

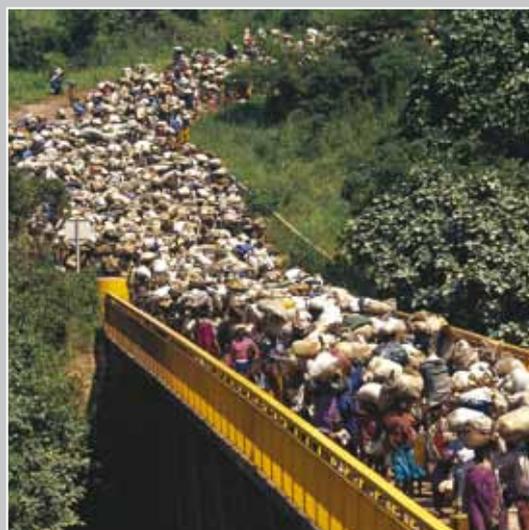
FORCED MIGRATION review

Issue 35
July 2010

DISABILITY AND

DISPLACEMENT

Plus: Brazil mini-feature and articles on: accountability, mobility, reproductive health in Darfur, repatriation decision-making and protection in natural disasters.



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From the editors

An oft-quoted statistic is the World Health Organisation's estimate that persons with disabilities account for 7-10% of the world's population. This would imply that there are three to four million persons living with disability among the world's 42 million displaced. It is not (yet) common practice, however, to include people with disabilities among those who are considered as particularly vulnerable in disasters and displacement and who therefore require targeted response.

The feature theme articles in this issue of FMR show why disabled people who are displaced need particular consideration, and highlight some of the initiatives taken (locally and at the global level) to change thinking and practices so that their vulnerability is recognised, their voices heard – and responses made inclusive.

The word 'inclusion' is found – unsurprisingly and uncontroversially – in many of the articles in this issue. Use of other words and phrases used by the wider disability movement has been harder to manage. Some people use 'people with disabilities' or 'living with disabilities', while others argue for the term 'disabled people' to reflect the disabling impact of society's attitudes. We did a lot of research, talking and thinking about this before we even issued our call for articles, and in the end we decided to allow authors to use the terminology they themselves prefer. We sincerely hope that this does not cause offence to any of our readers.

We ourselves, in producing this issue, have been challenged to make FMR more accessible to those with visual disabilities. We have received good advice about how a relatively small amount of work on the presentation of FMR

online can increase accessibility. All articles in this issue are available online in PDF and Word format and as audio files. Our website also offers links to software to aid accessibility.

This issue contains a mini-feature on Brazil which also appears in Portuguese on our website. We would like to thank UNHCR in Brazil for helping to make this happen.

All issues of FMR are freely available online at <http://www.fmreview.org/mags1.htm> We encourage you to post online or reproduce FMR articles but please acknowledge the source (with a link to our website) – and, preferably, let us know.

Forthcoming issues of FMR in 2010-11

- FMR 36: feature on the Democratic Republic of Congo and the Great Lakes, due out in November: see <http://www.fmreview.org/DR Congo/>
- FMR special supplement on HIV/AIDS, security and conflict, to be distributed with FMR 36: see <http://www.fmreview.org/AIDS/>
- The first two issues of 2011 will include feature themes on Non-state actors and Communications and technology.

Details of all forthcoming issues can be found at <http://www.fmreview.org/forthcoming.htm>

With our best wishes

Marion Couldrey & Maurice Herson
Editors, *Forced Migration Review*

Ask yourself

December 1996, forced repatriation of hundreds of thousands of Rwandan refugees from Tanzania at the Kagera river crossing.

Statistics tell us that up to 10% of the refugees crossing this bridge will have a disability of some sort. Or will the percentage be higher because of the conflict they have experienced? Or lower because some, because of their disability, may have been unable to leave the camps in Tanzania – or unable to leave Rwanda in the first place?



We are grateful to Adele Perry and to Gil Loescher for their valuable support and advice on the feature theme section of this issue.

We would like to thank those agencies who have generously provided funding for this particular issue: CBM, the Commonwealth Foundation, Generalitat Valenciana/Consellería de Educación, Handicap International, the Inter-Agency Network for Education in Emergencies, and Sightsavers.



Commonwealth
Foundation

We would also like to express our gratitude to the ABILIS Foundation for their support for this issue. ABILIS supports activities to empower persons with disabilities in the Global South; see <http://www.abilis.fi/> for more information.

Forced Migration Review

(FMR) provides a forum for the regular exchange of practical experience, information and ideas between researchers, refugees and internally displaced people, and those who work with them. It is published in English, Arabic, Spanish and French by the Refugee Studies Centre of the Oxford Department of International Development, University of Oxford.

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ISSN 1460-9819

Designed by

Art24 www.art-24.co.uk

Printed by

Newman Thomson Ltd
www.newmanthomson.com



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Invitation to write for FMR

You don't need to be an experienced writer. Email us with your suggestions, draft articles or internal reports – and we will work with you to shape your article for publication.

Too often experience gained in the field is confined to an internal report, circulated within one office or organisation only; and too often research is disseminated only via long academic articles in

costly academic journals. FMR aims to bridge the gap between research and practice so that practice-oriented research gets out to policymakers and the field, and field experience, lessons learned and examples of good practice are shared as widely as possible. But we need you to help us do that.

We encourage readers to send us written contributions on any aspect of contemporary

forced migration. Each issue of FMR has a theme but a significant proportion of each issue is set aside for any other subject relating to refugees/IDPs or stateless people.

Material may be submitted in English, Spanish, Arabic or French. For more details, please see <http://www.fmreview.org/writing.htm> or email us at fmr@qeh.ox.ac.uk

A shared vision

Shuaib Chalklen

I assumed my position as the United Nations Special Rapporteur on Disability at a time when we have an enormous opportunity to bring about sustainable change in the conditions of all persons with disabilities, with particular attention to Africa and other developing regions of the world.

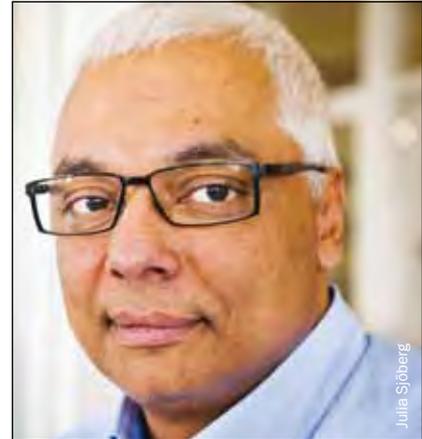
We are in the fortunate position of having 77 countries that have ratified the Convention on the Rights of Persons with Disabilities and a great many countries that have used the Standard Rules on the Equalization of Opportunities for Persons with Disabilities (adopted in 1993) as a tool to develop national policies, although the implementation of these policies remains a challenge. A growing number of governments, legislators and members of civil society beyond the disability community have begun to work with organisations of persons with disabilities, building broader constituency for advocating for the rights of persons with disabilities in society and development around the world.

While much progress has been made through the adoption of the Convention and increased efforts in

promoting the disability-inclusive Millennium Development Goals, persons with disabilities – at least 10% of the world's population – still remain among the poorest of the world's citizens. And the current competing political, social and economic concerns make the needs of persons with disabilities all the more pressing.

There is also the matter of persons with disabilities in situations of conflict and displacement, and in other situations of great risk. The devastating and tragic earthquake in Haiti brings to mind the situation of persons with disabilities within the present circumstances and their urgent need for food and shelter.

The previous Special Rapporteurs, Mr Bengt Lindqvist and Sheikha Hissa Al-Thani, noted that there was a lack of implementation of disability policies in countries around the world. I plan to focus on the blockages to the implementation of disability-specific programmes and policies. One of the means of encouraging the implementation of disability programmes and policies is through the sharing of information and technical cooperation.



My vision is for equal opportunities and the full participation of persons with disabilities in society and development, informed by international cooperation. I intend to bring together the disability community, governments, the United Nations system and civil society to promote this vision in practical action for a real change for persons with disabilities on the ground.

This issue of Forced Migration Review is a most welcome contribution to the work of bringing together our different communities, sharing information, encouraging cooperation and promoting this vision.

Shuaib Chalklen (shac@iafrica.com) is Special Rapporteur on Disability of the Commission for Social Development.

Disability in displacement

Aleema Shivji

People with disabilities face many additional difficulties before, during and after displacement but provision of appropriate assistance and protection for all is feasible.

Invisible at the best of times, persons with disabilities are among the most neglected during flight, displacement and return. Due to communication or physical barriers, negative attitudes or other obstacles, persons with disabilities face many hurdles in accessing assistance and protection. They may also face a heightened level of disability during displacement, because of changes in their environment or lack of appropriate care and services. Moreover, they are often seen as passive recipients of aid rather than active participants

with ideas, skills and expertise to share. It is not unusual to hear aid providers express views along the lines of: "How can we pay particular attention to persons with disabilities in situations of displacement? We already have so many things to think about when delivering aid and we don't have the expertise to deal with disability. Besides, there aren't that many persons with disabilities among displaced populations. In any case, our programmes do not discriminate – everyone can access them."

According to estimates by the World Health Organisation, persons with disabilities account for 7-10% of the world's population. One can extrapolate, therefore, that there are 2.9-4.2 million¹ persons with disabilities among the world's 42 million displaced, thereby debunking the myth that there are few among displaced populations. In contexts where many injuries are likely to have occurred – in conflict, earthquakes, etc – this number could be much higher as temporary or new permanent disability affects many people with injuries. In failing to take account of these persons with specific needs, humanitarian actors – mainstream and specialised

agencies alike – are not achieving their collective objective of reaching extremely vulnerable populations.

While some services need to be provided by specialised agencies, the majority of actions can be implemented by all humanitarian actors. Unfortunately, despite a growing willingness by mainstream agencies to include disability issues in their response mechanisms, many actors continue to feel they do not have the necessary ‘expertise’ to turn this enthusiasm into reality. Specialised organisations therefore have an important additional role to play – in advocacy, training and awareness-raising to help mainstream actors ensure better inclusion of persons with disabilities in their programmes before, during and after displacement.

Flight

Additional challenges for persons with disabilities often begin during flight. In the chaos of displacement, some are left behind because they need assistance to move and no-one stops to help them or because they are unable to call out for help due to speech impairments.

Difficulty in seeing, hearing or understanding may prevent some persons with disabilities from being aware of early warning systems and can also lead to them being disoriented and thus separated from their family during flight. Separation from or loss of a caregiver can have severe consequences for a person with disabilities, particularly if they are dependent on the caregiver for vital activities such as eating, moving or toileting. When families are displaced, they often need to make hasty decisions about what to take with them. Assistive devices such as wheelchairs are often left behind, making even simple tasks such as reaching latrines extremely difficult for the person with disabilities during displacement. In addition, in situations of conflict, persons with disabilities may be interrogated and sometimes detained at road blocks as they may be thought to be former combatants (e.g. males with amputations) or because of communication barriers (for example, persons with hearing or intellectual impairments).

Examples of solutions:

- In areas with recurrent displacement, identify and make a list of persons with disabilities plus any special needs they may have.³
- Following flight, prioritise persons with disabilities in reunification efforts, particularly those dependent on caregivers.

Displacement

Infrastructure and services in places of displacement are generally temporary in nature and rapidly installed – and often do not take into account special needs. The problem begins in the assessment and planning phases. Rapid assessments rarely target persons with disabilities or include questions on disability. While it would be unrealistic to expect that detailed information on disability could be collected during a rapid needs assessment, basic information such as the level of access to services, specific challenges and priority needs is crucial for designing appropriate responses. There is also a glaring lack of data on persons with disabilities among displaced populations. This could be due to a number of reasons, including absence of disaggregated data during registration and lack of training of registration teams in basic disability identification. This absence of data often leads people to believe few persons with disabilities are present among displaced populations, thereby contributing to their exclusion from relief services.⁴

Examples of solutions:

- Ensure simple disability questions are included in rapid assessments; involve persons with disabilities in assessment teams; and target them during household interviews, focus group discussions or other assessment activities.
- Collect data on the number of persons with disabilities, and type of disability, alongside age and gender data in registration

exercises. Assigning local volunteers to actively search for persons with disabilities can help.

Shelter, water, sanitation and other infrastructure

More often than not, temporary shelters, water and sanitation facilities and other infrastructure (temporary health centres and schools, camp offices, etc) are not accessible for all displaced persons. Uncovered drainage channels, tent ropes, uneven surfaces, steps or narrow doors can impose significant mobility restrictions for persons with visual or physical impairments. Long distances between water



Woman with visual impairment using handrail for guidance in a temporary settlement (Bangladesh).

points, latrines, camp services and temporary shelters can present additional challenges. The design of water points, wash areas and latrines can also inhibit some persons with disabilities from using them – some may not be able to use a traditional squatting position, a slippery surface can be a hazard for someone with limited balance or vision, or the pump handle might not be long enough for someone who cannot stand to pump water.

Examples of solutions:

- Construct temporary infrastructure using basic principles of accessibility with at least 10% of

water and sanitation facilities fully accessible; involve persons with disabilities at the design phase.

- House persons with disabilities and their families close to essential services and facilities.

Health, food, nutrition and distribution

Displacement often interrupts provision of essential health services for persons with disabilities – such as chronic disease medication, rehabilitation services or access to specific health items such as catheters that are necessary for survival. In addition, disruption of health services can result in permanent disabilities from injury, illness or birth-related causes. Some persons with disabilities may not receive enough nutrients from standard food rations; some may not be able to chew solid foods; while others may simply not be able to use the standard utensils provided in kitchen kits.

In addition, mass distribution schemes often effectively exclude persons with disabilities. Information about distribution times and locations may not be understood by persons with hearing, visual or intellectual impairments; distribution points may be far away or not accessible; and persons with significant weakness may not be able to stand in long queues or carry rations/relief items. In addition, some may require additional items for basic survival and dignity such as extra blankets, beds and mattresses, or supplementary hygiene items.

Examples of solutions:

- Ensure access to essential health services such as chronic disease treatments and provision of essential specific items such as catheters.
- Provide rehabilitation services as part of essential health services, particularly when there have been many new injuries.
- Distribute additional essential items to persons with disabilities such as high-energy foods, adapted items such as spoons and straws, hygiene items, mattresses and beds.

- Adapt distribution systems to incorporate separate queues, distribution points closer to affected populations, support to carry or transport received items, smaller parcel size, etc.

Protection, psychosocial and information dissemination

Persons with disabilities are extremely vulnerable to protection violations ranging from physical, sexual and emotional abuse to lack of access to justice systems and documentation. Children with disabilities are three to four times more likely to be physically or emotionally abused.⁵ Exclusion and violations can be caused by any number of reasons including communication barriers preventing access to complaints mechanisms, incapacity to run or call for help, inability to understand important messages or simply not being included in systems that generally focus on women and children. For example, during the recent displacements in Pakistan, a 21-year-old male with intellectual impairment left an IDP camp through a hole in the fence, was hit by a car, and was found four days later wandering around, injured. Being an adult male, he did not fit into a 'high-risk' category for protection.

Security risks such as lack of appropriate lighting and long distances to essential facilities like latrines pose additional challenges for those with reduced mobility or reduced ability to see or call out for help. Essential information about relief efforts (protection systems, distributions, coping mechanisms, health messages, etc) is often missed by persons with disabilities because they cannot hear broadcasted messages, see posters or leaflets, or understand complicated language.

Persons with disabilities, particularly those who are usually reliant on caregivers or a stable environment, face significant psychosocial distress in displacement contexts with loss of social supports and changes in their physical environment rendering them more dependent than before. Persons with new injuries may have difficulty adapting to their new disability – and caregivers often suffer significant distress as well.

Examples of solutions:

- Target male and female persons with disabilities of all ages in all protection monitoring initiatives.
- Assist persons with disabilities with communication difficulties to complete relevant forms and help all persons with disabilities to replace lost documentation and access justice and other systems.
- Provide all information in simple language, using at least two means of communication (oral and written) and ensuring it reaches people who cannot leave their shelters/temporary homes.
- Include persons with disabilities, persons with injuries and caregivers in psychosocial initiatives. Adapt interventions according to the members of the group.

Education and livelihoods

Obstacles that impede persons with disabilities' access to education and livelihoods opportunities in stable contexts are heightened in displacement contexts. Temporary schools may not be accessible, teachers may not be equipped or trained to include children with disabilities, and appropriate equipment and materials may not be available. Some may not be able to take part in cash- or food-for-work schemes due to the belief that persons with disabilities cannot participate in labour schemes, the nature of the job or lack of flexibility in tasks to complete, and may thus miss out on income-generating opportunities. In addition, persons with disabilities generally find it more difficult to replace livelihood tools lost or damaged during displacement or to access vocational training opportunities for some of the same reasons mentioned above.

Examples of solutions:

- Ensure that temporary schools (and child-friendly spaces) are inclusive of children with disabilities (via accessibility, staff awareness, appropriate materials and equipment).
- Include persons with disabilities in cash- and food-for-work and other livelihood recovery schemes or provide suitable alternatives.

Return

Challenges for persons with disabilities do not end once return begins. Information on the return process is often not presented clearly enough, using means everyone can understand. In addition, transport services do not take into account the needs of certain persons (e.g. using large trucks that are difficult to climb into), and often rely on central drop-off locations that are far from the place of origin, making it difficult for some to reach their homes. Furthermore, people often find themselves returning to environments which prove more challenging than the camp which was their temporary home. For persons with disabilities, especially for those who have received appropriate services for the first time while displaced, this can be a major deterrent to resettlement, as was seen during refugee return from Kenya to southern Sudan in recent years.

Examples of solutions:

- Include persons with disabilities in the planning phase to ensure

the return process is adapted appropriately.

- Arrange adapted transport for those who require it, and organise assistance and transport to the specific place of origin, including support to carry rations and personal items.
- Provide information and appropriate referral towards services available at the place of return.

A step forward...

Despite major advances towards better inclusion of persons with disabilities in displacement contexts, a lot of work still needs to be done. Handicap International and a number of other stakeholders⁶ have been lobbying for a UNHCR Executive Committee Conclusion on Disability.⁶ This Conclusion, which member states will adopt in 2010, will help promote implementation of the recent UN Convention on the Rights of Persons with Disabilities in humanitarian situations,

especially in refugee and other displacement contexts. It will provide practical guidance for all actors who share responsibility to fully include persons with disabilities in assistance programmes and initiatives for durable solutions.

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1. UNHCR (June 2009), 2008 Global Trends, <http://www.unhcr.org/4a375c426.html>
2. For more information about these and other solutions, contact Handicap International (erd_support@handicap-international.org) or see *Disabilities Among Refugees and Conflict-affected Populations*, Women's Refugee Commission, June 2008, <http://www.womenscommission.org/programs/disabilities>
3. See Simmonds article p10.
4. Nordstrom, K. World Blind Union (2004). *Quality Education for Persons with Disabilities*. <http://tinyurl.com/Nordstrom2004>
5. CBM, Disabled Peoples' International, IDA-CRPD Forum, Handicap International, International Disability and Development Consortium (IDDC), Leonard Cheshire Disability, Motivation, Women's Refugee Commission and World Vision, with the support of Quaker United Nations Office.
6. See Joyce article p44.

Second African Decade of Persons with Disabilities

Aïda Sarr and Kudakwashe Dube

1999-2009 was the first African Decade of Persons with Disabilities, established by the African Union to encourage the full participation, equality and empowerment of people with disabilities in Africa. During the first Decade, the Secretariat prioritised facilitating partnerships throughout society; assisting the most vulnerable groups – such as persons with intellectual disabilities, persons who are deaf-blind and those with albinism – to have a voice; and launching the African Campaign on Disability and HIV/AIDS to mainstream disability in AIDS services and response programmes.

The Secretariat also advocates for the ratification and implementation of the UN Convention on the Rights of Persons with Disabilities (UNCRPD) and monitoring of different protocols relating to the rights of disabled persons in Africa.

The Decade has now been extended to 2010-2019 – the Second African

Decade. The Secretariat is part of the broader movement against conflict and is currently cooperating with the African Union on matters related to disability, peace and security and the plight of disabled people in countries emerging from war situations. An important aspect of this work is to advocate for the implementation of policies related to disability by agencies involved with disaster management, refugees and other displaced persons, including policies and strategies for repatriation and resettlement. For instance, when the camps in Gulu, Uganda, were dismantled in 2009, disabled persons were left in the camp with few support services. Their plight was addressed after an international outcry and intervention.

Words and images

The words and images used by the media can create either a positive view of persons with disabilities or an insensitive portrayal that reinforces common myths that leads to discrimination. The Secretariat

has run training workshops for journalists and facilitated the creation of a network of African journalists to promote the rights of persons with disabilities. At least 200 African journalists have been trained and are now running regular disability-focused columns in a range of African media.

The Secretariat has produced guidelines for journalists, as well as other training resources such as an advocacy and lobbying manual, an evaluation manual and a resource mobilisation/fundraising manual for DPOs. Online at: <http://www.africandecade.org/trainingmaterials>

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Disabilities among refugees and conflict-affected populations

Rachael Reilly

In 2007 the Women's Refugee Commission launched a major research project to assess the situation for those living with disabilities among displaced and conflict-affected populations.

People living with disabilities may be left behind during flight, or may not survive the journey; they are often not identified or counted in registration or data collection exercises; they are excluded from or unable to access mainstream assistance programmes and forgotten when specialised services are set up.

They are often the most exposed to protection risks, including physical and sexual violence, exploitation, harassment and discrimination. The loss of family members or caregivers during displacement can leave persons with disabilities more isolated and vulnerable than they were in their home communities.

And their potential to contribute and participate is seldom recognised. Refugees and displaced persons living with disabilities are amongst the most hidden, excluded and neglected of all displaced persons.

Some refugees and displaced persons may have lived their whole lives with a disability. Others may have become disabled during the conflict or natural disaster which led to their flight. The disruption of health and social services during conflicts or after a natural disaster can deprive the local population, especially children, of essential preventative and curative medical services, resulting in permanent impairments which could otherwise have been prevented.

The Women's Refugee Commission was particularly concerned that displaced women, children and older persons face multiple discrimination on the basis of their gender, age and social status, as well as their disability. Women with disabilities are often exposed to sexual violence, domestic abuse and physical assault. Children with disabilities frequently suffer physical and sexual abuse, exploitation and neglect. They are excluded from education and not provided with the support to help them develop to their full capacity. In the Dadaab refugee camp in Kenya, Somali children with disabilities were sometimes tied up and had stones thrown at them, or suffered verbal abuse from other people in the community.

Mothers are often blamed for their children's disabilities and may suffer physical or sexual abuse from their husbands or other family members, and be harassed, stigmatised and abandoned as a result. Older persons with disabilities may be abandoned or neglected by family members who can no longer care for them; they may face extreme isolation and vulnerability and may be unable to access the basic health care, food and shelter they need to survive.



UNHCR/L Taylor

The Women's Refugee Commission mapped existing services for displaced persons with disabilities in five countries, identifying gaps and examples of good practice and making concrete recommendations on how to improve services, protection and participation for this neglected population. Field studies were carried out by local NGO service-providers and disabled persons organisations (DPOs) in Bhutanese refugee camps in Nepal, Burmese refugee camps in Thailand and Somali refugee camps in Yemen, and among urban Iraqi refugees in Jordan and urban Colombian refugees in Ecuador. Additional information came from Dadaab refugee camp for Somali refugees in Kenya and IDP camps in Sudan and Sri Lanka.

Key findings

Data collection:

In all the countries surveyed there was a lack of reliable and consistent data on the number and profile of displaced persons with disabilities. This problem was particularly acute in urban areas, where there was insufficient data on the number of refugees in general and little or no information on the number of refugees with disabilities. A lack of consistency in terminology and methodologies for data collection, cultural differences in definitions and concepts of disability, and lack of training or disability awareness amongst data collection staff all affected the accuracy of data. Inadequate or unreliable data meant that persons with disabilities were often not identified, and as a result appropriate services were not in place.

Physical infrastructure:

An additional problem in all the countries surveyed was that the physical layout and infrastructure of camps impeded access for persons with disabilities to facilities and services, including schools, health clinics, latrines, water points, bathing facilities and food distribution points. Difficulties with physical access and the poor design of camp buildings, including shelters, affected all aspects of daily life and increased the isolation of persons with disabilities. This was particularly the case in urban areas. In Jordan, researchers

found that Iraqi refugees with disabilities rarely left their homes. Researchers did find some positive examples of adaptations to improve physical access; in Dadaab refugee camp, for example, wheelchairs were designed with special wheels for use on the sandy terrain.

Access to mainstream and specialised services:

As well as lack of physical access, the research also found that mainstream services were either inappropriate or did not cater for the specific needs of persons with disabilities. Food distribution systems were inaccessible for persons with disabilities in several countries, and there were no additional or special food rations. Mothers in Nepal and Yemen, for example, said that they could not get specially formulated food for children with cerebral palsy and cleft palates. Refugees in Yemen said that people with visual impairments were cheated during food distributions, or had their rations stolen. In Dadaab, on the other hand, the World Food Programme gave refugees with disabilities priority during food distributions so they did not have to wait in long queues, and members of the community were mobilised to help collect food rations for persons with disabilities.

All the field studies highlighted a lack of specialised health care, psychosocial support and counselling services for persons with disabilities. There were no specialist doctors or specialist therapy provision, a lack of specialised medicines and generally no referrals to external services. Health clinics were often physically inaccessible for persons with disabilities, who were not given priority treatment and had to wait in long queues. Those with visual or hearing impairments often faced communication difficulties. In some countries, such as Thailand, there were well-established physical rehabilitation and prosthetics programmes, whereas in others, such as Yemen, such services did not exist. Some positive examples of community outreach health programmes for persons with disabilities were found in the Bhutanese refugee camps and for older persons in the IDP camps in Darfur.

Education and training:

A more positive finding from the research was the availability of inclusive education for children with disabilities. In all the countries surveyed, children with disabilities were attending school and in some countries school attendance rates for children with special learning needs were high. In refugee camps in Nepal and Thailand there were successful early childhood intervention programmes to identify children with disabilities and help them integrate into mainstream schools. Classroom support was provided for refugee children with special learning needs and there was ongoing training of special needs support teachers, as well as mainstream teachers to help support inclusive education. Teaching aids and appropriate curricula were developed and children with special needs were provided with mobility aids and learning accessories – such as Braille text-books, talking calculators and large print posters – to support their learning.

In general, the research found that inclusive education could be a good entry point for persons with disabilities to access other services. For example, through early childhood intervention programmes, refugee children with disabilities could be referred to appropriate health services, and parent support groups were a positive starting point to provide psychosocial support to parents of children with disabilities.

Elsewhere, while children with disabilities were not actively barred from attending school, neither were they actively encouraged to do so. Attendance rates were low and dropout rates high. There was a lack of special needs support staff or training for mainstream teachers and a lack of appropriate teaching aids, flexible curricula and assistive learning devices – and school buildings were physically inaccessible. In Yemen, for example, children with visual and hearing impairments did not have spectacles or hearing aids which made it very difficult for them to continue at school.

There were some examples of successful vocational and skills training programmes which helped refugees with disabilities learn

useful skills and find employment. Bhutanese refugees in Nepal set up small grocery shops, barber shops and weaving businesses after participating in skills training programmes. Elsewhere, vocational training schemes were not adapted for people with disabilities or they were actively excluded. In nearly all cases persons with disabilities faced huge social, attitudinal and legal barriers in finding employment because of their disability, in addition to their status as refugees and outsiders.

Participation:

Nearly all the people with disabilities interviewed during the field research said that they would like to be more involved in community affairs, camp management, programme planning and decision-making processes. However, there were very few opportunities for the formal participation of persons with disabilities. There were some positive examples of refugees and displaced persons with disabilities forming their own organisations and self-help groups, for example in the camps in Thailand and Nepal, as well as some positive community awareness-raising initiatives.

In general, the Women's Refugee Commission found that there was little contact between displaced persons with disabilities and local DPOs. One of the positive outcomes of the research was to build bridges between local DPOs and refugee communities in several countries. In Jordan the involvement of Jordanians with disabilities from a local DPO¹ as researchers in the project exposed them to the challenges faced by the Iraqi refugees and led to the inclusion of Iraqis in some of their projects.

Supporting practice and influencing policy

In June 2008, the Women's Refugee Commission published a comprehensive report outlining the findings of its field research, as well as a resource kit for UN and NGO humanitarian field workers on how to work with and promote the inclusion of persons with disabilities.² The resource kit includes practical advice on how to make refugee camps more accessible to persons with disabilities and how to promote their full and equal access to mainstream services and facilities.

Since 2008, the Women's Refugee Commission has been working to influence both policy and practice

to promote the rights of displaced persons with disabilities, for example putting together a guidance document for relief organisations operating in Haiti after the January 2010 earthquake.³ The guidelines were sent through InterAction to all its members working in Haiti as well as to its Protection and Humanitarian Assistance working groups. They were also sent to the Protection and Education clusters in Haiti and were posted on the One Response website for Haiti coordination. The Women's Refugee Commission plans to follow up on this with training workshops for service providers in Haiti – a model the organisation hopes to replicate in several other pilot countries. At the policy level, the Women's Refugee Commission has been active in a coalition of NGOs advocating for a UNHCR ExCom Conclusion on disabilities, which is due to be adopted in 2010.

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1. <http://www.landminesurvivors.org/>

2. *Disabilities Among Refugees and Conflict-Affected Populations and Resource Kit for Fieldworkers* <http://www.womensrefugeecommission.org/programs/disabilities>

3. <http://tinyurl.com/HaitiGuidance>

Addressing the data challenge

Kathleen B Simmons

The humanitarian relief community needs to collect disability-specific data through rapid needs assessments, registration processes, accessing local knowledge and disability monitoring.

Current literature suggests that data on disabilities among refugee and IDP communities are often uncollected or unknown by the larger NGOs and UN agencies that are providing the bulk of relief services.¹ Standard procedures such as rapid assessments and registration processes often do not include collection of information specific to the circumstances, needs and presence of refugees and IDPs with disabilities. In cases of armed conflict or natural calamity, this 'invisibility' can be fatal.²

The 2008 Women's Refugee Commission's report on *Disabilities*

*among Refugees and Conflict-Affected Populations*³ noted that identifying and collecting data on the number of persons with disabilities and the types and causes of disability have proven to be one of the greatest data challenges in the context of displacement. Addressing the specific needs of persons with disabilities in an emergency context requires that agencies have appropriate tools and training to recognise and record various types of disabilities. While the Sphere Project Handbook recognises persons with disabilities as falling within their 'vulnerable groups' category – people who should be

considered in all facets of service provision, along with the elderly, children and women – the Handbook does not provide minimum standards and requirements specific to these 'vulnerable groups'. Due to the diversity of disability, minimum standards of service are needed to guide agencies in qualifying and quantifying their response for refugees and IDPs with disabilities in order to fulfil their most basic rights to protection, health and dignity.

Data collection

Data collection processes for emergency interventions and recovery programmes must include:

- disability-specific rapid needs assessments

- registration processes that are inclusive of persons with disabilities
- information gathering from local NGOs and community leaders, and from national/local health and/or surveillance systems
- implementation of disability-monitoring mechanisms.

One of the greatest challenges to data collection for this sector of a displaced population is overcoming the misconception that persons with disabilities require such specific and complex services that agencies should only focus on their needs once the emergency phase is over.

This notion deflects attention from the urgency of collecting such data during the standard data collection processes. Consequently, the data collected during the emergency phase and used to develop the most critical survival services are devoid of any disability-specific information. This inadvertent negligence disregards the survival and protection needs of refugees and IDPs with disabilities and their carers. Literature and case-studies alike note the lack of standardised disability-specific data collection tools and monitoring mechanisms.

The development of a disability-specific rapid assessment tool is essential in order to ensure inclusive emergency interventions. The diversity of disability demands a reference guide for those who are conducting assessments in order to increase accuracy in recording the category and severity of disabilities and to ensure that the assessment accurately measures the needs of individuals with disabilities. Additionally, a set of definitions and indicators accepted by all NGOs and UN agencies would allow for more efficient coordination, information sharing, evaluation, comparison and analysis across data sources and over time.⁴ Training for data collectors or interviewers to detect and ask about disability is essential.

The assessment tool should enable data collectors to record:

- all categories of disability (physical, mental, sensory) and

all manifestations of disability within each category

- category of the disability
- singular, double or multiple disabilities
- criteria for identifying a disability
- the severity of (each identified) disability
- age and gender of person with disability
- number of persons with disabilities in a single 'household'
- onset of disability (at birth, after birth and prior to displacement, as a result of war/disaster, result of migration) and any necessary anecdotal information
- specific needs (transportation, assistive device, food ration assistance, water supply assistance, access to universal design latrine, accessible shelter, access to medications, access to specialised medical care, etc)
- carer situation (none/temporary/permanent)

The assessment tool will need to include a reference section with definitions of all categories and types of disabilities and severity criteria to ensure high quality and consistent data collection across humanitarian organisations.

One-off and ongoing refugee and IDP registration processes are important operational procedures that must seek to capture the presence of persons with disabilities within the displaced community. In cases where stigma, discrimination or lack of mobility result in making persons with disabilities a 'difficult-to-reach population', agencies will need to partner with community leaders, local NGOs and international NGOs with long-term presence in order to facilitate registration processes and help emergency responders to identify and register persons with disabilities. The registration process will not only provide a rough estimate of the number of those displaced with disabilities but will also enhance

their visibility and, most importantly, will directly connect refugees and IDPs with disabilities to essential services (including food ration cards, immunisation campaigns, protection initiatives, psychosocial first-aid programmes, etc). It is also important to ensure that people who become disabled over the course of displacement receive the information and services necessary to sustain their lives and livelihoods.

As mentioned, gathering information from local NGOs, local leaders and identified community members who care for persons with disabilities is important if agencies are to understand how it is to be a person with a disability in a particular society and the type of care, opportunities and protection – or lack thereof – that exist there. In situations where persons with disabilities – or persons with particular types of disabilities – are harder to reach, engaging with local leaders and organisations will be even more necessary. Their specialised institutional knowledge, resources and deeper understanding of the needs of persons with disabilities prior to displacement, as well as information on the types and prevalence of disabilities, will be of great importance in planning and implementing interventions and services. International agencies should support these local organisations and avoid poaching staff or creating parallel services. Instead, establishing partnerships and providing assistance will improve local capacity in an emergency context, improve existing services and create a more sustainable and strengthened support system for persons with disabilities.

Statistics on disabilities from the national and local health system or surveillance systems are another source of data. While the presence and/or capacity of these systems will vary greatly, they can be useful for data collection and for understanding the level of recognition of persons with disabilities within local and national government systems. Due to the impermanence of 'ability' in forced migration contexts, it is essential to establish a coordinated system that systematically collects

disability-specific data over the course of displacement. Disability monitoring mechanisms, such as disability surveillance, is a key data collection method that should be developed, implemented and charged with the duties of ongoing and systematic collection, analysis and interpretation of disability-related data. This information could be used to inform humanitarian actors on a way forward for effective disability mainstreaming, implementation and evaluation.⁵

Conclusion

While the Women's Refugee Commission, World Vision and other NGOs, as well as researchers, have more recently begun to map and mainstream the needs of refugees and IDPs with disabilities, organisations such as Handicap International and HelpAge International have long worked in this environment, providing specialised care and building up a wealth of institutional knowledge, capacity and data collection tools. Their expertise should be tapped to improve humanitarian data collection, planning and programme implementation. More importantly, agencies need to take responsibility for including refugees and IDPs with disabilities in rapid needs assessments and registration processes, accessing local knowledge and initiating disability monitoring mechanisms so that they can begin to design emergency interventions and recovery programmes with inclusion in mind.

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1. Lentz, K L (2008) *Final Report: Support to UNHCR and the Protection Cluster Working Group: Internally Displaced Persons with Disabilities* <http://tinyurl.com/Lentz2008>

2. Stocking, B (2003) Preface in S E A Harris, *Disability, Equality and Human Rights: A Training Manual for Development and Humanitarian Organisations* (p. viii). Oxford: Oxfam GB.

3. http://www.womensrefugeecommission.org/docs/disab_full_report.pdf

4. Gerben Dejong, Spring 2008 Forum: Dealing with disability. <http://www.issues.org/24.3/forum.html>

5. Center for Disease Control. Retrieved Jan 2010, from: <http://www.cdc.gov/ncepi/diss/nddss/phs/overview.htm>

Vulnerability and disability in Darfur

Maria Kett and Jean-François Trani

The difficulties faced by persons with disabilities throughout the displacement process contribute to their increased vulnerability.

During focus group discussions with women in IDP camps in Western Darfur – as part of a larger research project on vulnerability¹ – several women highlighted the increased difficulties persons with disabilities faced throughout the displacement process, beginning with their initial flight from their villages. For those with disabilities, their journeys had taken on average almost twice as long as other, non-disabled villagers, putting them at greater risk of further attack and insecurity along the route to safety. This was largely due to mobility or transportation difficulties. For example, one of the disabled women interviewed had to flee from her village with her husband, also disabled, and their three children, taking as many belongings as they could carry; however, they had to take turns to share their one mobility tricycle between them, thus significantly delaying their journey. Another elderly woman told of how, because of difficulties with walking, her flight from the *janjaweed* had taken more than five days, rather than the one or two days it had taken her fellow villagers, and she had to hide many times along the way for fear of further attacks.

None of the women interviewed mentioned receiving any assistance from neighbours or fellow villagers during their flight, though they did sometimes receive help once they were in the camps. Some of the help, such as collecting water and firewood, was undertaken by younger family members to assist those who could not collect the firewood themselves, thus putting these family members at an increased risk of attacks outside the camp. Some households set up food distribution mechanisms whereby one representative gathers vouchers from a series of households and collects all their supplies which are then divided up. These are helpful to some degree but only in the

case of those registered with food distribution programmes, usually in camps, and it depends on the goodwill of friends and neighbours to ensure the full food ration is handed over. In many instances this goodwill is not forthcoming.

One small group of women with disabilities ended up, in part because of their particularly destitute status, in what can loosely be termed a 'segregated' camp, alongside other extremely vulnerable people, including older adults and persons with leprosy. However, they were not included in any of the formal registration programmes and thus were excluded from programmes that specifically target 'extremely vulnerable individuals' (EVIs), despite being clearly in need of extra support.

The situation for most of the adults and children with disabilities in Darfur is especially challenging. In general, the attitude of non-disabled Darfurians to adults and children with disabilities is that of charity, based on religious beliefs. Prior to the conflict, adults and children with disabilities were frequently beneficiaries of *zakat*, the Islamic system of giving to those most in need. However, since the conflict and the large influx of humanitarian aid, the *zakat* system has largely fallen into disuse, leaving many people with disabilities in a vulnerable and precarious situation, unable to call upon traditional means of support and unable to access the new, limited systems of support that were supposed to be available in the camps but were often missing or fragmented.

In Darfur, for most of the displaced persons with disabilities, there is a chronic need for livelihoods, food and welfare support. For many persons with disabilities, their main source of income comes from

begging in the local market place. Furthermore, we found that in a camp the presence of a person with disabilities within the household can put extra strain not only on finances but also on family coping strategies. The traditional extended family system that could support persons with disabilities is often significantly reduced, with only close relatives being available nearby to continue to help and provide any support needed. In some cases families are separated during flight to a place of safety, sometimes by accident but often because a decision was made that – for the welfare of all other members of the family who must flee quickly and survive in the unknown surroundings of a camp – the person with a disability must be left behind.

Identification and registration

In order to assist those seen as especially in need, many agencies identify EVIs in order to provide targeted assistance with food and non-food items and programme delivery. This category varies according to the agency but usually includes orphans and unaccompanied children, female-headed households, older people, people with disabilities and people with mental health problems.

In Darfur as elsewhere, many other factors compound vulnerability, including gender and geographical

location. In the areas where we were undertaking research, local disabled peoples organisations (DPOs) were also used to assist with the identification of EVIs but these local DPOs are often under-staffed, over-stretched and under-resourced, as they try to effectively reach all persons with disabilities in need, often in camps some distance away with unstable and changing populations.

The fact that most of the persons with disabilities in the camps interviewed for this project seemed to be falling through the cracks highlights the need to improve the process by which persons with disabilities are tracked and registered by relief agencies. Official registration can benefit persons with disabilities in Darfur in a number of different ways, including by offering access to additional humanitarian aid, a reduction in health-care bills and free schooling.

It is debatable to what extent these benefits can actually be realised in the current context and whether persons with disabilities perceive registration to be beneficial. In theory, the process of registration eventually links to the Ministry of Social Welfare and is primarily undertaken by local DPOs in the field. However, the extent to which ministries actually take any responsibility for the welfare of



persons with disabilities appears to be limited, with most services provided by organisations such as the ICRC. Local DPOs have limited capacity for advocacy or awareness-raising campaigns and overall receive little external assistance as much of their previous support came from disability and development agencies that no longer operate in the region. Most support now is in-kind, such as the provision of assistive devices for a limited number

Disability in standards and guidelines

The UN Convention on the Rights of Persons with Disabilities (CRPD), which came into force in May 2008, covers situations of risk and emergency (Article 11) but does not specifically include displacement as a situation of concern. This may reflect the fact that the CRPD reaffirms already existing human rights legislation, such as the 1951 Refugee Convention, but does so with a specific focus on disabilities. Whilst all human rights legislation takes non-discrimination as the basis for its implementation, the Refugee Convention only specifically mentions disability in Article 24 on Labour Legislation and Social Security, which states that all refugees are entitled to the same social security rights as all citizens of the country.

The Guiding Principles on Internal Displacement mention disability specifically in Principle 4, which outlines the principle of non-discrimination of any kind, as well as highlighting how: “Certain internally displaced persons, such as children, especially unaccompanied minors, expectant mothers, mothers with young children, female heads of household, persons with disabilities and elderly persons, shall be entitled to protection and assistance required by their condition and to treatment

which takes into account their special needs.” And Principle 19 states: “All wounded and sick internally displaced persons as well as those with disabilities shall receive, to the fullest extent practicable and with the least possible delay, the medical care and attention they require, without distinction on any grounds other than medical ones. When necessary, internally displaced persons shall have access to psychological and social services.”

While the Refugee Convention focuses on entitlements (to welfare support), the Guiding Principles focus more on care and protection. However, more recently the UNHCR *Handbook for the Protection of Internally Displaced Persons* emphasises the need to ensure the protection of persons with disabilities and focuses on the inclusion of persons with disabilities, with particular emphasis on gender, violence and health as these relate to persons with disabilities. Meanwhile, in the current revision of the *Sphere Handbook*, disability – along with other key areas including gender, older people and children – is being mainstreamed from the start of the revision process to ensure sustained inclusion.

of individuals fortunate enough to come to the attention of the system.

Future challenges

In other chronic crisis situations, persons with disabilities often remain in camps or temporary settlements for years, long after most or all of the other non-disabled camp residents have been relocated or have left. While many persons with disabilities will find their own solutions to their displacement (as others in the camps do), the challenge is what should be done about those who cannot find alternatives to such camps.

For any of the three options – return, reintegration or resettlement – refugees and IDPs with disabilities face a number of challenges. If return is an option, there may be conditions attached such as having to demonstrate the ability to rebuild one's house, an option not always available to persons with disabilities. Reintegration may pose specific challenges for persons with disabilities, who may face increased discrimination and exclusions and loss of social support, particularly outside their own community. Finally, resettlement generally comes with a number of conditions attached which may act against persons with disabilities, for example a cap on medical treatment expenses. This leads to the very real problems of camps becoming de facto 'welfare camps'.

We have not yet got to this situation in Darfur but it is time for agencies and others focused on long-term durable solutions for all refugees and IDPs to give serious thought and attention to persons with disabilities.

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1. *Report on affected and excluded vulnerable children in Southern West Darfur* Dr Jean-François Trani and Dr Maria Kett, Leonard Cheshire Disability and Inclusive Development Centre, University College London. <http://tinyurl.com/Cheshire-Darfur>

The Darfur study was co-funded by UNICEF and Leonard Cheshire Disability and carried out in partnership with Intersos.

Perception and protection in Sri Lanka

Francesca Bombi

An assessment conducted in Sri Lanka in 2008 revealed that displaced people with disabilities were extremely vulnerable to protection incidents and their vulnerability was increased by their lack of voice.

Undoubtedly, the context of Sri Lanka is a complex one. The country has suffered from sporadic civil war since 1983, and in 2008, at the time when the assessment was conducted, Sri Lanka had entered a new period of open conflict, after the abrogation of the ceasefire in early January of that year.

The field assessment revealed a number of connections between conflict, displacement and disability. One of the most evident was that conflict and displacement are a cause of permanent physical disability either directly as a result of injuries or because the situation of conflict and resulting displacement had not allowed people with injuries to access health services and be treated – therefore injuries that might have been cured had become the cause of a permanent disability.

The field assessment further highlighted the existence of two different types of protection challenges confronting people with disabilities: protection challenges that are specific to persons with disabilities in situation of conflict and displacement, and protection concerns that confront the general population but to which people with disabilities might be more vulnerable because of their lack of voice within their family and community.

Specific challenges

It is usually much more difficult for people with disabilities to leave when conflict erupts; often they have to find alternative ways of escaping or they do not escape at all. A young woman with four children, three of whom were affected by severe disability, explained that her family was unable to leave their village, even though the shelling was very close to her house, because they

did not have the means to carry the three disabled children. While the rest of the villagers fled, this family remained behind, dug a hole in the ground and hid there for days.

Another man, a wheelchair-user, recounted that when the conflict was approaching his village, his family took the decision to split up and to arrange for his earlier departure as they worried about his inability to leave in an emergency. The man had to leave his wife and young teenage daughters without any male support in an area visited regularly by fighters, increasing their potential exposure to sexual and gender-based violence and forced recruitment.

Another issue that was raised by a number of persons with disabilities was the identification by the security forces of young injured or disabled Tamil men and women as ex-combatants. Young amputee men and women would regularly be stopped and interrogated at checkpoints as their disability singled them out as potentially having been involved with the rebel movement. Many of the young men and women who were experiencing these increased security controls were consequently not accessing health services for fear of being interrogated and arrested on the way.

In other instances people with hearing or speech impairments were harassed and arrested at checkpoints because of their inability to express themselves and answer questions posed by the security forces. Their disability was not immediately recognised by the security forces who considered it rather as 'suspicious behaviour'.

Other interviewees with disabilities talked of difficulties encountered

during their displacement. Because of cultural and religious beliefs about disability, some people with disabilities did not benefit from the solidarity of the host population and were unable to secure a shelter with host families. Moreover, even though organisations working on disability continue to advocate strongly for accessible IDP and refugee camps – and provide technical guidance to design and organise these settings, including, for example, accessibility of water points, distribution points, toilets, community areas, education areas and shelters – it is rare to find camps where the needs of people with disabilities are taken into account.

Accessibility does not only cover physical access. Access to information is also extremely important as it is the key to obtaining services and protection. Information in camp settings is generally given through traditional methods, such as announcements and signboards that do not reach visually or hearing impaired people, condemning them to exclusion and marginalisation.

Furthermore, there was often no consideration of the difficulties that people with disabilities might encounter in return and resettlement plans both during the travel back to their place of origin and in terms of rebuilding their lives.

Additional vulnerability

Because of their lack of voice and the family's and community's underlying acceptance that they are 'second-class human beings', persons with disabilities were more vulnerable than others to the type of protection problem not specifically linked to disability but that might affect the general population. The most affected were women, children and elderly persons, indicating that disability can multiply the vulnerability of those who already hold an inferior position in the family's and community's power dynamics.

It was also noted that, within the disability sphere, persons with mental disability were found to be extremely vulnerable, particularly to sexual and gender-based violence against women with mental disability and neglect of children with mental disability potentially leading to their death

People with disability were discriminated against within the family to the point of being physically hidden in the house and never let outside and they were often not mentioned in the official family documents. This was reported specifically as an issue for high-class families, indicating how protection concerns are not necessarily linked to poor economic conditions.

Very few offices of UN organisations and NGOs were physically accessible to persons with disabilities and the arrangements for meetings and events did not take into consideration the special needs of persons with disabilities, unless made by organisations working specifically in this field and who campaign to include people with disabilities in all activities.

Moreover, it was noted that when there was a person with a disability in the family there was often a disruption of the family structure and 'coping mechanism' - usually with negative effects on the security and wellbeing of the family. In some cases, children whose parents had become disabled had to drop out of school to work and provide for the family. Women whose sons or daughters were disabled could not work because they needed to take care of them, further adding to their vulnerability.

Interestingly, the findings strongly diverged from the perception on disability and displacement shared by many professionals consulted during the assessment. People with disabilities were generally viewed as 'different' from the other recognised vulnerable groups – women, children and the elderly – and disability was considered a specific subject requiring an 'expertise'. Furthermore, there was a general acknowledgment that, because of their limited numbers, displaced persons with disabilities were not a priority. In the end, all these arguments were used to justify the lack of knowledge and the consequent inaction on the subject.

This field assessment to identify vulnerabilities of people with disabilities to protection challenges in a context of conflict and displacement was one of the first of its kind and was limited in time and scope¹ but gives initial indications that

confirm the vulnerability of people with disabilities and highlight the need to fill the knowledge and intervention gap into which people with disabilities are falling.

Conclusions

Among the most pressing actions, governments and the international community, particularly organisations working on protection, should:

- develop the knowledge and capacity of governmental authorities and humanitarian and development organisations to identify protection issues affecting people with disabilities in situations of conflict and displacement, through assessments and sharing of information
- continue advocacy to ensure the inclusion of people with disabilities in humanitarian and development organisations' and governments' mandates and programmes
- continue advocacy to ensure that the 'charity' approach commonly used when addressing people with disabilities' concerns is substituted with the rights-based approach
- work together with disabled people's organisations as the best placed actors to raise awareness about people with disabilities' concerns and priorities
- ensure better representation of people with disabilities inside humanitarian and development organisations and local authorities as this will naturally increase these actors' awareness on the issue.

As one Sri Lankan colleague pointed out: "people with disabilities are vulnerable because they are hidden"; it is our responsibility to ensure that they are seen and their voices are heard.

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1. 60 persons with disabilities were interviewed in the North and East of Sri Lanka over a period of four months.

More than a ramp

Gulu Disabled Persons Union

“People with disability live in families and live in communities. We cannot be separated from society.” Simon Ongom, Chairperson of the Gulu Disabled Persons Union (GDPU)

The rebellion by the Lord’s Resistance Army (LRA) in northern Uganda left a terrible legacy of poverty, mutilation and sickness. It is estimated that 14% of the population suffer from a disability – significantly higher than in other parts of the country. Yet disability has been largely left out of reconstruction and in the villages people with disabilities are often shunned and isolated.

The Gulu Disabled Persons Union (GDPU), a network of five advocacy groups, is campaigning on various fronts, not least to make public buildings and services accessible in Gulu and Amuru districts. In November 2009, responding to pressure from this campaign, the Gulu municipal and district councils voted to make schools, hospitals and health centres throughout Gulu accessible. GDPU also plans to nominate its members for election to local parish development committees, where they can advocate for a village-based disability agenda.

Many of those working for GDPU have been displaced by the conflict – and now campaign to encourage those involved in protection, assistance, reconstruction and return to bear in mind the particular challenges facing all those living with disabilities.

Elisabeth Abur

Elisabeth has been a general member of Gulu District Association for the Blind since 1998, when she fled to Gulu municipality from the violence in her sub-county. Elisabeth describes her experience being blind during the conflict in Uganda: “I might sit outside, and other people might see the rebels coming from far, run and leave me, whereas I cannot see them. This happened to me. They [the rebels] gave me millet to grind and chicken so I prepared food for them. When they were finished they locked me in a hut so I could not hear which direction they were going and they left me there.” As a result, Elisabeth

left her village in 1998 and stayed at an IDP camp for six months.

People with disabilities have suffered disproportionately during and after the conflict in Uganda. Disabled persons either did not know of the impending violence or were unable to leave with others, similar to Elisabeth’s experience. Refugees fled to IDP camps, which could scarcely address the needs of people who were not disabled, let alone the disabled. In the congested IDP camps the blind have particular difficulty moving around. Seeking out food and water is a major problem. The deaf have problems communicating with others because of the lack of sign language interpreters in the camps. Disabled persons must depend heavily on others in order to survive in the IDP camps.

Elisabeth has attended workshops on business development and other subjects, and is active in mobilising people to attend the meetings and cooking for those meetings. “In the future I might campaign to be an LC3 [Local Councillor at sub-county level], so that I can advocate for other people’s rights. I want to make district leaders aware of the rights.”

Justin Okello

A survivor of polio at age three, Justin lost the use of his left leg and uses crutches to get around. His family was torn apart by the war with the LRA, with two of his siblings killed, five abducted and two of those five having yet to return. No-one knows if they are still alive.

Justin has been living with his wife and daughter in Alero IDP camp for more than 10 years. Although he lacks the capital to move out of the camp and start entirely anew, he refuses to remain idle and instead began making furniture from his home. He has developed a small business and is now training three of the other ‘stranded people’ and hopes to expand even



Simon Ongom

further. Justin has been cultivating community relationships because “some people think you can do it alone, but in advocacy, you need to have allies to help you.”

Simon Ongom

Simon, who has been physically disabled since the age of five, is currently chairman of the Gulu Disabled Persons Union. He cites the war as eroding the cultural norms of the Ugandan people. Persons with disabilities are more dependent than before but they are not being taken care of by families, the government or NGOs. The war has made everyone poor. Now, because of the relative peace, people are going back home – but those with disabilities are staying behind. The government and NGOs need to focus specifically on the needs of persons with disabilities who will not be able to return home until they have the support they require. “Not until persons with disabilities have equal opportunities will I relax.”

Santos Okumu

Santos is chairman of the Gulu District Association of the Blind and a board member of the Gulu Disabled Persons Union. The conflict displaced him and his community to IDP camps where the biggest challenges facing them now are food and shelter. Santos’ role in the persons with disabilities movement in the region

and nation can be traced straight back to the roots of the movement in 1980. Santos explains this was when Idi Amin was overthrown: "During the [following] crisis, humanitarian aid came to Uganda to provide food items. We were not able to access this aid. We were unable to line up. We became one voice... We mobilised people and we went to the District Commissioner. They brought the food to this very centre. That is how we got it."

As Santos states: "Accessibility is more than a ramp. It is also about information, communication and employment." Santos divides accessibility into three parts: accessibility to public buildings, accessibility to information and communication, and accessibility to service delivery from government, donors, NGOs and the community.

John Bosco Odong

John is a survivor of gunfire who has been displaced by the war. In 1989, as government forces raided his village, he was hit by a bullet. He was severely injured and spent six months in hospital. In 1998, while traveling to Anaka, he was caught in cross-fire and hit by bullets in the arm and leg. He currently lives in an IDP camp with his wife and children, unable to return to his land because he has no house to live in and is unable to build one himself. "Now people are moving back from the camps but people like me do not have the capacity to build a hut."

Bernard Odong

Born deaf and blind, Bernard has been a deaf blind advocate and a member of the Gulu United Deaf Blind Association since 1996. The main challenge for the deaf

blind is communication with doctors, citizens, neighbours and government representatives. "One of our members died because of communication problems. The medical team did not understand his condition so he died." Not enough sign language interpreters in general and in specific settings are a significant barrier to communication between the deaf and others.

In a cycle that repeats itself, the lack of sign language interpreters and advocates for the deaf blind result in the inability to communicate their needs to the government. The government in turn does not recognise the needs of the deaf blind community and does not support measures to help them.

Bernard, like many others, talked about the need for support for





Christine M. Carlsson, Advocacy Project Peace Fellow

Charles Ojok helps run the local school for deaf children.

returning displaced persons with disabilities. The disabled who return to their villages have special needs in comparison to the non-disabled. Unfortunately, neither the government nor NGOs have programmes or aid geared towards disabled persons.

Lucy Adong

Lucy has been a member of the Gulu Disabled Persons Union's board since 1992. When Lucy was three years old, she had eye cancer and became blind. During the war in Uganda, persons with disabilities were threatened and tortured because they had disabilities. "We lost many lives. In the rural areas it was worst for persons with disabilities. They could be tortured. The rebels would say that persons with disabilities were the mothers and fathers of the UPDF [government forces]. If

they did not find any other people [while raiding a village] they would target persons with disabilities." Lucy described her disabled friend, Charles Okoya Laliya, who was shot, then pushed into his hut. His hut was then set on fire.

Lucy's work with the disability movement has changed her immensely. "Now I have the courage to stand up and declare what should be done and what our rights are when fellow persons with disabilities are abused and mistreated. First I was shy and I would walk away. Now I have the courage."

The Gulu Disabled Persons Union is partnered by the Advocacy Project, which helps marginalised communities to tell their story, claim their rights and produce social change. For more information, see <http://advocacynet.org/page/gdupadvocates>

Intersection of disability and HIV/AIDS

Myroslava Tataryn

People with disabilities, and especially women with disabilities, are largely ignored by the mainstream HIV/AIDS community even though they are at a heightened risk of contracting HIV/AIDS.

All of the risk factors associated with HIV are increased for individuals with disability: poverty, severely limited access to education and health care, lack of information and resources to ensure 'safer sex', lack of legal protection, increased risk of violence and rape, vulnerability to substance abuse, and stigma. With little support from mainstream relief organisations, some disability groups are starting to address AIDS out of necessity, in spite of limited resources and the additional stigma it may bring.

Despite an overall decreasing national HIV prevalence rate, conflict-affected parts of northern Uganda continue to see HIV infection rates that are significantly higher than the national average. These increased rates can be attributed to several factors all intimately connected to the 20-year conflict and IDP situation in northern districts: disruption of the cultural and social systems, leaving children without proper parental instruction; increased sexual activity due to over-crowding in

camps; and rape, sexual abuse and exploitation of girls and young women.¹

In post-conflict northern Uganda, most major international relief organisations incorporate HIV/AIDS services into their programmes and initiatives. However, to date, none of them are implementing programmes specifically aimed at integrating people with disabilities and disability rights issues into HIV/AIDS programming. One national NGO, TASO Uganda,² is working with the National Union of Persons with Disabilities to train several persons with disabilities as HIV/AIDS counsellors and trainers. The international NGOs working in conflict zones, who often have more resources and influence at their disposal, continue to lag behind in the integration of AIDS and disability issues. The high rates of both HIV/AIDS and disability within conflict and post-conflict regions demonstrate a clear need for attention to the intersection of these issues.

Gulu District Association of Women with Disabilities

A small and courageous group of women with disabilities have come together to form the Gulu District Association of Women with Disabilities, supporting women with disabilities

who are living with HIV/AIDS and integrating AIDS issues into the overall activities of the organisation. The women, who are themselves HIV-positive, have spoken out publicly about their status and encouraged other women with disabilities to do the same. Many in their group have lost their jobs or livelihoods because of their HIV-related illness, and many are no longer supported by their partners because of the stigma surrounding their HIV-status and/or their disability.

The group has been able to offer social support to each other and create a forum for resolving domestic disputes connected to their HIV-positive status. They are currently seeking funding to support their members in sustainable income-generating projects to assist them with their daily needs.

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1. Justine Nannyonjo, *Conflicts, Poverty and Human Development in Northern Uganda*, Helsinki: UN University World Institute for Development Economics Research, 2005 <http://62.237.131.23/publications/rps/rps2005/rp2005-47.pdf>

2. <http://www.tasouganda.org/>

Shifting community views: reducing stigma in Dadaab

Devon Cone

Among the greatest protection risks facing refugees with disabilities in Dadaab are discrimination and stigmatisation.

Dadaab refugee camp is made up of three separate camps approximately 80 km from the Somali border. As of February 2010 it is the largest contained refugee complex in the world, housing 261,167 registered refugees, 246,646 of whom are Somali. 9,141 registered households in Dadaab include a person living with a disability.

One of the most obvious problems facing people living with disabilities in Dadaab is the hot, sandy, often flooded and overcrowded nature of the area. An orthopaedic technologist working with Handicap International in Dadaab explains: "The sand and heat in Dadaab make living with a physical disability very challenging. Even tricycle wheelchairs fitted with special wheels are very difficult to use ... and the disabled person ends up having to be pushed by several people. As for prosthetics, they wear out quickly in this climate. Refugees might use them minimally at home but they do not use them to travel any significant distance. This drastically limits a person's mobility, independence and dignity."

Significant measures have been taken to ensure that persons with disabilities have easy access to agency field offices, UNHCR registration and verification exercises, WFP food distributions, and so on, but day-to-day functioning remains difficult for most disabled refugees in Dadaab. However, the most significant issue facing refugees with disabilities in the camps is not usually the limitations caused by their physical impairment but rather the views of the rest of the community towards them.

Handicap International's Rehabilitation Team Leader has noted: "Contrary to what many people think, Somali mothers and

sometimes fathers are extremely caring and protective of their children with disabilities. The children are well taken care of, clean and loved. The problem comes with the rest of the community. Discrimination and stigmatisation are the biggest challenges we face in Dadaab when working with the disabled."

Blessing or curse?

According to traditional ideas, some Somalis believe that a disability is a blessing from Allah and should be appreciated. Many others, however, believe that an impairment is a punishment in response to behaviour of the parents which has offended Allah. A third possible explanation given by some refugees in the camp is that the person with the disability would harm people if physically able to do so, and therefore Allah curses him or her with a debilitating condition as a way of protecting the community.

Persons with disabilities, especially children, often face frequent protection problems including being beaten, stoned and facing verbal abuse. Often mothers who give birth to children with impairments are abandoned by their husbands who take the other children with them, leaving the mother alone with the disabled child. Alarming, in Dadaab some of these mothers tie their children to trees when they have to fetch water or conduct other activities. The idea in doing so is to protect children from hurting themselves or running away. In reality, however, these children often become an even easier target for the rest of the community. While unable to escape they are often stoned, beaten and burned, and sometimes sexually abused.

Addressing protection concerns

Agencies working in Dadaab are trying to curb this habit. Handicap

International staff visit households in the camps to identify people with disabilities and look out for instances of human rights abuses such as children being tied to trees or confined to the house. When they identify a protection issue such as those listed above, they refer the case to CARE and Save the Children who provide counselling and conduct home visits. Some of these cases are then subsequently referred to UNHCR in order to provide additional support and protection solutions.

Options, however, are limited which is why changing the perception of the community towards persons with disabilities needs to be one of the highest priorities.

UNHCR and NGOs are including refugees with disabilities in camp committees, sectoral planning meetings, Parent Teacher Associations and their own staff. In regard to the specific issue of abandoned mothers, youth groups are encouraging neighbours to watch over disabled children if their mothers have to leave, and HI plans to create day-care centres where children can be supervised by others for a short period of time. These efforts, though limited, have already helped provide some means of protection for disabled persons, especially children. As such they need to be financially supported and enhanced.

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The views reflected in this article are her own personal views and do not necessarily reflect the views of either Mapendo International or UNHCR.

Kakuma's first raffle

Menbere Dawit with the Kakuma Syndicate Disabled Group

In the face of continuing funding cuts to programmes, residents and staff in Kakuma refugee camp in Kenya have had to find new ways to support persons with disabilities.

From 2007 UNHCR and its partners scaled down their activities in Kakuma refugee camp, believing that southern Sudanese repatriation would lead to the closing of the camp. Although by the end of May 2009, approximately 36,000 southern Sudanese refugees had indeed repatriated to southern Sudan, Kakuma has since experienced an influx of organised relocations to the camp and spontaneous new arrivals from Somalia, Darfur, DRC and even some from southern Sudan.

A reliable register of persons with vulnerabilities in the camp is imperative to identify their problems/needs and to design effective programming with their direct participation but, with 25 community-based rehabilitation workers having been laid off at the end of 2007, there are now no staff to record the number or needs of persons with disabilities in Kakuma.

The gap in services has widened and people have been requesting assistance such as prescription glasses, Braille facilities, hearing aids and other devices which will assist them to become more independent as well as consultation meetings and income-generating/livelihood training sessions.

Funding cuts have brought a previously established orthopaedic workshop for persons with disabilities to a virtual standstill. Staff try to assist those who need their assistive devices repaired (wheelchairs, crutches, children's walkers, etc) but they and the workshop lack materials. They require wood and tools to repair and make devices as well as to be able to offer skills training in activities such as carpentry, embroidery, leatherwork and sewing, and in small business development. This centre was the only place where persons with disabilities could get together for work, training and leisure.

Trials and challenges

There are many extremely difficult and humiliating circumstances that persons with disabilities endure on a regular basis. Children lacking wheelchairs are trapped at home or sit in the bottom half of small suitcases and push themselves around. Some caregivers, who look after persons with disabilities on their own, sometimes tie that person to a tree or bed to prevent them from hurting themselves or disturbing neighbours.

The majority of camp residents have communal latrines and too often people do not clean up after themselves. Consequently, many persons with disabilities whose mobility is limited and who do not have wheelchairs are forced to crawl in, invariably soiling themselves. Pit latrines should be constructed with seats for individual persons with disabilities and there should be wheelchair- and tricycle-accessible ones too.

Some people suffer exploitation and abuse because of their disability, either being housebound and alone during the day or not having the capacity to shout out or defend themselves. This is especially true of persons with mental challenges who fall victim to the abusers in our communities.

The lack of funding and scant awareness of involving persons with disabilities in managing their lives, being self-reliant and influencing their own futures has contributed to their 'invisibility'.

If caretakers, families, relatives, friends and community members are taught coping mechanisms and given training and material support, the beneficiaries would not only be persons with disabilities but everyone down the line.

In 2007, Kakuma's wheelchair basketball team was invited to Nairobi by the Kenya Wheelchair Association because its high calibre



Dadiri, an 8-year-old Somali boy with spinal bifida, Kakuma, 2010.

of players would help the association to make better informed decisions in selecting the Kenyan national team. Unfortunately, there was no funding for the trip or for the repair of the special competition wheelchairs.

Kakuma has many talented persons with disabilities who are waiting for employment opportunities. We have fine orators, musicians, carpenters, welders, teachers, tailors, Braille transcribers, weavers and tie-dye artists, to name but a few – and if they had training or livelihoods opportunities, this would assist in reducing illiteracy, idleness, insecurity, dependence, depression and sexual violence and its consequences, and would improve livelihood opportunities with respect to repatriation or resettlement.

Taking action

While advocating for more funds for persons with disabilities, UNHCR decided to do a bit of local fundraising among the refugees through a raffle. Essentially it was to raise the issue of disability, engage community leaders in learning about community members who have disabilities and gather funds to begin the process of assisting and reaching out to persons with disabilities. UNHCR's Community Services staff brought eight handmade blankets, a long dress and eight packets of coffee to be used as prizes. In a textbook example of refugees helping themselves and taking ownership of their lives, they held a raffle and were able to raise 97,035 Ksh (\$1,508).

Following the raffle, the chairman of the largest community (Somalis) in the camp stated: "Bearing in mind that we are poor refugees dependent on the assistance of the international community, we are very pleased to have raised approximately 100,000 Ksh from our meagre resources towards supporting the neediest persons in our society, the disabled. Indeed, this is a lesson to us that together we can achieve a lot." The chair of the Ethiopian community said: "This was done independently and the refugee community participated eagerly to support persons with disabilities and it makes us proud to have made our own money and be accountable to ourselves. We appreciate the idea of the raffle so that we reached this achievement. It helped all of us to be aware of persons with disabilities and initiated all to support them with courage."

The greatest problem was getting an agreement among some of the larger communities about how the money raised would be dispensed. Therefore, having an association of persons with disabilities with a broad support base is imperative as the implementing partner. It is a testament to the belief, respect and reliance the community has in this group that the community handed over the raffle money towards

running the orthopaedic workshop. While this is a small step, it is also a giant one because it shows that capacity building has had a positive effect. Through this group, persons with disabilities are making their voices heard and beginning to take responsibility for their lives.

Since then, persons with disabilities who used to work at the orthopaedic workshop have formed the Syndicate Disabled Group, an association that is now registered with the government of Kenya. The group has 300 members and is working to set up meetings in all parts of the camp to allow everyone easier access. The Syndicate Disabled Group is running the orthopaedic workshop and is providing training to other persons with disabilities. The group is also advocating to be included in consultations regarding services which affect persons with disabilities. Persons with disabilities have now designed and built our first large covered gathering place



UNHCR Kakuma

where refugees and staff from the UN, NGOs and government can all meet together in the shade.

Orthopaedic workshop, Kakuma.

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Displacement limbo in Sierra Leone

Sam Duerden

When does war end and peace begin? When a peace accord is signed? When the intervention forces leave and those responsible are put on trial? Or when civilians can return home and resume their livelihoods?

In Sierra Leone, eleven years after the signing of the Lomé peace accords, which eventually brought a chaotic, decade-long civil war to a formal close, the war continues for a group of people who came to symbolise the horror of the fighting. These are the amputees who, during the war, had their hands or other parts of limbs amputated by rebel forces. If displacement is ended by the free

choice to return home or resettle, then many of this group are still displaced.

The stories of some of the amputees I met in Kenema town in eastern Sierra Leone between September 2007 and March 2008 illustrate four dimensions that link their current settlement 'choice' to external factors deriving directly from the war: first, the original violence and forced

removal from homes and villages; second, the disabilities and wounds suffered, many remaining untreated and at risk of further deterioration; third, ongoing poverty linked to destroyed infrastructure and a devastated economy, exacerbated by personal physical restrictions; and fourth, unique psychological and psychosocial needs linked to the nature of their injuries.

The Kenema Amputees and War Wounded Welfare Association was established to support the basic needs of the wounded and to campaign for their rights. Its 62

members range in age from 13 to 65 and before the war came from a variety of towns and villages and had a range of occupations and livelihoods: painters, mechanics, church pastors, students and farmers. Only a handful are now independent in meeting their basic needs, most relying on the charity of friends or family or sometimes strangers and a smattering of NGO assistance.

With no or extremely curtailed ability to generate income, and with unmet health and education needs and severely limited mobility, shelter is an urgent need but one that the amputees cannot meet on their own.

There are also acute mental and psychological issues that for many of the group reinforce the fact of displacement and dislocation on a daily basis. A 37-year-old woman with three dependents whose foot had been amputated explained: "If I decided to go back to my village, my life will be worse than this. Sometimes when we meet with the others [amputees] we will feel happy, because we will look at each other and play happily. But if you are in the village you are alone."

Being in a group helps the individuals to cope with the trauma of their original and current experiences. In their home villages they would often be alone and certainly without those who had

similar experiences. Together in a group they can both get succour from each other and campaign together. One member commented after a group activity that the main benefit he received was an increase in respect from family members and others at home, as well as in self-respect, for literally getting out of the house and doing something. In a village, this would not have been possible.

However, there are also social pressures in the town setting. A female amputee, aged 28, explains: "Men will see me and they will like me but then they will leave me because I can't wear long trousers to follow men or to go to clubs. ... Sometimes young women come to me. We will play together, we will laugh together, but when there are any social activities they will leave me. This causes a lot of suffering to me."

It is not economic incentives or social opportunities that encourage the amputees to stay in Kenema town. Rather, it is a matter of minimising the ongoing effects of a war that remains not just as a scar but an ongoing battle, alienating and displacing the victims from preferred, if not better, choices and alternatives.

I visited the amputees again in October 2009. One of the group I had originally met had died – from his

under-treated war wounds. Another had had her lower leg amputated, but had also given birth to a healthy child. Most of the amputees had moved into new settlements on the outskirts of Kenema. Built with the help of the Norwegian Refugee Council, they are a vast improvement on what they had before – but still with problems of accessibility, water supply and electricity. Basic medical and health care remain inadequate or absent and although registration had also finally begun as the preliminary phase of paying reparations, progress remains slow.

The numbers may be small but the suffering is acute. For the individual it is the experience of displacement repeated daily. It is also an experience likely to continue because without the power of political constituency (satisfying their needs will do little for overall development indicators) or external interest (they are too small in number to pose any sort of security risk), the problems of the amputees and war wounded are just a drop in the under-development that continues to afflict Sierra Leone as a whole.

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Kenema, Sierra Leone.

The Convention: on paper and in practice

Cassandra Phillips, Steve Estey and Mary Ennis

While various international instruments are in place to protect the rights of persons with disabilities, knowledge of these at a grassroots level is limited. At the same time, holding governments that have signed or ratified some of these mechanisms accountable is no easy task, especially in times of disaster.

In March 2008, the UN Convention on the Rights of Persons with Disabilities (CRPD) came into force. The CRPD is intended as a human rights instrument with an explicit social development dimension; it adopts a broad definition of disability and affirms that all persons with all types of disabilities must enjoy all human rights and fundamental freedoms.¹ Building on several existing UN treaties and conventions, including the Convention on the Elimination of all Forms of Discrimination against Women (CEDAW) and the Convention on the Rights of the Child (CRD), the CRPD is the first and only international agreement to explicitly stipulate the rights of persons with disabilities in international law.

As of May 2010, there were 144 signatories and 87 ratifications to the CRPD. The first step is for countries to sign the CRPD, which signifies that they agree with it in principle. The next step – ratification – signals the State Parties' intent to undertake the legal rights and obligations contained in the Convention.

In addition, there is an Optional Protocol which establishes two procedures to strengthen the implementation and monitoring of the CRPD. The first allows individuals to bring petitions to the CRPD Committee, claiming breaches of their rights; and the second gives the CRPD Committee authority to undertake inquiries into serious violations of the CRPD. To date, 88 States Parties have signed the CRPD's Optional Protocol; among these, 44 have ratified the Optional Protocol.

Within the CRPD, Article 11 addresses the obligations of States Parties towards persons with

disabilities during humanitarian emergencies. While it is not explicit about what measures States Parties should take in such situations, Article 11 does reference the need for States Parties to ensure that they comply with their international human rights and international humanitarian law obligations towards persons with disabilities during this time. Read in conjunction with other relevant articles of the CRPD, such as Article 4 (General obligations), Article 9 (Accessibility), Article 10 (Right to life), Article 17 (Protecting the integrity of the person) and Article 19 (Living independently and being included in the community), Article 11 is a powerful tool to ensure that people with disabilities are included in all aspects of humanitarian response and displacement, from recovery to rebuilding and resettlement.

Article 11 - Situations of risk and humanitarian emergencies

States Parties shall take, in accordance with their obligations under international law, including international humanitarian law and international human rights law, all necessary measures to ensure the protection and safety of persons with disabilities in situations of risk, including situations of armed conflict, humanitarian emergencies and the occurrence of natural disasters.

See UN Enable website for full text of the Convention: <http://www.un.org/disabilities/default.asp?navid=14&pid=150>

In practice

The social situation for persons with disabilities is grave in many developing countries long before

natural disasters strike. In Haiti, for example, in addition to the economic hardship and political unrest affecting society, persons with disabilities are generally treated as outcasts as a result of social stigma, stemming mainly from superstition and the practice of voodoo. The January 2010 earthquake exacerbated further the vulnerability of children and adults with disabilities, particularly those with mental health issues and cognitive disabilities. The recent exposure by international aid organisations of deplorable conditions at a psychiatric institution in Port-au-Prince and in rural children's orphanages speaks to the need to protect the rights of persons with disabilities.

Haiti signed and ratified both the CRPD and the Optional Protocol in July 2009. If, as indicated above, the human rights of Haitians with disabilities continue to be violated, then it is safe to assume that they may be unaware of or unable to access the CRPD – because of barriers such as poverty, rural isolation, illiteracy and lack of disability accommodations.² Monitoring of the CRPD and the Optional Protocol is important at a government level. Research indicates that, in Haiti, Article 40 of the Constitution, which provides for the publication and dissemination of laws, orders, decrees, international agreements, treaties and conventions in Creole and French, is not yet generally applied. Neither the State Party nor civil society is advancing the CRPD agenda, although Article 33 of the CRPD stipulates that persons with disabilities and their representative organisations need to be involved fully in the monitoring process of the CRPD.

To this end, Disabled Peoples International (DPI), the largest grassroots cross-disability organisation in the world, is committed to raising awareness about the CRPD and its Optional Protocol. DPI was actively involved in

the CRPD drafting negotiations at the UN, holding consultations in member countries and regions to ensure a cross-disability perspective through the sharing of lived experiences.

DPI members are currently involved in revising the Sphere standards and, with Handicap International and World Vision International, in drafting the UNHCR ExCom Conclusion on Disabilities.

DPI's 134 member organisations provide peer support, self-help and advocacy training, and advice to groups on universal design principles. In Thailand after the 2005 tsunami, DPI's Asia Pacific Regional Office supported the establishment of the Phang Nga Society of Disabled Persons (PSDP), a self-help organisation for 4,000 persons with cross-disabilities in Phang Nga Province. PSDP provided 60 wheelchairs to people with disabilities injured by the tsunami, and advocated successfully for the building of wheelchair-accessible ramps.

The value of peer support during recovery and resettlement should not be underestimated since strong peer relationships help to empower persons with disabilities. This is clear in the work of Kaganzi Rutachwamagyo, now Head of the Disability Resource Center in Dar es Salaam, Tanzania. Rutachwamagyo, who uses a wheelchair, provided peer support to survivors with disabilities in refugee camps following the Rwandan genocide. He believes that peer support contributed to the refugees' survival and psychological well-being in Benaco Camp.

Following a disaster, persons with disabilities are scattered, and local disabled people's organisations (DPOs) may lose capacity. Liaison and cooperation with international relief agencies in rebuilding and resettlement are key to sustainability of local DPOs. When the 2004 Asian tsunami hit the south-western coast of India, international aid workers identified the need to ensure the whole disability community was included in rehabilitation but this was not put into practice.³ The result was increased isolation and neglect of particularly vulnerable groups such as persons with cognitive



Haiti, 2010.

disabilities, women with disabilities, and children.

Conclusion

In general, governments have not been successful in reporting to treaty monitoring bodies about how they are applying the various human rights conventions to persons with disabilities; the monitoring bodies have been equally remiss in not asking for this information. Adoption of the CRPD should facilitate change – and the ExCom Conclusion should help raise additional awareness.

Persons with disabilities still face significant barriers at every stage of humanitarian crisis and internal displacement: as they flee, in and around camps, en route to and upon return home. While addressing these challenges appears formidable, inclusion of DPOs in disaster management programmes, inter-agency coordination mechanisms and rehabilitation is essential to enable the immediate and long-term needs of persons with disabilities in disasters to be brought to the fore.

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- <http://www.un.org/disabilities/>
- Such as plain language translation of CRPD in Creole.
- Kett, Stubbs and Yeo, IDDC, 2005 <http://www.ucl.ac.uk/le-ccr/projects/conflict/iddc>

CRPD tools

Once the CRPD was adopted in 2006, DPI created a *Ratification Toolkit* to support the global campaign for signature and ratification of the CRPD and then, in 2007, with funding from the Ministry of Foreign Affairs (Finland), published an *Implementation Toolkit* to assist States Parties with the subsequent implementation phase of the CRPD.

The Ratification and Implementation Toolkits are online at <http://www.icrpd.net/> (English, French, Spanish)

New Zealand: beyond the quota

Rowan Saker

The New Zealand government accepts refugees with disabilities and has established structures and partnerships to facilitate their participation in society.

New Zealand's commitment to ensuring that refugees with a disability are not excluded from the country's refugee resettlement quota is longstanding. In accepting Asian refugees from Uganda in 1973, Labour Prime Minister Norman Kirk insisted that New Zealand's refugee intake include a significant proportion of 'handicapped' (the terminology has since changed) cases. Reporting Mr Kirk's announcement, the capital city's *Evening Post* newspaper wrote: "New Zealand should not say it wants only 'the best apples in the barrel'. He [Kirk] was sure that most New Zealanders would agree that these were the people who needed help most."

It was evident even then that injury and disease were all too often the consequence of dispossession and flight, and that compassion should not be limited to providing refuge for the young and able bodied only. New Zealand continued to accept refugees considered harder to settle on health and other grounds in the following decades and today refugees with special needs, who for whatever reasons – including medical – are considered harder to settle, continue to be accepted as part of New Zealand's annual refugee quota.

Quotas and commitments

New Zealand is party to both the 1951 Convention Relating to the Status of Refugees and its 1967 Protocol. More than 30,000 refugees have arrived since 1944, when refugees were first distinguished from other immigrants in official statistics. The government formalised its commitment to a set quota of refugees (which included people from each of the UNHCR's designated vulnerable categories) in 1987 when it established an annual quota of 800 refugees.

Currently the quota stands at 750 and is divided into three subcategories: Women at Risk (minimum 75 places), UNHCR Priority Protection (600 places including up to 300 for family

reunification and 35 for emergency cases) and Medical/Disabled. This last has a maximum of 75 places available.

The Medical/Disabled subcategory is designed to accommodate refugees with medical, physical or social disabilities – factors which would normally place them outside the usual criteria for acceptance by resettlement countries. Generally, applicants under this category have a medical condition that cannot be treated in their country of refuge, and resettlement to New Zealand is considered life-saving or of such benefit that it will significantly improve their medical condition and well-being. Medical cases are referred for advice concerning the availability of suitable treatment in New Zealand. Feedback from these sources is taken into consideration in the decision-making process.

In cases where there is an apparent physical or psychological condition, full medical reports are provided by UNHCR for assessment by health authorities in New Zealand. The full disclosure of the condition and its effects is essential for planning purposes, facilitating an effective early warning process for health authorities to ensure they have time to plan appropriate and necessary treatment and support for those refugees arriving in New Zealand, while ensuring that New Zealand's relatively small (in world terms) publicly-funded medical system is not overwhelmed.

As with the Women at Risk category, the Medical/Disability category accounts for around 10% of the annual quota. The numbers in each category have varied over the years depending on the referral and acceptance rate of refugees in the other categories. If UNHCR does not refer enough cases to New Zealand for a particular category, then the numbers in other groups, such as protection or family reunion, may be increased accordingly.

New Zealand's refugee policy aims to ensure its quota remains targeted at refugees in the greatest need of resettlement, while balancing this with its ability to provide good settlement outcomes to those accepted under the programme. The balance between meeting these commitments and New Zealand's capacity to absorb and provide for a number of people who will inevitably need significant health, education and welfare assistance in their initial years is a fine one, and has necessitated the development of durable solutions in order to provide an effective response.

Strategy and structure

The constitutional framework of New Zealand places great importance on respect for peoples' cultural, ethnic, racial and religious differences and their right to participate equally in society. The rights of resettled refugees are protected by New Zealand law, which covers all forms of discrimination and racism and upholds peoples' rights and freedoms of speech, religious belief and political opinion. A Health and Disability Commissioner was established in 1994. Specific bodies such as the Human Rights Commission, Office of the Race Relations Conciliator, refugee councils and incorporated associations also support the rights and interests of resettled refugees. Increasingly, local councils are appointing ethnic community coordinators to facilitate understanding of ethnic and racial diversity and to provide assistance and support to ethnic communities on a range of matters.

The New Zealand Settlement Strategy (NZSS) was launched in 2004 (revised in 2007) to provide an integrated framework that focuses on proactively supporting migrants, refugees and their families to settle in New Zealand. The NZSS provides the basis for a 'whole-of-government' approach to supporting good settlement outcomes. The Settlement National Action Plan (SNAP), launched in 2007, sets out what will be done at a national level,

with a range of initiatives including funding for resettlement of refugees, assessment of refugee qualifications, English language tuition for school children and adults, careers advice and support for those seeking work, and the development of a national network of settlement information services. Regional strategies and action plans in Auckland and Wellington are also in place to support the responsiveness of settlement activities in these regions.

Settlement Support New Zealand (SSNZ) is a national settlement network set up to direct newcomers and their families to services they might need during their first years in New Zealand, and is delivered in 18 locations around the country. This entails a collaborative approach involving central government (through the Department of Labour), local authorities and NGOs as appropriate to each location. The initiative focuses on better co-ordinated delivery of settlement advice and information at a local level, and on improving the responsiveness of local services to the needs of newcomers. Refugee Services Aotearoa New Zealand is the key NGO funded to resettle refugees, providing case management, social work and trained volunteer support. Once refugees have moved on from this service they are able to access the SSNZ local point of contact for referral to relevant services.

Over time, New Zealand's refugee policy has evolved in response to changing global circumstances and needs. The New Zealand government has, however, demonstrated a continuing commitment to devote a proportion of its quota to refugees who can significantly benefit from the medical or disability support available in New Zealand.

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Early engagement

Celia Brandon and Candy Smith

New Zealand welcomes refugees with disabilities – but how well are they supported after arrival?

Each year, the New Zealand government selects 750 refugees for resettlement. Assessment services and support for disability cases among these 750 have improved over the past few years, thanks to strong advocacy from Refugee Services (the primary agency helping refugees to settle within their new communities) and other specialist agencies such as CCS Disability Action. Quota refugees have six weeks of orientation, screening and assessment at the Mangere Reception Centre in Auckland before resettling throughout the country. Prior to 2006 refugees with disabilities arriving in New Zealand would not receive specialist support until they had been housed in the community (six or more weeks later). Introduction of assessment at the point of arrival has meant that support is now better streamlined and responds more closely to people's needs.

Challenging the system

Many of the issues for people with disabilities focus on accessing much needed resources – which are also scarce for the general population. Some refugees with disabilities arrive in the country without basic resources such as a wheelchair or appropriate assistive devices. Some have lived without these supports for a long time (for example, children or even adults may have been used to being carried rather than

having a wheelchair) and there needs to be a period of transition.

Difficulties around accessing appropriate interpreting support are generic for many refugee clients. Refugee populations in New Zealand tend to be small and it can be difficult finding appropriate professionally trained interpreters – and finding interpreters who can support refugees with a hearing impairment (i.e. who also have sign language skills) can be even more problematic. Finding adequate housing can also be difficult. In some cases there has to be a compromise between being housed where there is community support and being housed where specific disability needs (such as for modified housing) can be provided for.

Accessing the necessary support has meant working through systems which tend to have a 'one size fits all' philosophy and whose staff may not be accustomed to working with very different cultural traditions and beliefs. This requires time, education and resources.

Providing professional disability-related support

To address the gap between arrival in New Zealand and receiving disability support, CCS Disability Action linked up with the Mangere Reception Centre to ensure that professional staff are available when refugees with disabilities first arrive, working alongside the family to advocate for them and help them cope with the unfamiliarity of their new lives from a disability perspective. Early engagement enables a smoother transition into the community. In addition to this, staff have set up service networks at the centre in order to enable the government's needs assessment agency¹ to do assessments while people are still at the centre, before they are moved out into the community and elsewhere in the country. The needs assessment can then be sent on to disability support agencies in the city of destination so that action can be taken before



Khazow Yakow, an Iraqi refugee, was paralysed after being shot during Saddam Hussein's regime. Refugee Services helped her receive the support she needed when resettled in New Zealand.

the refugees arrive. CCS Disability Action staff have also worked with the resettlement centre to find economical ways to provide better access to its facilities, installing features such as ramps and handrails.

As service representatives became more familiar with each other, and good relationships were forming between Community Support Staff and the disabled person and their family, it became clear that needs assessments were not addressing 'whole-of-life' needs, only their need for interim support (which often changed once the family were settled into their own home). Families did not know what was available nor what they could ask for and were often hesitant to ask for anything. To address this, a Community Support Coordinator now meets the family prior to the needs assessment and talks about what might help them in their new environment, making suggestions based on what is available – such as a wheelchair, home-based support, carer support, funding for a vehicle or vehicle modifications. The discussion revolves around how they can be supported in a community context rather than in segregated facilities. CCS Disability Action also now funds a full-time staff member to support refugees with disability arriving in New Zealand.

Emerging from this relatively new area of work for CCS Disability Action are a number of new challenges, not least supporting families who have life experiences that New Zealanders cannot imagine. An immediate priority will be to effect change in the provision of education for refugee children and youth with disabilities, as data show that they are far more likely to be referred to special schools than is the case with non-refugee children and youth with disabilities.

Recommendations for effective support:

- Involve community support staff (or social workers) who have had similar life experiences in service delivery.
 - Establish contact with the family of the disabled person prior to any needs assessments.
 - Establish and maintain full communication between all agencies involved.
 - Always use an interpreter who can communicate effectively with service providers and the family.
 - Do not assume that all staff know about effective disability support.
- Avoid involving too many professional people – resettlement is stressful enough already.
 - Government funding agencies should independently contract disability support organisations to work in partnership with resettlement centres.
 - Resettlement centre environments should be accessible to disabled people, families with young children and the elderly.

Providing that service providers and the New Zealand government are able to learn from the different communities of refugees who are resettled in New Zealand, our country will be enriched by diversity and in turn may be able to share with other countries some examples of good practice.

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1. The Taikura Trust is the needs assessment agency working on behalf of the Ministry of Health.

Failing London's disabled refugees

Neil Amas and Jacob Lagnado

Small, refugee-led community organisations are disproportionately taking the strain for supporting London's disabled asylum seekers and refugees

Mary, a 26-year-old Zimbabwean refugee living in London, stands less than one and a half metres tall and walks with difficulty, a result of restricted growth due to a condition that makes her bones brittle and vulnerable to breaking. Each time she breaks a major bone she faces months in hospital. For this reason, she is terrified of stairs and other such challenges.

It seems surprising to learn, therefore, that when she first claimed asylum in the UK, the UK government's asylum support

service housed her on the second floor of a building without lifts and with no additional support for her condition. As her story unfolds, a litany of barriers to appropriate support is revealed. To overcome these, she has taken great strength from both her own spirit and determination and also from the emotional and practical support of a local Zimbabwean women's group, whom she describes as 'aunties' to both her and her child. She is quick to emphasise that some individual doctors and social workers have also gone beyond the call of duty

to help her but that these have been exceptional cases in a bigger system of health and social care support for disabled asylum seekers and refugees that appears to have failed her. It appears her case is far from untypical for others in her situation.

There is a significant gap in support for this population, compounded by the complexity of law around asylum and disability rights and entitlements, by their refugee-specific needs and by inappropriate provision from those with a duty of care. Anecdotally, it appears that disabled refugees and asylum seekers rely on friends, family and refugee community organisations (RCOs) rather than on the extensive network

of mainstream disability agencies, statutory and voluntary, in London.

During the course of our research it became clear that there is a significant lack of official data, confirming the hypothesis that this was a 'hidden' population. Both central and local government agencies spoken to do not keep accurate records of how many asylum seekers or refugees are disabled. Voluntary agencies, from large disability charities to refugee support agencies and small community organisations, either do not keep count of disabled refugee clients or else use widely varying counting methods. Larger disability charities appear to have very little contact with disabled refugees and asylum seekers, often do not know whether or not their clients are refugees or asylum seekers and are also unclear as to their rights and entitlements. So most of this population go to RCOs for support. There they find assistance which is both in their own language and culturally appropriate.

Rizgar runs a very busy Kurdish disability support organisation from one cramped room. Surrounded by piles of papers, and with worn-out furniture and an ageing computer, Rizgar works seemingly around the clock, and mostly alone, to offer an impressive depth of support, from form-filling to home care, from legal representation in claiming benefits to interpreting. This is provided on a minimal budget, with volunteers playing an occasional but crucial role. Rizgar's situation is typical of the disability RCOs we spoke to.

Such groups often provide a less tangible but no less important role: the opportunity to meet others from a similar cultural background, and engage in mutual support, for example with childcare. But RCOs are hampered by limited resources and find it difficult to keep up to date on relevant legislation.

Confusion about entitlements is a barrier to access to services at all levels, and asylum support law is a complex area. There is a stark contrast between the experiences of asylum seekers and refugees seeking assistance from statutory service-providers. While refugees

had mainly positive views, asylum seekers had experienced great difficulties due to the complexity of the law around their entitlements, confusion and lack of knowledge about entitlements amongst social workers, contested responsibility for asylum seekers with care needs, and a reported wilful reluctance by some social services departments to assume responsibility.

A crucial issue impacting on the statutory support received by disabled asylum seekers and refugees is immigration status. With social services, as in so many areas, immigration status appears to determine the quality of the support received. Despite a statutory duty to assess people with disabilities regardless of their immigration status, and provide appropriate care, asylum seekers appear to be in some cases refused this service. In addition, the law was felt to be applied inconsistently and inappropriately, with statutory agencies trying to offload their responsibilities onto each other and with confusion about entitlements. The asylum claim process itself posed extra challenges for disabled asylum seekers and refugees, such as lack of provision at asylum interviews for deaf interpreting.

Language is also a major barrier to accessing mainstream support. Although this affects refugees and asylum seekers generally, it has a disproportionate impact on those who are disabled because of their probable need for good support networks, especially if they are far from friends and family. It therefore compounds the isolation which disability may already cause.

There is clearly a significant support gap between the specialist refugee sector and the mainstream disability sector. While RCOs play a crucial role, resources are over-stretched and they are falling short of comprehensively meeting the needs of this population. Most mainstream organisations are also failing to meet these needs, because individuals are not being referred there, because they are confused about eligibility or because they are seen as inaccessible. Disabled asylum seekers and refugees are

therefore falling through the net in terms of overall support. With mainstream providers doing little to reach them and current funding trends threatening to further weaken RCOs, this gap is likely to widen.

RCOs also seem to be characterised by organisational precariousness due to a number of interrelated factors. One of these is the competitive funding environment, in which small RCOs are not only disadvantaged in comparison with larger organisations which are better equipped to bid for service contracts but also in direct competition with many other RCOs. Another factor is a shortage of professional staff competent in fundraising, reporting, policy advocacy and understanding UK voluntary sector systems and structures, often compounded by language difficulties. This marginalisation is likely to continue, just as the increasingly restrictive policy environment and exclusions from benefits and resources will continue to put pressure on RCOs to provide a much needed safety net.

The report recommends to all statutory and voluntary organisations as well as RCOs that they improve data collection on numbers of disabled asylum seekers and refugee clients and the nature of their disabilities, and that mainstream disability organisations and local health and social-care services actively pursue joint working opportunities with RCOs, and vice versa.

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This article is based on research undertaken by the Information Centre about Asylum and Refugees and commissioned by the Metropolitan Support Trust, which wanted to understand exactly what kind of support disabled refugees and asylum seekers were receiving and from whom.

Full report at:
<http://tinyurl.com/ICAR-London>

Reception of asylum seekers with disabilities in Europe

Ana Beduschi-Ortiz

With regard to the reception of asylum seekers in the European Union, provisions for the protection of people with disabilities are found in a wide range of regulatory sources.

Full and effective participation in society by people with disabilities implies the obligation to provide them with specific protection. EU Directive 2003/9 specifies that national legislation must take into account the specific situation of vulnerable people, such as those with disabilities, with regard to material reception conditions. In all cases, their specific needs should be individually assessed. This means that EU Member States should provide “medical or other necessary assistance” to asylum seekers with particular needs. In the case of disabled asylum seekers, this is all the more necessary when they are processed in administrative reception centres which are often not adapted to their specific needs.

Although the Directive makes it an obligation on Member States to take into account specific situations with regard not only to disabled persons but also minors, the elderly, pregnant women and victims of violence, Member States enjoy a wide margin of interpretation in the implementation of the obligation. Although it respects the principle of institutional and procedural autonomy, the text of the Directive could have gone further in determining the content of the obligation itself. It therefore leaves national legislators with the duty of determining the extent of the “other necessary (assistance)”.

Administrative detention

In November 2007 an EU report confirmed that Member States had satisfactorily translated Directive 2003/9 into national legislation.

However, it acknowledged that a number of social rights were not being respected in practice and that, because of the extensive discretionary power granted to national authorities, the protection of asylum seekers was not homogeneous across the Union. The Commission emphasises that, even if the detention of asylum seekers with specific needs is not prohibited, it should only be used as a last resort – and that its use must be duly justified. This

find themselves in administrative detention centres. Clearly, asylum seekers who have specific needs because of a disability should receive specific treatment or assistance, adapted to their needs, although the Directive does not state the extent of this. It falls to Member States to define the conditions for its implementation, which could, in effect, remove all substance from the obligation.

Social rights

A number of Member States do not guarantee effective access to social rights for asylum seekers. Apart from the general and rather fluid obligation to take into account the specific situation of vulnerable asylum seekers, including those with disabilities, the Directive does not define the means by which the States should conform to this obligation. Thus nothing is specified concerning, for example, the obligation to make reasonable adjustments to the working environment to facilitate the integration of disabled workers despite the EU’s stated commitment to eliminating

discrimination at work. Similarly, nothing is specified with regard to social security, although the European Court of Human Rights has clearly stated that nationality must not be the sole criterion determining the scope of application for benefits for a disabled adult.

The situation of a disabled asylum seeker is therefore very precarious, even if certain basic social rights are provided for in general by the Directive.

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is not what happens. Recourse to administrative internment has been legitimised, legalised and frequent. This practice, which should be considered exceptional, has thus become commonplace. The situation becomes all the more worrying when it concerns the reception and administrative detention of disabled asylum seekers.

Directive 2003/9 also specifies that Member States should ensure that asylum seekers, when they lodge their application for asylum, have access to reception conditions that “guarantee a standard of living which is adequate for health and guarantee subsistence for applicants” – including when they

Resettlement for disabled refugees

Mansha Mirza

Over the past few decades there have been some positive (albeit inconsistent) changes in US refugee admissions policy as well as in UNHCR's guidelines for resettlement, especially relating to refugees with disabilities.

Historically, US refugee admissions policy hinged on the notion of 'political persecution' and was coloured by foreign policy interests. This bias was addressed to some extent by the introduction of a new system for determining refugee resettlement priorities in 1996, whereby priorities for refugee resettlement were revised to

groups deemed 'vulnerable', such as persons facing danger of *refoulement*, women at risk, persons in urgent need of medical treatment and persons for whom other durable solutions are not feasible. Inclusion of people with disabilities in the priority one category has opened up opportunities for their resettlement in the US.

outside the country of first asylum rather than resettlement.

Over the years UNHCR's official position on resettlement for disabled refugees appears to have changed somewhat. One indicator of this change is the development of a tool by UNHCR to help field officers and its NGO partners to identify individuals in need of immediate intervention, especially resettlement. Initially developed as a tool to identify women at risk, the Heightened Risk Identification Tool (HRIT) was extended in 2007 to include other at-risk individuals. In its current form, the HRIT includes six categories with different heightened risk indicators and checklists for determining the cause and level of the risk and its impact on individuals and their families. Disability is included as an indicator under the health needs category of the HRIT.

Disability as a factor warranting special resettlement intervention by UNHCR is also reflected in its more recent 2004 *Resettlement Handbook*² which addresses how general resettlement guidelines could be applied to various categories of 'vulnerable' refugees. Among these, disabled individuals are subsumed under the broader category of refugees with medical needs. Despite acknowledging that people with disabilities are eligible for resettlement like all other refugees, and that in some cases they would need special resettlement intervention, UNHCR still shies away from identifying disability as a priority resettlement category. The 2004 *Resettlement Handbook*, like the 1996 guidelines, maintains that "Disabled refugees who are well-adjusted to their disability and are functioning at a satisfactory level are generally not to be considered for resettlement."

In the past, UNHCR has made attempts to encourage resettlement countries to accept disabled refugees and those with special medical needs. One such attempt was the establishment of the 'Ten



Refugees from Burma/Myanmar at Umpium Refugee Camp, Thailand.

introduce greater diversity in the numbers and types of refugees to be resettled in the US.

The new system also sought to create an enhanced role for UNHCR and NGOs to refer those refugees for resettlement who were perceived to be most vulnerable, across three priority categories. Within this new system, 'Priority one' – which had previously been reserved for emergency cases – now includes persons facing compelling security concerns in countries of refuge. People with mental and physical disabilities are included in this category along with other refugee

Like US refugee admissions policy, UNHCR resettlement guidelines for disabled refugees have also evolved over time. UNHCR has historically considered resettlement as an option of last resort for refugees with disabilities. According to the 1996 manual entitled *UNHCR Community Service Guidelines on Assisting Disabled Refugees: A community-based approach*, "it is more advisable to help the integration of the disabled in their own communities."¹ Even in the context of inadequate local resources in the country of first asylum, the 1996 guidelines recommended alternative solutions such as temporary medical evacuation

or More' plan in 1973 whose aim was for resettlement countries to accept – annually – ten or more (later, twenty or more) persons with disabilities, plus their families, who might otherwise not meet admissibility criteria. At the time of writing, Denmark, Norway and New Zealand were either following this policy or had some alternative quota for admission of medical/disabled refugees. Other countries, such as Ireland, Finland, Chile and the US, were not specifically following the policy but did consider refugees with medical needs as a priority category for resettlement. At the same time, some countries like Australia specifically restricted the admission of refugees with disabilities and medical needs, citing cost of health care and community services as prohibitive criteria.

More recently, in at least one location UNHCR used the process of group resettlement for disabled refugees. Group resettlement is a relatively recent initiative devised by UNHCR to streamline the identification and processing of refugees being considered for resettlement. While mostly used for the resettlement of ethnic minorities among refugee populations, this approach was used for the first time with refugees with disabilities living in Dadaab, a border town in Kenya. In 2005, UNHCR launched the 'Disabled Refugees and Survivors of Violence Profiling Project' in the Dadaab refugee camps. Some 5,500 individuals were screened through the project, of whom approximately 2,000 disabled refugees and their families were identified as meeting UNHCR's resettlement criteria and were mostly resettled in the US.³

However, it appears that this endeavour was neither well-documented by UNHCR nor systematised for replication in the future, thereby creating significant information gaps for field officers as well as for disabled refugees living in refugee camps.

Lessons and recommendations

Several implications emerge from the above. Firstly, presenting disability as a medical issue may indeed allow UNHCR and collaborating NGOs to establish urgency of resettlement intervention for disabled refugees.

However, locating disability within the medical and health-related needs category harks back to the medical model of disability, which has long been decried by disability activists for reducing the experience of disability to biomedical explanations and for focusing exclusively on remediation of individuals rather than correcting discriminatory societal practices. It would be preferable therefore to relocate disability out of the category of medical needs into a category of its own; better still, since disability is a cross-cutting issue, it could comprise a sub-category under all existing categories considered vulnerable – women, survivors of torture, unaccompanied minors, older persons and so on.

Secondly, it may be argued that the language of vulnerability compels refugees to present themselves merely as vulnerable and needy while ignoring their personal resources and resilience. In order to counter this phenomenon, some in the field advocate for a case-by-case process for determining which refugees need special assistance rather than presupposing refugees' vulnerability on the basis of their disability or some other characteristic. Indeed, there could be situations where disabled refugees are able to provide for themselves in other ways and therefore do not need special resettlement assistance or prioritisation. However, eliminating disabled refugees as a sub-group whose access to resettlement opportunities warrants special attention would be premature in the face of existing discriminatory practices of resettlement countries. Evidence from the field indicates that disabled refugees do not have equitable access to resettlement opportunities on a par with non-disabled refugees. While this might not make all disabled refugees vulnerable, it does marginalise them within existing resettlement policies. And as long as this marginalisation prevails, retaining a separate category for disabled refugees in need of special resettlement assistance is vital.

Compared with other resettlement countries, the US is not only open to resettlement of disabled refugees but also identifies people with disabilities as a priority category for

resettlement, making it a potential trailblazer in this regard. In order to encourage other resettlement countries to follow the example of the US, a good starting point would be to add disability issues to the agenda of the Annual Tripartite Consultations on Resettlement that UNHCR, resettlement countries and NGOs have been hosting since the late 1990s.

It would also be a good idea to invite disability rights representatives to these meetings as they can play an important role in persuading their respective governments to open up resettlement for disabled refugees. Cost-burden arguments against resettling disabled refugees carry ideological implications that are discriminatory against disabled refugees and disabled citizens alike in that people with disabilities are perceived as a drain on health-care and social service systems with no benefits to offer to society. Governments of receiving countries are thus exposed as paying lip service to disability rights within state boundaries while continuing to discriminate against people with disabilities at the borders.

Finally, UNHCR needs to review and clarify its resettlement policy vis-à-vis disabled refugees. Current policy is confusing at best and gives the impression that UNHCR favours resettlement for disabled refugees only as an option of last resort. This position might serve as a deterrent and a source of confusion for field officers. The wording of the policy should spell out equal access to resettlement for disabled and non-disabled refugees while situations where people with disabilities will be prioritised for resettlement should be specified. Disabled refugees living in refugee camps should be made aware of their eligibility for resettlement and positive examples should be documented so that they can be replicated in other refugee situations.

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1. <http://www.unhcr.org/refworld/docid/49997ae41f.html>
2. <http://www.unhcr.org/4a2ccf4c6.html>
3. See Women's Refugee Commission (2008) *Disabilities Among Refugees and Conflict-Affected Populations* <http://www.womensrefugeecommission.org/programs/disabilities>

Brokering the culture gap

Rooshey Hasnain

Although refugees who enter the United States are encouraged to integrate into American life, many struggle to navigate the country's service delivery system, especially those with disabilities.

On 31 July 2009, the United States finally joined 141 other countries in signing the UN Convention on the Rights of Persons with Disabilities (CRPD), the most comprehensive human rights treaty of the 21st century. Although most disability service agencies in the US theoretically include individuals of all ethnic, racial, cultural and linguistic backgrounds among their clients, few service providers are proactive in reaching out to refugee communities. At the same time, many service providers in the general disability sector lack knowledge of how refugees from a given country or culture perceive their disabilities, and how these perceptions influence their aspirations. Little attention is paid to disability in refugee communities in the US, and even less information and data are available about their particular lived experiences.

Cultural and institutional barriers

Preliminary inquiries with US-based service providers in the two key sectors – refugee resettlement and disability support systems – suggest that the lack of assistance given to refugees with disabilities can be traced to various barriers between refugees and US service providers. In general, they typically stem from language/literacy barriers, or cultural barriers at the community and systems levels. As a result, many refugees miss out on disability benefits and services available to them, which in turn leads to isolation, limited life options and a diminished quality of life.

A key aspect of the problem is that service providers in both resettlement and disability support sectors currently have few culturally and linguistically relevant methods for collecting information from, and data about, refugees with disabilities. Without such data, many US organisations serving refugees with disabilities are not fully aware of their specialised challenges, needs and capacities, and/or of the range

of disability and rehabilitation services they could benefit from if access were better facilitated.

A 28-year-old Iraqi refugee recently arrived in Chicago with his sister. He has a physical disability that prevents him from climbing or descending stairs on his own, yet he is housed in an upstairs apartment. He needs assistance to get down the 40 steps from his apartment, and he cannot climb the stairs at the resettlement agency, which prevents him from attending English language classes or having access to other resources and activities. He is unaware of the vocational rehabilitation and training services available to him.

Because few programmatic initiatives are currently in place to respond to refugees facing individual or multiple barriers, it is critical that future research address methods to identify such individuals and provide a framework to link them with disability service providers and systems. The growing influx of refugees to the US means that the agencies providing services to them need additional resources and capacities. Even when resettlement agencies succeed in linking refugees with disabilities to services, their staff members are often insufficiently familiar with the available or appropriate options.

In addition to the systemic barriers, US disability agencies often promote values and ideologies that differ from those of the refugees, as the agencies are highly influenced by the values, policies and goals of the mainstream middle-class white US culture. For instance, US culture is highly individualistic and its emphasis on personal autonomy and independence contrasts strongly with the beliefs of many refugee groups, which emphasise family and interdependence. As a result, disability professionals often miss opportunities to address the unique

needs of refugees since they may be promoting concepts and values that are foreign to newcomer groups. Therefore, many US-based refugees may be less likely to seek, request or accept assistance from mainstream service providers.

Gap in research

Little is known about the impact of disability on the refugee experience and few refugee organisations or disability service providers capture data on this group. In the US, the goal of both community-based refugee agencies and the mainstream disability and rehabilitation systems is to reach out to under-served groups, yet refugees with disabilities remain hidden and socially excluded. One often overlooked strategy to improve this situation is for providers and researchers to encourage refugees with disabilities to share their resettlement experiences and their needs, aspirations and capacities via community educational forums and dialogue. This information may help providers to better understand their unique challenges and therefore to be better able to connect refugees with disabilities to the same type of life opportunities available to refugees without disabilities – thereby also empowering them.

Building partnerships

To address this service and research gap, refugee-serving agencies, along with academics, training and research centres, hospitals and disability groups, are increasingly forming partnerships and facilitating dialogue about the meaning of disability in refugee communities. Through these partnerships, the various groups serve as cultural brokers, linking their refugee clients to the specific disability and rehabilitation supports, such as mobility aids, vocational counselling and rehabilitation planning, family support, job training, recreation and post-secondary education. In general, newcomer refugees under-utilise these services because of the awareness gap between the two sectors. However, training and capacity-building programmes are now enabling refugee communities

to be partners in the development of services, in research and in providing training. For example, refugees with disabilities, their families or other community members may be invited to take part in advisory committees or to act as consultants to discuss conceptual differences across languages, setting the programming needs and agenda for cross-cultural disability-related issues.

Such initiatives are already taking place in various parts of the US, including Massachusetts, Colorado and Illinois. In various urban, rural and suburban communities in these areas, refugee agencies are increasing their efforts to connect their refugee clients to disability and rehabilitation services that could help them become integrated into American life. These unique partnerships all play a critical key role in brokering connections for refugee clients who have disabilities, thereby reducing the inequities they face.

Multicultural brokering

Through such capacity-building partnerships, service providers are now being trained to use the Multicultural Brokering (MB) model¹ as the framework to work with marginalised and vulnerable groups, including those with disabilities. Disability and refugee providers have begun using MB to look at the cultural issues they face in their work with refugee clients who have disabilities, and with their families. In this model, a cultural broker or mediator acts to bridge the cross-cultural gap between the service provider and client when problems arise, using various types

of culturally relevant outreach and relational strategies that can help to improve access and opportunities for this group.

While newly arrived refugees with disabilities need information and services to help them integrate in their new country, they often face daunting challenges on multiple levels due to differences in culture and language. The multicultural brokering framework can help providers, community groups, and systems of different cultural backgrounds act in creative ways to support individuals with disabilities, reduce barriers and negotiate positive outcomes.

Despite the dramatic increase in numbers of refugees arriving in the US in recent years, the issue of disability among refugees remains poorly researched and documented. Therefore, US-based researchers need to:

- collect substantially more specific data on the status of arriving refugees with disabilities across many areas (employment, education, assistive technology access and therapies)
- conduct more interviews with refugees with disabilities who have had successful experiences with disability and refugee service agencies, in order to develop a knowledge base that can serve as models for other agencies and systems

In Minnesota, a Somali family with a six-year-old son with autism was initially unwilling to seek community support because Somali culture often attaches great shame to having a child with a disability. Cultural brokers and other individuals involved in the case worked to help the family in a variety of ways. For example, the family was helped to meet other Somali families in their neighbourhood who also have sons and daughters with autistic spectrum disorder and who, though they had initially been reluctant to seek outside help, were now willing to meet with other families and act as role models.

The cultural brokers also facilitated new connections between the refugee families and disability service delivery sectors by educating the Somali community about disability through the medium of English language courses at the local community agency. As a result of these efforts, the family's attitude regarding their child's disability shifted from embarrassment to openness. The family is now more engaged in a network of similar families in the community who receive appropriate rehabilitation and behavioural services for their children with autism spectrum disorders.



Rooshey Hasnain

Young girl with cerebral palsy receiving community-based rehabilitation assistance.

- conduct and evaluate multicultural brokering interventions with refugees with disabilities and their families to develop a body of evidence about this approach
- investigate current policies and practices relating to refugees with disabilities to identify what is working and what is not.

To be effective, both disability and refugee resettlement systems must be proactive rather than reactive in providing culturally and linguistically suitable services and supports to meet the complex needs of US-based refugees with disabilities. It is important for refugee communities, researchers, service providers, practitioners and policymakers in the disability sector to bring the voices of refugees with disabilities to the forefront of US-based research and policy development.

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1. For more information, see <http://cirrie.bufflo.edu/cdresources.php>

Education access for all

Helen Pinnock and Marian Hodgkin

Despite the challenges and barriers experienced by displaced learners with disabilities and the evident need for further human and financial resources, inclusive education in crisis contexts is possible.

According to the International Disability and Development Consortium, at times of emergency and displacement children with disabilities are exposed to greater risk of being separated from their families or being unable to escape from danger, find their way to safety or identify their families. Furthermore, children and young people who previously had access to support services and may have used assistive devices or mobility aids may lose these during displacement, further reducing their previous level of functioning and independence.

Education can play a protective role in emergencies, providing key life-saving messages and a safe space for children and young people to gather and receive care and support from responsible adults.

The need to provide inclusive services at the outset – and guidance to do so – has been recognised. Through a process of consensus over what the guidance should be, the Inter-Agency Network for Education in Emergencies' (INEE) handbook, *Minimum Standards for Education: Preparedness, Relief, Recovery*², provides guidance on holistic education in crisis and post-crisis contexts and a common framework for design, implementation, monitoring and evaluation as well as for advocacy and policy formulation. The INEE Minimum Standards is an official companion to the Sphere Project's Minimum Standards in Disaster Response handbook³, and has recently been updated; inclusion is now a key issue that is mainstreamed throughout the INEE handbook.

While it is important to have clear legal and normative standards to hold governments and humanitarian agencies to account, steps need to be taken to make them a reality. One of the barriers to making progress on protecting and including people

with disabilities in emergency response is the fear that inclusion is 'too difficult' in a crisis – and thus no action is taken. It is important to make clear that committing to inclusion is not about demanding the impossible or reaching for unrealistic goals but rather about allowing the principles of inclusion to inform all work, asking who is currently excluded from learning and participation and what all of us can do to improve the situation.

Challenging attitudes and breaking barriers

When examining the challenges to ensuring that people with disabilities have access to education in crisis, it is important to consider attitudinal and environmental barriers as well as demand and supply.

When communities are displaced, school facilities may be less accessible and the journey to school may take longer and be more dangerous or simply less familiar, meaning that children with disabilities are likely to stay at home. Often when schools are damaged or just not well maintained, children or young people with disabilities are disproportionately affected, as access to classrooms may be difficult, appropriate seating may not be available or sanitary facilities may not be accessible, which can be particularly problematic for girls. Furthermore, teachers may be unwilling to accept disabled children in the classroom if they are considered a burden, disruptive or unable to learn. Some teachers assume that they need special training to support disabled children.

Where families are unable to pay school fees or buy the necessary supplies, they may give priority to children without disabilities. Some children with disabilities are more likely to be kept at home, possibly even hidden from outsiders, and therefore are unlikely

"I have now realised all children are the same and need to be appreciated. My encouragement to parents who have disabled children like mine is to appeal to them not to hold them in solitary confinement but instead to embrace reality and strive to give them the best in life."

(Father of Ranya, a six-year-old who has been attending a school for two years in an IDP camp in Sudan)¹

to attend school. And families may feel that their children with disabilities will not be able to succeed in a conventional school.

Contexts vary hugely and humanitarian actors should work hard to avoid assumptions. For example, case studies collected among disabled people displaced by conflict in Mozambique found that there was strong community support for inclusion throughout the crisis. Many families in flight carried disabled people with them over long distances, despite experiencing greater risk and hardship as a result.

Humanitarian needs assessments should always ask any stakeholders simple questions focused on inclusion, such as: "Who was most excluded from education before the emergency?", "Who is most likely to be most excluded now, and why?" and "What are the best estimates of the numbers of the people thus affected?" Assessors should always ask specific questions about the situation of disabled people and, if it is possible, talk to people with disabilities and disabled people's organisations.

Those working on planning and budgeting should recognise that there will be a number of disabled (and otherwise excluded) people who will need certain barriers to be removed if they are to participate in services. If budgets need to be set before the most marginalised people's needs have been confirmed, a flexible 'inclusion' budget line should be built in. At the very least, estimates that around 10% of the

target population are likely to have had a disability before the crisis should be used to cost support for disabled people's access to services.

After the initial assessment, emergency interventions should factor in sufficient time to secure more precise information on issues facing excluded people, and then develop appropriate interventions.

In Pakistan in 2005, after widespread displacement caused by the Kashmir earthquake, Save the Children Sweden established community education councils linked to rehabilitated schools. Each school council included at least two children, who were asked to report who was not in school and why they thought these children were absent. The school councils found that often girls and children with disabilities were kept at home because their families thought that going to school was not safe or that these children would not benefit from education. Communities were worried about unfamiliar routes to school, often through unsafe territory. Parents of disabled children feared their children might receive serious injury or get lost. Without open-minded investigation, such reluctance to send disabled children to school could have been interpreted as traditional resistance to inclusion, rather than stemming from practical concerns. Once the children had been identified, the community education council developed plans to make it easier for them to come to school and to have a positive experience once there.⁴

When barriers to inclusion for children and young people with disabilities have been identified, education practitioners can work with communities and local governments to exploit opportunities presented by the emergency to encourage change to exclusionary practices and attitudes:

- When developing a back-to-school campaign with the local community, emphasise that every child has the same rights to education and that sending all children to school is appropriate and safe.
 - Arrange rotas of adults to escort children to school,
- in particular assisting those with limited mobility.
 - Work with disabled people's organisations and parents to identify reasons why families are resisting education for their children – and engage them to work with teachers on issues of discrimination, or even assist in classrooms where appropriate.
 - When (re)building school facilities, consider how to introduce more inclusive buildings with ramps, increased natural lighting and flow of air, and white walls to help children see better.
 - Incorporate inclusive education messages in teacher training (which will often be planned as part of an emergency education response) and advise teachers and volunteers how to manage diverse classes through seating arrangements, buddy systems or the development of low-cost inclusive teaching and learning materials.⁵
 - Highlight the inclusive things that teachers, the education programme and/or the community are already doing in order to foster the desire for improvement.
- In contexts of displacement the learning environment is usually not ideal for anyone, regardless of whether or not they are disabled. Investing effort in improving the accessibility of classrooms, ensuring safety to and from school and providing teachers with inclusive teaching techniques and support is likely to improve the provision of education for every learner, create a more pleasant environment to teach in, and result in more participatory and inclusive communities.

Conclusion and recommendations

Education in emergencies is still a relatively new humanitarian sector, and structures, capacities and tools are still being developed. There are thus opportunities to find ways of working to ensure that those who are currently excluded are sought out and included in emergency response:

- Demystify the idea of inclusive education for those working in emergencies, and empower all teachers, staff, officials and

volunteers with the awareness that working for inclusive education is something that everyone can contribute to.

- Make inclusive assessments, programme design, monitoring and evaluation standard practice, challenging the invisibility of disabled or other excluded and marginalised children and young people.
- Encourage donors to provide dedicated funding lines for work with the most excluded, recognising that costs per beneficiary may be higher.
- Require agencies to report on inclusion – both positive and negative aspects. INEE's experience is that inclusive education efforts are often documented but agencies are often understandably reluctant to record whom they fail to reach. Identifying and acknowledging shortcomings helps others to learn and is an important step to giving excluded people the visibility they need if they are to ever experience inclusion.

INEE's Inclusive Education and Disability Task Team includes representatives from a range of UN agencies, international and national NGOs and academics. The Team supports the INEE membership and the work of the Education Cluster in improving the information management systems, capacity building and technical guidance available to those working to provide education for learners with disabilities affected by displacement and crisis. To find out more, or to join, please email the authors.

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1. Quote provided by World Vision in INEE *Pocket Guide to Inclusive Education* 2009, available at <http://www.ineesite.org/inclusion>
 2. <http://tinyurl.com/INEE-Standards>
 3. <http://www.sphereproject.org>
 4. Case Study from the INEE *Pocket Guide to Inclusive Education* 2009, p14.
 5. Look out for forthcoming INEE *Pocket Guide to Supporting Learning for People with Disabilities*.

Services and participation in Yemen

Aisha M Saeed

Assessing the needs of refugees and asylum seekers with disabilities has traditionally been much neglected in refugee assistance programmes. Assessments in Yemen have highlighted shortcomings in service provision and enabled local actors to prioritise accordingly.

Yemen receives thousands of refugees and asylum seekers each year, due to its strategic location, and is the only country in the Arab Peninsula that is signatory to the 1951 Refugee Convention and the 1967 Protocol. However, Yemen does not have national refugee legislation or an asylum policy or institution to deal with issues relating to refugees and other asylum-seeking populations in the country. Refugee and other asylum-related matters are mostly governed by different provisions of national laws.

Out of the total 170,000 Somali refugees registered upon arrival, as of the end of 2009 about 13,000 were living in Kharaz camp, 24,000 in the capital, Sana'a, and 15,000 in the urban area of Aden. The rest are either scattered elsewhere in other governorates or have left the country.

Refugees with disabilities in Kharaz camp and in the urban area of Aden are identified by several UNHCR partners but by no single methodology. ADRA uses socio-economic assessments and Intersos uses the Heightened Risk Identification Tool (HRIT), which unfortunately does not provide sufficient information to enable a distinction to be made between sensory impairments and mixed disabilities, nor is disability included as an indicator under the other risk categories (i.e. women at risk or older persons) but only under health needs and disability.

Save the Children Sweden identified children with disabilities in Kharaz camp through door-to-door surveys. Carried out in collaboration with the Yemeni government's Office of Social Affairs and Labour in Aden, these highlighted many shortcomings in

service provision for children with disabilities and recommended that:

- Children should be referred to specialist doctors in Aden or specialists should be sent into the camp to identify their need for assistive devices and other medical assistance.
- Relevant capacity building should be provided for an increased number of community workers.
- Children should be allocated among community workers according to their disability and the capacity of the workers, not according to their place of residence in the camp.
- Children's eye problems in particular should be addressed.

In collaboration with the Women's Refugee Commission and UNHCR, the Association for Developing Persons with Special Needs (ADPSN) – a local association serving people with a variety of disabilities – conducted a participatory assessment survey in Kharaz camp. This involved structured and semi-structured group discussions with refugees with disabilities of various genders, ages and ethnicities, family members of children with disabilities, implementing agencies' staff and community representatives.

The survey highlighted numerous shortcomings in interventions targeting refugees living with disabilities. These included inadequate referral for specialised treatment, lack of any optical or hearing health services (despite significant numbers of refugees suffering from visual or hearing impairments), a lack of assistive



High chair for refugee child made by persons with disabilities enrolled in vocational training run by the Association for Developing People with Special Needs, Aden.

devices and an absence of any income-generation projects or vocational training schemes targeting refugees living with disabilities. The report also showed that community-based rehabilitation workers (CBRs) and social workers are not adequately trained to assist refugees with mental disabilities.

Services for refugees with disabilities

Current activities focus on counselling by CBRs and social workers, partial social assistance to the most vulnerable disabled refugees and limited medical attention. However, there is no comprehensive multi-sectoral approach which takes into account the varying forms of disabilities and the need for mainstreaming the needs of refugees living with disabilities into all programmatic activities in the various sectors.

Furthermore, refugee children living with disabilities face numerous obstacles in both camp and urban settings which severely hinder their access to education, starting with lack of physical access to schools as most schools do not have wheelchair ramps and many children with disabilities live far from the schools. Refugee children with visual and hearing impairments do not have assistive

devices and there is a lack of qualified teachers trained in addressing the educational requirements of refugees living with disabilities. There are no classes for children with learning difficulties in any of the schools which serve refugees.

ADPSN signed an agreement in 2009 to become a UNHCR partner. This agreement enabled refugees with disabilities to have easy access to rehabilitation services, such as physiotherapy, assistive devices and vocational training being provided by ADPSN in a government centre it supervises for the rehabilitation of people with special needs. It also provides capacity building such as training in early intervention for agency staff (including camp CBRs), training of trainers on awareness of disability for school staff and a course on physiotherapy for medical staff from Aden and the camp.

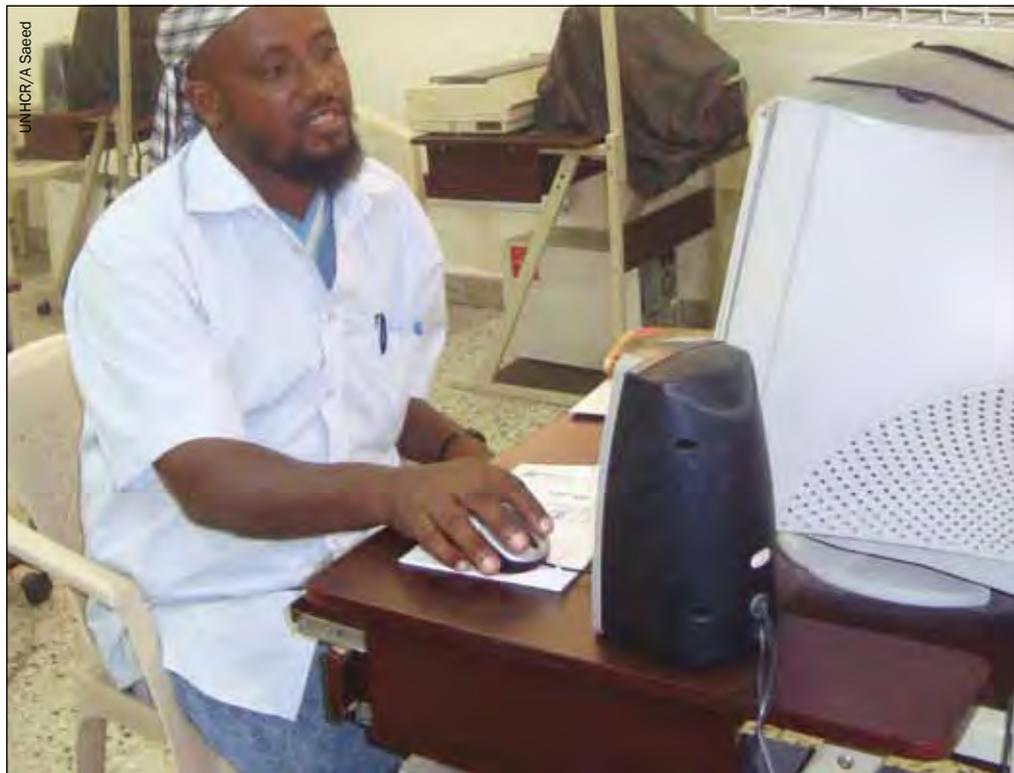
CBR work in the camp is supervised by Save the Children Sweden and is implemented through the combined efforts of disabled children, their families, the community, schools and relevant health, education and social services. The main objective is to promote the right of disabled children to integrate into the community and their right to education and medical care. Four CBR workers under close supervision from the school management carry out regular home visits to train families in rehabilitation exercises using the World Health Organisation manual. CBR workers also try to coordinate with the clinics over referral of cases for surgery and treatment outside the camp and to include children with disabilities in mainstream schooling.

Community participation and self-management

The participatory assessment conducted with refugees with

disabilities indicated that people with disabilities are perceived as a burden on the community. None of them is a member of any of the committees or sub-committees in the camp. They are not involved in any planning or programming. Information is transmitted to people

preventive measure, UNHCR and WFP want to address the need for additional commodities to be given to children, given the high rate of chronic malnutrition amongst children which has an effect on the development of the brains of these children. Special education



Computer literacy class offered by the Association for Developing People with Special Needs, Aden.

with disabilities through elders, residential block leaders, CBRs, clinics and social workers. The first time that two small groups of men and women took part in the annual participatory assessment conducted by UNHCR was in 2007. In 2009 the project for people with disabilities created the opportunity for them to meet and establish their own committee in Aden and in the camp. The head of the committee in Aden and UNHCR partners participated in a meeting with ADPSN to discuss coordination and the work plan for 2010. The committee now participates in the coordination meetings in Aden every month, and the two committees – in Aden and the camp – will be given capacity building like any other refugee committee.

The challenges that remain include the lack of job opportunities for refugees in general and for those with disabilities in particular. As a

for children with disabilities in the camp remains a challenge, especially those with intellectual disabilities.

What has become clear, however, is that running a project for refugees with disabilities with a local NGO that is already supervising a government centre for people with disabilities has the advantages of sustainability and low cost. It also has a significant impact on the co-existence of refugees with the local population.

Finally, identifying people with disabilities must continue on a regular basis, and dependency among people with disabilities must be addressed.

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Disability in the UN cluster system

Adele Perry and Anne Héry

The cluster system offers space for raising awareness among humanitarian actors and for putting disability on the agenda but it impairs local and cross-cutting dynamics at field level.

The rationale for the reform of the UN humanitarian system was that, by clarifying the roles and responsibilities among UN agencies and by trying to enhance sectoral and cross-cutting coordination, the humanitarian response would be improved – providing better coordinated and more coherent, timely and adequate assistance to the most vulnerable populations.

But how does the sectoral approach affect the capacity of humanitarian actors to respond to cross-cutting issues, for example ensuring that persons with disabilities are taken into account in the overall response?

Opportunities

Immediately following the start of the emergency in 2008 in Gaza, a disability working group was set up which was then quickly turned into a sub-cluster on disability within the health cluster.¹ The objective of the sub-cluster was to share information on disability and injury, coordinate action and support to local actors, raise awareness of disability among mainstream humanitarian stakeholders, and advocate for better assistance for persons with disabilities. The disability sub-cluster disseminated information about inclusion of persons with disabilities in relief activities, strove to have one representative in each cluster and invited mainstream agencies to attend its meetings. Most importantly, local NGOs were active participants.

Several elements in this approach made it efficient; the health cluster functioned well and had a clear understanding of the role of the sub-cluster and both the lead agency in the sub-cluster and its members were active. The disability sub-cluster enabled concrete coordination between actors operating in Gaza and assisted in obtaining funding and directing it to local actors.

In the field, the protection cluster generally holds responsibility for

addressing the situation of the most vulnerable populations. However, as many different evaluations of the cluster system have shown, the functioning of the clusters differs widely from one country to another and from one cluster to another, and the competence and personality of the cluster lead are key to the system's ability to provide an adequate and timely response and appropriate consideration of disability issues. Thus the choice about which cluster to invest in for better inclusion of persons with disabilities and injuries in a humanitarian response will continue to depend on the context.

Nevertheless, the fact that the system provides a strong incentive for coordination means there are increased opportunities for accessing other operational stakeholders. This is crucial for enabling immediate coordinated action to ensure that persons with disabilities are included from the start in all sectors. In particular, this allows inclusion of disability issues in rapid assessments. A cluster system that functions well also allows information and tool sharing on disability and provides the best space to raise awareness of disability issues among other actors.

In the Philippines, for instance, Handicap International was able to conduct awareness-raising sessions in the WASH (water, sanitation and hygiene), shelter, protection and health clusters, and included disability in the protection rapid assessment tool. The grouping together and coordination of actors can definitely give a stronger voice to the affected populations' concerns and thus make it possible to lobby other humanitarian stakeholders from a position of greater strength.

Clusters provide a space for raising a cross-cutting issue such as disability at a more global and political level, as well as opportunities to

educate major actors and attempt to put disability on their agenda. At the global level, clusters foster the endorsement and promotion of standards and guidelines. Within the global health cluster, disability indicators have been included in the essential health package and in the health resource mapping tool. The global cluster should allow the development and dissemination of technical expertise and best practices. Here again, the protection cluster could be the catalyst for progress in including persons with disabilities in global humanitarian response.

Constraints and flaws

However, along with the advantages it brings, the cluster system also has its downsides. One of them lies in the structure of the system itself, which slices the emergency response into sector-oriented, top-down activities, thereby impairing the local cross-cutting initiatives and dynamics that are essential at field level.

For a cross-cutting issue such as disability, none of the individual clusters is adequate for addressing the needs of persons with disabilities. Disability should be taken into account in shelter, water and sanitation, nutrition, health, education and livelihood activities. Thus a decision to locate the disability sub-cluster within the health cluster has its limitations, in the sense that it tends to encourage the view of disability as a purely health issue rather than as a cross-cutting issue. As far as the protection cluster is concerned, the fact that protection is in itself a cross-cutting issue, and a most sensitive political issue, tends to create obstacles and delays in taking immediate and concrete steps to provide assistance to persons with disabilities.

Furthermore, the creation of a sub-cluster on disability may not always be the best way forward as it tends to remove responsibility from other actors. All in all, the amount of time and resources that needs to be invested in cluster coordination and to work on disability is huge. Leading the sub-cluster in Gaza

represented one and a half full-time jobs during the first phase of Handicap International's response.

The inability of the cluster system to meaningfully include local actors is one of its well documented flaws. For persons with disabilities this exclusion can be particularly harmful since local NGOs are key disability actors, often developing beneficiary-oriented and essential community-based activities. Such activities, however, are difficult to include in the cluster approach.

Discussions have taken place within the Global Protection Working Group on how best to address a number of cross-cutting issues, including disability, but the group will need to commit more and longer-term resources if significant progress is to be made. Up till now the whole humanitarian system is far from being disability-friendly and responses to the latest crises have shown only a little improvement. Persons with disabilities are still generally invisible at the earliest stage and are excluded from the assessment and planning processes.

It is time for cluster leads to take responsibility for mainstreaming disability; it is not only about disseminating guideline and tools but about being more efficient, more practical and addressing the realities of persons with disabilities.

Recommendations

A dedicated sub-cluster is relevant where there are large numbers of persons with injuries or disabilities such as Gaza or Haiti. In such situations:

- Ensure there is funding for a dedicated cluster lead and support staff.
- Ensure the sub-cluster lead has a technical background in disability.
- Provide sensitisation on disability in all other clusters in the initial stages through presentations and distribution of information and toolkits.
- Continue to raise awareness of disability in other clusters by ensuring disability focal points are assigned to all other clusters to report on the activities of the

Gaza Disability Sub-Cluster

In addition to information sharing and coordination, the sub-cluster also had an opportunity to mainstream disability in other aspects of the humanitarian response. Through the presence of the sub-cluster lead at meetings of all cluster leads, not only was the issue of disability continually raised but the Humanitarian Response Fund application form for the Occupied Palestinian Territory now contains a section where applicants must outline how disability, along with gender, will be considered in the project. Moreover, during the Gaza consultation meetings for the Consolidated Appeals Process, the disability sub-cluster was given its own space to discuss the needs of people with disabilities related not only to health issues but also to education, shelter and psychosocial and mental health.

The disability sub-cluster lead was also involved in providing technical assistance to UNDP and UNIFEM to ensure that persons with disabilities were included in post-conflict needs assessments and research. By assisting in the design of questions for focus groups and surveys, and ensuring researchers were sensitised to disability issues, the disability sub-cluster was instrumental in ensuring that good quality data was gathered.

disability cluster and also to report on the activities of the other clusters to the disability sub-cluster.

- Ensure that disability is included in rapid assessments in the initial stages and dedicate time to gathering more in-depth data later through coordination with both local actors and international actors.
- Work with the humanitarian coordination team to ensure they are aware of disability issues and provide space for these issues to be raised in coordination meetings.
- Promote the inclusion of persons with disabilities in the design of projects through bilateral coordination with mainstream organisations.
- Lobby for the inclusion of disabilities as a mandatory cross-

Representatives from the disability sub-cluster also participated in the development of the contingency plans of several clusters and the situation of people with disabilities was highlighted in potential scenarios related to humanitarian emergencies. In addition, the disability sub-cluster lead worked with the Protection Cluster Working Group to develop a work plan for addressing the protection needs of Persons with Special Needs, which includes people with disabilities.



Jamila al-Habbash, 15, lost both her legs in a missile strike in eastern Gaza. She receives training to wear her artificial legs at the Artificial Limb and Polio Centre in Gaza.

cutting issue to be included in the design of all projects.

Where there is no formal disability sub-cluster, a dedicated disability focal point or team of people should be employed to ensure implementation of the above recommendations. By attending meetings of other clusters and working with the humanitarian coordination team, disability focal points can ensure disability is mainstreamed.

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1. Health cluster information
http://www.who.int/hac/global_health_cluster/en/

Negotiating inclusion in Sri Lanka

Valerie Scherrer and Roshan Mendis

In providing assistance to displaced people with disabilities in Sri Lanka, partnerships and negotiating skills have proved essential.

During the final month of intense conflict in Sri Lanka in 2009, over 230,000 people were reportedly forced to flee their homes because of the fighting. These new IDPs joined 65,000 other IDPs who had previously escaped from the northern conflict area between the end of 2008 and mid April 2009. With such a huge influx of newly displaced people the temporary camps were overwhelmed.

In such a situation of displacement, as in any humanitarian situation, people with disabilities and their families have the same basic needs as any other person but, because of invisibility, inaccessibility and marginalisation, they often slip through the cracks and are not part of the mainstream response. Additionally, people with disabilities may have other specific needs.

It became clear to CBM, an international NGO supporting long-term partners working with people with disabilities in northern Sri Lanka, that people living with disabilities who were caught up in the displacement urgently needed assistance. CBM started up a partnership with LEADS, a local NGO who, in line with their mission to care for the most neglected people, included these families specifically in their emergency response.

LEADS, because of their long-standing relationship with the Government of Sri Lanka, was in a position to provide assistance to the IDPs in the camps, including to the large number of displaced families with disabled family members. Up till then, LEADS had not specifically included persons with disabilities in any of their work. CBM on the other hand has been working for more than 100 years in the field of disability, supporting partners through providing strategic, technical or financial support. Together the two agencies were able to bring the relevant mix of skills, knowledge and capacity to the situation.

The LEADS/CBM project aimed to provide for the basic humanitarian needs of people living with disabilities and their families: suitable emergency shelter and facilities, sanitation units, meals, community cooking facilities and a common hall. LEADS managed the entire project on the ground, using their local staff. CBM provided training on inclusion of persons with disabilities, technical and strategic support, and financial support.

Towards inclusion

Emergency responses usually involve following minimum standards, with common shelter design based on existing guidelines such as Sphere and on local contexts. Unfortunately, most of these guidelines are not inclusive and do not take into consideration the needs of persons with disabilities. LEADS faced major obstacles in building accessible settlements as the cluster shelter had defined minimum dimensions for shelter construction and requested LEADS to adhere to these – but these specifications did not take accessibility features into consideration. Since LEADS were building accommodation for persons with disabilities they needed to exceed the minimum standards for size.

The primary reason put forward as an argument against exceeding minimum standards was on the grounds of maintaining equity and uniformity in the shelters being provided, and avoiding non-conformity which might give rise to conflict. In comparison with existing shelters categorised as temporary and 'emergency-type', these proposed designs were viewed as being of a semi-permanent nature. However, in the end it was agreed that a positive bias would not compromise equity as those with disability required some 'compensation' to help them cope with their difficulties in living conditions. Furthermore, given the generally accepted preferential manner of treatment of people with disabilities in Sri Lanka, it was not seen as a major threat to harmony. Ultimately, through advocacy efforts with local government,

LEADS received permission to build appropriate accommodation, although they did need to compromise somewhat on the size of the shelter.¹

The whole process of seeking to stay accountable to the coordination mechanism before building caused huge delays and placed at risk LEADS' organisational credibility in the eyes of supporting partners and authorities. Relationships were somewhat soured between local staff and cluster members. The perception of LEADS as an organisation was also affected by criticisms of reluctance in coordination being levelled at them. LEADS also found itself sandwiched between the government's wishes and maintaining coordination within the cluster.

The fact that LEADS faced these obstacles shows perhaps the lack of awareness and agreed consensus in implementation amongst humanitarian stakeholders about the presence, rights and needs of people with disabilities. There are people with disabilities in all target groups and their needs and rights are presently being ignored by mainstream humanitarian actors who need sensitisation and training in this. Standards and guidelines for Disaster Risk Reduction and humanitarian action at the international and national levels should include standards concerning the rights of persons with disabilities – and CBM continues to advocate at the international level for the Sphere standards to pay adequate attention to persons with disabilities using its partner experiences in implementing inclusive emergency responses such as in Sri Lanka. Meanwhile, LEADS is now working to resettle these displaced families and restore their livelihoods. The recently constructed shelters will soon be used as rehabilitation sites.

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1. reduced to 13'x12' from the original 17'x12' but still maintaining accessibility features; average standard temporary shelter would have been about 10'x13'.

Social inclusion: a Pakistan case-study

Munazza Gillani, Mohammad Bilal Chaudhry and Niazullah Khan

An inclusive approach to water and sanitation provision can facilitate good hygiene behaviour, improve self-reliance and reduce the prevalence of many preventable diseases.

In 2009, following violence in northwestern Pakistan and the flight of some two million people from their homes, Sightsavers undertook a rapid assessment in Jalozaï IDP camp (NWFP Province). Assessors identified 188 persons with disabilities. Of these, 49% had mobility difficulties, 24% were blind or had poor vision, 9% were hearing- and speech-impaired and 18% had an intellectual disability or multiple disabilities.

In collaboration with its partner, Human Resource Development Society (HRDS), and with the financial support of the Overseas Aid Committee of the Isle of Man government, Sightsavers initiated a project to improve the social inclusion of people with disabilities through promoting accessible water and sanitation facilities and appropriate health/hygiene conditions. Their initial needs assessments had indicated: a) lack of awareness

regarding different disability issues and possibilities for independent living, b) poor accessibility of water and sanitation facilities, and c) poor hygiene and health conditions.

Sanitation facilities in the IDP camps cater for people in general with no special recognition of the challenging access for some vulnerable groups of people, especially persons with disabilities and the elderly who are currently unable to access any sanitation facilities. The existing latrines, washrooms and drinking water points present a constant challenge to these persons, leaving them with no alternatives but the use of unhygienic and undignified alternative arrangements at home.

Confined to home

Sakeena Bibi is in her sixties and has been blind from birth. She is unmarried and lives with her sisters-in-law, brothers, nephews and nieces. She is happy that the whole family

takes care of her needs but at the same time she considers herself a burden to them. She feels as if she is living in a cave in the camp, her independence lost. She cannot go anywhere alone – to other tents, streets, water points or latrines. Everything is unfamiliar to her – a major hurdle to her mobility – and she has not yet adjusted to these changes. Only once during the last year has she ventured out of her block to meet relatives with her family. She spends all her time in the tent or in the block of ten tents. For her daily sanitation needs, Sakeena is dependent upon her eldest sister-in-law. They have constructed a mud wall around their tents to cover and protect them from cold and rain and to give them some privacy – but there is little dignity for Sakeena, and little possibility of good hygiene and cleanliness.

Initially, the community was not ready to adopt hygienic sanitation practices as they were used to open defecation. HRDS first introduced ventilated improved pit (VIP) latrines and then introduced accessible

latrines and washing facilities for persons with disabilities, and made water points more accessible. The accessible latrines have been constructed close to the living areas of people who are blind or disabled. They are exclusively for use by people with disabilities, and every disabled person has got a key to the latrine. To improve visibility, the door and door handle have been painted in sharp colour contrast. The water points and taps are also painted in bright colours to make them more visible for partially sighted people, and the height of the water points



Sakeena Bibi with her nephew



has been altered to make them accessible for wheelchair users.

Sakeena and other disabled and elderly IDPs have been taught how to use the new, accessible latrines. Sakeena's tent is quite close to one of the new accessible latrines, and now she can go there on her own, using her white cane. They have also received hygiene kits which – as the different items have good colour contrast – are user-friendly for people with poor vision. Camp residents have also been encouraged to attend awareness-raising sessions on disability and rights of persons with disabilities.

In addition, Sightsavers screened the camp population for eyesight problems, providing spectacles where appropriate. Through all these interventions, Sightsavers and its partner HRDS have learned to adopt a broader perspective of inclusive community development in the context of accessible water and sanitation facilities.

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In-house (dis)ability

Safak Pavey

In May 2007 UNHCR established an internal working group to look at developing in-house policies for people with disabilities both for the benefit of people of concern to us and for staff members.

Under the assumption that one cannot do anything for others unless applying the same rules at home, I am convinced that the UN system, including UNHCR, cannot provide effective services for displaced people with disabilities unless the principles are applied equally in-house to its staff and work environment. Simply put, it is a question of practising at home what you advocate abroad.

Our working group was multi-disciplinary in nature and included colleagues from many parts of the organisation. When it first started the process of developing a 'disability-confident' workplace and employment policy, three main themes emerged:

1. How does UNHCR address the needs of colleagues who become disabled in the course of their careers?
2. How disability 'welcoming' and 'confident' an employer is UNHCR in the recruitment and retention of staff members with disabilities?
3. How aware were UNHCR staff, particularly those at the decision-making levels, of the principles and rights enshrined in the Convention on the Rights

of Persons with Disabilities? How prepared and willing was UNHCR for the "shift from the medical to the social and human rights model of disability"¹ as a principle embedded in the Convention?

These questions were difficult then and are no easier to answer three years further on. We rapidly realised that any policy initiative would need to address issues, some quite complex, existing across the UN system relating to infrastructure, the UN-wide insurance system and security restrictions, UNHCR's rotational work policy, access to medical facilities, workplace safety and budgets. We agreed, however, that measures could be taken immediately to protect the privacy and dignity of staff members with disabilities; interim solutions could be found to allow them to continue working effectively, perform their daily duties and have an opportunity to develop their careers. With this in mind we started working on some specific, individual cases which varied from a field office not allocating the small amount of funds necessary to make a basic technical adjustment to enable our colleague to perform one of their core duties, to having to fight against a manager's prejudice against appointing a fully-

competent and specialised colleague on the basis of their disability.

We had to challenge the UN-wide medical clearance system to recognise a colleague's functionality with a disability recently acquired in the line of duty to allow that person to return to work as they wished instead of being pensioned off. We also tried to reverse appointment decisions for colleagues who were assigned to positions that they could not perform with their particular disability. And we had to overcome our security restrictions to allow wheelchair-using staff or visitors to access UNHCR headquarters through an alternative entrance.

Parallel to this work, our team decided to establish an inventory of relevant policies that UNHCR had in place – the number of policies that could be used to the benefit of staff members with disabilities (for example, flexible working arrangements). We could then develop some standards and guidelines, in consultation internally and with counterparts in other UN agencies as well as with respective national specialist bodies and civil society entities.

Within the UN family, ILO turned out to be the most progressive and was then the only UN agency that had already introduced relevant employment policies and guidelines.



UNHCR/S Hopper

At the 4th meeting of the Inter-Agency Support Group (IASG) for the Convention on the Rights of Persons with Disabilities, Onny Eikhaug, Programme Leader for 'Design for All' at the Norwegian Design Council joins Safak Pavey, UNHCR Public Relations Officer, and Rama Gheerawo, inclusive design research fellow from Royal College of Arts in the UK, in evaluating UNHCR's Emergency Kit according to disability accessibility design standards. November 2009.

They had a specific unit to work on disability-related issues with an expert team. In cooperation with them and using their policy as an example we started developing ours, with some adaptations to account for the peculiarities of UNHCR.

We agreed that policy development and implementation in this area would have to be progressive (although any new offices could be provided with sufficient information to establish appropriate standards from the outset). In this regard, in-house awareness raising and advocacy promoting good practices was highlighted as an opportunity, and it was suggested that appropriate inputs be made during the consultation process with external partners.

Moving forward

We organised some discussions and seminars with the invaluable support of some prominent external individuals and organisations. At a special event to mark the International Day for Persons with Disabilities in 2007, Gil Loescher shared a frank account of learning to live with his disability acquired in the suicide bombing of the UN building in Baghdad in 2003. He noted how his own harrowing experience had helped him to understand better what disabled refugees meant when

they said that they were 'invisible' in their communities during his visits to various refugee settlement areas and told us ironic anecdotes about the inaccessibility of the offices of specialist disability NGOs in the refugee camps.

After hard work and a lot of patience, by December 2008 we had both our operational and staffing policies approved and officially issued

in-house. It was also stressed that both managers and staff need to be more aware of disability issues and contribute to confidence building.

In response to the concerns that the policy would not be effective without resources, we had prepared a follow-up action plan, which included some pilot projects with experts such as: an Internship Scheme, a Disability Mentoring Scheme, a Disability-Friendly Workplace and Disability Standard Survey, and a Staff Training Module ('Championing Disability in the UN workplace'). Our working group also stressed that there are ways to implement the policy without a lot of resources. But a year and a half later, we have still not reached the point of implementing specific actions in accordance with the basic principles we had agreed – such as making the recruitment process more encouraging for qualified disabled applicants or carrying out pilot building modifications.

At a meeting of the Inter-Agency Support Group for the implementation of the Convention on the Rights of Persons with Disabilities hosted by UNHCR in 2009, we arranged for experts to give presentations to us about how in the real world the concepts of accessibility of the workplace, reasonable accommodation and

'universal design' principles were applied. Taking the UNHCR emergency kit that is deployed in every crisis where we intervene in the world, the design experts and I tried to open it and set up various items in the kit – but none of the items, from tent to emergency first-aid kit, could be opened or set up by a disabled or female person. Everything seemed to have been designed for a full-strength young male. How then are vulnerable, injured people or humanitarian workers with less strength supposed to access these products and services, especially in the midst of the confusion during an emergency? If these products and services were designed according to universal design principles and procured or purchased with the inclusion of disabled people then they would have been accessible for all at no extra cost.

However, we have come a long way over three years of trying to adapt our work space in UNHCR to the principles of the Convention on the Rights of Persons with Disabilities. UNHCR is actually now one of the few more progressive UN agencies in this area, perhaps because our staff are relatively familiar with real-life disability-related issues from field experiences and are flexible and practical as a result.

But there is still so much to do. While acknowledging the in-house goodwill and support, if we really want to achieve something concrete in this area then we need to allocate specialist attention, resources and staff to it. It is time that the UN family, from bottom to top, institutionalised this process. This would mean that disabled people would be represented proportionately and good practice can be created afresh for others to aspire to and follow.

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1. Understanding disability as a result of the interaction between environmental factors and persons with impairment, rather than considering disability to reside in the person.

Resources on disability and displacement

See RSC's Forced Migration Online resource summary at <http://www.forcedmigration.org/browse/thematic/disability/>

The case for a Conclusion

Brendan Joyce

Why support UNHCR's proposed ExCom Conclusion on Disability?

The current understanding of disability, known as the 'social model', holds that the root causes of the disadvantages experienced by persons with disabilities do not lie with individuals or their impairment but rather with the discrimination inherent in facilities which are not accessible, attitudes which fail to recognise the rights, capacities and dignity of persons with disabilities, and a system which fails to notice and account for variation from the 'ableist' norm.

Advocacy efforts by disabled persons, disability NGOs and disabled persons organisations (DPOs) resulted in the creation of the Convention on the Rights of Persons with Disabilities (CRPD) in 2006 – but the vast majority of UNHCR's policies and operational tools were written before the CRPD. As a result, most tools either fail to consider disability at all or maintain a 'medical model' view of disability, which equates disability to impairment.

In fact, UNHCR's 1996 publication, *Assisting Disabled Refugees: A Community-Based Approach*, provides some practical advice to field staff in line with the social model of disability. It advises on implementation of community-based rehabilitation and promotes the importance of participation and accessibility. Unfortunately, many other sections revert to the medical model, stressing individual treatment over structural and social change. These guidelines have also been criticised as not drawing on the lived experience of persons with disabilities and not making specific enough recommendations. Furthermore, the majority of UNHCR staff are unaware of its existence and until recently it was only available in hard copy in Geneva. Ironically, since this criticism was made, the guidelines have been uploaded to UNHCR's Refworld website in a format inaccessible to the screen readers used by visually impaired people.¹

UNHCR's 2004 *Resettlement Handbook* equates disability to injury or severe

trauma and offers resettlement as a protection tool only when a person is "in need of specialised treatment unavailable in their country of refuge." By contrast, UNHCR's *Handbook for the Protection of Women and Girls*, published in 2008, comprehensively discusses disability and reflects current approaches to disability.²

At the time of writing (May 2010), following extensive lobbying,³ a draft text for an ExCom Conclusion on 'the protection of and assistance to asylum seekers, refugees, stateless and displaced persons of concern to UNHCR with disabilities' (title still under debate) is being prepared.

Why a Conclusion on Disability?

Executive Committee (ExCom) Conclusions constitute broad expressions of consensus regarding the principles of international protection. As 'soft law', they are not legally binding in the same way as CRPD but are "relevant to the interpretation of the international protection regime".⁴ ExCom Conclusions can serve a number of functions including:

- introducing or reinforcing principles which may later be accepted as binding parts of customary law
- supplementing the Refugee Convention and Protocol to cover protection gaps
- providing interpretative guidance of refugee law to states and judiciaries
- providing operational guidance to UNHCR and NGO staff
- serving as lobbying and advocacy instruments
- setting standards of behaviour for non-state actors.

Conclusions 105 and 107 are informative examples of the potential value of a Conclusion of Disability. They reiterate rights articulated in the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and the Convention on the Rights of the Child (CRC) respectively and extend the principle of non-discrimination beyond the

very limited definition provided in the 1951 Refugee Convention. Conclusion 107 introduced a number of accepted child protection principles, such as 'the best interests of the child', to the refugee law discourse. Conclusion 105 led to the 2008 *Handbook on the Protection of Women and Girls* and the establishment, by the Centre for Refugee Research which was involved significantly in the creation of the Conclusion, of an advocacy and monitoring body for the protection of refugee women and children. Conclusion 105 even led to a target of 10% of resettlement places for women at risk. Each of these Conclusions addresses a gap in the refugee protection framework and provides operational guidance to UNHCR staff, making them amongst the most utilised of all ExCom Conclusions.⁵

The necessity and appropriateness of a Conclusion on Persons with Disabilities becomes apparent, therefore, given:

- the significant unmet protection needs of refugees and other displaced persons with disabilities
- the lack of attention to disability and use of outdated models of disability in UNHCR's policies, guidelines and tools
- the 'invisibility' of persons with disabilities and the lack of UNHCR staff properly sensitised to their needs, rights, capacities and dignity
- the active discrimination in resettlement policies by some states and UNHCR
- the recent entering into force of CRPD and the need to reinforce and normalise its principles.

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1. See <http://www.unhcr.org/refworld/pdfid/49997ae41f.pdf>

2. <http://www.unhcr.org/protect/PROTECTION/47cfae612.html>

3. E.g. lobbying paper prepared for UNHCR/NGO Consultations June 2009: <http://tinyurl.com/lobby09>

4. See <http://www.unhcr.org/pages/49e6e6dd6.html>

5. Bryan Deschamp, *Review of the use of UNHCR Executive Committee Conclusions on international protection*, 2008 <http://www.unhcr.org/483d701f2.pdf>

Brazil and the spirit of Cartagena

Luiz Paulo Teles Ferreira Barreto and Renato Zerbini Ribeiro Leão

The Declaration of Cartagena is important as it includes elements that link the three threads of international protection – humanitarian law, human rights and the rights of refugees – in legislation, interpretation and operation.

The Cartagena Declaration on Refugees (1984) was the outcome of meetings between government representatives and specialists from ten Latin American countries who met in Cartagena de Indias, Colombia, to consider the situation of refugees in Central America. It established the basic concepts of the issue in the human rights field and launched the term ‘massive violation of human rights’ as an element in the broader definition of refugees. On the Cartagena Declaration’s 10th Anniversary, the San José Declaration on Refugees and Displaced Persons (1994) provided further innovatory insight into the specific protection of the internally displaced, stating that their displacement was mainly caused by the violation of human rights, thereby expressly recognising convergences between the international systems of protection of the human person and emphasising their complementary nature.

The Mexico Plan of Action, which marked the 20th Anniversary of the Cartagena Declaration, proposes actions to strengthen international protection for refugees in Latin America. As host of the Southern Cone’s preparatory meeting for the 20th anniversary, Brazil contributed to the historic consolidation of principles and regulations for the international protection of the human person. The protection of human rights and strengthening of the democratic system are the best measures that can be taken in the quest for lasting solutions and in the prevention of conflicts, exoduses of refugees and serious humanitarian crises.

The spirit of Cartagena

The Brazilian state has made efforts to catch the ‘spirit of Cartagena’. It has not only incorporated the concepts of the 1951 Convention and the 1967 Protocol but in 1997 passed a law defining a refugee as any person who “due to grave and generalised violation

of human rights, is obliged to flee their country of nationality to seek refuge in another country.”

In practice, the spirit of Cartagena has been gradually built into Brazilian legislation since the Constitution was promulgated in 1988. The first article of the Constitution of Brazil enumerates its fundamental elements, including “the dignity of the human person” and the third article describes the fundamental objective of Brazil as “to promote the well-being of all, without prejudice as to origin, race, sex, colour, age and any other forms of discrimination.” Moreover, the fourth article – referring to the principles governing international relations – cites among other criteria “the prevalence of human rights; the self-determination of the peoples; cooperation among peoples for the progress of humanity; and granting of political asylum.”

Furthermore, the Constitution stresses that “all persons are equal before the law, without any distinction whatsoever, Brazilians and foreigners residing in the country being assured of inviolability of the right to life, to liberty, to equality, to security and to property....” It stresses that “the rights and guarantees expressed in this Constitution do not exclude others deriving from the regime and from the principles adopted by it, or from the international treaties to which the Federative Republic of Brazil is a party.”

Since the 1990s Brazil has ratified and is ratifying most of the international human rights treaties, so that these already form part of the Constitution. The country also participates unconditionally in the human rights regimes of both the UN and the Organisation of American States. As a result, the nation is under an obligation to observe the principles and regulations of these regimes. Thus, in 1997 Brazil met no obstacle in incorporating the Cartagena principles into national legislation.

Resettlement

The full application of regulations for the international protection of the human person and actions undertaken to consolidate this state policy are of genuine concern to Brazilian society whether through government or civil

society action, or both together. For example, Brazil has undertaken a refugee resettlement programme in close collaboration with civil society and UNHCR. Brazil and UNHCR signed the Macro Agreement for the Resettlement of Refugees in Brazil in 1999. However, it was not until 2002 that Brazil received its first group of resettled refugees. The group consisted of 23 Afghans who were settled in Rio Grande do Sul. However, owing to Brazil’s lack of experience in the resettlement of refugees, the gap between Afghan and Brazilian culture and UNHCR’s



Resettled refugees in language class, Brazil.

own lack of experience of the social, political, economic and cultural characteristics of Brazil, only nine of those 23 people have remained in Brazil in the long term.

Subsequently, improvements were made to the programme – through training resettlement specialists and exchanging international experiences in this sector. As a result Brazil is now a leader in the reception and resettlement of refugees, and CONARE, the National Committee for Refugees, has been noted as implementing best practice in the reception of resettled refugees. CONARE officials hold interviews with resettlement candidates for Brazil in the first country of asylum, for example. Brazilian officials seek to represent the real economic, social and cultural situation of the country to interviewees in the most explicit manner possible, providing a fair representation of the potential for integration and helping to avoid later frustration among settlers.

Brazil also does ‘fast-track’ resettlement in response to requests for emergency resettlement presented by UNHCR.

In an overview of the issue of asylum in Latin America, a UNHCR document in 2004 stated that there are three parallel situations in this region: 1) countries that continue to receive a reduced number of asylum seekers and refugees as part of the mixed flows of

regional and hemispheric migration; 2) countries that host a significant number of Latin American asylum seekers and refugees; and 3) emerging resettlement countries. Brazil falls into the third of these categories.

Thus it is hardly surprising that Brazil has played a leading role in terms of resettlement within celebrations for the 20th anniversary of the Declaration of Cartagena, which called for “solidarity resettlement for Latin American refugees” by countries in the region who receive a large influx of refugees as a result of conflicts and humanitarian tragedies in Latin America. Representatives of all countries in the region approved this initiative. Thus, as a result of this regional initiative, Brazil saw its population of resettled individuals grow from 25 in 2003 to 208 in 2006 and 397 in 2009, of whom three-quarters were Colombians.

Brazil is working hard to demonstrate the spirit of fraternity and human solidarity with international society through a multilateral approach within the framework of the current regulatory norms on international protection.

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Enhancing refugees’ integration: new initiatives in Brazil

Liliana Lyra Jubilut

Recent initiatives in Brazil have strengthened protection and enhanced integration opportunities for refugees.

Brazil’s commitment to refugee law and protection since the mid-1950s resulted in the passing of a bill on refugees in 1997 (Law 9474). This not only broadened protection for refugees by including gross violation of human rights as a criterion for refugee status but also created an administrative procedure for refugee status determination (RSD) and established the basis for refugee protection and integration in Brazil. This third task is undertaken by the Brazilian government, UNHCR and civil society together. Bringing social actors other than the government into the fold is regarded as a positive aspect of refugee protection and integration in Brazil, providing for a more holistic commitment to the cause of refugees. The government is, however, the most relevant actor in refugee protection, given that the National Committee on Refugees (CONARE), which has responsibility for RSD, votes by simple majority and is composed of six representatives of government and only one representative of civil society.

Civil society, on the other hand, has led the way in supporting the integration of refugees in Brazil, providing, through direct work or partnership, up to

60% of the total budget for refugee integration in the country. This highlights the fact that in the first 10 years of modern refugee protection in the country, the focus of the government seems to have been on eligibility rather than on integration. This trend, however, has started to change since the 10th anniversary of the 1997 law.

Since 2007 the Brazilian government has begun to devote attention both to refugee protection (through maintaining procedures on RSD that uphold international standards) and refugee integration, and has started to establish public policies on refugees. The federal government is looking into the insertion of refugees in existing public policies in Brazil; where this is not possible, it is considering the creation of specific public policies for refugees.

Concern for the economic and social rights of refugees has now extended to the local government level where there have been new initiatives to improve refugee protection through integration.

State Committees on Refugees

One of these initiatives has been the creation of State Committees on Refugees, in the states of São Paulo and Rio de Janeiro. These two states have the two

most relevant centres for refugee protection in the country, given that the two UNHCR implementing partners for local integration are in these cities and assist over 90% of the refugees in Brazil.¹

The first State Committee on Refugees was established in São Paulo in April 2008, presided over by the Secretary of Justice and the Defence of Citizenship. It brings together representatives from several other ministries – Economy and Planning, Housing, Assistance and Social Development, Employment and Work Relations, Education, Health, Institutional Relations, Culture, and Public Security – and from UNHCR, local UNHCR implementing partners and State defence attorneys. At the end of 2009 Rio de Janeiro established its State Committee with similarly wide representation.²

So far, the State Committee in São Paulo has acted in three different situations: on an issue of public security involving resettled refugees in the countryside, on a health issue concerning a hospital and resettled refugees, and by including 102 refugees and asylum seekers in its State work programme. It is clear from the Committee's actions to date – i.e. involving groups of refugees but not the whole refugee population – that the Committee does not want to micro-manage individual cases but has yet to adopt public policies that will benefit the whole refugee population in the State. It is important that the Committee has started to act in specific cases that were brought to its attention but it is essential that broader public policy issues be its main concern in future actions.

At the municipal level, a committee was set up in the city of São Paulo involving organs of the City hall, under the coordination of the Municipal Commission on Human Rights, and civil society to debate public policies for

refugees and immigrants there. This is an important example of local government acting to protect refugees.

These initiatives on refugee integration and on public policies for refugees in Brazil appear to be rooted in three factors. Firstly, in recent years Brazil has begun to be concerned with development and economic and social rights for its native population and this focus seems to have spread to refugees as well.

Secondly, in light of the growing urbanisation of the world's refugee population, UNHCR has started to work towards securing the rights of refugees in urban settings and is therefore highlighting the need for a more comprehensive integration and protection of refugees in urban settings such as in Brazil.

Lastly, the focus on refugee integration has been one of the main axes of the Mexico Plan of Action under the Cities of Solidarity initiative.³ The main goal of this initiative is to promote access to basic services in health, education, employment and housing – all best achieved through public policies.

It is important to highlight, however, that the State Committees for Refugees should not be seen as an end in themselves. Rather, they work as a catalyst for the creation of public policies to help ensure full protection of refugees in Brazil, guaranteeing both their civil and political rights and their economic and social rights.

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1. UNHCR also has implementing partners for resettlement and for protection.

2. For information regarding the representation in Rio de Janeiro's Committee, see Decreto 42182 of December 2009.

3. <http://www.acnur.org/biblioteca/pdf/3453.pdf>

Amnesty for clandestine refugees in Brazil

Alex André Vargem

Alongside the more than 3,800 refugees recognised by the Brazilian government, others arrive in the holds of cargo ships and slip unregistered into Brazil. "After my village was attacked, I ran away through the forest and walked to the port where I found a ship ... I had no idea where I was but finally I ended up here in Brazil."

Between 1998 and 2005 nearly half of those refused refugee status in Brazil were Africans. If their asylum application is rejected, a refugee has 15 days to lodge an appeal with the Ministry of Justice. Between 1998 and the end of 2006 there were 1,040 appeals, of which only 10 were successful. The government claims that many of those appealing do not fall under the refugee law but are economic migrants. With no prospect of getting refugee status elsewhere, these people stay illegally in Brazil.

In mid-2009 the Brazilian government offered an amnesty. 'Irregular' foreigners who had arrived before February that year had 180 days to claim amnesty. Many of these people live

illegally because they have been refused recognised status but being 'without papers' makes them reluctant to expose themselves to the government. They fear expulsion since it is the federal police who have the authority to grant amnesty.

Among the obstacles for obtaining an amnesty is the price: R\$64 (US\$32). Since many of those who might be eligible are unemployed or work illegally, they are unable to pay. The Public Defender has begun a process to lift the charge.

Some organisations of African refugees and of the black movement in Brazil are trying to gather information about African refugees and submit it to the government.

Some African refugees see the amnesty as a chance to be regularised, to be recognised by the Brazilian state – a way to a brighter future.

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Local integration of refugees in Brazil

Julia Bertino Moreira and Rosana Baeninger

Local integration is a complex economic, political, social and cultural process.

In October of 2009 there were 4,131 refugees from 72 nationalities living in Brazil. Of these, 3,822 arrived 'spontaneously', of whom nearly half came through their own networks, and 418 were resettled through the Brazilian programme, coordinated by the National Committee for Refugees (CONARE) with UNHCR support. The single largest group is from Angola (1,688) and the second largest from Colombia (598).

Resettlement

With its active programmes to resettle refugees, Brazil is considered as an 'emergent' resettlement country. The first programme was the Solidarity Resettlement Programme established in 1999 in agreement with UNHCR to settle refugees who were still persecuted or at risk of persecution or could not adapt to their first country of asylum. The second programme is the Regional Resettlement Programme, proposed by the Brazilian government in 2004, in order to protect refugees fleeing persecution and conflict in Latin America and also to help countries receiving large numbers of Colombians, such as Costa Rica and Ecuador.

The country does not set annual quotas for resettled refugees, not even by nationality. CONARE has prioritised two vulnerable groups: refugees without legal or physical protection and women at risk. In 2005, the Brazilian resettlement programme set up an innovative emergency procedure for refugees at immediate risk, whereby such refugees can have their applications examined within 72 hours and if they are granted asylum they can be resettled in Brazil within seven days.

CONARE is also responsible for analysing asylum applications and formulating public policies for refugees living in the country. The committee convenes meetings of government agencies, civil society organisations and UNHCR, which is able to contribute to the meetings but has no voting rights. CONARE estimates that the refugee recognition rate is 30%, which is comparable to international levels. The eligibility decisions have included gender persecution and have drawn special attention to children and other vulnerable groups at risk.

Local integration

A recent research project¹ interviewed refugee families who had arrived 'spontaneously' and were living in Rio de Janeiro and Sao Paulo during 2007. Most of the refugees reached the country through social networks, since 25.1% had a relative and 23.3% had a friend living in Brazil. In terms of labour market integration, 56.4% were working, although over half of these were working

in informal job occupations. Only 2.8% were included in the government assistance programme (Bolsa Família) and 11% were receiving financial support from UNHCR.

To be successfully integrated, refugees need employment, language skills and access to public services, as well as citizenship rights, duties and political participation and social relations with their community. Activities to facilitate local integration are mainly carried out by civil society organisations, although UNHCR and the government also take part. Caritas Arquidiocesana in São Paulo and Rio de Janeiro helps asylum seekers newly arrived in the country as well as refugees who have been living in Brazil for a long time. Asylum seekers may receive financial support from UNHCR for up to six months. The religious institutions provide them with legal and practical assistance, working with partners (including from the private sector) to offer legal support during the refugee status determination process, Portuguese lessons, employment training, food and dental care. Brazil has the largest support network for refugees in Latin America, with almost 100 local organisations involved.

In general, refugees benefit from the social services – such as education and health care – provided by the Brazilian government at federal, state and municipal levels. Nevertheless, there are a few specific services created to meet refugees' particular needs: a special programme for mental health care financially supported by CONARE, public housing for refugees living in São Paulo, and educational scholarships offered by the Federal University of Minas Gerais and the Federal University of Juiz de Fora.

In 2007, the federal government began to contribute to the financial support given by UNHCR for refugees living in Brazil, allocating almost US\$350,000 to CONARE, which transferred these funds to Caritas. Caritas and its partners provide resettled refugees not only with financial support but also with help in finding jobs and housing. Yet, even after ten years of resettlement programmes, challenges still remain, especially relating to refugees' self-sufficiency.

Challenges

The most critical obstacles to the social and economic integration of refugees in Brazil are lack of employment and housing, and discrimination. Our research showed that refugees consider their working conditions and pay as unsatisfactory. They find it difficult to access basic public services, particularly health care and housing. And finally they feel discriminated against by the local population. Brazilian society does not know precisely what a refugee is, frequently perceiving them as 'fugitives' from justice, making their social and labour market integration even more difficult.

To facilitate local integration, and to meet refugees' particular needs, more financial resources are needed to support implementation of specific refugee policies. The establishment of new institutions such as the São Paulo Committee for Refugees, Rio de Janeiro Committee for Refugees and São Paulo Municipal Committee for Immigrants and Refugees offer some hope. All of these include civil society participation and aim to formulate and implement public policies for refugees and other immigrants living in Brazil.

Nonetheless, the decision to put specific refugee policies into practice is controversial given the potential for disputes with the local community. The inclusion of refugees in governmental assistance programmes (such as Bolsa Família) as well as the implementation of specific policies for them may cause hostile reactions from the local population. Programmes that benefit both the refugees and the host community are essential.

In order to overcome discriminatory attitudes towards refugees, education and information programmes are needed to raise awareness about the status of refugees

and their situation in Brazil. A good example of such a programme is the health campaign developed by UNHCR in partnership with the local NGO Ação Comunitária no Brasil that took place in the Complexo da Maré slum quarter in Rio de Janeiro. Awareness was raised through drama, presenting a play performed by Angolan refugees and young Brazilians. This kind of effort is critical because it strengthens refugees' social relations with the local population, a vital component for successful local integration.

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1. 'Refugee population living conditions in Brazil', by Population Studies Center at University of Campinas (NEPO/UNICAMP) in partnership with UNHCR and Caritas São Paulo and Rio de Janeiro, financially supported by Human Rights Special Secretary of the Brazilian Federal Government.



Luis Eduardo Garzón, a resettled refugee from Colombia, with his handicrafts at the annual national fair for small-scale farmers in Brasília, Brazil, 2007.

Accountability to disaster-affected populations

Steering Committee for Humanitarian Response

The hardest aspect of accountability to disaster-affected persons seems to be managing the tensions between the timeliness and the quality of a response.

There are many different stakeholders to whom an organisation is accountable. Sadly, accountability to donors, to the general public, to governing bodies and to headquarters (in the case of field offices) can easily 'squeeze out' accountability to affected populations unless active efforts are made to uphold it. Although all operations have financial or legal accountability requirements, there is no such obligation for accountability towards disaster-affected persons. There are standards that organisations can voluntarily commit to (such as the HAP Standard¹) but there are no built-in sanctions if they choose not to do so.

The Steering Committee for Humanitarian Response (SCHR)² carried out a Peer Review on 'Accountability to Disaster-affected Persons' in 2009 with three main objectives:

- to understand the range and diversity of approaches to accountability to disaster-affected persons
- to share best practices, challenges and learning in taking forward the adoption, integration and use of different approaches to accountability, and their relative effectiveness and practicality
- to inform decisions about prioritising and integrating the diversity of accountability approaches.³

Managing accountability

From this Peer Review emerged a range of conclusions and recommendations. Organisations need to actually demonstrate that they value accountability – first through strong leadership commitment, and second by valuing and rewarding accountable

approaches, both at programme level and with individual staff. Accountability is strongest when the values of individual staff resonate with the values of the organisation.

One agency⁴ offers regular, mandatory refresher training, which is widely appreciated as a way of reminding and encouraging staff to respect core organisational principles. Another agency reflects on elements of its own staff code of conduct and its principles in annual staff reviews, including: respect for others (victims, staff, outside contacts); sensitivity to cultural, social and religious environment; and respect for local standards of conduct.

Several organisations recognised the potential for the staff appraisal process to be used more strategically to monitor performance according to values as well as objectives. Performance appraisals that include measures that promote accountability to affected groups can provide a strong incentive to staff. One organisation included feedback from refugee committees as part of the performance review of staff members working in camps.

Accountability towards disaster-affected populations is about approaches to work and not a menu of 'accountability activities'. It is more a process than an end state – requiring a culture of accountability. That said, specific resources are required for staff time, the development of staff skills and specific processes such as complaints handling. Organisations need to plan for such costs and allocate resources accordingly, so that accountable processes feature throughout the project cycle.

Accountability has institutional and individual dimensions. A systems approach to accountability

is insufficient. It only takes an organisation so far down the road to being more accountable. Accountability is best addressed by inserting and embedding it in existing procedures and tools – to make it part of how an organisation works in all its facets, not just in programming.

Accountability towards affected persons is possible when the organisation is accountable to its own staff and members. Organisational cultures that tolerate abuse of power by management, or that fail to provide a trusted means of bringing grievances to the fore, are likely to undermine and impede efforts to promote accountability to affected communities.

Changing the relationship with affected groups

Accountability cannot be pursued as a project; it requires organisations to work differently rather than do different things. It is about pursuing a process which changes the nature of the relationship with affected groups. For example, feedback and complaints mechanisms reduce the power disparity between the organisation-as-provider and individual-as-recipient. Such mechanisms need to be designed with input from affected groups, so that they are appropriate to the context; proactive efforts are needed to capture the perspectives of all sub-groups of a population.

The Peer Review observed informal complaints mechanisms in action in Ethiopia and Haiti. However, although the opportunity to lodge complaints was valued, organisations were making untested assumptions – firstly that all sections of a community know they have a right and means to complain, and secondly that the necessary processes would kick in once a complaint was received.

Organisations commonly use 'complaint' or 'suggestion' boxes.

Some individuals, however, do not trust the security of the mechanism and fear retaliation by the organisation through decreased support if they “complain too much”, or by the perpetrator if a complaint becomes known to them.

Although they can be a commendable means of enabling complaints about staff or services, boxes need to be used as one element of a broader feedback system. Proactive efforts are required to reach a wider cross-section of the population – those least able either to write or to have the means to pay someone to write a complaint, or to be mobile enough to post it, or to have the confidence to complain at all.

‘Participation’ of affected persons, as an element of accountability, is rarely fully realised. It tends to be limited to assessments and to be used as a way of extracting information and little effort is made to provide affected populations with feedback. Meaningful participation emerges from the two-way dialogue that characterises feedback procedures. It requires that affected persons are involved in key decision making, including validating operational successes and identifying failures.

One of the earliest lessons to come out of the Peer Review was that accountability to disaster-affected persons cannot be isolated from an organisation’s accountability to the other population groups it seeks to serve. This requires joining up the thinking, learning and practices across the development and disaster-response domains. Accountability as a process needs to be embedded in all phases of programming, especially emergency preparedness. In order to be accountable during an emergency response, the necessary foundations of dialogue, understanding and staff skills need to be laid beforehand. One agency recognises the importance of emergency preparedness planning for accountability during response, yet staff feel that the time constraints during the immediate ‘life-saving’ phase make full implementation of accountability principles impossible.

Though transparency is understood as a dimension of accountability, organisations find it challenging. The Peer Review suggested that

information should be shared unless there is a good reason not to, which would lead to stronger trust between organisations and affected groups.

Partnership and membership relations pose specific challenges to promoting and ensuring accountability to disaster-affected persons. There is an inherent tension between, on the one hand, working in a relationship based on trust and mutual respect and, on the other, working to ensure that the relationship results in a good quality (that is, accountable) response. Control and trust are often approached as competing concerns, yet examples demonstrate that trust can be built on shared control.

However, accountability cannot be delegated to partners. ‘Indirect accountability’ is no accountability in practice, without a clear and agreed demarcation of roles and responsibilities which are then monitored. Partners need to be involved in any accountability processes, should be held accountable for their actions and should trust the partnership relationship enough to share concerns heard from communities.

One agency has launched a ‘capacity development initiative’ to enhance members’ capacities in their programmes and activities, their internal organisation and their external relations. One of the first steps is self-appraisal, including examining a) transparency in relation to disaster-affected communities, b) participation of disaster-affected populations and their representatives in programme decisions and in giving their informed consent, and c) assessment of programmes and performance. The process guidelines identify community representatives as key stakeholders to be involved in the process.

In one case in Yemen, community representatives were invited to a senior programme review meeting where they gave feedback about what they felt were the strengths and weaknesses of the programme and what they thought should change in the future. In Colombia an agency has instigated follow-up monitoring visits six months after completion of emergency

interventions. These are used to assess with affected populations the appropriateness of the assistance provided and thereby improve on-going programmes. Another agency there undertakes the evaluation in three stages: first, communities are asked to identify what was good and bad about a programme; then the agency team undertakes a self-evaluation of the work; and finally the two are consolidated into an agreed overview analysis.

Understanding

Two significant semantic hurdles emerged during the Peer Review process. Firstly, ‘accountability’ is not easily translatable from English, or becomes confused with legal, financial or even religious terms. Secondly, and more widespread, is the concern that ‘accountability’ has become a much-abused word which may mask poor understanding or misunderstanding among staff.

More generally, the very term ‘accountability’ is not well understood among staff of participating organisations, particularly at the level of country programmes. The term itself can frequently block individuals’ understanding, so that actual accountability is kept at a distance, as policy-level rhetoric rather than a responsibility that needs to be acted upon. This points to the need for incremental and practical guidance on how organisations can realise their accountability to disaster-affected persons – such as through complaint mechanisms, or the provision of feedback to disaster-affected persons on key decisions or learning, or their involvement in such stages.

Accountability requires organisations to change the way they work, by creating a different relationship with persons of concern where the aim is to diminish the power disparity between them. Learning from the Peer Review points to the need for attention to both policies/systems and attitudes/behaviours.

Premature conclusions?

All nine organisations developed an action plan in response to the Peer Review and it is anticipated that it is in these action plans that the conclusions and the real impact

of the peer review will be seen – putting the learning into practice.

Although each of the nine organisations involved embarked on the Peer Review from a different starting position, there are a number of lessons that resonate with all of them:

- acknowledging, making visible and diminishing the power imbalance between organisations and disaster-affected persons
- involving affected persons meaningfully in key decisions and processes that influence their lives

- building relationships with affected persons that are characterised by dignity and respect
- sharing relevant information and communicating transparently (providing feedback to disaster-affected persons as well as consulting them)
- behaving with integrity, keeping to commitments made and engendering trust.

Individual staff make it possible for organisations to realise their responsibility and commitment to accountability towards affected populations. It is perhaps on their

personal commitment and drive that accountability to disaster-affected persons rests most securely.

This article was provided by SCHR (schr@ifrc.org) with the support of UNHCR (contact José Riera riera@unhcr.org)

1. Humanitarian Accountability and Quality Management Standard (2007) <http://tinyurl.com/HAPstandard>

2. An alliance of major international humanitarian organisations aiming to support increased quality, accountability and learning within the humanitarian sector. SCHR uses Peer Review as a tool for facilitating learning within and between its members. UNHCR joined them in this particular Review.

3. The report of the peer review is available at <http://tinyurl.com/accountability-SCHR>

4. Examples are real ones from the report but individual agencies are not named here.

To return or stay?

John Giammatteo

The views of Sri Lankan refugees in India challenge some of the assumptions inherent in promoting repatriation as the most desirable durable solution to protracted displacement.

Voluntary repatriation has long been seen as the foremost durable solution to forced displacement and the solution that would benefit the greatest number of refugees. This perspective assumes that, once the original cause of flight is redressed, refugees will not only still identify with their homeland but also want to return. These assumptions are challenged, however, by many of the Sri Lankan Tamil refugees living in Tamil Nadu, India.

Sri Lanka's ethnic conflict has resulted in waves of migration, with some of the earliest refugees arriving on Indian shores after violence in 1983 and throughout subsequent years of fighting between the Government of Sri Lanka and Tamil militants. Today, over 125,000 Sri Lankan Tamils live in India, 75,000 of whom live in camps in the Indian state of Tamil Nadu. This population has been forced to adapt to new lives away from their home country and new generations have been born in exile – generations who may or may not identify with their parents' native place.

In November 2009 a one-month research project, undertaken with

the help of the Organization for Eelam Refugee Rehabilitation (OfERR),¹ investigated the reactions and opinions of Tamil refugees regarding the possibility of repatriation following the defeat of the Liberation Tigers of Tamil Eelam (LTTE) in May 2009.

Interviewees were drawn from the three main waves of refugees: in 1984, 1990 and 2006. One third had suffered more than one displacement and had returned to Sri Lanka only to leave again a few years later and one third were either born in India or came to India for the last time before the age of ten.

Of the 30 interviewees² surveyed in this project, 15 said they would stay in India and 15 said they would go back to Sri Lanka. There was no strong divide along gender lines. People who came from the Mannar and Trincomalee regions of Sri Lanka were more likely to say they would return to Sri Lanka, while those from Jaffna and Mullaitivu were more likely to say they would stay in India. Likewise, those who last arrived in 2006 were more likely to say they would return to Sri Lanka than those who last arrived in 1990.

Changing expectations

None of the interviewees had expected to stay in India this long. Laxsman, a 22-year-old man who came from Sri Lanka at the age of three, explained that his mother "felt [that on] arriving in India in 1990, we would definitely return in three months to Sri Lanka. But 19 years have passed." Similar sentiments were repeated over and over, even by those who had arrived comparatively recently, in 2006.

The focus on return, and the hope that it would come soon, created a sense of anticipation among the refugees in Tamil Nadu. Security was first and foremost in their minds. Refugees felt that it was only to safeguard their lives that they were in India. Everything else – such as a comfortable (and permanent) living space – was a secondary priority. As pointed out by Murugan, who arrived in Tamil Nadu in 2007:

"Actually, when I came here ... all my expectation was to keep my life. That's all. Then, after coming here there are some restrictions – we can't go out of the camp without permission and we cannot go out of the camp for work for two or three days. Everyday we have to sign at the gate as we leave... So these types of restrictions are here... Some tightened freedom is there..."

The underlying assumption for him was that some restrictions might not be ideal but they are manageable, provided his life is safe. Even the physical settings of some camps reflected a similar reality, with family residences divided for years only by sheets.

For some of the interviewees, this attitude of anticipation has shifted in significant ways within the past few years. For Ganesh, a 66-year-old man who first came to India in 1990, events experienced in exile have changed his expectations:

[interpreter] *"He's not returning to Sri Lanka because his family, his wealth and all have been destroyed in Sri Lanka... After the tsunami, he feels Sri Lanka is no better... [in] the nearby houses, nearly 122 people died in the tsunami... relatives and neighbours also, so he feels that [if he has] no relatives and neighbours in Sri Lanka, why settle back in Sri Lanka?"*

For Ganesh, the 2004 tsunami had made him rethink his expectations of returning home. Interviewees cited how other specific events like the cessation of the 2002 Ceasefire Agreement forced them to reconsider any return to Sri Lanka. For others, the process was more mundane – a gradual understanding over the last few years that return would not be immediate, if at all. Illness, age, a child's birth, education or lack of knowledge of the homeland all influenced expectations about returning home for different people.

These attitudes have found parallels at official levels as well. OfERR and other agencies had recently completed a project to update some camps with permanent wooden dividers between individual spaces. One such camp is located at Arni, a camp to the west of Chennai which was established in 1990 in an old warehouse.

The government originally provided spaces inside for each family, divided by cloth walls, and only within the last year has the cloth been replaced by plywood sheets. Similarly, Tamil Nadu's chief minister said in October 2009 that he would make a plea to India's central government to confer Indian citizenship on the Sri Lankan refugees. A month and a half later, Tamil Nadu announced Rs 1 billion

of aid for the refugees, including them in various government schemes and setting money aside to improve camp facilities and amenities.

The younger generation

As in many refugee situations, a whole generation has been born in exile – or left their home country at a very young age. In the case of Sri Lankan Tamils in India, asylum is not a path to citizenship and refugee children born in India are not Indian citizens. Instead, their births are registered with the Sri Lankan Deputy High Commission in Chennai, and registration then leads to citizenship in Sri Lanka. However, for many in this generation a return to Sri Lanka may not be their first choice.

This generation still see themselves as Sri Lankan Tamils, follow news about Sri Lanka and have views on both the conflict and Sri Lankan politics. Secondhand news is filtered through parents, people in camp, relatives in Sri Lanka and newspapers and other media sources.

Unlike for their parents, however, camp life for the younger generation is routine and seen as 'normal' or comfortable. Nimal, a 25-year-old man who arrived in India at the age of five, described his everyday camp life, saying, "So when you talk of my schooldays, we go to school, we come back, we worship, we go to the evening tuition centre, we study, we come back, we go to sleep, and again we get up and go." Another interviewee said that, growing up in India, his habits, culture and even style of dress were Indian and not Sri Lankan. Likewise, Laxsman said:

"I was only three years old when I arrived in India. India gives me education, shelter and other things. I love Sri Lanka because it is my motherland but I love India more, because it gives me my life."

In interviews and informal conversations, people from the younger generation would often say that they wanted to stay in India as they did not 'know' Sri Lanka. The younger generation's future can also be an important push or pull factor for parents, some of whom felt that their children's education might be jeopardised by returning, others believing

that their children would receive a better education in Sri Lanka.

Family in Sri Lanka

News and information collected from relatives and friends in Sri Lanka played an important role. If relatives said that it was safe and encouraged them to come back, some interviewees expressed a desire not only to return and to do so quickly. Kalyani, who had already submitted a letter to UNHCR asking to return, had originally left Mannar following government restrictions placed on fishing. Through her brother who was still in Mannar, she had heard that the fishing ban had been lifted and the district was now safe. She was eager to return to Sri Lanka, especially as her husband was sick and one of his legs was paralysed. Her brother was encouraging her to come back to Sri Lanka, asking why she continued to suffer in India when all her family could help her and look after her husband if they returned.

Similarly, those who did not have regular communication with family in Sri Lanka, or whose family did not feel safe, were less likely to say they would return. Anand – a 29-year-old man who came to India in 1990 – said he had regular contact with his relatives but they were moving from place to place without "security for their life" and advising Anand not to return: "You have to give some more time. We will let you know when the time is right." He had no immediate plan to return – barring what he saw as a permanent solution – and planned to stay in India, availing himself of Indian citizenship if it were offered to him.

For any voluntary repatriation programme to be successful among the Sri Lankan Tamil population in India, it must acknowledge the nuanced and individualised nature of the factors affecting the desire or possibility of return – and address the expectations aroused by presenting repatriation as the most favoured solution.

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1. <http://www.oferr.org>

2. Via 30 semi-structured formal interviews with camp residents and OfERR volunteers, as well as informal conversations and observations. All names are pseudonyms.

Responding to IDP reproductive health needs

Shanon McNab and Isabella Atieno

Despite the administrative, logistical, political and cultural challenges of working in Darfur, the Gereida Comprehensive Emergency Obstetric and Newborn Care Centre has made significant progress in a short time.

Following the surge of violence in 2004, more than 2.4 million men, women and children in Darfur were displaced. Several hundred thousand of them fled to the southern Darfur town of Gereida, effectively tripling its population. While living in a camp setting in Gereida, these IDPs (internally displaced persons) had access to a government-run hospital that offered only minimal, often poor-quality reproductive health (RH) services, for a prohibitively high fee. The American Refugee Committee (ARC), a partner of the RAISE Initiative, recognised this vulnerable population's need for free, high-quality, comprehensive emergency obstetric and newborn care (EmONC) and family planning – and decided to construct, outfit and staff a comprehensive EmONC centre.

Access to both family planning and comprehensive EmONC is vital to reducing maternal mortality. Although all women need family planning to time and space their births, this is often even more vital to women who are displaced. Furthermore, family planning is one of the most cost-effective, high-yield interventions available to prevent maternal and child death and disability, infertility and high-risk pregnancies amongst vulnerable women. EmONC refers to the care of women with obstetric complications during pregnancy, and of women and newborns during delivery and shortly thereafter. Comprehensive

EmONC includes the ability to carry out surgical interventions (specifically caesarean sections) and blood transfusions, both of which are crucial to managing obstetric complications. When EmONC services are low quality,



The new EmONC Centre in Gereida provides comprehensive emergency obstetric and neonatal care.

unavailable or available only at a high cost to the patient, women and newborns die needlessly.

Existing facilities

Prior to ARC and RAISE's intervention, most pregnant women in Gereida delivered at home and many died from potentially treatable complications. In addition,

strict national policies prohibiting non-physicians from performing caesarean sections made it difficult to maintain a staff capable of handling complicated deliveries. If no doctor was on duty, women in need of a caesarean section would be forced to travel three hours to reach the nearest EmONC facility. Even if women were able to overcome the substantial financial and logistical obstacles to procuring a vehicle for this journey, the lack of security on the roads posed extra challenges.

In terms of family planning, Gereida's hospital had no designated staff member to ensure the availability of affordable, adequate supplies, or to educate women about them. Although ARC and RAISE saw a tremendous need for these services, what little data existed documented very low demand for family planning without a clear indication of why this was the case. To better understand IDPs' knowledge and attitudes around family planning, ARC conducted informal focus groups. These showed that women wanted to use family planning methods for birth spacing, citing improved health for mother and child and improved economic circumstances as likely outcomes. The major barriers to accepting family planning – for both men and women – were lack of knowledge of methods and ill-informed fears about side effects.

The new EmONC Centre

After months of discussion with the Sudanese Ministry of Health (MoH), the decision was taken to build the Gereida Comprehensive Emergency Obstetric and Newborn Care Centre, to be open 24 hours a day, seven

days a week, with RH services available free of charge to both the IDP and local populations. The doors opened on 28 October 2009, and the facility's first birth took place that same day. With a staff of more than 25, the Centre offers outpatient care, ante- and post-natal care, delivery, laboratory and pharmacy services, an operating theatre, neo-natal care, blood transfusions, latrines and a bathing area. Most importantly, women are now guaranteed qualified staff to assist with obstetric complications at all hours of the day.

In addition to EmONC, the new Centre has had important successes related to family planning. Significant increases in the uptake of family planning have occurred each month since the Centre opened; in fact, the number of new family planning clients has more than tripled since October 2009. The Centre has also hired a full-time RH manager to coordinate supplies and offer good private family planning counselling. Furthermore, the Centre has experienced a marked increase in internal referrals; for example, women who come for post-abortion care (PAC) are now referred to family planning services, where once they might have been overlooked.

Investment in the data collection system has also improved the Centre's ability to evaluate the quality of its services. The system has been entirely updated and staff have been trained in data collection and management. The RH manager now reviews monthly reports with the hospital staff to determine which services are improving and which need further attention.

To better educate the local population about RH, the Gereida Centre has trained several health educators who conduct community-based education sessions about family planning methods and EmONC services. The ARC Gereida team believes that these outreach health educators have played a large role in the increased number of visits to the Centre over the last four months.

The dissemination of information to the local community and the increase in the number of women seeking family planning methods are important successes. To understand

the significance of these gains, it is important to examine the challenging context in which they were achieved.

Challenges to service availability

Securing the necessary approvals from government offices, constructing the Centre and ensuring a consistent flow of commodities were each intensely time-consuming. ARC worked in close partnership with the MoH on this project; however, its realisation still took almost two years. Meanwhile, due to logistical complications, ambulances that had been purchased for the Centre sat unused in Khartoum, waiting to be transported to Gereida where the violence continued to escalate and emergency services remained unavailable.

Availability of logistics and supplies:

Notwithstanding the updated logistics system at the Centre, ensuring the flow of necessary supplies – which is absolutely essential – is extremely difficult. Supply orders have sometimes arrived incomplete, or long after stocks have been depleted, forcing ARC to purchase supplementary supplies from various local pharmacies. Because word of mouth is the main driver of patient visits, it has serious implications for maintaining clients' trust if supplies run out; if women cannot consistently obtain the services and supplies they expect, they may influence other clients and potential clients to stop using the Centre.

Government health policy:

The Sudanese MoH has strict guidelines outlining which contraceptive methods may be offered in the country. At this time, contraceptive implants are not recognised, making it illegal to provide them or even to educate patients about them. The MoH is collaborating with the ARC Gereida team to advocate for a change in this policy but IDPs in Gereida currently do not have access to this method.

The MoH also restricts non-physician health workers from providing services when a doctor is not available. According to official policy,

only doctors may perform caesarean sections or insert IUDs; however, with proper training other cadres of health workers have been shown to provide such services with error rates as low as those of doctors. This policy, combined with the difficulty of employing and retaining doctors in such remote settings, impacts women's access to care. Given the scarcity of doctors in IDP settings, and women's need for a full range of family planning methods, the need for continued advocacy is clear.

Religious and cultural barriers:

The majority of IDPs in Gereida are practising Muslims and live within a culture where family planning is not universally accepted. Though Islam does not prohibit the use of family planning, traditional methods are considered to be the most natural and are more often acceptable to men. Furthermore, the MoH highly recommends that women be accompanied by their husbands when they go to a facility for family planning. ARC's focus group results were clear: men will be more accepting of the various contraceptive methods if they are educated about them, and if access to family planning is free. Centre staff continue to work diligently to educate the community on the many services they provide and the contraceptive options available.

Looking to the future

In their continued efforts to increase the number of women coming to the Centre for family planning methods, staff members have two main priorities: to advocate to the MoH for adoption of contraceptive implants in the national policy and to continue to send clear messages, via health volunteers and educators, about the Centre's available services.

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**Reproductive Health Access,
Information and Services in Emergencies**

Migration, mobility and solutions: an evolving perspective

Katy Long and Jeff Crisp

There is growing recognition that refugees' mobility is a positive asset that can contribute to their lasting protection.

Freedom of movement is a fundamental human right and is central to the functioning of the international refugee protection regime. The very ability to seek asylum depends on the ability to move in search of rights that have been denied in the country of origin. In a broader sense, it is now increasingly recognised that human mobility provides an important means for people to improve their standard of living and to contribute to the economic and social life of their countries of origin and destination. Despite a growing recognition of this, however, the international community has been slow to incorporate mobility into its responses to forced migration. Solutions to displacement have focused on containing or reversing movement, rather than on restoring the lost rights which prompted flight in the first place.¹

For most of its 60 years, UNHCR stuck firmly to the belief that 'there is no place like home'. Even in the Cold War years – when refugee repatriation was relatively rare – resettlement and local integration programmes were projected as the making of new, permanent 'homes'. Those refugees unable to access these solutions were frequently encamped in what often became protracted refugee situations, their freedom of movement severely restricted by host states who awaited their eventual 'return home'. However, the last three years have seen a significant shift in thinking and UNHCR now believes that the protection and enhancement of refugees' mobility may in fact offer a means of ensuring their enduring access to meaningful rights and sustainable livelihoods.

UNHCR's changing attitude to mobility can be explained by a number of factors. There is a growing body of academic research indicating that forced migrants' return home

is frequently neither possible nor desirable, and that transnational diasporic community networks can contribute positively to the de facto protection of refugees, asylum seekers, IDPs and other persons of concern to UNHCR. The difficulties encountered in finding sustainable solutions to protracted refugee situations have also influenced the development of new policies.

A sedentarist approach to forced migration crises does not reflect the reality of refugees' decision-making processes or provide forced migrants with an adequate choice of livelihood strategies. Nor are anti-mobility strategies able to offer a serious answer to the increasingly complex challenges faced by those seeking to provide effective international protection to those in need. These challenges – which include mixed migration flows, the onward movements of refugees and asylum seekers, the growth in human smuggling and trafficking operations, and the increasing urban self-settlement of refugees – are all symptomatic of a serious imbalance between international responses to forced displacement and the socio-economic protection needs of those who are displaced. These protection gaps will not be bridged by attempts at more effective population containment but instead require more effective protection of forced migrants' rights to move freely.

Enhancing refugees' mobility is now recognised as a key factor in both understanding and addressing refugee movements from camps to cities. Protecting mobility is also seen as a key part of combating the human rights violations that frequently occur as a result of irregular or secondary movements from the first country of asylum, often in search of effective protection. And increasingly mobility is also seen

as offering a possible solution to refugees' displacement in itself, through the use of regularised international labour migration channels and the strengthening of refugees' and IDPs' prospects for post-return mobility. Refugees from Kenya's Kakuma and Dadaab camps, for example, face restrictions on their freedom of movement and access to local labour markets. With no durable solution to their situation in prospect, significant numbers have found their own 'solution' by self-settling in Nairobi – but because this escape from aid-dependency is often illegal under the laws of the host states, greater socio-economic independence often comes at the price of loss of international protection.

UNHCR's new urban refugee policy, published in September 2009, reflects the need for protection strategies that work with, rather than against, refugee mobility.²

Similar changes can be seen in UNHCR's response to continued concerns over onward movements of refugees and asylum seekers from first countries of asylum. Although recognising states' political and security concerns regarding the irregularity of many such movements, UNHCR now insists that 'effective protection' in a country of first asylum must include access to adequate and dignified means of subsistence, and that failure to ensure this is a justification for continued movement.

Improving access to protection

Given this recognition that refugees' onward movement is defensible in at least some cases, the challenge is to provide better access to protection within processes of onward movement and mixed migrations. From this perspective, human smuggling and human trafficking networks need to be tackled not in order to secure states' borders but in order to better protect their clients' and victims' human rights.

People with protection needs will move – and should be able to move – in order to find effective protection. This principle is central to the very concept of the international refugee regime. This helps to explain why UNHCR has become increasingly interested since 2006 in the possibilities offered by promoting regularised labour migration as a solution to refugee exile, particularly in terms of meeting socio-economic needs. UNHCR's 2007 10-Point Plan for providing refugee protection in mixed migration flows suggests that:

“There will be circumstances where people who do not meet the criteria for refugee status may nevertheless be in a position to access alternative temporary migration options. These could variously allow them to stay legally in the country of arrival, or to move to a third country for humanitarian reasons, or for the purposes of work, education or family reunion. Efforts to address mixed population movements should also explore a place for regular migration options, temporary or even longer term...”³

Regularised labour migration may also play an important role in addressing the needs of protracted or residual refugee populations unable to access the three traditional durable solutions of repatriation, resettlement or local integration:

“Refugees in such situations could perhaps be admitted to the migrant worker and immigration programmes maintained by states that are unable to meet their own labour market needs. Many of these programmes, it should be noted, also offer opportunities for long-term residence and naturalisation, and thus offer the prospect of a durable solution as well as an interim one.”⁴

These ideas are not only being developed at a policy level but are also being implemented in practice. In West Africa, the free movement protocols agreed upon by the Economic Community of West African States (ECOWAS) are now being used to provide residual refugee populations from ECOWAS states with both greater socio-economic mobility and increased political security.⁵ In 2009, Nigeria issued residual refugee populations from Sierra Leone and Liberia with three-year ECOWAS residence

permits, alongside the re-issuing of passports from Sierra Leone and Liberia, and the government of Sierra Leone has recently offered some 5,600 passports to former refugees wishing to integrate locally in their host countries.

As the ECOWAS case shows, durable solutions for refugees must, in some way, involve the regaining of meaningful citizenship, which is not necessarily connected to accepting more mobility. Yet it is equally clear that in many cases, fragile states emerging from conflict cannot provide returning refugees with a sustainable socio-economic livelihood or access to meaningful political rights. UNHCR has begun to explore how repatriation could be linked to greater encouragement of post-return mobility, most prominently in its work on the 2003 Afghan Comprehensive Solutions Framework, which – although hampered by significant state security interests – argued for the need for an integrated long-term “migration and development” approach to Afghan population flows.

The value of internal post-repatriation mobility is also increasingly recognised. UNHCR's current return and reintegration policy is explicit in rejecting the idea that successful returns to refugees' countries of origin require refugees to return to their pre-displacement lives:

“Reintegration does not consist of ‘anchoring’ or ‘re-rooting’ returnees in either their places of origin or their previous social and economic roles. For example, refugees and IDPs who have experienced urban or semi-urban lifestyles during their period of displacement may well move to towns and cities upon their return. Such forms of mobility should only be regarded as a failure of the reintegration process if returnees are unable to establish new livelihoods or benefit from the rule of law in their areas of origin, and thus feel that they have no choice but to settle in alternative locations.”⁶

Conclusion

In embracing mobility as a potential tool of protection, UNHCR is shifting towards a rights-based approach to displacement,

acknowledging that it is refugees' inability to access their human rights – rather than their physical exile, which is only a symptom of the loss of such rights – which should be the focus of international protection efforts. Meanwhile, however, states continue to impede the movement of both refugees and migrants across international borders. Increasing concern with border securitisation, the impact of global economic recession and rising domestic xenophobia have created a political cauldron of intolerance in both the North and the South. Asylum and migration space is shrinking; states perceive no immediate political advantages in allowing refugees' greater freedom of movement.

This means that the real challenge in the coming years – for researchers, UNHCR and refugees themselves – will be how to persuade reluctant states that acknowledging and protecting the mobility of refugees may in fact help to ‘solve’ twenty-first century displacement crises more effectively than insisting on return ‘home’. Collaborative research on this topic will be vital if we are not only to turn research findings into UNHCR policies but to turn such policies into practice, with the ultimate aim of securing the most effective protection possible for all refugees.

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1. This article is written in response to Giulia Scalettaris' article on 'Refugees and mobility' (published in FMR 33) in which she concluded that UNHCR still retained an anti-mobility policy bias.

2. UNHCR policy on refugee protection and solutions in urban areas. September 2009 <http://www.unhcr.org/4ab356ab.pdf>

3. UNHCR, Refugee Protection and Mixed Migration: a 10-Point Plan of Action, January 2007 <http://www.unhcr.org/refworld/pdfid/45b0c09b2.pdf>.

4. UNHCR, 'Protracted Refugee Situations: A discussion paper prepared for the High Commissioner's Dialogue on Protection Challenges' Geneva, December 2008. <http://www.unhcr.org/492ad3782.html>.

5. See 'Local integration in West Africa' by Alistair Boulton, FMR 33 <http://www.fmreview.org/FMRpdfs/FMR33/32-34.pdf>

6. UNHCR, UNHCR's Role in Support of the Return and Reintegration of Displaced Populations: Policy Framework and Implementation Strategy. February 2008. <http://www.unhcr.org/47b06de42.html>.

Protection in natural disasters

Elizabeth Ferris

Preparing for, responding to and recovering from natural disasters is as much about human rights as about delivery of relief items and logistics.

Guidelines and principles are important for policymakers but they are also important to the first responders. In May 2010, a workshop in El Salvador was organised for fire-fighters, specialised military units, government agents, and the Red Cross who are the first outsiders on the scene when disaster occurs.¹ As one military commander asked: “When it’s 3.00 am and the electricity has gone and the waters are rising and people don’t want to leave their homes, what is the right thing to do? Do we force them to leave against their will? Is it a violation of their human rights to force them to leave?”

In recognition of the human rights dimension of disaster preparedness and response, the Representative of the Secretary-General on the Human Rights of Internally Displaced Persons developed the *Operational Guidelines and Field Manual on Human Rights in Situations of Natural Disasters*², which outline a human rights-based approach to disaster preparedness, response and recovery. In particular, the Guidelines emphasise the fact that people do not lose their basic human rights as a result of a natural disaster or their displacement. Even in the worst disaster situation people are entitled to the basic rights guaranteed to all residents and citizens, though they may in addition have particular needs related to the disaster. The primary duty to protect and assist those affected by natural disasters lies with the national authorities of the affected countries.

The Guidelines stress that human rights encompass not only civil and political rights but also economic, social and cultural rights. However, in the midst of a disaster, it is often difficult to simultaneously promote all rights for all of those affected. Thus for practical reasons, the Guidelines divide human rights into four groups:

- rights related to physical security and integrity (e.g. protection of the right to be free of assault and rape)
- rights related to basic necessities of life (e.g. the rights to food and water)
- rights related to other economic, social and cultural protection needs (e.g. the rights to education and compensation for lost property)
- rights related to other civil and political protection needs (e.g. the rights to personal documentation and political participation)

The first two groups of rights are usually the most relevant during the emergency phase. Thus, in the initial disaster response, it is usually more important to ensure adequate access to water than to provide replacement identity cards to those displaced. However, the Guidelines insist that only the full respect of all four groups of rights can ensure adequate protection of those affected by natural disasters, including those who are displaced. Unfortunately, discrimination in provision of assistance and lack of consultation with affected communities are particularly commonplace.

Over the past two years, the Brookings-Bern Project on Internal Displacement has organised a series of workshops on protection and natural disasters in different regions, drawing together representatives from governmental disaster response agencies, international organisations, human rights groups, and national NGOs and Red Cross/ Crescent societies. These workshops – in Guatemala, India, Thailand, Madagascar, South Africa, El Salvador and Indonesia – have all been different, reflecting different regional and national experiences with natural disasters. In some countries, there are long traditions of human rights and strong human rights institutions, while in others

the idea of a rights-based approach to natural disasters is completely new.

In most countries there are few opportunities for human rights institutions to meet regularly with government policymakers to talk about the human rights of communities affected by disasters. In countries where discussion of international human rights standards was difficult, there was at least an acceptance of the need for disaster



preparedness plans which protect the most vulnerable and ensure that plans are not discriminatory. A common theme running through all of the workshops was the difficulty in finding solutions for those displaced by disasters, particularly when the displaced are unable to return to their communities. In this regard, the recently-revised *Framework on Durable Solutions*³ was found to be a useful tool.

At whatever phase of engagement with natural disaster, there is still much to be done to work out how to translate general principles into practice to protect people when disasters strike.

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1. Organised with the Center for Coordination of Disaster Risk Reduction in Central America (CEPRENAC) and Protección Civil-El Salvador.

2. <http://tinyurl.com/OpGuidelines>

3. <http://tinyurl.com/IDPs-durable-solutions>

Floods in Kampung Malayu, Jakarta, Indonesia, 2007.

RSC Harrell-Bond Lecture 2010: António Guterres Wednesday 13 October 2010, 5pm, Oxford

António Guterres, former Prime Minister of Portugal and current High Commissioner for Refugees, will give the RSC's 2010 Harrell-Bond lecture in Oxford on Wednesday 13 October. Title and venue to be confirmed. This event will be open to the public and free of charge. Details will be posted on the RSC website at <http://www.rsc.ox.ac.uk>

New paper on current trends and future directions of forced migration research and policy

The RSC has recently published a 50-page paper mapping contemporary issues and highlighting themes and topics requiring further attention from researchers, policy makers and practitioners.

The paper presents seven interconnected themes as being of key research interest and of immediate and future relevance to policymakers: state fragility and forced migration; the economics of forced migration; environmental displacement; displaced groups with specific needs; durable solutions; humanitarian space and spaces of protection; realising protection: legal and institutional challenges. The paper also identifies areas likely to demand attention in the future.

Forced Migration Research and Policy: Overview of Current Trends and Future Directions. Online at <http://www.rsc.ox.ac.uk/PDFs/RSC-FM-policy-and-research-overview.pdf>

Forced Migration Online survey – with prize draw

Forced Migration Online is asking all those who use its site (www.forcedmigration.org) to spare a few minutes to provide feedback to help them better address user needs. Please go to <http://www.surveymonkey.com/s/forcedmigration>

The survey will run from 14 June to 31 August 2010. It has 24 questions and should take only 5-10 minutes of your time.

Prize draw: Contributors will be entered into a prize draw, with the chance to win a bundle of books on forced migration worth over US\$300. To be in with a chance of winning just make sure to fill in the optional name and email address fields at the beginning of the survey.

Researching forced migration?

See 'Researching Forced Migration: A Guide to Reference and Information Sources' at <http://forcedmigrationguide.pbworks.com/>, produced by Elisa Mason, an independent information specialist focusing on forced migration issues.

Also by Elisa Mason:

http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1509589

(how to find full-text forced migration information online)

<http://fm-cab.blogspot.com/>

(a current awareness service highlighting web research and information relating to refugees, asylum seekers, IDPs and other forced migrants)

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Thank you to all our donors in 2009-2010

FMR is wholly dependent on external funding to cover all of the project's costs, including staffing. We are deeply appreciative to all of the following donors both for their financial support and their enthusiastic collaboration over the last two years.

Australian Government Department of Immigration and Citizenship

• Brookings-Bern Project on Internal Displacement • Catholic Relief Services • CBM • CIDA • Commonwealth Foundation • Danish Refugee Council • DFAIT Canada • DHL • European Union • Feinstein International Centre, Tufts University • Generalitat

Valenciana/Conselleria de Educaci3n

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Welcome to Luxembourg

Luxembourg is a small country and although it has a very high proportion of migrants and foreigners it is rarely represented in discussions on refugees and migrants. Yet its policy towards asylum seekers with disabilities merits wider attention, as shown by this testimony by a refugee family in Luxembourg.

My name is Mukamutesi Ziada. I am 46 years old, I am married to Kabera Andere and we have four children. Kirezi Christian, 18 years old, and Uwizeye Joslain, aged 13, both have intellectual disabilities. Even before we were displaced, Christian could not go to school in Congo because there were no appropriate educational establishments in our region of Congo. In 1998, when Joslain was still two years old, the war broke out and, fearing because of our Rwandan origins, we fled to Goma. There too our sons could not go to school, both because there was no qualified teaching for them and because of insecurity.

After my husband went into exile for political reasons and my two oldest children went to Rwanda to continue their higher studies, it became harder and harder for me to look after my two younger sons alone. So I too went to Rwanda, where I had been born. Here too conditions were not good for the boys' progress as they grew up.

Luckily, after some time their father, who had obtained political asylum in Luxembourg, was granted permission by the government for family reunification there. The International Organization for Migration, which undertook all arrangements for our travel, was informed about our two disabled children and they made all the relevant administrative arrangements for us.

We arrived in Luxembourg in May 2009. The Luxembourg Office for Reception and Integration (Office Luxembourgeois d'accueil et d'intégration) quickly made us aware of how things work

and of the rights of people with intellectual disabilities. In September, at the start of the school year, Joslain joined a special needs school and one month later there was a plan in place to enable him to catch up on his education.

The school and the Ministry of Transport also arranged suitable transport for him between home and school. It is obvious that Joslain is delighted and is eager to go to school, not least because it is all a novelty for him. The rules are that Christian, having reached 18 years of age, should go into sheltered accommodation, and the Association des Parents d'Enfants Mentalement Handicapés (Association of Parents of Children with Mental Disabilities) is making sure that all of the necessary administrative procedures are fulfilled. At the same time the disability employment office is looking into his case to ensure that his rights are respected and his opportunities widened.

I am grateful to the state of Luxembourg for having put in place good systems to receive refugees and especially those with disabilities. I am also grateful to organisations such as Caritas which has supported us throughout so that our children's rights are respected and their potential realised.

Mukamutesi Ziada

For more information, please contact Ana-Marija Soric (ana-marija.soric@caritas.lu) at Caritas Luxembourg (<http://www.caritas.lu>).

