access to Services in a Country of Resettlement:*

_____

7. Severity of Condition/Rate of Change/Prognosis:
(i.e. deterioration/improvement, including anticipated rate of change, life expectancy)

_____

Expected Changes in Health Status/Prognosis If:

7.1 Remains in present environment: _____

7.2 Resettles in a third country: _____

8. Capability to Carry Out Activities of Daily Living Independently If:

8.1 Remains in present environment: _____

8.2 Resettles in a third country: _____

9. Recommendations (include Urgency of Action): _____

_____

10. Other Comments: _____

_____

_____

11. Travel - Would the patient need...?

Medical escort: ☐ If yes: Nurse: ☐ Doctor: ☐

Wheelchair: ☐ Stretcher: ☐

Medical apparatus on board: ☐ Please specify:

12. Documenting Personnel:

Name: _____ Signature: _____

Hospital, Clinic,
Agency, Other: _____ Date: _____

Name: _____ Signature: _____

Hospital, Clinic,
Agency, Other: _____ Date: _____

Assessment Form for a Person who is Disabled or Chronically Ill

(Complete a separate form for each member of a family who is disabled or chronically ill.)

Case No: _____

Principal Applicant's
Name: _____

_____

1. Name of person who is disabled
or chronically ill: _____
(underline family name)

   Sex: female ☐ male ☐ Year of Birth: _____

2. Has lived: ☐ with family ☐ with friends since: ☐☐ (mm yy)
   ☐ with relatives ☐ alone

3. If the disabled or chronically ill person lives with someone who is registered separately, provide the full name of the head of that family:

   _____
   (underline family name)

4. Does this person have an illness that has lasted more than three months? ☐ yes ☐ no

   If "yes", give the name of the illness and explain how it affects this person.

   _____

5. This person has difficulty (mark any boxes that apply):

   ☐ using his/her legs
   ☐ using his/her hands or arms
   ☐ seeing
   ☐ hearing
   ☐ speaking
   ☐ learning
   ☐ because of acting sometimes in in a strange way
   ☐ with fits
   ☐ other (specify)_____

6. Describe this disability: _____

   _____

7. Explain **how** and **when** the disability began: _____

_____

8. The list below includes activities required for normal daily living.
Mark the *Immediate Assistance* box for any activities that the person is *not now able* to do and with which he/she *does not have someone to help.*
Mark the *Training* box beside any activity the person cannot do without assistance. This will show areas where rehabilitation training may be helpful.

Immediate Assistance	**Training**	
☐	☐	obtaining food, water, fuel (cross out any that do not apply)
☐	☐	preparing food
☐	☐	eating food
☐	☐	washing himself/herself
☐	☐	dressing
☐	☐	cleaning his/her house
☐	☐	preventing injuries to parts of his/her body that have no feeling
☐	☐	moving around **inside** his/her house and immediate living area
☐	☐	moving around **outside** his/her living area
☐	☐	going to the toilet or latrine
☐	☐	working
☐	☐	going to school
☐	☐	understanding what is said to him/her
☐	☐	expressing thoughts, needs and feelings
☐	☐	taking part in family activities
☐	☐	taking part in community activities
☐	☐	other (describe) _____
		_____

9. Explain how the person previously has been able to accomplish any of the tasks for which immediate assistance is needed:

_____

10. If a change in the location where the person is living or any special adaptations in or around the house (such as handrails or a ramp) would help in meeting daily needs, please explain:

_____

11. If the person is an adult, indicate any:

previous occupation _____

current occupation _____

12. Describe any assistance this person needs to establish or improve an occupation:

_____

13. Has the person ever regularly taken medicine to cure or control illness or disability?

yes ☐ *no* ☐

If "yes", explain **who** told the person to take this medicine, **where** it was obtained, **when** the person started taking it and **whether** the person is still taking it:

_____

14. Describe any other rehabilitation training or medical treatment the person has had for the illness or disability. Explain **who** provided this treatment, **where** it was provided, **when** it began and **whether** it is still being provided:

_____

15. Add any further details that may be useful to those arranging assistance for this person:

_____

_____

_____

_____

_____

16. _____

Name of the Interviewer | Organization of Interviewer | Date of Interview

17. **Plan for Immediate Action**

The space below is to be used by medical, rehabilitation and social services staff to indicate what action should be taken in regard to this case.

Action Required	*To be Carried Out by*	*Recommended by*	*Date*
☐ Immediate assistance			
☐ Further assessment of			
☐ General medical examination			
☐ Specialized medical examination (specify type):			

Additonal Comments: _____

18. **Rehabilitation Plan**

1. The rehabilitation goal for the refugee is: _____
2. This goal should be achieved by what date? _____
3. If the refugee requires medical treatment, explain **what** treatment is needed and **who** will provide it:
4. Describe any rehabilitation training that is required and who is responsible for it:
5. Explain what role the refugee and/or the refugee's family will play in this training:

Guidelines for International Medical Referrals of Refugees under Project AP/VAR/401

I INTRODUCTION

1.1 On 14 December 1981, the High Commissioner, in BOM/84/81, announced the establishment of a Special Trust Fund for Handicapped Refugees with funds from the 1981 Nobel Peace Prize. The establishment of the Trust Fund in 1981 was therefore an important initiative of UNHCR in recognition of the International Year of Disabled Persons.

1.2 Although initial guidelines governing the application of the Trust Fund were elaborated in IOM/17-BOM/15/83 of 21 February 1983, the difficult decisions which had to be made in the light of an increasing number of requests from field offices for special medical evacuation required more comprehensive guidelines. Revised procedures still currently in use are contained in IOM/15/86-FOM/18/86 of 13 March 1986.

1.3 In general, all refugee patients should be treated locally in the public hospitals and related facilities normally available to nationals and in private hospitals and clinics only when justified by special circumstances. Local medical assistance should continue to be given in the context of the existing local SA, LS or MA projects in accordance with the Letters of Instruction governing such projects.

1.4 In exceptional cases, where adequate facilities are not available locally, a refugee patient may be referred for specialized treatment outside the country of asylum. Such referrals should normally be within the same region unless appropriate care is available at a lower cost outside the region. The following general principles should be considered by the field office concerned when handling medical referral cases.

1.5 It has to be clearly understood that the refugee medical evacuation programme is set up mainly to correct or minimize physical and mental disabilities. It is not a means of achieving resettlement. It should be recalled, however, that, in addition to places under the "Twenty or More" Plan and other special country programmes reserved for evacuations on urgent grounds, a few countries offer a limited number of places, especially for medical emergencies, with a view to providing urgently needed treatment followed by long-term rehabilitation within the framework of resettlement. It should therefore be clearly indicated on medical evacuation requests made by field offices, whether assistance is needed for treatment only or whether there are circumstances which would justify resettlement. In cases where this cannot be clearly determined by the field office, the Resettlement Section at Headquarters, in co-operation with the Social Services Section will endeavour to identify the most appropriate solution for the refugee and advise the field office accordingly.

II. GENERAL PRINCIPLES

2.1 Recommendations for medical evacuation should be initiated at the local health facilities in which the patients concerned have been examined or treated. When resources for specialized treatment are inadequate or not available locally, the patient's physician should forward an official recommendation for medical evacuation to the field office concerned, with a detailed medical certificte indicating the diagnosis, history of the illness, treatment received to date, further treatment needed and the prognosis both with and without the proposed treatment. A physician may wish to indicate where such treatment is available. See further details below under **prognosis**.

2.2 All recommendations for international medical referrals should be objectively appraised and discussed in detail by the recommending physician and the patient's counsellor, both to prevent abuse of the system and to explore alternatives such as the international purchase of drugs or therapeutic aids not available locally. Upon receipt of such recommendations, the patient's counsellor in consultation with the Representative or Head of the field office and implementing agency concerned, should consult a second physician, preferably a UN doctor, for a second medical opinion.

2.3 Having determined that the need for international medical evacuation exists for a particular patient, and after all relevant considerations such as the results expected, the absence or limitation of local facilities for treatment, and the cost involved have been taken into account, the counselling service of the field office or implementing agency concerned should prepare a detailed social report on the case. This social report should briefly indicate the benefits to be expected from the proposed medical referral especially in relation to the employment, education and family situation of the patient concerned and should also describe any particular circumstances (asylum/refugee status, attitudes, language difficulties, etc) surrounding the case.

2.4 When a field office decides to present a recommendation for medical evacuation to Headquarters both the social report and all relevant medical documents on the case should be forwarded by the **field office** for Headquarters' consideration following the procedure described and including the information requested in section 8.5 of the *Handbook for Social Services*. For cases involving mental disturbances see also section 5.3.1. Medical evacuations must not take place without prior authorization by Headquarters.

2.5 The social report is necessary for Headquarters to decide whether medical evacuation should be authorized and, if so, for making appropriate arrangements for treatment. A report sent to Headquarters should include:

a) details on the refugee's background:
- family situation
- language(s) spoken
- ethnic and religious background
- education
- employment history
- circumstances relating to his/her refugee status relevant to the process of treatment or rehabilitation;

b) a chronological summary of testing and treatment already provided
c) the social consequences anticipated if:
   - treatment is only provided locally
   - the proposed treatment abroad is provided (e.g., the refugee would/would not be able to work);
d) whether an escort will be required; and whether a wheelchair, a stretcher or other medical apparatus will be needed during the course of travel;
e) the opinion of the field office concerning the degree of priority the case should receive.

2.6 The recommendation to refer a patient for treatment abroad should be discussed with the patient and, where appropriate, his kin without making any promises or commitments while Headquarters studies the case. When a case is not accepted for medical evacuation, the decision should be clearly explained to the patient and local alternatives pursued.

2.7 Patients who are referred for medical treatment abroad should return to their countries of asylum upon completion of treatment. Both the patient and his/her authorized escort must have valid travel documents with a return clause. The patient and the escort must agree, in writing, to return to the country of asylum after treatment, or whenever requested to do so. A patient may not apply for resettlement while undergoing medical treatment abroad.

2.8 Patients may not refer themselves to local hospitals of their own choice nor transport themselves on their own initiatives or the initiative of third parties for treatment in foreign countries expecting that UNHCR will pay the costs involved. Costs resulting from such arrangements will not be borne by UNHCR.

2.9 The medical evacuation of refugees should be based on need and the possibility of a contribution by the patient or the patient's family to the cost of treatment should be investigated. Patients and family members who have adequate resources should be required to cover all or part of the costs of treatment, including the costs of transportation and subsistence during the treatment.

2.10 The field office initiating a medical referral request should report the condition of the patient to Headquarters not later than one month after treatment is completed and the patient has been discharged. Medical reports on treatment should be provided by the institution which treated the patient concerned.

2.11 Patients and their family members should be adequately counselled regarding the possibility of failure of the treatment. In case of the death of a refugee patient, UNHCR cannot accept responsibility for the return of the body, which will be buried in the place of death. Relatives wishing to attend the funeral will have to do so at their own expense.

2.12 When a patient qualifies for medical evacuation under these guidelines, referral will normally be authorized by Headquarters initially to the nearest country with suitable facilities for treatment within the region of asylum of the patient. Inter-regional referral will not normally be considered by Headquarters until opportunities for treatment in the patient's region of asylum have been explored.

2.13 A comprehensive medical file should be prepared by the recommending physician and other competent medical authorities in the country of asylum and should accompany the patient to the country of treatment.

III. CRITERIA FOR SELECTION

3.1 **Refugee Status**
Only persons of concern to the High Commissioner under his mandate may benefit from the medical evacuation programme.

3.2 **Age**
Priority should be given to children and young people whose illness has been diagnosed with a favourable prognosis as explained below. Field offices should hesitate to refer patients who are above 50 years of age abroad for heart surgery, kidney transplants and other operations where the prospects for cure are limited.

3.3 **Heads of Families**
Heads of families, including female heads of families, may on account of the number and ages of their dependent children be considered priority cases when compared with adults without family responsibilities.

3.4 **Prognosis**
The purpose of the medical programme is to preserve life and improve the patient's health in the most efficacious and economical manner. The field office should not refer a case for medical evacuation unless the attending physicians report that the recommended medical evacuation has a reasonable chance of enabling the patient to lead a normal life, or at the very least that his/her health will be substantially improved. Cases which do not satisfy these criteria should be treated locally. This does not preclude the treatment of certain irreversible physically handicapped cases such as polio victims and amputees whose conditions may be improved with rehabilitation therapy.

3.5 **Onset and Duration of Illness**
It is best to effect medical referral at the earlier stages of illness when the prognosis is most likely to be favourable. Cases should not be referred for medical evacuation if:

i) the patient's health is deteriorating so rapidly that death is likely even with timely treatment;
ii) the health of the patient has reached such an advanced stage of deterioration that survival or recovery are doubtful;
iii) the condition has been treated correctly but unsuccessfully over a long period of time.

Such cases should continue to receive local medical treatment.

3.6 **Non-Referable Health Problems**
In view of the high cost of treatment and doubtful prognosis, the following health conditions are normally inappropriate for medical evacuation:

- dental treatment
- degenerative diseases of known or unknown causes but of unknown or very doubtful cure
- chronic diseases including alcoholism
- terminal diseases including terminal cancers, irreversible disabilities (hearing loss, incurable blindness)
- conditions requiring aesthetic or cosmetic plastic surgery
- other health conditions requiring expensive sophisticated surgery and medical care exceeding what is normally available to nationals of the country of asylum. Examples are brain surgery, kidney or heart transplant, and major skeletal reconstruction.

IV QUALITY OF ASSISTANCE

4.1 The level of assistance, i.e., accommodation, feeding, clothing, etc should correspond to what is normally available to nationals and refugees in the country of treatment. The patient and his family should be informed accordingly in advance of their departure.

4.2 The quality of equipment and supportive aids, such as wheelchairs, eye glasses and prostheses, supplied to individual patients shall in general not exceed that which is available to nationals of the country of treatment.

4.3 Refugees who wish to purchase items such as decorative eye glass frames, fuel operated tricycles, and special prostheses must do so at their own expense.

4.4 In some situations, as with children, mental patients or in cases where adequate facilities for interpretation are not available in the country of treatment, an escort may be required. This is not automatically provided for, however, and must be included in the request to Headquarters with a justification. Once approved, an appropriate escort must be selected and the duration of his/her stay with the patient during treatment should be predetermined based on medical advice.

CASE REFERENCE No. FO: _____ COUNTRY OF ASYLUM: _____
HQ: _____ DATE OF ARRIVAL: _____

UNHCR RESETTLEMENT REGISTRATION FORM

1. APPLICANT/HEAD OF FAMILY

A. FAMILY NAME: _____ B. GIVEN NAMES: _____

C. OTHER NAMES: _____ D. MAIDEN NAME:* _____

E. PLACE OF BIRTH _____ F. DATE OF BIRTH G. SEX**

COUNTRY: _____ M F

LOCALITY/CITY: _____ (DAY) (MONTH) (YEAR)

H. NATIONALITY: _____ I. MARITAL STATUS:** SINGLE/ENGAGED/MARRIED/

(OR IF STATELESS, COUNTRY OF FORMER HABITUAL RESIDENCE) DIVORCED/WIDOWED/SEPARATED/COMMON-LAW

J. NAME OF FATHER: _____ K. ETHNIC/TRIBAL ORIGIN: _____

NAME OF MOTHER: _____

FATHER:** ALIVE/DEAD MOTHER:**ALIVE/DEAD L. RELIGION AND/OR SECT: _____

M. PRESENT ADDRESS: N. REFUGEE STATUS RECOGNISED BY:

_____ COUNTRY OF ASYLUM ON: _____

TELEPHONE: _____ UNHCR ON: _____

2. IMMEDIATE FAMILY MEMBERS AND DEPENDANTS a) living with Applicant

NO.	NAME	RELATIONSHIP TO APPLICANT	PLACE OF BIRTH	DATE OF BIRTH	PLANNING TO RESETTLE WITH APPLICANT YES/NO
1.	Applicant				
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					

* If applicable
** Please circle as appropriate

b) in country of origin or other countries of asylum

No.	NAME	RELATIONSHIP TO APPLICANT	PLACE OF BIRTH	DATE OF BIRTH	PLANNING TO RESETTLE WITH APPLICANT YES/NO

3. RELATIVES OR FRIENDS IN OTHER COUNTRIES (WITHIN AND/OR OUTSIDE CONTINENT OF PRESENT RESIDENCE)

NAME	RELATIONSHIP TO APPLICANT	STATUS** (IF KNOWN)	ADDRESS/TELEPHONE	SINCE (YEAR)

4. EDUCATION & TRAINING OF APPLICANT & FAMILY MEMBERS (in country of origin and country of asylum)

No.***	NAME AND LOCATION OF SCHOOL OR TRAINING INSTITUTE	PERIOD FROM	PERIOD TO	DEGREES, DIPLOMAS, TRAINING CERTIFICATES/SKILLS AND OTHER COMPETENCIES ACQUIRED

* Including immediate family members in other locations in country of present residence.
** Status: i.e. refugee, citizen, asylum seeker, etc.
*** Use number 1 for applicant and numbers 2-10 corresponding to the specific family member in item 2a.

5. LANGUAGES (LIST MOTHER TONGUE FIRST)

No.*	LANGUAGE	UNDERSTAND		SPEAK		READ		WRITE	
		easily	not easily	easily	not easily	easily	not easily	easily	not easily

6. EMPLOYMENT RECORD IN COUNTRY OF ORIGIN AND COUNTRY OF ASYLUM OF APPLICANT AND ALL FAMILY MEMBERS/DEPENDANTS OVER 15 YEARS OF AGE.

No.*	NAME AND ADDRESS OF EMPLOYER	TYPE OF WORK	PERIOD	
			FROM	TO

7. TRAVEL AND IDENTITY DOCUMENTS; DOCUMENTARY EVIDENCE OF REFUGEE STATUS

TYPE OF DOCUMENTATION	NUMBER	ISSUING AUTHORITY	VALID	
			FROM	TO

8. COUNTRIES IN WHICH APPLICANT HAS STAYED, RESIDED OR TRANSMITTED SINCE LEAVING COUNTRY OF ORIGIN

COUNTRY	PERIOD		TRAVEL DOCUMENTS USED	REMARKS
	FROM	TO		

* Use number 1 for applicant and numbers 2-10 corresponding to the specific family member in item 2a.

9. HEALTH STATUS (INCLUDE ALL FAMILY MEMBERS INDICATED IN ITEM 2a SUFFERING FROM SPECIFIC HEALTH PROBLEMS)

No.*	NAME	RELATIONSHIP TO APPLICANT	HEALTH CONDITION	MEDICAL REPORT ATTACHED YES/NO

10. FOR FEMALE APPLICANTS ONLY (AND/OR FEMALE FAMILY MEMBERS INDICATED IN 2a)

PREGNANCY:** YES/NO IF YES GIVE NAME OF PERSON EXPECTING: _____

EXPECTED DATE OF DELIVERY: _____

ANY SPECIFIC PROBLEMS:** YES/NO _____

IF YES, SPECIFY: _____

_____

11. PENAL RECORD

CONVICTION:** YES/NO IF YES, SPECIFY:** CRIMINAL / POLITICAL

DETENTION/IMPRISONMENT PERIODS:

No.*	PLACE	PERIOD FROM	PERIOD TO	SENTENCED YES	SENTENCED NO	CHARGES

ADDITIONAL INFORMATION ON CONDITIONS OF DETENTION

* Use number 1 for applicant and numbers 2-10 corresponding to the specific family member in item 2a.
** Please circle as appropriate.

12. CONCISE STATEMENT OF EVENTS AND REASONS WHICH LED APPLICANT TO LEAVE HIS/HER COUNTRY OF ORIGIN OR USUAL RESIDENCE.

13. ADDITIONAL REMARKS: DESCRIPTION OF APPLICANT'S SITUATION, FAMILY RELATIONSHIPS, CHANGES IN MARITAL STATUS INCLUDING DATES AND SUPPORTING DOCUMENTATION AVAILABLE, AND ANY OTHER INFORMATION FOR RESETTLEMENT AUTHORITIES.

PLACE AND DATE	SIGNATURE OF APPLICANT AND CERTIFICATION OF CORRECTNESS OF ABOVE DATA
PLACE AND DATE	SIGNATURE OF UNHCR INTERVIEWER

14. RESETTLEMENT STATUS TO BE COMPLETED BY UNHCR STAFF ONLY

DATE OF SUBMISSION	COUNTRY	DECISION	REMARKS

15. ANY OTHER RESETTLEMENT-RELATED RELEVANT INFORMATION/REMARKS

UNHCR RESETTLEMENT SOCIAL ASSESSMENT FORM

1. Name _____

2. Date of birth _____ *Place of birth* _____

3. Brief history describing hardships or trauma experienced:

   a) *in country of origin* _____

   _____

   b) during flight _____

   _____

   c) in country of asylum _____

   _____

4. Family situation
   a) name of family members/relatives who are part of same household

   _____

   _____

   _____

   b) describe the role of family in supporting the refugee:

      i) in country of origin _____

      _____

      ii) during flight _____

      _____

      iii) in country of asylum _____

      _____

5. Simple description of the refugee as he appears (describe what you see; highlight the positive, *not just the negative. Avoid labels.*)

   _____

   _____

   _____

   _____

   _____

   _____

   _____

6. Whether medical attention is being received or required?
Note: all medically-at-risk cases require an up-to-date medical report.

_____

_____

7. Living conditions in the place of residence. Please specify whether:

Private _____

_____

Camp _____

_____

8. Income/employment situation and prospects of all family members.

_____

_____

9. Daily activities: how the refugee and his family occupy themselves daily?

_____

_____

10. Assistance received: from Government/UNHCR/other

_____

_____

11. Prospects for self-reliance

_____

_____

12. Efforts made to promote local integration or voluntary repatriation.

_____

_____

13. Reasons why resettlement is considered the most appropriate solution.

_____

_____

14. Date _____ Signature: _____

Title: _____

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