Disabilities Among Refugees and Conflict-Affected Populations

Executive Summary

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

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

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

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

The research found that, in general, services and opportunities for refugees with disabilities were better in refugee camps than in urban settings. Due to the more geographically and socially cohesive nature of refugee camps, it is easier to identify refugees with disabilities, adapt programs to be more inclusive and

set up specialized services. It is also easier to effect attitudinal and programmatic change in refugee camps. Urban refugee communities are more dispersed and less physically cohesive. Many urban refugees are undocumented and lack any legal status. They are often afraid of the authorities and prefer to remain "hidden." This makes it much harder to identify persons with disabilities or to integrate them into mainstream or specialized services.

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

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

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

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

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

Access to education for children with disabilities was one of the most successful areas in all the countries surveyed. All the field studies showed that children with disabilities had access to schools and no cases were found of children with disabilities being actively excluded from school. The field surveys identified many successful examples of inclusive education programs for children with disabilities, including early

childhood intervention programs; ongoing training of special needs support teachers and mainstream teachers in special needs education; the development of special teaching aids, appropriate curriculum and teaching resources; home support and liaison programs; parent support groups; and, where necessary, the establishment of separate schools, or learning environments, for children with particular needs (e.g., schools for blind or deaf children).

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

Access to vocational and skills training, income generation and employment opportunities for refugees with disabilities varied considerably. There were some examples of very successful vocational and skills training programs that were specially geared for persons with disabilities and had helped them to learn useful skills and subsequently either find employment or set up their own small business. In other settings, vocational training courses had not been adapted to meet the needs of persons with disabilities and the teachers were not specially trained. Elsewhere, persons with disabilities were either actively excluded from vocational training or given no encouragement to attend. In all the countries surveyed, persons with disabilities said that they were keen to learn new skills and wanted to find jobs. However, they faced huge social, attitudinal and legal barriers in finding employment, not only because of their disability, but also because of their status as refugees and outsiders. The field research demonstrated that it was easier for refugees with disabilities in camps to find work or set up their own small businesses than it was for refugees in urban areas, where they were competing on the open market.

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

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

In general, the quality of information on protection risks faced by refugees with disabilities was poor. Respondents in the field studies cited a range of protection problems, but gave few concrete examples. Almost without exception, everyone interviewed mentioned discrimination, stigmatization, harassment, neglect and exclusion of persons with disabilities as major protection concerns, both within their own communities and in the host communities. In several countries, the field studies found that women with disabilities were at risk of sexual violence, domestic abuse and physical assault, although again, few

concrete examples were given. In one country, nearly all the respondents mentioned that older persons with disabilities were doubly discriminated against and were at risk of neglect and possible abandonment, especially when they became, or were perceived as having become, a burden for their families. The same country also highlighted physical abuse against children with disabilities.

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

Key Recommendations to All Humanitarian Actors

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