K4D | Knowledge, evidence and learning for development

Situation of persons with disabilities in Lebanon

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Question

What is the current situation of persons with disabilities in Lebanon?

Specifically, please identify information on the period since 2013 on the following aspects:

a) Recent data (quantitative or qualitative) on the state of persons with disabilities in Lebanon, such as data on prevalence or on access to basic services for persons with disabilities.

b) Assessments of laws on the rights of persons with disabilities in Lebanon.

c) Analyses of the political, social, cultural, and economic context for persons with disabilities in Lebanon.
Relevant issues could include, for example: norms and behaviours towards persons with disabilities; gender equality; social cohesion; the impact of violent conflict on the mental health and psychosocial needs of persons with disabilities; and any issues particular to Lebanon.

Please identify issues particular to persons with disabilities amongst Syrian refugees within the above aspects.

Wherever possible in the report, please provide findings that are disaggregated, e.g. by age and gender.

Summary of evidence

- **An estimated 10-15% of the Lebanese population has physical, sensory, intellectual, or mental disabilities**, according to the more reliable data available. The rate of prevalence is estimated at about 10% among refugees who have fled from Palestine to Lebanon from 1947, at about 8% among Palestinian refugees from Syria, and at 10-22.8% among refugees who have fled Syria since 2011.
- **There is a systemic lack of provisions for rights, resources, and services** for persons with disabilities in Lebanon, due foremost to inaction by the State. As a result, persons with disabilities experience widespread discrimination, marginalisation, exclusion, and violence, at the hands of a range of State and non-State institutions and individuals, in the home and outside. This applies to all areas of their lives. In particular, work and basic services for them are scarce, not accessible, and of poor quality.
- **The legal framework on the rights of persons with disabilities is limited, and not enforced**. Legislation and policies have not embraced a rights-based approach, and tend to exclude disabilities that are not physical from consideration.
- **Persons with disabilities face adverse political, social, cultural, and economic conditions**. This has extremely detrimental effects on their rights, capacities, experiences, and quality of life.
    - **Actors in formal politics have taken little to no action** towards the rights of persons with disabilities.
    - General knowledge, attitudes, and behaviours towards persons with disabilities in Lebanon often rely on **charitable or medical approaches to disabilities**, rather than social or rights-based ones. Lack of knowledge, prejudice, and stigma against persons with disabilities are common – especially against those with intellectual or mental disabilities. Family caregivers also experience a high burden of care work, which negatively affects persons with disabilities.
- **Multiple types of structural inequalities and living conditions combine to shape the experiences of different persons with disabilities**:
    - **Economic, social, and political structures create the broad conditions for vulnerabilities and capacities**. These structures include socio-economic class, the types of disabilities, gender, age, nationality, and being a refugee. They particularly disadvantage, respectively: poorer and less educated persons; persons with intellectual or mental disabilities; women, girls, and boys; children, youth, and older persons; and Palestinian and Syrian refugees.
    - **However, more precise factors provide finer-grainer analyses of vulnerabilities and capacities**, especially: family support systems; economic situation; access to services; peer support networks; and assistive devices.
- **Foreign aid actors had largely ignored disability issues until 2016-2017**.
- **Persons with disabilities and their supporters have significant capacities, with much past and present activism and mobilisations**. They have expertise and skills not just about their situation and available assistance, but also about effective mobilisation and activism, and about the overall situation in the country.
- **Disability in Lebanon remains under-researched**, particularly on: the relations between Lebanese political economic and disabilities; rural areas; and the situation of migrant workers (as caregivers and as persons with disabilities).

Contents

1. Overview of findings

Data on the state of persons with disabilities

An estimated 10-15% of the Lebanese population has physical, sensory, intellectual, or mental disabilities, according to the more reliable data available. The rate of prevalence is estimated at about 10% among refugees who have fled from Palestine to Lebanon from 1947, at about 8% among Palestinian refugees from Syria, and at 10-22.8% among refugees who have fled Syria since 2011[1].

There is a **systemic lack of provisions for rights, resources, and services for persons with disabilities** in Lebanon. This is due foremost to inaction by the State. The lack of effective remedies leads to impunity for these failings. As a result, persons with disabilities experience widespread discrimination, marginalisation, exclusion, and violence, at the hands of a range of State and non-State institutions and individuals, in the home and outside. This applies to all areas of their lives. In particular, work and basic services for persons with disabilities are scarce, not accessible, and of poor quality. This holds true for employment, social protection and social care, health care and rehabilitation services, access to the built environment, education, access to information, participation in public and political life, and law enforcement. For example:

- **80% of persons with disabilities "are not or have never been employed"** (CESCR, 2016, p. 4, §21). Among Palestinian refugees with disabilities, unemployment is estimated at 90% (JS15, n.d., p. 8).
- **Health care and rehabilitation services are not available at scale, are often inaccessible, and are not inclusive.**
- **Only 1% of school-age children with disabilities are enrolled in mainstream public schools** (JS15, n.d., p. 3). 29% of Palestinian refugee children with disabilities "are not enrolled in any educational institutions" (UNRWA, 2017, p. 4).

In this context, care for persons with disabilities is primarily taken on by families, especially women and girls.

Assessment of laws

The **legal framework on the rights of persons with disabilities is limited, and not enforced**. Internationally, Lebanon has signed but **not ratified the UN Convention on the Rights of Persons with Disabilities**, and is also not a party to major treaties such as the 1951 Convention on refugees and its 1967 Protocol, and to the UN Convention on the rights of migrant workers.

Domestically, following pressure from civil society, Lebanon adopted Law 220/2000 on the rights of persons with disabilities in 2000. However, this law, and subsequent **legislation and policies, have not embraced a rights-based approach** to disability, instead adopting an outdated medical model of disability (Lakkis, Nash, El-Sibai, & Thomas, 2015, pp. 10, 12). Law 220/2000 has a narrow definition of disability which, in practice, has excluded disabilities that are not strictly physical. It also sets out no enforcement mechanisms on a number of issues (e.g. on the inclusion of persons with disabilities into the labour market). In addition, other problems with the

[1] For data, sources, and citations, see the tables on prevalence rates, p. 12 sq.

Lebanese legal framework strongly affect persons with disabilities, particularly the laws on mental health and on nationality, and the lack of a law setting a minimum age of marriage.

As widely noted in the literature, a major problem with Law 220/2000 is also that it has **simply not been implemented and enforced by the State**. In some cases, well over a decade after the adoption of this law, the ministries concerned had not issued any application decrees. More broadly, the Lebanese government and parliament have taken a course of inaction on the rights of persons with disabilities. They have done nearly nothing to set up the decrees, procedures, policies, budget lines, and public bodies that are either expected under Law 220/2000, or requested by associations of persons with disabilities and other human rights organisations.

Political, social, cultural, and economic context

There is a consensus in the literature that persons with disabilities face **adverse political, social, cultural, and economic conditions**. This has extremely detrimental effects on their rights, capacities, experiences, and quality of life.

In analyses of this context, the most frequently mentioned issue is that **actors in formal politics have taken little to no action** towards the rights of persons with disabilities. Particularly in national politics, government, parliament, and administrations have not followed through, and have in fact sometimes put up obstacles against these rights. This is due to a combination of reasons, from the larger political deadlock, to a lack of vision and knowledge on disability, infighting about allocations of roles and budgets, and neglect towards the issue of disability.

In addition, general knowledge, attitudes, and behaviours towards persons with disabilities in Lebanon often rely on **charitable or medical approaches to disabilities**, rather than social or rights-based ones. This holds true for family members, communities, and service providers (WRC & UNICEF, 2018b, p. 8). Further, **lack of knowledge, prejudice, and stigma** against persons with disabilities are common – especially against those with intellectual or mental disabilities. **Family caregivers also experience a high burden of care work**, because support services are lacking and expensive. This leaves persons with disabilities exposed to gaps in support and dependent on their relationship with their caregiver.

Multiple types of structural inequalities combine to shape the experiences of different persons with disabilities in Lebanon, including:

- **Socio-economic class**. In particular, the wealth, income, and education of persons with disabilities and of their families appear as positive factors across references, though class as such is rarely discussed explicitly.
- **The types of disabilities**. For example, persons with intellectual disabilities are at much higher risk of gender-based and sexual violence (WRC & UNICEF, 2018a).
- **Gender**. Women, girls, and boys with disabilities are subjected to high levels of discrimination, exclusion, economic exploitation, and violence, at home and outside of it. Being a child, a refugee, or displaced, increases risks. However, finer-grained analyses note that broad group-based categories fail to capture the nuances of vulnerabilities and capacities, and need to be combined with more precise factors, particularly: family support systems; economic situation; access to services; peer support networks; assistive devices (WRC & UNICEF, 2018c, p. 25).

- **Age**:
    - **Children and youth with disabilities** are subjected to the same risks as those related to gender. Multiple references note that children and youth are strongly affected by the poor availability and quality of basic services such as health and education, and that they are institutionalised at high rates. Children and youth of both genders are victims of gender-based discrimination. Syrian and Palestinian refugee children with disabilities suffer prevalent discrimination. As with gender, more precise factors capture vulnerabilities and capacities better (WRC & UNICEF, 2018a, pp. 13–14).
    - **Older men and women with disabilities** often see their rights, needs and abilities neglected or misunderstood, which leaves them excluded from services. Older refugees face particularly stark difficulties, and are often isolated.
- **Nationality and being a refugee**. **Palestinian and Syrian refugees** with disabilities, as well as their caregivers, experience specific difficulties. They often live in poor conditions, and face widespread discrimination in both laws and practices. This puts them at high risk of exclusion from public and private services, of exploitation, and of violence. Different refugees experience different situations based on inequalities that combine disability, class, gender, age, nationality, and legal status.

Foreign aid actors had largely ignored disability issues until 2016-2017. This further marginalised the rights, needs, vulnerabilities and capacities of many poor Lebanese, Syrians, and Palestinians with disabilities in the country. This has seemingly started changing from 2017.

Lastly, a few references call attention to the **capacities, activism, and mobilisations of persons with disabilities in Lebanon, and support from their allies**. While the references do document the dire situation experienced by persons with disabilities, they also emphasise the strengths present amongst persons with disabilities and their supporters. Self-led activism by persons with disabilities has a rich history in Lebanon, with mobilisations for the rights of persons with disabilities, but also for broader political goals of peace and socio-economic justice. Lebanon has a number of national and local organisations of persons with diverse disabilities[2]. They have expertise and skills not just about the situation and available assistance, but also about effective mobilisation and activism.

Similarly, a few service providers, associations, and aid actors have advocated for the rights of persons with disabilities, and/or carried out activities that have had positive effects for participating persons with disabilities and their caregivers. In particular, a few organisations have adopted practices that build on the strengths of persons with disabilities, instead of just emphasising their impairments, vulnerabilities, and difficulties.

State of knowledge and gaps

Regarding the evidence base on the report topic, there is a **small but good-quality body of available literature**, in which diverse academic and practitioner sources use a variety of rigorous quantitative and qualitative methodologies. Authors offer largely consistent findings about the situation. However, the coverage of issues is uneven in terms of issues, types of groups and inequalities, and locations. Some aspects are much researched, such as education, others less

[2] For a selection of associations of persons with disabilities in Lebanon, see for example: https://www.daleel-madani.org/civil-society-directory?f%5B0%5D=field_intervention_sector_s_%3A15.

so, such as rural areas. There also remain major gaps, thematically (e.g. on the implications of Lebanese political economy for persons with disabilities), and on specific groups (e.g. on migrant workers with disabilities in the country).

This report is organised as follows. Section 2 summarises the state of knowledge and highlights key gaps. Section 3 presents data on the prevalence of impairments and disabilities in Lebanon, and on the state of rights, resources, and services for persons with disabilities. Section 4 offers assessments of the applicable international and national laws on the rights of persons with disabilities. Section 5 analyses the political, social, cultural, and economic context for persons with disabilities in the country.

2. State of knowledge and gaps

This report is based on a rapid review of academic, practitioner, and policy literature published since 2013 in English, French, and Arabic on the report topic. Searches and inclusion criteria were kept open to perspectives from both social sciences and medical fields.

This rapid review found a **small though growing body of academic, practitioner, and policy literature** on the situation of persons with disabilities in Lebanon. For now, quantitative and qualitative data on persons with disabilities remains "a persisting gap" (LHF, 2018, p. 7); also see (UNS, n.d., p. 26, §92). There have been few studies, and a lack of data collection. Where data collection has been done, it has often been inconsistent, and sometimes methodologically weak[3].

This has been a problem on part of the Lebanese State, but also on part of foreign aid actors, such as UN agencies (see e.g. JS15, n.d., pp. 2, 9–10). For example, in practitioner and policy references produced for aid work, few needs assessments focus on specific needs, such as those generated by disability. This particularly applies to the needs of persons with disabilities, including children (UNICEF Lebanon, 2015, p. 4, §23).

The limited literature available on the report topic is **patchy, fragmented, and often siloed** e.g. by sector. Piecing together a fuller picture requires drawing on many separate references.

Based on observations from this rapid review, **most of the available literature is of good quality, and is diverse when taken as a whole**. Most studies use rigorous methodologies, with a mix of quantitative and qualitative methods used to generate findings. Overall, sources are diverse in type (academic, practitioner, and policy), and in geographic origin (with a mix of Lebanese and other sources). There seems to be a good gender balance amongst authors. A number of references were written by or with persons with disabilities in Lebanon.

The references selected for this report offer largely **consistent findings** about the situation of persons with disabilities in Lebanon. Further, findings are typically conclusive, though the findings in a few quantitative studies can only be indicative due to their small or non-randomised samples. Many findings go beyond showing correlations, and are able to demonstrate and explain causalities.

Nonetheless, the knowledge base has several weaknesses in sources and coverage. **Some categories of sources are under-represented**. On the one hand, academics from medical fields, Lebanese and Arab NGOs, associations of persons with disabilities (in Lebanon and elsewhere), and UN human rights bodies, are well represented. On the other hand, relatively few references are authored by academics from social sciences, international Western NGOs, and international aid organisations. This is starting to change. For example, an increase in the number of references produced by aid and donor sources is visible from around 2016.

Further, different types of literature tend to cover different topics, which means that some topics are much discussed e.g. in academic literature but not in practitioner references, and vice versa. For example, much of the academic literature is medical, and focuses on documenting the prevalence of disabilities, its manifestations (e.g. capacities), and its immediate medical causes (e.g. nutrition, genetics). Conversely, academic references offer fairly little by way of producing or

[3] See this point made e.g. in Joint stakeholders 15 [JS15], n.d., pp. 2, 9–10.

considering data on access to services, contextual conditions (e.g. economic, political, social, or legal).

As for coverage, the literature, considered overall, is notable for **successfully looking at a range of situations and statuses** based on different types of disabilities, socio-economic class (e.g. high levels of poverty amongst persons with disabilities), gender, age, nationality, and displacement. It is also notable for discussing how these various situations and statuses intersect, and what the implications are for persons with disabilities (e.g. what does it mean to be a Syrian refugee girl with an intellectual disability vs. a Lebanese man with a sensory disability).

Yet, coverage is uneven. Some aspects are relatively better researched. Education is one example, a 2016 review of academic literature published between 1990 and 2014 confirms that inclusive education for children with developmental disabilities has been little researched not just in Lebanon, but also in Arab-majority countries more broadly (Alkhateeb, Hadidi, & Alkhateeb, 2016). **Other aspects are under-researched**. One of them is disability in rural areas. Syrian refugees with disabilities have also been comparatively less researched, even compared to Syrian refugees in general. Publications on this sub-group have only been picking up pace recently.

Most importantly, there appear to be **major gaps**. **Some gaps are thematic**. A major one is the role of Lebanese political economy in shaping disability in Lebanon. For example, there is little discussion of the implications for the situation of persons with disabilities of structural factors such as: Lebanese elites' overall lock on power; appropriation of public and private wealth; and clientelist-sectarian welfare, including in providing care services for persons with disabilities[4]. Few references compare the experiences of persons with disabilities from different socio-economic classes. There is also little discussion of the role of non-family workers, especially domestic migrant workers, in providing care for persons with disabilities in middle-class and wealthier households.

There are also gaps due to how structures of inequalities are approached. In particular, most references address gender merely by disaggregating analysis between women, men, girls, and boys, with a few references even seemingly just conflating 'gender' with 'women and girls'. Very few references analyse gender as a socially constructed relationship of norms and practices. This leaves issues such as masculinities and femininities, and their implications for persons with disabilities in Lebanon, under-examined. Similarly, while poverty is discussed, the relational, exploitative nature of labour experienced by many persons with disabilities is not systematically examined. For example, only a few references mention that persons with disabilities typically receive low wages.

Other major gaps are about specific groups. This rapid review found no inclusion of migrant workers as persons with disabilities in considerations. It also found nearly no discussion of refugees other than Palestinians and Syrians (e.g. Iraqis who fled to Lebanon from 2003). Lastly, it found no discussion of the many Lebanese who have emigrated or who travel back and forth between Lebanon and another country of residence. They are not considered, be it as persons with disabilities or as Lebanese citizens who may shape the situation within Lebanon.

[4] One of the few exceptions is: Berghs & Kabbara, 2016, pp. 279–280. For more on the role of sectarian and communal organisations in providing welfare services, see e.g.: Cammett, 2014.

3. Data on the state of persons with disabilities in Lebanon

Prevalence of impairments and disabilities

General prevalence of all impairments and disabilities

Figures on the prevalence of impairments and disabilities in Lebanon are patchy, often dated, and contested, with stark variations between estimates from the Lebanese State on the one hand, and from multiple other sources on the other hand.

In particular, the **Lebanese State** has presented lower figures of prevalence rates and population sizes (JS1, n.d., p. 10, §52; Kabbara, 2013; Lakkis et al., 2015). It claims that the disability prevalence rate stands at 2% of the population. One explanation for this rate is that Lebanon's official statistics body uses a medical model of disability, instead of a social one (Kabbara, 2013, p. 8; Lakkis et al., 2015, p. 4).

For example, estimates vary as well on "the number of persons who were physically disabled as a result of civil war and subsequent political violence" in Lebanon (JS1, n.d., p. 10, §52). In 1992, the government estimated, based on police reports, that 13,455 persons had been left with permanent disabilities as a result of the war, out of 197,506 persons wounded. Subsequent governmental research based on primary sources estimated that 9,627 persons had been left permanently disabled (JS1, n.d., p. 10, §52). However, this figure too is based on a narrow definition of "people with physical disabilities", and it "does not take into account victims since 1990"[5]. For example, the Ministry of Social Affairs insists on a definition of disability that excludes persons with hearing difficulties (Kabbara, 2013, p. 10).

Some of the figures from **multilateral organisations** have also been questioned. For example, the UNHCR process for recording disabilities during registration has produced prevalence figures that are much lower than other humanitarian surveys, such as the one conducted by (HA & HI, 2014, pp. 18–22). Beyond the overall prevalence rate, there are also discrepancies in the types of impairments recorded. At the time HelpAge and HI collected their data, similar UNHCR data listed 23% of disabilities as 'unspecified'. In addition, sensory impairments were less likely to be identified than physical ones. Whereas visual impairments made up just 2 per cent of the impairments identified by UNHCR, the NGOs' survey identified 28% of impairments as visual. Similar, though less extreme, differences could be found with hearing and speech impairments. Consequently, "those with debilitating but less severe conditions, such as visual impairments, [were] not being identified and [were] not receiving the support they need to access services" (HA & HI, 2014, p. 19).

In contrast, **non-State actors** (including academics, NGOs in the fields of development, humanitarianism, and human rights, and Lebanese associations of persons with disabilities), have presented higher figures. Many expert sources in the literature see several reasons to deem these figures to be more credible than the ones put forward by the Lebanese State.

First, the higher figures are in line with worldwide figures of disability prevalence. The 2011 World Report on Disability, produced by the World Health Organization and the World Bank, put the typical proportion of persons with disabilities in any population at approximately 15%. Within this,

[5] JS1, n.d., p. 10, §52, footnote 37.

the rate stands at 19% among women and girls, and 12% among men and boys (WRC & UNICEF, 2018c, p. 10).

The higher figures on disability prevalence in Lebanon are also more in line with statistical expectations for the specificities of the Lebanese context. Communities affected by crisis or violence may have even higher rates of disability than the typical 15%, because in such contexts "people acquire new impairments from injuries and/or have reduced access to health care" (WRC & UNICEF, 2018b, p. 5, referring to the study by HA & HI, 2014).

Given that State information on disability has thus been challenged by numerous credible Lebanese and non-Lebanese sources, the present report makes little reference to State-provided facts and figures, except when describing official State laws or procedures.

The tables below (Table 1, Table 2, and Table 3) present a sample of available figures, first about the total population of persons living in Lebanon, and then about the sub-groups of Palestinian and Syrian refugees in Lebanon. To the extent possible based on information in the sources, the tables list: prevalence rates; population size; year of data collection; any key information about the studies; and the citation for the source. Data are ordered from most recent to older year of data collection.

Table 1: Prevalence of all impairments and disabilities (physical, sensory, cognitive, mental, or other) in the total population of persons living in Lebanon

Rate of prevalence of disabilities	Size of population with disabilities	Population concerned	Year of data collect.	Key information about the studies on prevalence	Source citing the prevalence figures
15%	≈ 900,000 persons	Persons living in Lebanon	2016	Estimate determined applying the global estimate of 15% of prevalence in any population to the population of Lebanon, i.e. approximately 6 million people according to 2016 data by the World Bank	(WRC & UNICEF, 2018b, p. 5)
10%	≈ 400,000 persons	"Population in Lebanon" / "citizens" (unclear if includes non-nationals)	2006	- Statistics calculated by the "Inclusivity network in Lebanon"; - Results in an emergency relief project conducted by Lebanese Physical Handicapped Union (LPHU) during the population displacements in July-August 2006	(JS15, n.d., p. 2)

Source: Emilie Combaz, compiled from several sources (see citations in the table)

Table 2: Prevalence of all impairments and disabilities (physical, sensory, cognitive, mental, or other) among Palestinian refugees who either fled from Palestine to Lebanon from 1947, or have fled from Syria since 2011

Rate of prevalence of disabilities	Size of population with disabilities	Population concerned	Year of data collect.	Key information about the studies on prevalence	Source citing the prevalence figures
10%	N.A.	Palestinian refugees who fled from Palestine to Lebanon	2017	2017 Vulnerability Assessment of Syrian Refugees (VASyR), which surveyed 4,966 households, comprised of 24,415 individuals, amongst Syrian refugees registered with UNHCR in Lebanon. Two-stage cluster sampling in all governorates. Physical or mental disabilities	(VASyR, cited in LHF, n.d., p. 3)
10%	N.A.	Palestinian households in Lebanon with at least one family member with a disability	2017	No specific source indicated for the specific figures. Overall sources of information used for the briefing: testimonies of Palestine refugees living in Lebanon, reports of organisations working in Lebanon, and data collected by UNRWA[6]	(UNRWA, 2017, p. 4)
8%	N.A.	Households of Palestinian refugees from Syria who report having at least one member with a disability	2017	2017 Vulnerability Assessment of Syrian Refugees (VASyR) – see earlier description	(VASyR, cited in LHF, n.d., p. 3)
10.3%	N.A.	Palestinian refugees who fled from Palestine	2015	Nationally representative household survey of 3,382 Palestinian households, with a mix of Palestinians who fled from Palestine to Lebanon from 1947, and Palestinians who have fled from Syria to Lebanon since 2011	(Chaaban et al., 2016, pp. 96, 99)
8.1%	N.A.	Palestinian refugees who fled from Syria	2015	Same as above	(Chaaban et al., 2016, p. 192)
10%	N.A.	Households of Palestinian refugees from Syria who report having at least one member with a disability	2015	N.A.	(Abdulrahim, Harb, & UNRWA, 2015, cited in Baroud, 2017, p. 1)

[6] The listed sources include: UNRWA & American University of Beirut, *Survey on the Socioeconomic Status of Palestine Refugees in Lebanon 2015* (http://www.unrwa.org/resources/reports/survey-economic-statuspalestine-refugees-lebanon); UNRWA, *PRS vulnerability assessment* (unpublished), 2016; UNHCR, *The Situation of Palestinian Refugees in Lebanon*, February 2016 (http://www.refworld.org/docid/56cc95484.html); UNICEF, *Child Protection and Gender Based Violence, Baseline Survey, Preliminary Results*, 2015, unpublished.

N.A.	≈ 6,000 persons	Palestinian refugees who fled from Palestine to Lebanon	2014	- Palestinian embassy in Lebanon; - Working paper presented at regional workshop "*Towards a decent job for everyone*", Beirut, 2014	(JS15, n.d., p. 8)

Source: Emilie Combaz, compiled from several sources (see citations in the table)

Table 3: Prevalence of all impairments and disabilities (physical, sensory, cognitive, mental, or other) among Syrian refugees who have fled from Syria to Lebanon since 2011

Rate of prevalence of disabilities	Size of population with disabilities	Population concerned	Year of data collect.	Key information about the studies on prevalence	Source citing the prevalence figures
22.8%	N.A.	Syrian refugees in Lebanon	2017-2018	Survey of 8,876 Syrian refugees in Lebanon and Jordan, conducted by iMMAP& Humanity & Inclusion; report of findings pending	(Humanity & Inclusion, 2018, p. 1)
14%	N.A.	Households of Syrian refugees in Lebanon who report having at least one member with a disability	2017	2017 Vulnerability Assessment of Syrian Refugees (VASyR), which surveyed 4,966 households, comprised of 24,415 individuals, amongst Syrian refugees registered with UNHCR in Lebanon. Two-stage cluster sampling in all governorates. Physical or mental disabilities	(UNICEF, UNHCR, & WFP, 2017, pp. 11–12)
12%	N.A.	Households of Syrian refugees in Lebanon who report having at least one member with a disability	2015 & 2016	2015 & 2016 Vulnerability Assessments of Syrian Refugees (VASyR), which surveyed a sample of Syrian refugee households registered with UNHCR in Lebanon. Physical or mental disabilities	(UNICEF et al., 2017, pp. 11–12)
> 10%	N.A.	Syrian refugees in Lebanon	2015(?)	No specific study cited; possibly refers to weekly and periodic reports by UNHCR	(JS15, n.d., p. 9)
20%	N.A.	Syrian refugees in Lebanon	2013	Research, including a survey, on the number and needs of Syrian refugees in Jordan and Lebanon who have specific needs, i.e. who live with impairment, injury, or chronic disease. Physical, sensory, or intellectual impairments, but not mental ones. Survey in the governorates of: North Lebanon; Bekaa; Beirut City; and Mount Lebanon	(HA & HI, 2014, p. 6)[7]

Source: Emilie Combaz, compiled from several sources (see citations in the table)

[7] Throughout this study, the margins of error are ±2.2% at country level, and ±4.4% at governorate level.

In academic, practitioner, and policy literature on persons with disabilities in Lebanon, there is a **growing trend to pay more attention to all persons with special needs**, by considering not just persons who have any form of disability, but also categories such as older persons, persons with chronic illnesses, persons with temporary illness or injury, persons with serious medical conditions, and/or persons who need support in basic daily activities. Frequently cited practitioner references that adopt this approach are e.g. (HA & HI, 2014; UNICEF et al., 2017). The present report will reflect this by providing a few indications, especially on older persons, as and when this seems relevant to DFID's query.

Prevalence of specific impairments and disabilities

The national prevalence of **Autism Spectrum Disorder** (ASD) is estimated at 1.48%, with a 95% confidence interval (0.84-2.12), according to a national cross-sectional survey on 1,373 children aged 16-48 months who were in nurseries in all governorates (Saab, Chaaya, & Boustany, 2018, p. 1). The study found a male-to-female ratio of 1.13 (Saab et al., 2018, p. 1)[8].

Findings on factors associated with ASD were as follows (Saab et al., 2018, pp. 1, 3):

- Factors associated with not having ASD were: being a first- or second-born; having a mother who received moral support during pregnancy; and having a mother who was employed in the past year.
- Factors associated with having ASD were: a family history of mental illness; having a mother who has no university education; and having a mother who experienced complications during delivery.

The associations were statistically significant in bivariate analyses. In the multivariable analysis, not all variables had statistical significance (probably due to the small numbers in the sample). However, none of the crude and adjusted odds ratios changed direction, and the statistical test for goodness of fit shows the multivariable model fits the data adequately (Saab et al., 2018, pp. 1, 3).

This study is the first one estimating ASD prevalence in the entire Lebanese population. Its authors call for more robust studies "to better understand this disorder and factors associated with it in Lebanon […] that have distinct cultural/environmental characteristics" (Saab et al., 2018, p. 1).

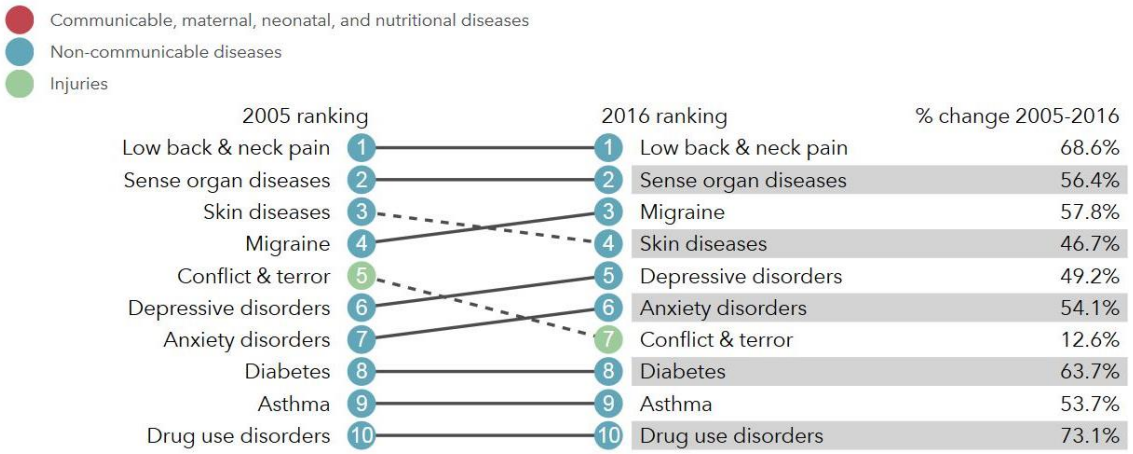
One earlier cross-sectional survey, based on similar methods, had studied a sample of 998 toddlers (16-48 months) from 177 nurseries in the governorates of Beirut and Mount Lebanon (Chaaya, Saab, Maalouf, & Boustany, 2016, p. 514). It estimated the prevalence of ASD at 1.53%, or one in 66 children, with a 95 % confidence interval (0.77-2.29). The male-to-female ration was 1.05, i.e. 1 in 65 for boys, and 1 in 67 for girls (Chaaya et al., 2016, p. 518).

[8] The survey asked responding parents to fill the Modified Checklist for Autism in Toddlers (M-CHAT) for screening, as well as a self-administered questionnaire to find out about associated factors (Saab, Chaaya, & Boustany, 2018, p. 1). Data collection "took place from February 2014 until January 2016" (Saab et al., 2018, p. 2). Most of the responding parents were mothers (Saab et al., 2018, p. 2).

Variables associated with impairments and disabilities

Data compiled by the Institute for Health Metrics and Evaluation identifies **what health problems cause the most disability** in Lebanon. Specifically, the dataset identifies and ranks the health-related causes of years lived with disability in 2016 as well as in 2005, for all ages. The chart below, from IHME (2018), represents the top 10 causes of disability in Lebanon, in 2005 and 2006, and shows the percentage change between both years.

Chart 1. Top 10 health problems that caused years lived with disability (YLDs) in 2005 and 2016, and percent change between 2005 and 2016, for all ages (IHME, 2018)



Gender has important associations with disabilities. For example, one cross-sectional study randomly selected 905 Lebanese men and women aged 65 years or more who lived in the community in Greater Beirut. It involved 59% of men, and 41% of women. The study also disaggregated data into a younger group (70-year olds or younger), and an older one (over 70 years old), who respectively represented 44.3% and 55.7% of the population (Mitri, Boulos, & Adib, 2017). It found that elderly women had worse functional capacities, health, and socio-economic status, compared to men. In fact, the older group of women had significantly more functional disabilities compared to men of the same age group. Among all women, "poor nutritional status, self-perceived health, absence of physical activity, comorbidity, polymedication and depression were significantly higher" (Mitri et al., 2017, p. 1). Women were also "less educated and more likely to live alone" (Mitri et al., 2017, p. 1).

Further references offer findings on **correlations or causalities between disabilities and different variables**. This includes studies on:

- The prevalence, correlates, and treatment of **mental disorders among Lebanese adults**, with focus on comparison between those aged 18-59, and those aged 60 and over (Karam et al., 2016).
- **Older persons**:
    - Determinants of poor cognitive functions among older Lebanese (Bou-Orm, Khamis, & Chaaya, 2018).
    - Determinants of the nutritional status of older persons in urban Lebanon (Mitri, Boulos, & Adib, 2017).

    - Malnutrition and associated risk factors among older persons living in community homes (Doumit, 2015).
- Children, e.g. a study on growth disorders among public school children in North Lebanon (Hayek, Berro, & Fayad, 2018).
- Palestinians, e.g. two studies on food insufficiency and food insecurity as risk factors for disability among Palestinian refugees (Salti & Ghattas, 2016; Salti, Nuwayri-Salti, & Ghattas, 2013).

State of rights, resources, and services for persons with disabilities

There is a **systemic lack of provisions for rights, resources, and services** for persons with disabilities in Lebanon. The State has made little investment towards "making information, public goods and services accessible" (CESCR, 2016, p. 5, §22 (d)). The State has not supported the provision of reasonable accommodation (CESCR, 2016, p. 5, §22 (d)). As a result, persons with disabilities receive inadequate levels of assistance. This has had severe negative consequences for them, such as reinforcing isolation, stigma, and barriers to accessing services (UNICEF Lebanon, 2015, p. 4, §23).

Due to this structural context, persons with disabilities are subjected to **widespread discrimination, violation of their rights, marginalisation, exclusion, and violence,** all of these being generated in all areas of life by a range of State and non-State institutions and individuals in Lebanon[9].

Persons with special needs, "including older persons, individuals suffering from trauma, socially marginalized groups and persons with disabilities (PwDs), constitute the most vulnerable population groups". This is the case among both the displaced (including Syrian and Palestinian refugees) and Lebanese host communities. These individuals face continued problems in realising their basic rights and accessing basic services (LHF, n.d., p. 3). In this context, the needs of persons with disabilities, older persons, individuals suffering from trauma, socially marginalised groups, and other persons with special needs, "continue to exceed what service providers can address including the provision of rehabilitation services, assistive devices and mental health care" (LHF, n.d., p. 3).

Access to information, including about rights

The State has not made information accessible to persons with disabilities (CESCR, 2016, p. 5, §22 (d)). This includes information about elections (JS15, n.d., p. 7). Even the National Council for Disability Affairs (NCDA) "frequently struggles to access information" from ministries (Lakkis et al., 2015, p. 4). Instead, access to information "is based on informal social and political networks" (Lakkis et al., 2015, p. 4). As a result, "relatively powerless people – such as many people with disabilities – do not have easy access to information that could help bring about change" (Lakkis et al., 2015, p. 4).

[9] There is a consensus across academic, practitioner, and policy literature on this point. See e.g. (Committee on Economic, Social and Cultural Rights [CESCR], 2016, p. 4, §18); (Joint stakeholders 15 [JS15], n.d., p. 2); (Lebanon Humanitarian Fund [LHF], 2018, p. 7); (UNICEF Lebanon Country Office, 2015, p. 4, §23).

Indeed, individuals with disabilities, and associations of persons with disabilities, have inadequate access to information about their rights and about relevant services (Lakkis et al., 2015, p. 4). In particular, Lebanese organisations of persons with disabilities struggle to access government information on education, health, and budgets. This "[l]ack of disclosure makes it difficult […] to advocate effectively for their full participation in public life" (Lakkis et al., 2015, p. 5). For instance, this partial, limited access to information has contributed to leaving the commitments laid out in Law 220/2000 unfulfilled (Lakkis et al., 2015, p. 4).

Further, **new communication technologies are not a universal fix**. They are certainly transforming access to information for groups of persons with disabilities who have specific impairments, and who have the money to pay for these technologies. However, these technologies "are not accessible to poor people with disabilities" (Lakkis et al., 2015, p. 5). There is also no ready technological fix that will enable other groups, such as people with learning disabilities, to overcome their particular barriers to information. Many persons with disabilities have no alternative to requesting information through friends and relatives.

Yet, a number of persons with disabilities need to receive and understand specific information to achieve their rights. For example, third parties may need to provide tailored, understandable information to "children with disabilities, who frequently live in residential institutions", and to persons considered to lack legal capacity (Lakkis et al., 2015, p. 5).

Remedies and reparations

There is a "**lack of effective remedies, legal or otherwise**, available to victims" of all forms of discrimination in Lebanon (CESCR, 2016, p. 4, §18). Similarly, victims of political violence, and their families, have not been able to systematically obtain reparations when political violence has led to disabilities, injuries or death (JS1, n.d., p. 8, §41).

Paid work, and skills training

The Lebanese State has **not implemented and enforced the legal provisions on labour issues** set out in Law 220/2000 for persons with disabilities. In particular, the employment quota in that law is not enforced (CESCR, 2016, pp. 4-§21, 5-§22 (e)). Underlying this are poor policies that prevent persons with disabilities from working, as the labour market has remained exclusive, closed and inaccessible to them[10].

The State has taken no action to help workplaces become inclusive and suited to employ persons with disabilities, nor to provide rehabilitation programmes that would enable persons with disabilities to perform the jobs required in the labour market. Instead, the National Employment Office, which is in charge of policies and funding in these areas, has kept directing its funding for persons with disabilities towards jobs that are not on demand in the labour market, and towards specialised centres or "protected workshops" specific to persons with disabilities who perform work (JS15, n.d., p. 5). In contrast, the State has not allocated any budget in support of employers who hire a person with a disability, to enable these employers to make the necessary adjustments to their workplace, and to provide enhanced or alternative devices to ensure that the person with a disability can perform his/her job (JS15, n.d., p. 6).

[10] Joint stakeholders 9 [JS9], n.d., p. 9; Joint stakeholders 14 [JS14], n.d., p. 14; Joint stakeholders 15 [JS15], n.d., p. 5.

As a result of all the legislative shortcomings and poor State practices highlighted above, many persons with disabilities are unemployed. **80% of persons with disabilities "are not or have never been employed"** (CESCR, 2016, p. 4, §21). Among Palestinian refugees with disabilities, the unemployment rate reaches an estimated 90% (JS15, n.d., p. 8). Among refugees from Palestine, the extremely poor households "are twice as likely to have a family member with a functional disability living in their household", compared to the average household of Palestine refugees in Lebanon (UNRWA, 2017, p. 4)

This is not due to a general high rate of unemployment. Instead, this is due to three missing actions: supportive laws for persons with disabilities and for work institutions in adapting their workplace; anti-discrimination policies; and vocational, social, and health-related rehabilitation that is connected to the requirement of the labour market. The exclusion of persons with disabilities from the labour market results in the extreme poverty and social marginalisation of the persons affected (JS15, n.d., p. 5).

Even where persons with disabilities do work, there are **problems with the quality of that employment**. Their employment opportunities do not always afford them "a decent standard of living and career prospects" (CESCR, 2016, p. 5, §22 (e)). Further, some persons with disabilities have not freely chosen or accepted the work they do. For example, there remain practices of "traditionally assigning certain jobs to persons with disabilities" (CESCR, 2016, p. 5, §22 (f)).

Persons with disabilities also do **not have equal access to training** compared to persons without disabilities (CESCR, 2016, p. 4, §22 (c)). The provisions from Law 220/2000 on training and labour placement are not implemented either. Indeed, Lebanon has not implemented any significant measures to promote vocational training for persons with disabilities (UNESCO cited in OHCHR, 2015, p. 13, §76).

Social protection and social care

The Lebanese **State fails to provide "financial assistance and other support** services to families of children with disabilities" (CRC, 2017, p. 8, § 28 (c)). Family allowances and assistance for persons with disabilities, as well as funding for health care and benefits in education and retirement, are unavailable to a large proportion of the population in Lebanon (Solidar, 2015, p. 7).

This is a systemic problem that affects much of the population, not just persons with disabilities and their families: **coverage by Lebanese social security has "serious shortcomings"** (Solidar, 2015, p. 7). With the prevalence of the informal economy, a significant part of the Lebanese population is left outside of formal social protection. About 40% of the Lebanese population are outside any health insurance system, and 40% to 50% are not enrolled in the National Social Security Fund, while 8% have private insurance (Solidar, 2015, p. 7).

The general failings of social protection in the country, combined with the lack of implementation of Law 220/2000, leaves the most vulnerable members of the population outside the coverage of the formal social protection systems. Those excluded from that framework are, among others, persons with disabilities, older persons, the unemployed, foreign workers, women, and farmers (Solidar, 2015, pp. 7–8).

As a result, responsibility for "**caring for persons with disabilities falls primarily on their families**" (CESCR, 2016, p. 4, §21). Specifically, this tends to be the responsibility of mothers, who have to seek out support and services (Stade, Khattab, & Ommering, 2017, p. 274). The "absence of a centralised system of effective social protection" makes most social expenditures fall on individuals, families, and private institutions such as civil institutions and non-governmental organisations (Solidar, 2015, p. 8).

One consequence is that many families end up institutionalising their children who have a disability. In contrast, better helping caregivers, especially by increasing social benefits and other support services, would enable families to de-institutionalise their children with disabilities (CRC, 2017, pp. 9, §28 (d), §29 (d)).

Care facilities are usually not accessible to persons with disabilities, including children with disabilities (CRC, 2017, p. 9, §29 (b)).

Health care, rehabilitation services, and assistive technologies

In principle, under Law 220/2000 and other legislation and policies, Lebanese holders of the disability card issued by the Ministry of Social Affairs "are entitled to a wide range of healthcare services, including primary, secondary and rehabilitation services, to be covered in full by the relevant ministries" (Baroud, 2017, p. 2). Syrians with disabilities should have access to primary healthcare (PHC) services, via the PHC network of the Ministry of Public Health (MoPH), or via mobile clinics. Palestinian refugees from Syria should have access to PHC through UNRWA clinics. Palestinians and Syrians should also have access to secondary healthcare through arrangements respectively with UNRWA and UNHCR (Baroud, 2017, p. 2).

However, the Lebanese State has **not implemented and enforced the legal provisions on health care for persons with disabilities** set out in the 220/2000 law (JS1, n.d., p. 1). While a committee on health, rehabilitation and support was created under the law, it had not convened or taken action once by mid-2015. To multiple Lebanese associations of persons with disabilities, this manifested that the relevant ministries had no serious intention of implementing the law (JS15, n.d., p. 4). In addition, while the Ministry of Health runs a special fund for persons with disabilities, the budget of the fund has not been allocated sufficient resources (CESCR, 2016, p. 4, §22 (b)).

Further, in addressing the **effects of the Syrian crisis**, both the MoPH and humanitarian organisations have funding shortfalls. In addition, the effects of the Syrian crisis have strained the infrastructure and financial sustainability of both primary and secondary healthcare organisations, especially in the North and Beqaa governorates (Baroud, 2017, p. 2)

Low availability of services

In this overall context, **rehabilitation services are insufficient in availability, hard to access, and inadequate** (CRC, 2017, p. 8, §28 (b); LHF, n.d., p. 3). Rehabilitation services, and physical, occupational, and other therapies, are scarce (Baroud, 2017, p. 3; JS15, n.d., p. 4). For example, a number of persons with disabilities need, but do not receive, mobility aids and medical devices. This harms their way and quality of life (Baroud, 2017, p. 2). The problems with rehabilitation services aggravate the marginalisation of persons with specific needs. For example, in 2017, the lack of adequate services meant that only 1,854 persons with disabilities

received support from the sectoral partners of the Lebanon Humanitarian Fund. This met a mere 20% of the Fund's sector target (LHF, n.d., p. 3).

Similarly, **health care services for persons with disabilities are inadequate**, particularly in public hospitals (CRC, 2017, p. 8, §28 (b)).

Poor access to services

Further, **access to health services for persons with disabilities remains poor** (Baroud, 2017, p. 3; JS15, n.d., p. 4). It is primarily hindered by high costs, as the ministry of health cover only a small fraction of health costs (JS15, n.d., p. 4). Financial costs are the most commonly cited barrier to accessing healthcare, even as persons with disabilities are often less educated and are less in employment that persons without disabilities (e.g. Baroud, 2017, p. 2). The lack of financial coverage for specific health care services is reportedly a further barrier (Baroud, 2017, p. 2). In some cases, transportation costs are also an additional financial barrier due to the extra costs they generate, and due to their lack of adequacy (Baroud, 2017, p. 2).

Access is also subject to discretionary decisions and favouritism. The disability card has only been granted to a limited number of Lebanese persons with disabilities. This may be due to the strict definition for disability set by Law 220/2000. It is also due to favouritism in its distribution[11]. For Lebanese with disabilities denied the disability card, covering healthcare costs is a significant difficulty (Baroud, 2017, p. 3).

Similarly, the personal disability card is not accepted by all relevant facilities, including health care ones (Baroud, 2017, p. 3; CESCR, 2016, p. 4, §22 (b)). Some of the organisations denying care to persons with disabilities who hold a disability card state that ministries reimburse them late for services provided[12].

Further, persons with disabilities face discrimination in their dealings with health care services. As a result, most holders of the personal disability card can only access health services after having paid out large amounts of money (Baroud, 2017, p. 3; JS15, n.d., p. 4).

Access to health facilities is also hindered by their built environment and their functioning. Public and private hospitals and health centres do not always conform to inclusive norms. They often lack the right engineering and automated equipment, such as ramps and elevators, and the right supportive communication systems (Baroud, 2017, p. 3; JS15, n.d., p. 4). This applies to children with disabilities, to whom care facilities are usually not accessible (CRC, 2017, p. 9, §29 (b)).

Lastly, the lack of information about available services leaves persons with disabilities unaware of services that are available. In one study, the majority of persons with disabilities "reported receiving health information from their communities, through WhatsApp groups, or via the directory prepared by informal groups of [persons with disabilities] from their community" (Baroud, 2017, p. 3). In contrast, very few obtained information from humanitarian organisations, health centres, or the existing hotline (Baroud, 2017, p. 3).

[11] Raef & El-Husseini (2015), cited in Baroud, 2017, p. 2.
[12] Raef & El-Husseini (2015), cited in Baroud, 2017, p. 2.

Poor quality of services provided

In addition, **the quality of care for persons with a disability also remains low** (JS15, n.d., p. 4). The State does not ensure the provision of rights-based medical and other services to persons with disabilities (CESCR, 2016, p. 4, §22 (b)). Medical staff expected to provide services or rehabilitation to persons with disabilities severely lack awareness on the various needs of persons with disabilities. This leaves staff unable to deal with these needs (Baroud, 2017, p. 3; JS15, n.d., p. 4).

Further, many persons with disabilities report being exposed to protection risks while receiving healthcare services. This can take the form of being discriminated against, or being subjected to violence – psychological, physical, and/or sexual (Baroud, 2017, p. 3).

Effects of poor provision on persons with disabilities

In this negative context of severe barriers to health care, many persons with disabilities are **left with unmet needs, which is detrimental to their physical and mental wellbeing**. In a 2017 convenience-sample survey of persons with disabilities and injuries, respondents reported coping with the lack of health care services and with their unmet needs through several ways: “turning to relatives or friends for financial assistance (57.2%), abandoning treatment or medication (55.6%), and the sale of possessions or property (30.7%)” (Baroud, 2017, p. 2). Other coping mechanisms reported were “working on illegal migration (21.4%), begging (7.4%) and returning to Syria for care (7.0%)” (Baroud, 2017, p. 2). Further, where care is provided but is inadequate, this may cause new disabilities, and can lead to moral and psychological harm and abuse (JS15, n.d., p. 4).

Access to the built environment, housing, and shelter

Public and private institutions have not adapted and equipped their built environment to enable access for persons with disabilities. Whereas civil engineering studies in Lebanon have demonstrated the low cost of adaptations, engineering and equipment remain scarce in places of public use in the country, as confirmed by surveys (JS15, n.d., p. 6). Schools and care facilities are usually not accessible to persons with disabilities, including children with disabilities (CRC, 2017, p. 9, §29 (b)). Persons with disabilities receive inadequate levels of assistance to access collective centres and tented settlements, and therefore face barriers in this area. This has had severe negative consequences for them (UNICEF Lebanon, 2015, p. 4, §23).

One gender-related consequence is that providers of services on gender-based violence can rarely offer fully accessible counselling spaces, (WRC & UNICEF, 2018b, p. 13).

Here again, while national legislation does contain obligations for public and private actors to take the necessary steps in engineering and equipment, **State inaction has prevented implementation and enforcement**. The ministries concerned have not issued the application decrees, nor performed the required procedures. After the July 2006 war, the reconstruction of destroyed infrastructure and buildings even offered an opportunity to make the new buildings accessible and inclusive from the start. Yet, the State failed to use that chance to advance the rights of persons with disabilities to have freedom of movement and equal access (JS15, n.d., p. 6).

Several reasons underlie this inaction on part of the State. First, the ministries and public departments that have a role in adapting the built environment fight over their attributions of powers. This "hinders any serious movement towards law enforcement" (JS15, n.d., p. 6).

Second, the general budget for buildings, public and private places of public use contains no chapters on engineering adaptations and equipment. This deprives local administrations from the financial liquidity required to enable access for persons with disabilities. This leaves adaptations of the built environment entirely reliant on individual or civic initiatives (JS15, n.d., p. 6). Further, the general budget lacks clear, specific clauses on adaptations and equipments in the built environment for persons with any type of disability, be it e.g. physical, visual, auditory, or mental. All the ministries involved in this area also lack have clear roles and budget allocations, such that the State ensures that all persons with disabilities, regardless of their impairment, can access the built environment thanks to the right engineering, equipment, and assistive technologies (JS15, n.d., pp. 6–7).

Education

Children and youth with disabilities have **very little access to education and learning opportunities, whether public or private, mainstream or specialised, formal or non-formal**[13]. Persons with disabilities are thus widely denied their right to education, and do not have equal access to education compared to persons without disabilities[14].

The options available for schooling – public or private, mainstream or specialised – are very limited and of poor quality (HRW, n.d., p. 5; JS15, n.d., p. 3). For example, public and private schools often demand that families of children with disabilities pay discriminatory fees and expenses such as transportation (HRW, 2018, p. 3). Public and private school also lack the infrastructure and environment that would be appropriate to learners with disabilities (HRW, 2018, p. 3; JS14, n.d., p. 7, §48). This includes a lack of adequately trained teachers, and of individualised approaches to children's education (HRW, 2018, p. 3).

The lack of good options for schooling **leads many parents to raise their children with disabilities within the family**. As a result, a large number of these children remain uneducated, especially in areas that are distant from the capital or the centre of the country (JS15, n.d., p. 3).

The major cause of this situation is that the **Lebanese State has not implemented and enforced the legal provisions** on education for persons with disabilities set out in the 220/2000 law (HRW, n.d., p. 5; JS15, n.d., pp. 2–3). This State inaction is associated with several obstacles to the right to education of persons with disabilities:

- The State has **not embraced the model of inclusive education**, instead standing by the model of integration. Yet, integration falls short and does not constitute inclusive education. Integration "implies that children with disabilities attend regular schools as long as they can adapt to the requirements and methods of the system", instead of authorities "radically transforming the education system to be inclusive" (IDA, n.d., p. 2).
- There is a **lack of clear and specific policies** to implement the right to education of children with disabilities (JS15, n.d., pp. 3–4). By the time of its last universal periodic review at the UN Human Rights Council, in mid-2015, Lebanon had adopted had no

[13] HRW, 2018; JS15, n.d., p. 3; UNICEF et al., 2017, p. 40.
[14] CESCR, 2016, p. 4, §22 (c); HRW, 2018; JS15, n.d., p. 3.

"national strategy to integrate children with disabilities in education" (JS14, n.d., p. 7, §48). It had also adopted no additional measures to integrate children with disabilities more and better into the mainstream system, not to promote vocational teaching (UNESCO, n.d., p. 12, §31).

- The **Ministry of Education has failed to take responsibility** for the education of persons with disabilities (JS15, n.d., pp. 3–4).
- The **Ministry of Social Affairs has not transferred the budget** dedicated to the education of persons with disabilities towards the more inclusive actions needed, such funding programmes in the public education system and in mainstream schools (JS15, n.d., pp. 3–4).
- The **number of teachers specialising in supporting children with disabilities is insufficient**. This is made worse by the overall poor quality of education in Lebanon, with an "insufficient number of professionally trained teaching staff at all levels, […] inadequate teacher training and materials, and poor infrastructure in the public school system" (CRC, 2017, p. 11, §34 (d)). Appropriate training for staff in the education and public sectors is scarce, leaving staff unable to deal with the needs of persons with disabilities (HRW, 2018; JS14, n.d., p. 7, §48).
- The **curriculum has not been adapted** to suit the needs of learners with visual, hearing, or mental disability. Associated with this is a lack of resources dedicated to making the curriculum accessible (JS14, n.d., p. 7, §48).
- The **dearth of statistics, data, and studies** related to persons with disabilities contributes to hindering progress (HRW, 2018; JS14, n.d., p. 7, §48).

All this being said, there have been **some positive developments in recent years**. The State has started to taken small-scale steps to improve access to public schools "for children with physical, sensory, and learning disabilities—although not children with intellectual or psychosocial disabilities" (HRW, 2018, p. 23).

Separate social care institutions

The policy of the Lebanese state is still to **isolate school-age children with disabilities by placing them into separate social care institutions that perform poorly**. These institutions work as boarding schools and are supposed to provide teaching to children with disabilities. The terms of enrolment into these institutions dictate that children stay there separated from their families, and isolated in the institutions (JS15, n.d., pp. 2–3).

These institutions are not deemed to belong to the educational system, and are thus **not subject to any monitoring by the Ministry of Education** (HRW, 2018, p. 4; JS15, n.d., p. 2). Instead, the Ministry of Social Affairs subsidises "a number of residential institutions where Lebanese children with disabilities live" (HRW, n.d., p. 6). The responsibility of the Ministry of Education for the education of persons with disabilities is limited to organising official exams for persons with disabilities enrolled in those social institutions that have education programmes. Even in that capacity, the Ministry has failed to perform its role (HRW, 2018, p. 4; JS15, n.d., pp. 2–3).

As a result, there is an **absence of rights-based control and enforcement** over these institutions, in several regards (CRC, 2017, p. 9, §29 (e); HRW, 2018, p. 4). First, the placement of children with disabilities in alternative care settings is not subjected to periodic review. Second, the quality of care in these settings is not monitored. This poses major risks, especially for

children with psychosocial or intellectual impairments. Third, there lack “accessible channels for reporting, monitoring and remedying maltreatment” (CRC, 2017, p. 9, §29 (e)).

The setting of these social institutions leads to **several problems for children with disabilities and their families**. First, it denies enrolled children the fundamental right to live with their families. Second, it also deprives them of living in their local communities throughout their enrolment time. Third, children receive a poor quality of education in these institutions, compared to their peers in the public system of education. Fourth, in this setting, enrolees’ parents cannot choose the type of education their children receive (JS15, n.d., p. 3). Fifth, children with disabilities are at risk of maltreatment (CRC, 2017, p. 9, §29 (e)).

Other than these poorly performing institutions, no other specialised social institutions are available to offer education for children with disabilities, leaving children with disabilities and their parents with no alternatives other than the mainstream school system. That system, however, is not inclusive, whether the schools considered are public or private (JS15, n.d., p. 3).

Public schools

The **public educational system is not inclusive**[15]. **Only 1% of school-age children with disabilities are enrolled in mainstream public schools** (JS15, n.d., p. 3). Access to inclusive education thus “remains very limited” (CESCR, 2016, p. 4, §21).

Mainstream public schools routinely refuse to accept children with disabilities from their local communities[16]. They also apply “discriminatory fees and expenses that further marginalize children with disabilities from poor families” (HRW, 2018, p. 1).

Lebanon has not implemented any significant “measures to improve the integration of children with disabilities in mainstream education”[17]. The Ministry of Education has only taken up a minimal role, and barely carried out actions, in facilitating the enrolment of school-age children with disabilities into mainstream public schools. For example, the only step it took between 2011 and 2015 was to develop a strategic plan for the educational integration of children with disabilities, and this plan was not even submitted to the governmental Cabinet for work and adoption (JS15, n.d., p. 3). In April 2016, the Ministry of Education announced that it would open 60 schools over two years for children with learning disabilities. However, Human Rights Watch has expressed concerns “as to whether these schools will be inclusive” (HRW, n.d., p. 5).

In addition, public schools “**do not provide a welcoming environment** for students with special needs” (UNICEF et al., 2017, p. 40). The mainstream school environment is not adapted to the basic needs of persons with disabilities – both adults and children[18]. Schools and care facilities are usually not accessible to persons with disabilities, including children (CRC, 2017, p. 9, §29 (b); UNICEF et al., 2017, p. 40).

The quality of public education is especially low **in rural areas**. This is a shortcoming for example in adaptations of the school environment (JS14, n.d., p. 7, §51).

[15] HRW, n.d., p. 5; JS14, n.d.; JS15, n.d., p. 3.
[16] HRW, 2018; JS15, n.d., p. 3; Kabbara, 2013, pp. 14–15.
[17] UNESCO cited in OHCHR, 2015, p. 13, §76.
[18] HRW, 2018; JS14, n.d., p. 14; JS15, n.d., p. 15; Solidar, 2015, p. 4.

To address some of the gaps, Lebanese **NGOs have provided support** to children with physical, sensory, and learning disabilities (HRW, 2018, p. 23).

Private schools

Children with disabilities are **regularly denied admission** to private schools (HRW, 2018, p. 44). In the few cases where children are allowed to attend, their families are "required to pay discriminatorily higher fees" for tuition and other services than other students (HRW, 2018, p. 44). In addition, at some private schools, families have to pay themselves for the accommodations called for by their child's impairment (HRW, 2018, p. 46).

Private schools do not provide inclusive education for children with disabilities either (CRC, 2017, p. 9, §29 (b)). Their facilities are usually not accessible to persons with disabilities, including children with disabilities (CRC, 2017, p. 9, §29 (b)). Their teaching is also not adapted. For example, one national survey looked at the assessment practices for students with learning disabilities in the 57 private schools that offered special education to students with learning disabilities at the time of research. It concludes that there are significant ethical problems in these practices. Almost half of the teachers and administrators said they were ill-prepared to assess student performance following their teacher education. Administrators turn out to be significantly more involved in assessments than teachers. Even though special education teachers saw alternative assessments as important, some of their practices still bore the imprint of traditional methods (ElSaheli-Elhage & Sawilowsky, 2016).

In contrast, some private schools have "made significant efforts to include children with disabilities in classrooms, including by providing them with a shadow teacher and additional supportive material" (HRW, 2018, p. 5). However, the cost has usually been borne by the child's family (HRW, 2018, p. 5).

Non-formal education

Programmes of non-formal education "have very limited coverage of children with special needs", because of **a lack of resources and a lack of capacity** to provide inclusive education (UNICEF et al., 2017, p. 40).

Participation in public and political life

Obstacles keep **preventing many persons with disabilities from exercising their right to participate** in public and political life. This impedes their right to vote in all types of public elections, from elections of representatives at national level, to elections of local representatives in municipal councils or union councils (JS15, n.d., p. 7).

One cause of this situation is that **no laws explicitly recognise these human rights for persons with disabilities** – neither the special laws on the rights of persons with disabilities, such as Law 220/2000, nor other legislation, do so (JS15, n.d., p. 7).

Further, the Lebanese State has **not implemented and enforced the legal provisions on elections for persons with disabilities** set out in the 220/2000 law. No procedures have been put in place to enable persons with disabilities to access special information about elections. Adaptation standards in the civil engineering of public places, including voting places, are not

upheld and applied. Procedures which would guarantee free and secret voting for persons with disabilities are not implemented (JS15, n.d., p. 7).

Participation in the **Lebanese National Youth Parliament** has not been inclusive, as the State has not effectively enabled all children to participate fully and has not provided the Youth Parliament with adequate support and resources. Children who have been marginalised include children with disabilities, as well as children living in poverty, refugee children, and lesbian, gay, bisexual, transgender and intersex children (CRC, 2017, p. 5, §16 (e)).

Participation in cultural life and leisure

UNESCO recommends that Lebanon realise the right to take part in cultural life by facilitating participation in cultural heritage and creative expressions for "communities, practitioners, cultural actors and NGOs from […] vulnerable groups", such as persons with disabilities, and by ensuring equal opportunities for women and girls to address gender disparities (UNESCO, n.d., pp. 13–14, §36-37).

Treatment by law enforcement

A rigorous study conducted in 2014-2015 examines the prevalence of severe mental illness in a sample of 198 male prisoners and 14 female prisoners from Roumieh and Baabda prisons (Catharsis, 2015). It finds a higher prevalence rate for psychotic and bipolar disorders among prisoners than in the general population. Three inmates were psychiatrically ill at the time of their sentencing, yet were sentenced as if they were not ill. Further, a number of inmates have developed a psychiatric illness during their stay in prison. In addition, a number of sentenced inmates who have a serious psychiatric illness (psychotic and bipolar disorders) and who were to be incarcerated in a special psychiatry unit actually reside in the buildings for non-psychiatrically ill inmates. Yet, against this whole context, the study finds a lack of screening of mental illnesses among inmates, and a lack of specialised care "for inmates who are in dire need for it" (Catharsis, 2015, p. 57).

4. Assessment of laws on the rights of persons with disabilities

Relevant international laws

State of Lebanese ratifications

Lebanon is **not party to the UN Convention on the rights of persons with disabilities**, having merely signed it. It is also not party to the 1951 Convention relating to the Status of Refugees and its 1967 Protocol. On the other hand, Lebanon is party to other UN human rights treaties whose provisions protect civil, political, economic, social, and cultural rights for all, including persons with disabilities. The table below summarises the status of Lebanon in relation to key UN human rights and refugee treaties and protocols, at the time of the writing of this report (OHCHR, n.d.; UNTC, 2018a, 2018b).

Table 4. Current status of Lebanon in relation to key UN human rights treaties and protocols

TREATIES	SIGNATURE?	RATIFICATION OR ACCESSION?
TREATIES AND PROTOCOLS LEBANON IS A PARTY TO		
International Convention on the Elimination of All Forms of **Racial Discrimination**		12 Nov 1971
International Covenant on **Civil and Political Rights** (ICCPR)		03 Nov 1972
International Covenant on **Economic, Social and Cultural Rights** (ICESCR)		03 Nov 1972
Convention on the Rights of the **Child** (CRC)	26 Jan 1990	14 May 1991
Convention on the Elimination of All Forms of Discrimination against **Women**		16 Apr 1997
Convention against **Torture** and Other Cruel Inhuman or Degrading Treatment or Punishment		05 Oct 2000
Optional Protocol to the CRC on the sale of children for **child prostitution and child pornography**	10 Oct 2001	08 Nov 2004
Optional Protocol of the Convention against **Torture**		22 Dec 2008
TREATIES AND PROTOCOLS LEBANON HAS MERELY SIGNED WITHOUT BECOMING A PARTY		
Optional Protocol to the CRC on the involvement of **children in armed conflict**	11 Feb 2002	
Convention for the Protection of All Persons from **Enforced Disappearance**	06 Feb 2007	
Convention on the Rights of **Persons with Disabilities**	14 Jun 2007	
Optional Protocol to the Convention on the **Rights of Persons with Disabilities** (allowing **individual complaints** to the UN Committee)	14 Jun 2007	
TREATIES AND PROTOCOLS LEBANON HAS NOT SIGNED		
Convention relating to the Status of **Refugees**		
Protocol relating to the Status of **Refugees**		
Second Optional Protocol to the ICCPR aiming to the abolition of the **death penalty**		
International Convention on the Protection of the Rights of All **Migrant Workers** and Members of Their Families		

Lebanese laws and policies in light of applicable international laws

According to a joint assessment conducted by several Lebanese associations of persons with disabilities[19] in 2015, a major cause behind the violation of the rights of persons with disabilities lies with the state of laws in Lebanon. Specifically, the associations point to the non-ratification of the UN Convention on the rights of persons with disabilities, and to the lack of development of national legislation that would translate these internationally recognised rights into Lebanese laws and norms. At the same time, they note that Lebanon did sign the UN Convention, thus

[19] The associations are: Lebanese Physical Handicapped Union; the Youth Association of the Blind; the Lebanese Association for Self-Advocacy; the Palestinian Disability Forum; Darb El Wafaa Association for the persons with disabilities; Takat; the Lebanese Down syndrome Association; the Association of Visually Impaired People; and the Youth Friendship Club.

implicitly recognising the rights set out in the treaty, and that the rights in the Convention are internationally recognised, since the Convention has entered into force after being ratified by over one hundred States. Consequently, they argue that the lack of ratification does not exempt the Lebanese State from developing national laws corresponding to the provisions of this UN treaty (JS15, n.d., p. 1).

Domestic laws and associated policies

Existing laws, bodies, and key policies

As a result of pressure from civil society actors, the Lebanese Parliament adopted a law on the rights of persons with disabilities on 29 May 2000, known as Law 220/2000 (see e.g. JS1, n.d., p. 10, §53; Lakkis et al., 2015). This law recognises a range of rights for persons with disabilities, including in the fields of employment, transportation, housing, health, and education[20]. In particular, all Lebanese citizens with a disability can supposedly "register for a disability card via the Ministry of Social Affairs (MoSA) […], as long as they meet the definition for disability" under Law 220/2000 (Baroud, 2017, pp. 1–2).

Law 220/2000 also recognises the National Council for Disability Affairs (NCDA). It includes members elected by, and from, organisations of persons with disabilities, and persons with disabilities (Lakkis et al., 2015, p. 4). Lebanon has also adopted a Programme to Safeguard the Rights of Persons with Disabilities (CESCR, 2016, p. 2, §4 (i)).

Law 422 on the Protection of Juveniles in Conflict with the Law or at Risk defines a child at risk as: "a child exposed to 1) exploitation or threat to health/safety/upbringing; 2) Sexual abuse or physical violence that exceeds non-harmful measures; 3) begging and on the streets" (cited in WRC & UNICEF, 2018a, p. 12).

Problems and gaps in the contents of domestic laws

However, there remain **major failings in the contents, implementation, and enforcement of public laws, policies, and practices**. Problems and gaps remain both with disability-focused legislation and with other legislation that has implications for persons with disabilities.

Problems with disability-focused laws

Approaches not based on human rights

On disability-focused issues, the Lebanese State has **still not adopted a human rights-based approach to disability** (CRC, 2017, p. 9, §29). As a result, Lebanon has still not adopted "rights-based policies and programmes for persons with disabilities" (CESCR, 2016, p. 4, §22).

Even Law 220/2000 on the rights of persons with disabilities did not embrace a rights-based model of disability (IDA, n.d., p. 1). Instead, it remained based on the outdated medical model of disability where disability is viewed as a "limitation resulting from impairment" (Lakkis et al., 2015, pp. 10, 12). This contradicts international human rights standards (IDA, n.d., p. 1). Indeed, the

[20] JS14, n.d., p. 7, §48; JS15, n.d.; Kabbara, 2013, pp. 11–12; Lakkis et al., 2015, p. 4.

very definition of disability in Law 220/2000 is not in conformity with international standards (CESCR, 2016, p. 4, §22 (a)).

So far, the State has **failed to upgrade national legislation** that is supposed to prepare the ground for implementing the UN Convention on the rights of persons with disabilities (JS15, n.d., p. 2). UN human rights bodies, as well as a number of human rights organisations and organisations of persons with disabilities, call for adopting national laws to guarantee the full range of human rights of persons with disabilities, and for adopting the policies and procedures necessary to protect and promote these rights (see e.g. JS15, n.d., p. 15).

Sectors where laws on disabilities are problematic

One area where legislation is problematic is **work**. Law 220/2000 recognised the right to work of persons with disabilities. The law mentioned the employment of persons with disabilities in both special centres, and the mainstream labour market. It set out a quota of employment of persons with disabilities in the public and private sectors (JS15, n.d., p. 5).

However, Law 220/2000 provided for no enforcement measures and no support to make the labour market inclusive for persons with disabilities (JS15, n.d., p. 5). In particular, it lacks policies that would eliminate disability-based discrimination in searching for, applying, and occupying a job. It also lacks provisions on job opportunities to persons with disabilities within an accessible and inclusive labour market. It sets out no procedures to help the work institutions become inclusive and capable of employing persons with disabilities. Conversely, it fails to ensure that vocational, social, and health-related rehabilitation programmes are available and linked to the requirements of the labour market (JS15, n.d., p. 5).

Existing laws also fail to fully require an inclusive **built environment**. According to numerous Lebanese and other associations of persons with disabilities, amendments are needed to ensure that no disabilities are excluded from legal provisions on access, whether the disability is e.g. visual, auditory or mental. Similarly, the associations call for amendments to set a legal obligation to make the environment accessible to all, regardless of their type of disability (JS15, n.d., pp. 6–7).

A 2015 review of **laws related to mental health**, conducted by psychiatrists who work in Lebanon, concludes that these laws do not conform to international standards, such as those in the UN Convention on the Rights of Persons with Disabilities. The authors find an absence of clear legislation that would protect patients from abuse and orient Lebanese psychiatrists' decisions. This leaves medical practitioners facing clinical dilemmas in their practices. The authors base their conclusions on an analysis of Lebanese laws about: the treatment and legal protection of persons with mental disabilities; criminal laws on offenders with mental disorders; and laws regulating incapacity. A comparison between these texts and international standards on the rights of persons with disabilities demonstrates "the recurrent contradiction between them" (Kerbage, El Chammay, & Richa, 2016, p. 48).

This is confirmed by a 2016 study on the situation of **prisoners with mental or psychological illnesses**, and their status under Lebanese criminal law. It shows that domestic legislation falls far short of international human rights standards, such as those adopted in legal texts and case law at the UN and the Council of Europe. For example, current Lebanese laws and judicial practices mean that persons with a mental illness who were sentenced to prison for committing a crime remain incarcerated "pending healing" of their mental health condition, rather than being imprisoned only for the duration of their sentence with possible parole, or at least until their

mental state is deemed not to pose a major security risk (Catharsis & Sharaf el-Din, 2016, pp. 17–50).

Law 220/2000 does not explicitly recognise the right of persons with disabilities to **participate in public and political life**, on an equal basis with persons who have no disabilities. No further legislation has subsequently filled that gap. Law 220/2000 does mention procedures that facilitate this participation, such as the adaptation of the built environment for all places meant for public use, which covers voting locations during elections. In addition, the Cabinet issued a decree to facilitate the participation of persons with disabilities in general elections, and the Ministry of Interior circulated the decree. Nonetheless, the State has not adopted inclusive standards to ensure that persons with disabilities can take part in electoral processes, be it to vote or run as candidates. It has also not set up procedures to ensure that persons with disabilities can "vote independently, freely and confidentially" (JS15, n.d., pp. 7–8).

Similarly, Law 220/2000 does not mention **access to information** (Lakkis et al., 2015, p. 4).

There also remains a **lack of effective legal remedies** available to victims of discrimination (CESCR, 2016, p. 4, §18).

Groups for whom laws on disabilities are problematic

Law 220/2000, which is meant to advance the rights of persons with disabilities throughout Lebanon, has in practice not protected **Palestinian refugees with disabilities**. Different sources give slightly different interpretations of the law and its implications for Palestinians with disabilities.

- Some sources believe that Law 220/2000 itself does not exclude Palestinian refugees from the rights it lays out, as the law refers to "disabled person", not "disabled Lebanese" (JS3, n.d., p. 3, §6; JS12, n.d., p. 9, §14.2). Such sources conclude that, in principle, Palestinians with disabilities should enjoy rights equal to those of Lebanese with disabilities under that law, i.e. that applying the law would advance the rights of Palestinians with disabilities (JS12, n.d., p. 9, §14.2).
- Other sources believe that Law 220/2000 only applies to Lebanese nationals, whereas Palestinian refugees are considered to be foreigners under Lebanese nationality laws (JS15, n.d., p. 8; UNRWA, 2017, p. 4). Such sources conclude that, even if Law 220/2000 were fully implemented and enforced, it would still not cover the rights of Palestinian refugees with disabilities, thus leaving a problematic gap (JS15, n.d., p. 8).

<u>Problems in other laws that affect persons with disabilities</u>

By 2015, laws in Lebanon included **no requirement to provide information in formats that are accessible and usable** for persons with disabilities (Lakkis et al., 2015, p. 4).

Among other issues that affect persons with disabilities, Lebanon has still not set an obligatory **minimum age for marriage in law**. This is left up to the officials of various religious sects, resulting in acceptance of ages of marriage between 9 and 18 years old (UNICEF Lebanon, 2015, p. 1, §3).

The **1951 Law on Registration of Personal Status** is among a number of laws that need reviewing in order to eliminate all forms of discrimination against children with disabilities, as well as against the "children of migrant workers, refugee children and children in marginalized situations, including Dom and Bedouin children" (CRC, 2017, p. 4, §14 (b)).

Lebanese laws on nationality create acute problems for specific groups of persons with disabilities, given how the scope of laws for the rights of persons with disabilities is currently laid out and applied. In particular, all Palestinian refugees, including Palestinians with disabilities, are considered to be foreigners under Lebanese laws. This deprives Palestinians with disabilities of the protections and provisions reserved to Lebanese nationals with disabilities, as set out in disability-specific legislation such as Law 220/2000. This bars Palestinians with disabilities from accessing resources and services in fundamental sectors such as paid work, health care, rehabilitation services, education, and housing (JS15, n.d., p. 8).

Impunity for past violence has meant that Lebanese law-makers have **not recognised the right to reparation of "all victims of political violence**, and their families, regardless [of whether] they are disabled, injured or killed" (JS1, n.d., p. 8, §41).

Problems with implementation and enforcement of domestic laws

Beyond shortcomings in existing laws, however, the major problem, emphasised by nearly all authors, is that the Lebanese State bodies have **not implemented and enforced the provisions of the law**[21]. By the time of the 2015 Universal Periodic Review of Lebanon by the UN Human Rights Council, i.e. a full 15 years after the adoption of Law 220/2000, the ministries concerned by the provisions of that Law had not issued any implementation decrees (JS15, n.d., p. 1; Solidar, 2015, p. 7). All parts of the State had failed to apply the provisions of that law on health, education, elections, training, and job placement (JS1, n.d., p. 10, §53). Similarly, as of 2015, the Law on the National Council on Disability had also not been implemented (JS1, n.d., p. 10, §54). By mid-2017, the State had yet to finalise its national plan of action for the rights of children with disabilities (CRC, 2017, p. 9, §29).

[21] See e.g.: (Committee on Economic, Social and Cultural Rights [CESCR], 2016); (Joint stakeholders 1 [JS1], n.d., p. 10, §53); (Joint stakeholders 15 [JS15], n.d.); (UNICEF Lebanon Country Office, 2015, p. 4, §23).

5. Political, social, cultural, and economic context for persons with disabilities

Inaction and obstacles from actors in formal politics

Several reasons explain why the Lebanese State has still neither adopted a human rights-based approach to disability nor implemented and enforced its Law 220/2000 on persons with disabilities.

A major reason for inaction has been the **crisis and deadlock in the formal political system**. This has blocked progress on disability rights in Lebanon (Lakkis et al., 2015, p. 4).

Another reason is that the government and ministries concerned **lack a vision, national policy, or general strategy** on how to implement the law and achieve equal opportunities in society (JS15, n.d., p. 1). The ministries concerned also fail to coordinate among themselves when considering how to implement the law. This wastes opportunities for implementation (JS15, n.d., p. 2).

The general **budget** also fails to address the basic needs of persons with disabilities. Consequently, it does not make provisions to implement the law in the sectors of labour, education, health, rights to an inclusive environment, and civil and political rights (JS15, n.d., p. 2). Further, funding mechanisms for the Fund for persons with disabilities is not set out in detail in the laws passed by Parliament. This is part of a larger, recurrent pattern in recent years where the Parliament has set up Funds without specifying funding sources, instead merely naming State endowments and private donations as potential sources of income. This was also done e.g. with the Fund for the Environment, and with the Fund to help the poorest households be able to pay their rent (Marot, 2015, p. 106).

Similarly, disability issues are **absent from agendas in local development** (JS15, n.d., p. 2).

Another reason for the lack of action in formal politics lies with the **absence of criteria on the inclusion of persons with disabilities** in the structures of the ministries, departments, boards, and decisions (JS15, n.d., pp. 1–2).

An additional reason for the lack of action in formal politics is that the public sector **lacks awareness and knowledge** on the issues of disability, and on the rights and needs of persons with disabilities (JS15, n.d., p. 2).

Indeed, another reason behind the lack of action in formal politics is that **disability issues are not part of the standard information required in public studies or official statistics** (JS15, n.d., p. 2). This leads to very few statistics, data, and studies being produced on these issues (JS14, n.d., p. 7, §48). In turn, this persistent data gap on disability limits targeted interventions aimed at improving the situation for persons living with disabilities, e.g. for children with disabilities (UNS, n.d., p. 26, §92).

For example, the State system for data collection on children's rights includes no "uniform system to document cases of child exploitation, violence and abuse", and does not systematically disaggregate data (CRC, 2017, p. 3, §10 (a)).

In fact, the ministries concerned do not just fail to collect information about disabilities: they provide **information that lacks transparency**, sometimes even making it impossible to access any information (JS15, n.d., p. 2).

In addition, UNICEF, UNHCR, and the World Food Programme (WFP) note the emergency context of Lebanon, with a "**colossal number of marginalized and vulnerable individuals**", which is background against which "the specific needs of refugees with disabilities remain largely unaddressed" (UNICEF et al., 2017, p. 40).

Knowledge, attitudes, and behaviours towards persons with disabilities

Knowledge, attitudes, and behaviours among Lebanese and foreign actors

Family members, communities, and service providers **"often view persons with disabilities through medical or charitable models", rather than through social or rights-based models** (WRC & UNICEF, 2018b, p. 8).

One extensive mixed-method study was conducted in 2017 on knowledge, attitudes, and practices towards children – with and without disabilities. It concluded that even many persons with disabilities, as well as their caregivers, **lack knowledge on disabilities**. Specifically, its findings about children with and without disabilities, and their caregivers, were as follows (Stade et al., 2017, pp. 21–22):

- "Alarming knowledge gap with regard to disabilities".
- Not knowing that children's rights also include the right to expression, to participation in decision-making, and to social inclusion (in addition to a right to basic services).
- Attitudinal challenges and knowledge gaps on gender differences.
- Attitudinal challenges because of growing conservative norms (e.g. on child marriage, family planning, and forced pregnancies).
- Gap between attitudes that are favourable to positive discipline, and persisting practices of negative discipline.
- "Knowledge gaps on vaccinations, breastfeeding and menstruation".

The same study also found shortcomings among providers of public services, including UNICEF and partners. Some of the findings were (Stade et al., 2017, pp. 21–22):

- "Insufficient capacity to professionally identify disabilities".
- "Insufficient integration of disability perspectives with other programmes".
- Capacity gaps in medical ethics.
- Inadequate practices in child protection, with protection against violence being particularly insufficient.
- Insufficient capacities to build trust with women, so that women are ready to report gender-based violence and violations of child protection to formal authorities.
- Need to make communication for positive change more participatory.

One example of lack of knowledge, shared by diverse respondents in the study, is that there is "widespread confusion about the difference between, on the one hand, physical and intellectual disabilities and, on the other hand, physical and mental illnesses" (Stade et al., 2017, p. 282).

Prejudice and stigma are common against members of marginalised groups in Lebanon, including persons with disabilities, and refugees (CESCR, 2016, p. 19, §19 (c); Kabbara, 2013, pp. 10–11). As persons with disabilities receive inadequate levels of assistance, they are left to face stigma and isolation. This has had severe negative consequences for them (UNICEF Lebanon, 2015, p. 4, §23). There is specific hostility towards persons with intellectual or mental disabilities (Stade et al., 2017, p. 282).

Problems in knowledge, attitudes, and behaviours related to disability and persons with disabilities are worsened by the **paucity of State campaigns to raise awareness of the rights of persons with disabilities**. For example, in 2017, the UN Committee on the Rights of the Child concluded that the Lebanese State needs to conduct awareness-raising campaigns to eliminate all forms of discrimination affecting children with disabilities – as well as the "children of migrant workers, refugee children and children in marginalized situations, including Dom and Bedouin children" (CRC, 2017, p. 4, 14 (b)). Such campaigns, meant to combat stigmatisation and prejudice against children with disabilities, need to be directed towards government officials, the public, and families. Some campaigns need to be carried out at the community level and in schools (CRC, 2017, p. 9, §29 (f)). International aid organisations have also not conducted campaigns to help change knowledge, attitudes, and behaviours towards disability and persons with disabilities (Stade et al., 2017, pp. 281–282).

Caregivers' situations, and implications for persons with disabilities

Several studies confirm that the caregivers of persons with disabilities – who are often women and girls – carry the bulk of care work, giving rise to difficulties for both caregivers and persons with disabilities.

For example, one qualitative study explores **how family members experience, interpret, and adapt to caring at home** for a close relative who survived a stroke. It is based on interviews with six Lebanese caregivers, conducted in 2012-2013. Caregivers were asked about their difficulties, satisfactions, and coping strategies, during a first interview and then a second interview conducted 6 to 12 months later (Taha & Kazan, 2015). The overarching finding is that caregivers, faced with major difficulties, respond by getting satisfaction from caring for the survivor. Their satisfaction stems from meeting challenges, and from creating order in the uncertainty and chaos caused by the stroke (Taha & Kazan, 2015, p. 98).

Caregivers report experiencing many burdens in caring for their relative (Taha & Kazan, 2015, pp. 92–95):

- abnegation, as they sacrifice their own wishes and needs to prioritise caring for the survivor;
- difficulty adapting to their changed role in their relationship with the survivor;
- financial difficulties due to the high, often prohibitive costs of paying for healthcare and assistance at home;
- overload of tasks, whereby caregivers who lack family support have to care for the survivor and keep on working, doing household work, and performing social tasks;

- feeling trapped in their caregiving role, with social isolation and a lack of freedom, due to the survivor's total dependency that requires continuous care;
- facing survivors' emotional and behavioural troubles and vulnerabilities, such as nervousness, hyper-sensitivity, despondency, child-like attitude, antagonism, or authoritarianism;
- physical and psychological vulnerability (e.g. pains, anxiety, thoughts of suicide), due to the lack of rest and to the drastic change in life conditions and prospects.

Caregivers also report **a stark lack of social support**, as their families and in-laws fail to support them sufficiently in taking care of the survivor. This lack of interest for the caregiver and/or the survivor leaves caregivers disappointed, their expectations of support let down. In addition, most interviewees report that their access to formal social support is restricted. Home care provided by qualified, experienced healthcare professionals remains out of reach, leaving caregivers unable to carry out certain actions for survivors (e.g. carrying the survivor to the bathroom). In a few cases, caregivers also report a lack of professionalism by some care providers, such as a lack of hygiene, or inattention towards the survivor. Some caregivers also note the inadaptation of the physical infrastructure in public spaces (Taha & Kazan, 2015, pp. 94–95).

The above findings about difficulties are similar to those from a quantitative study on the well-being of 65 mothers of children with Autism Spectrum Disorders (ASD), compared to 98 mothers of children without ASD. The study found that mothers of children with ASD had significantly worse well-being, and showed lower levels of perceived social support. It also found a significant negative correlation between the child's behavioural problems and maternal well-being (Obeid & Daou, 2015).

At the same time, in the study on caregivers of stroke survivors, interviewees report four types of **satisfactions from caregiving**. First, they have acquired new learning and skills. They report learning to remain patient and positive in their interactions with the survivor. They also report learning to provide certain treatments or carry out certain actions, such as bathing and dressing the survivor. This learning occurred either by observing professionals performing these actions, or from prior caregiving experience. Second, caregivers feel satisfied to contribute to caring for the survivor and supporting his/her readaptation. They particularly mention helping the survivor re-gain physical and psychological autonomy, and assisting him/her in daily life activities. Third, they derive satisfaction from their selfless dedication and giving. They express pride in these, and mention three main motivations behind their caregiving: love, duty, and reciprocity. Fourth, caregivers report gratitude – both the gratitude they receive from the survivor, and the gratitude they themselves have towards health professionals. With the latter, caregivers appreciate the humane care professionals provide the survivor, and the reduced fees some professionals apply to poor families they work with (Taha & Kazan, 2015, pp. 95–96).

Caregivers' coping strategies comprise two aspects. One is their familiarisation with their new routines, whereby they accept their current situation, master their role as home-based caregivers, and make use of further support to perform their caregiving. The latter involves hiring caregivers and domestic helpers, or calling on family for support (Taha & Kazan, 2015, pp. 96–97).

Caregivers' other strategy consists of reconciling with their new lives, in search of well-being. This takes on three forms. Firstly, caregivers find ways to strengthen their self-esteem, by

thinking of themselves too and setting aside time for themselves. For example, they take care of their own health, do activities they enjoy, engage back in social life, or seek to re-create life as a couple with the spouse who is a stroke survivor. Throughout, maintaining a positive attitude and living with great hope is central to caregivers. This manifests among others by making plans about the future, and hoping that the survivor will recover some physical and mental capacities (Taha & Kazan, 2015, pp. 96–98). Secondly, caregivers rely on religious and spiritual beliefs, particularly by maintaining faith and by praying. Thirdly, caregivers try and live life one day at a time. They do so for several reasons, the main one being that it lets them face uncertainty about the future successfully (Taha & Kazan, 2015, p. 98).

The above findings on satisfactions and coping strategies are similar to those in a quantitative study about the resilience of female family caregivers taking care of home-dwelling older relatives who are functionally or cognitively impaired. The study draws on data from structured interviews with 140 female primary family caregivers who cohabit with a person aged 65 or more. It finds four factors to be significantly associated with caregivers' resilience. The meaning ascribed to caregiving most explains the variance in resilience, followed by caregivers' sense of self-efficacy. Problem-focused and emotion-focused coping strategies also made a significant contribution (Seoud & Ducharme, 2015)[22].

Effects of specific structural inequalities on persons with disabilities

Family members, communities, and service providers often **fail to recognise that social factors other than disability, such as age and gender, shape the experiences** of persons with disabilities. This is because they approach disability from a medical or charitable model, rather than through a social or rights-based one. For example, they often fail to recognise that various social factors may increase a person's vulnerability to gender-based violence, and therefore fail to act on these factors when they consider preventing the violence, helping the person, or empowering her/him (WRC & UNICEF, 2018b, p. 8).

Types of disabilities

The in-depth study on knowledge, attitudes, and practices conducted for UNICEF in 2017 found **specific hostility towards persons with intellectual or mental disabilities**. "There is more willingness to socially include anyone with physical disability than there is to include persons with intellectual disability" (Stade et al., 2017, p. 282). Respondents feared that persons with intellectual disabilities might become violent (Stade et al., 2017, p. 282).

Children and adolescents with intellectual disabilities – both girls and boys – are at a higher risk of sexual abuse. Parents of children with such disabilities highlighted this "as the most immediate and urgent risk" to their children, in a needs assessment conducted in 2017 (WRC & UNICEF, 2018a, p. 40)[23].

[22] For a brief discussion of this article, see: Lupari, 2015.
[23] The needs assessment is: Women's Refugee Commission & UNICEF (2017). Disability Inclusion in Child Protection and Gender-Based Violence Programs. Training Needs Assessment Report: Psychosocial Support (PSS) Programs, November 2017. It is cited in: Women's Refugee Commission [WRC] & UNICEF, 2018a, p. 40.

Gender

There is a consensus in the literature in emphasising that **women, girls, and boys with disabilities are widely denied equal rights and subjected to exclusion, exploitation, and violence**. Indeed, they "are among the most vulnerable to neglect, abuse, and exploitation" (LHF, n.d., p. 3). The causes of gender-based violence against persons with disabilities "are rooted in the inequalities and power imbalances between women and men, the inequalities associated with disability, and in many cases in Lebanon – the displacement of the individual or family from their country of origin" (WRC & UNICEF, 2018b, p. 21). In particular, women and girls with disabilities suffer intense discrimination in realising their rights, due to inequalities based on both gender and disability (JS15, n.d., p. 6).

Economic exploitation

Women and adolescent girls with disabilities, as well as female caregivers of persons with disabilities, are at **high risk of economic exploitation**, as identified in a training needs assessment conducted by the Women's Refugee Commission and UNICEF in 2017[24]. In the assessment, women with disabilities and adolescent girls with disabilities report "examples where family members have forced them to engage in begging on the street" (WRC & UNICEF, 2018b, p. 5).

In turn, this puts them at risk of sexual abuse (WRC & UNICEF, 2018b, p. 5). Girls with disabilities are especially at higher risk of sexual abuse when they are engaged in begging on the street (WRC & UNICEF, 2018c, p. 10).

Additionally, the mothers and wives of persons with disabilities "may be seen as 'easy targets' for exploitation". One risk factor behind this is that gender roles have shifted, e.g. as caregiving wives work outside home, in what is perceived as working in the place of their husband who has a disability. Another risk factor is that caregivers' households may be under growing economic stress (WRC & UNICEF, 2018b, p. 5).

Gender-based violence, and sexual violence

Women and girls with disabilities are among the groups most at risk of gender-based or sexual violence, beside married girls (including child mothers), adolescent girls, boys and girls who are unaccompanied or separated, older women, female heads of households, and socially marginalised groups (LHF, n.d., p. 3; WRC & UNICEF, 2018b, p. 5). In addition, the complexity of cases is reportedly increasing regarding the vulnerabilities concerned and the response services needed (LHF, n.d., p. 3).

Boys and men with disabilities also face some gender-based violence. "Boys with disabilities, especially those with intellectual disabilities, may be at higher risk of sexual abuse" than their peers without disabilities (WRC & UNICEF, 2018c, p. 10). There are fewer reports of gender-based violence against men with disabilities in Lebanon. However, in a 2017 training needs assessment, young men with new disabilities reported that their changed roles in relationships, households, and communities "can result in harassment from others if they are not

[24] Women's Refugee Commission & UNICEF (2017). Disability Inclusion in Child Protection and Gender-Based Violence Programs. Training Needs Assessment Report: Gender-Based Violence (GBV) Programs, November 2017. This reference is cited in: Women's Refugee Commission [WRC] & UNICEF, 2018b, p. 5.

perceived to meet the gender expectations" (WRC & UNICEF, 2018c, p. 10). The young men consulted also said they lacked information about sexual and reproductive health (WRC & UNICEF, 2018c, p. 10).

Domestic violence, sexual harassment, and sexual exploitation are the main concerns in protection for women and for adolescent girls and boys, according to several assessments conducted in 2014 by the International Rescue Committee, UNICEF, and partner organisations (UNICEF Lebanon, 2015, p. 1, §5). This especially affects women and girls living with disabilities, unaccompanied girls, single heads of households, child spouses, and child mothers (UNICEF Lebanon, 2015, p. 1, §5).

Intimate partner violence against women with disabilities is a pervasive problem, as confirmed by a training needs assessment conducted by the Women's Refugee Commission and UNICEF in 2017[25]. Such violence has also been pervasive for women without disabilities. However, women with disabilities may be more likely to be victims of intimate partner violence, because they typically experience extreme disempowerment in their relationship (WRC & UNICEF, 2018b, p. 5).

Women with disabilities face **constant, persistent, and aggressive sexual harassment committed by men**, as documented in a training needs assessment conducted by the Women's Refugee Commission and UNICEF in 2017[26]. Perpetrators of such harassment in the community were often male taxi drivers or street vendors. According to the women with disabilities interviewed, these men choose to harass them because they assume that the women with disabilities they target do not have husbands or men to protect them, and that there would be fewer repercussions for the harassment (WRC & UNICEF, 2018b, p. 5, 2018c, p. 10).

<u>Further factors that affect the gender-related situation of persons with disabilities</u>

Broad categories shaping vulnerabilities and capacities

At a general level, **being a child, being displaced, or being a refugee, are factors associated with greater gender-based problems** for persons with disabilities.

Gender-based discrimination and violence against children, including **children with disabilities,** is widespread (UNICEF Lebanon, 2015, p. 1, §3; WRC & UNICEF, 2018b, p. 5). Child marriage is a significant risk for girls who have disabilities, as confirmed by a training needs assessment that the Women's Refugee Commission and UNICEF conducted in Lebanon in 2017[27]. Girls "with minor disabilities are more likely to be pressured into an early marriage before they are perceived as 'less desirable' due to both their age and disability" (WRC & UNICEF, 2018b, p. 5). Actors who work against gender-based violence, women with disabilities, and caregivers of persons with disabilities, reported this practice (WRC & UNICEF, 2018b, p. 5). It is part of a

[25] Women's Refugee Commission & UNICEF (2017). Disability Inclusion in Child Protection and Gender-Based Violence Programs. Training Needs Assessment Report: Gender-Based Violence (GBV) Programs, November 2017. This reference is cited in: Women's Refugee Commission [WRC] & UNICEF, 2018b, p. 5.
[26] Women's Refugee Commission & UNICEF (2017). Disability Inclusion in Child Protection and Gender-Based Violence Programs. Training Needs Assessment Report: Gender-Based Violence (GBV) Programs, November 2017. This reference is cited in: Women's Refugee Commission [WRC] & UNICEF, 2018b, p. 5.
[27] Women's Refugee Commission & UNICEF (2017). Disability Inclusion in Child Protection and Gender-Based Violence Programs. Training Needs Assessment Report: Gender-Based Violence (GBV) Programs, November 2017. This reference is cited in: Women's Refugee Commission [WRC] & UNICEF, 2018b, p. 5.

larger context where gender-based discrimination leads many girls to be pushed into child marriage, particularly among Syrian refugees (UNICEF Lebanon, 2015, p. 1, §3).

Being a refugee or a displaced person increases the exposure to risks of sexual or gender-based violence, as demonstrated in data "collected through the Gender-Based Violence Information Management System (GBVIMS), agency assessments, focus group discussions, and protection monitoring" (LHF, n.d., p. 3).

Specific factors of vulnerabilities and capacities

However, **not all persons with disabilities are automatically at high risk of gender-based violence in Lebanon**. This is an important point to take into account e.g. for providers of services to prevent and respond to gender-based violence (WRC & UNICEF, 2018c, p. 25).

Some persons with disabilities have **resources and power that help decrease the risks** of gender-based violence (WRC & UNICEF, 2018c, p. 25). These include (WRC & UNICEF, 2018c, p. 25):

- Strong family support systems;
- A steady economic situation;
- Good access to services;
- Solid peer support networks;
- Appropriate assistive devices that remove certain disabling barriers.

In contrast, **certain specific life situations put persons with disabilities in Lebanon "at higher risk** of violence, abuse and exploration" (WRC & UNICEF, 2018c, p. 25):

- Women and girls with disabilities who live outside of families, and/or who lack networks of supportive peers (WRC & UNICEF, 2018c, p. 25).
- Women, men, girls, and boys who have intellectual disabilities, as well as those who are deaf or have severe hearing impairments. They tend to be the most excluded, and face more discrimination. "There is a risk that perpetrators will target these individuals, assuming that these survivors will not be believed if they report abuse" (WRC & UNICEF, 2018c, p. 25).
- "Female caregivers of children with disabilities – particularly single women caring for children with disabilities" (WRC & UNICEF, 2018c, p. 25). They face high risks of sexual exploitation (WRC & UNICEF, 2018c, p. 25).
- Female caregivers whose husband has a disability, particularly when the impairment results from new injuries. These women may be forced to take on new roles and tasks in the household and the community, when their husband can no longer fulfil these (WRC & UNICEF, 2018c, p. 25).
- Adolescent girls with disabilities. They are often excluded from activities, and often lack information and networks of supportive peers. They are at high risk of early marriage, and can face specific risks of gender-based violence (WRC & UNICEF, 2018c, p. 25).

Lack of access to information, resources, and support to address gender-based problems

Even as women with disabilities, girls and boys with disabilities, and young women and men with disabilities are at higher risks of gender-based violence, many persons with disabilities and their caregivers **lack knowledge and awareness about the risks of gender-based violence**. This may lead them to not prioritize participation in activities for the prevention of such violence (WRC & UNICEF, 2018c, p. 19).

In addition, persons with disabilities and their caregivers **lack information and awareness on the activities and services available** on gender-based violence, and how to access services for case management. Their lack of information and awareness is due to both physical and attitudinal barriers that hinder their access to such services (WRC & UNICEF, 2018b, p. 5, 2018c, p. 19).

Further, providers of **services on gender-based violence can rarely offer fully accessible counselling spaces**, because accessible, inclusive built environments are scarce (WRC & UNICEF, 2018b, p. 13).

Age

Children and youth

During childhood and youth, girls and boys with disabilities are at **high risk of discrimination, marginalisation, exclusion, and violence** (UNICEF et al., 2017, p. 40; UNS, n.d., p. 25, §92).

Discriminatory practices are "prevalent against children with disabilities", as well as against "foreign children, refugee children[,] and children from poor Lebanese households", as noted by UNICEF[28]. Discrimination and the denial of effective integration apply to all areas of social life (CRC, 2017, p. 8, §28 (a)).

Indeed, girls and boys with disabilities are "among the most vulnerable to **neglect, abuse, and exploitation**" (LHF, n.d., p. 3). They "are at a higher risk of violence, abuse and exploitation, both inside the home and in the wider community", as recognised in the Lebanon Crisis Response Plan 2017-2020 (WRC & UNICEF, 2018b, p. 5). These risks become exacerbated during gradual emergencies, and when no targeted interventions reduce inequities for children with disabilities (UNS, n.d., p. 25, §92).

Services for children with disabilities and their caregivers

Children with disabilities are strongly affected by the **poor availability and quality of basic services.** The points below just highlight a few key issues – see the sub-section on rights, resources, and services, from p. 17 sq, for complementary details.

Children with disabilities are **institutionalised at worryingly high rates**, even though a rights-based approach would seek to de-institutionalise them, as noting in a recent warning by the UN Committee on the Rights of the Child. De-institutionalisation would require improving support to the caregivers of the children concerned, by increasing social benefits and other services the caregivers receive (CRC, 2017, pp. 9, §28 (d), §29 (d)).

[28] Cited in OHCHR, 2015, p. 8, §29; also see JS15, n.d., p. 6; UNICEF Lebanon, 2015, p. 1, §3.

Facilities for **schooling and care** are usually not accessible to children with disabilities (CRC, 2017, p. 9, §29 (b)). Children with disabilities also face inadequate health care services, especially in public hospitals, and "inadequate and insufficient rehabilitation services" (CRC, 2017, p. 8, §28 (b)). Further, children with disabilities have poor "access to health care, including early detection and intervention programmes" (CRC, 2017, p. 9, §29 (c)).

The **data gap** on disability limits targeted interventions aimed at improving the situation for children living with disabilities (UNS, n.d., p. 26, §92).

Intersections with other structures of inequalities

Gender-based discrimination and violence towards children, including girls and boys with disabilities, is also widespread – see the sub-section on gender, from p. 39 sq, for further detail[29].

Nationality-based discrimination against children, including children with disabilities, is also prevalent. In particular, Palestinian and Syrian refugee children with disabilities are subjected to discrimination and denied effective integration into all areas of social life, including education (CRC, 2017, p. 8, §28 (a)). Similarly, Syrian refugee children with disabilities are particularly faced with inadequate health care services, especially in public hospitals, and with "inadequate and insufficient rehabilitation services" (CRC, 2017, p. 8, §28 (b)).

Differentiated factors of vulnerabilities and capacities

Children with disabilities and their caregivers find themselves in diverse situations, which are associated with **different types and levels of risks to their mental health and psycho-social well-being (MHPSW)**. A training needs assessment that the Women's Refugee Commission and UNICEF conducted in Lebanon in 2017[30] identified the differentiated risks at play, and how they relate to risk categories used for activities in psychosocial support [PSS] (WRC & UNICEF, 2018a, p. 13).

As a starting point, **all children with disabilities are considered to be part of a vulnerable group** that is to be included in community-based PSS activities. This applies equally to children with physical, sensory, or intellectual disabilities (WRC & UNICEF, 2018a, p. 13).

Further, the Women's Refugee Commission and UNICEF **specify a number of situations where children with disabilities and their caregivers are categorised as 'vulnerable'** (WRC & UNICEF, 2018a, pp. 13–14):

- Children with disabilities who live in poor conditions (e.g. with poor housing) and who do not have their basic needs met. This particularly affects refugee children with disabilities – especially girls[31] (WRC & UNICEF, 2018a, p. 13).
- Children with disabilities who are out of school. Most children with disabilities, especially those with intellectual disabilities, are deprived of access to education. This exclusion is more pronounced for refugee children with disabilities (WRC & UNICEF, 2018a, p. 13).

[29] UNICEF Lebanon, 2015, p. 1, §3; WRC & UNICEF, 2018b, p. 5, 2018c, pp. 10–12.
[30] Women's Refugee Commission & UNICEF (2017). Disability Inclusion in Child Protection and Gender-Based Violence Programs. Training Needs Assessment Report: Psychosocial Support (PSS) Programs, November 2017. This reference is cited in: (Women's Refugee Commission [WRC] & UNICEF, 2018a, p. 5).
[31] See the sub-section Nationality and being a refugee, p. 29 sq.

- Children with disabilities experiencing bullying or harassment. Children with disabilities face bullying and physical violence in their community. This leads some parents to consider placing their child into residential institutions (WRC & UNICEF, 2018a, p. 14).
- Children with disabilities who witnessed potentially traumatic events. Refugee children with disabilities have witnessed war violence and other traumatic events (WRC & UNICEF, 2018a, p. 14).
- Child caregivers – especially girls – who look after their sibling who has a disability. Adolescent girls often play a role in caring for a person with disabilities in a household (WRC & UNICEF, 2018a, p. 13).

Further, a number of specific situations put children with disabilities and their caregivers into **even more adverse situations, where they face medium to high levels of risks to their MHPSW**, rather than just 'vulnerable' (WRC & UNICEF, 2018a, pp. 13–14):

- Children with disabilities who are survivors of abuse and exploitation. Both girls and boys "with intellectual disabilities are at risk of sexual violence in the community" (WRC & UNICEF, 2018a, p. 13).
- Children with disabilities forced into child marriage. In particular, adolescent girls risk "being married early, before their disabilities make them 'undesirable'" according to dominant social norms (WRC & UNICEF, 2018a, p. 13).
- Children with disabilities who experience high level of psychosocial distress. This affects two groups of persons. First, it affects adolescents and young people with new physical disabilities, whether these stem from injuries or a worsening medical condition. The persons concerned "report feeling depressed, with some reporting suicidal ideations and attempts" (WRC & UNICEF, 2018a, p. 13). Second, "[s]ome refugee children and young people with intellectual disabilities who have witnessed violence" experience a deterioration in their communication and social skills, and in their personal hygiene and daily care (WRC & UNICEF, 2018a, p. 13).
- Children with disabilities engaged in the worst forms of child labour. For example, some "adolescent girls with disabilities are being forced into begging on the street, exposing them to added risks of sexual abuse and exploitation" (WRC & UNICEF, 2018a, pp. 13–14).

Consequently, women, children, and youth with disabilities, as well as their caregivers, face a range of risks that **affect their MHPSW**[32]. A training needs assessment that the Women's Refugee Commission and UNICEF conducted in Lebanon in 2017[33] identified the most common issues in MHPSW (WRC & UNICEF, 2018a, p. 5):

- Regressions in skills and behaviours amongst children and adolescents with intellectual disabilities "who have witnessed and / or experienced violence" (WRC & UNICEF, 2018a, p. 5).
- "Suicidal ideations and attempts among adolescents and youth with new disabilities" (WRC & UNICEF, 2018a, p. 5).

[32] Refugees with disabilities also report specific war-related distress (Women's Refugee Commission [WRC] & UNICEF, 2018a, p. 5). See the sub-section 'Nationality and being a refugee', p. 29 sq.
[33] Women's Refugee Commission & UNICEF (2017). Disability Inclusion in Child Protection and Gender-Based Violence Programs. Training Needs Assessment Report: Psychosocial Support (PSS) Programs, November 2017. This reference is cited in: Women's Refugee Commission [WRC] & UNICEF, 2018a, p. 5.

- Violence against children and adolescents with disabilities. This includes: “sexual violence against girls and boys with intellectual disabilities; bullying and physical violence perpetrated by community members; and physical abuse perpetrated by caregivers, especially in refugee households who face added socio-economic stress” (WRC & UNICEF, 2018a, p. 5).
- “Fear and depression among mothers of children with disabilities” (WRC & UNICEF, 2018a, p. 5). Many mothers have “difficulties adjusting to having a child with disabilities”. This often leads them to develop “fear and depression about the future – for them and their child” (WRC & UNICEF, 2018a, p. 14).

Lack of information on risks and available support

Yet, even as children with disabilities and their caregivers face higher difficulties in sustaining MHPSW, many parents of children with disabilities “**lack knowledge and awareness about the psychosocial risks** that some children with disabilities face” (WRC & UNICEF, 2018a, p. 15). Consequently, they may not prioritise their participation in PSS activities. Further, they “**lack information about available [psycho-social support] activities**” (WRC & UNICEF, 2018a, p. 15).

Similarly, even though girls, boys, young women, and young men, with disabilities are at higher risks of gender-based violence, they **lack information and awareness on what activities related to gender-based violence exist, and on how to access case management services**[34]. This is due to both physical and attitudinal barriers that impede their access (WRC & UNICEF, 2018b, p. 5).

Older persons

Many Lebanese and outside actors have a limited understanding of older people’s special needs and abilities. They also lack the capacity to ensure this group’s full inclusion. As a result, older men and women face greater challenges in accessing basic services, and in meeting their basic and specific needs through these services. This is because providers rarely make these services inclusive and accessible for older persons. This limited availability has significant negative consequences for older men and women with specific needs, such as those with physical disabilities (LHF, n.d., p. 3).

Nationality and being a refugee

Being a refugee or a displaced person increases the exposure to risks of **sexual or gender-based violence** (LHF, n.d., p. 3). 93% of incidents of sexual or gender-based violence reported by refugees occurred in Lebanon (LHF, n.d., p. 3).

As a result of multiple adverse factors, **refugee women, children, and youth with disabilities, as well as their caregivers, face a range of risks that affect their MHPSW**. This includes risks that are distinct from those faced by other persons with disabilities in Lebanon (WRC & UNICEF, 2018a, p. 5).

[34] Women’s Refugee Commission & UNICEF (2017). Disability Inclusion in Child Protection and Gender-Based Violence Programs. Training Needs Assessment Report: Psychosocial Support (PSS) Programs, November 2017. This reference is cited in: Women’s Refugee Commission [WRC] & UNICEF, 2018a, p. 5.

In analyses conducted for community-based PSS activities, **refugee children** with disabilities are categorised as a vulnerable group. This is because they often live in poor conditions (e.g. in terms of housing) and do not have their basic needs met. They live in households that struggle with increased socio-economic stress. In turn, children and adolescents with disabilities are then at greater risk of physical abuse perpetrated by caregivers (WRC & UNICEF, 2018a, p. 5). Socio-economic stress in the household also increases the risk that adolescent girls with disabilities engage in begging on the street, face violence in the home, and/or are married before they are 18 years old (WRC & UNICEF, 2018a, p. 13).

29% of Palestinian refugee children with disabilities "are not enrolled in any educational institutions" (UNRWA, 2017, p. 4). Most refugee children with disabilities are thus out of school. Those with intellectual disabilities and refugees are especially deprived of access to education. This makes them vulnerable to problems in MHPSW (WRC & UNICEF, 2018a, p. 13).

Refugees with disabilities often report experiencing **distress related to witnessing and/or surviving war-related violence** (WRC & UNICEF, 2018a, p. 5). This includes children with disabilities who, like other refugee children, witnessed war violence and other potentially traumatic events (WRC & UNICEF, 2018a, p. 14). Some of the refugee children and young people with intellectual disabilities who have witnessed violence experience a deterioration in communication skills, social skills, personal hygiene, and daily care (WRC & UNICEF, 2018a, p. 13). This places their MHPSW at medium to high risk (WRC & UNICEF, 2018a, p. 13).

Some **children and young people with intellectual disabilities** who are refugees and who have witnessed violence experience a deterioration in communication skills, social skills, personal hygiene, and daily care (WRC & UNICEF, 2018a, p. 13). This places their MHPSW at medium to high risk (WRC & UNICEF, 2018a, p. 13).

Older refugees also face significant difficulties. The most important mechanism that older people use to cope with the risks generated by displacement is often their networks of support in family and community. This is particularly true for those with specific needs. However, older refugees adjusting to new settings find it a major challenge to know "where and how to access support and services" (LHF, n.d., p. 3). If the needs of older refugees are not met, their social isolation can increase, and their access to services decrease (LHF, n.d., p. 3).

<u>Palestinian refugees (who have fled from Palestine since 1947-1948, or from Syria since 2011)</u>

State of rights, resources, and services for Palestinian refugees with disabilities

There is a consensus in the literature that Palestinian refugees with disabilities are denied their rights, discriminated against, and excluded, due to three main sets of causes: general problems affecting all persons with disabilities in Lebanon; problems specific to Palestinian refugees in Lebanon; and, where applicable to the person, problems stemming from the combination of disability with other structural inequalities, such as those based on gender and age (see e.g. UNRWA, 2017, p. 4).

To begin, many Palestine refugees with disabilities and their families suffer **marginalisation due to the general problems affecting all persons with disabilities in Lebanon**. These problems include, among others: limited availability of, and access to, specialised services; inadequate awareness of the needs of persons with disabilities; and insufficient protection of the rights of persons with disabilities (UNRWA, 2017, p. 4).

In addition, **all Palestinian refugees in Lebanon are subjected to specific structural discrimination and denial of rights**. The inequality is anchored in both laws and practices – a core issue being that all Palestinian refugees are put into a distinct category of non-nationals in Lebanon[35]. Beyond the law though, Palestinians are deprived of their rights through discrimination (JS12, n.d., p. 9, §14.2). Even the national public bodies tasked with advancing the rights of persons with disabilities discriminate against Palestinians with disabilities and perpetuate the denial of human rights against this group (JS3, n.d.; JS12, n.d., p. 9, §14.4).

The structural discriminations against all Palestinians affects Palestinian refugees with disabilities, who are thus subjected to multiple forms of discrimination. As a result, Palestinians with disabilities do not have "equal opportunities to participate in social and economic life with integrity" (JS15, n.d., p. 8).

Most Palestinian refugees with disabilities live in **extremely difficult economic conditions**. There is a strong correlation between disability and poverty in Palestinian communities in Lebanon: among Palestine refugees in Lebanon, the extremely poor households "are twice as likely to have a family member with a functional disability living in their household", compared to the average household of Palestine refugees in Lebanon (UNRWA, 2017, p. 4). Refugees from Palestine who are over 15 years old who have functional disabilities and chronic illnesses have lesser opportunities for employment, compared to Palestine refugees with lower rates of disability and illness (Chaaban et al., 2016, p. 94).

Palestinians with disabilities fall under strict laws and ministerial decrees that **strongly restricts their entry into the labour market**, effectively barring all Palestinians from seeking many job opportunities and from holding most jobs[36]. Their unemployment rate reaches an estimated 90%. This increases the burden of disability on Palestinian refugees with disabilities. It leaves them deeply dependent "on the offerings of UNRWA, and other international organizations" to meet their needs (JS15, n.d., p. 8).

In **social protection**, Palestinian refugees are both deprived of their rights and exploited. They "have to pay full social security contributions" (Solidar, 2015, p. 8). Yet in return, they can only benefit from the indemnity for end of service, without being entitled to family allowances, to comprehensive health coverage, and to maternity leave (Solidar, 2015, p. 8). This matters particularly to households with a person who has a disability, as extremely poor households from Palestine were almost twice more "likely to have a family member with a functional disability living in the household" than the average household (Chaaban et al., 2016, p. 95).

In **health care and rehabilitation services**, Palestinian refugees with disabilities are barred from the official health services, again under the stated rationale that they are distinct non-nationals (JS3, n.d.; JS15, n.d., p. 8). Palestinian refugees with disabilities have been denied disability cards by the Lebanese State (JS12, n.d., p. 10, §14.6). As a result, they can only obtain health care and rehabilitation from UNRWA and some NGOs. These alternative provisions are made up of fragile, scattered and unsustainable services. The existing programmes on the prevention of disability and on rehabilitation for persons with disabilities do not have the resources appropriate to ensure continuity. Further, Palestinians' unfavourable legal status typically leads these programmes to prioritise work for temporary relief. This work alone

[35] JS3, n.d.; JS15, n.d., p. 8; UNRWA, 2017, p. 4.
[36] JS3, n.d.; JS15, n.d., p. 8; Solidar, 2015, p. 8.

overwhelms their capacities and prevents them from providing support to overall development for persons with disabilities (JS15, n.d., p. 8).

In relation to **environment and housing**, Palestinian refugees are denied the right to own property outside the refugee camps. Yet, the camps lack adapted, accessible built environments and equipment (JS3, n.d.; JS15, n.d., p. 15). This forces Palestinians with disabilities to "live in deteriorating conditions" (JS15, n.d., p. 8). For example, the reconstruction of the Nahr el-Bared camp has not been designed for inclusion. Instead, it has ignored the standards that would have met the needs of persons with disabilities, and the civil engineering studies on inclusive which demonstrated the possibility of implementing a disability- inclusive approach (JS15, n.d., p. 9).

In **education**, the rights of Palestinian refugees with disabilities are limited to receiving "basic official education", with a reliance on UNRWA schools (JS15, n.d., p. 8). However, UNRWA schools fail to adopt educational inclusiveness in curricula, in how educational staff deal with the needs of children with disabilities, and in the built environment (Chaaban et al., 2016, p. 77; JS15, n.d., p. 8). For example, a 2015 survey found that almost 30% of children with disabilities whose families had fled from Palestine were excluded from the educational system (Chaaban et al., 2016, p. 94). Palestine refugees with a disability were "less likely to be attending UNRWA or public or private schools, and more likely to be enrolled in public vocational schools and in schools for people with special needs" (Chaaban et al., 2016, p. 77). On the other hand, one large-scale survey conducted for UNICEF found that the Palestine refugee mothers surveyed who have children with disabilities "preferred the remedial education offered inside UNRWA schools to the official curriculum" (Stade et al., 2017, p. 120).

A 2015 survey about Palestinian refugees in Lebanon found that, among children with disabilities whose families had fled from Palestine, 62% were enrolled in UNRWA schools, 8.9% were enrolled in special education, and 28.9% were not enrolled in any school at all (Chaaban et al., 2016, p. 69). Non-enrolled children came from poorer households. While around 10% of respondents overall reported receiving assistance from an organisation other than UNRWA, this rose to nearly 17% among respondents who cited disability or illness as a reason why their children did not attend school. Similarly, 62.4% of such households reported being in the Social Safety Net (SSN) system, "significantly higher than the proportion of SSN in the overall population" (Chaaban et al., 2016, p. 74).

Access to education has major implications for individuals' life course. For example, in 2015, "the highest prevalence of acute illness, chronic disease and functional disability" was found among refugees from Palestine aged 15 years and over who never attended school. Conversely, the lowest prevalence was among those of the same age group who has a baccalaureate degree or higher (Chaaban et al., 2016, p. 94).

The recent **decrease in funding to UNRWA** has led that agency to reduce aid to all Palestinians in Lebanon. This trend has particularly hit the medical assistance that Palestinians with disabilities receive (JS3, n.d.; JS15, n.d., p. 9).

Specific sub-groups based on structures of inequalities: gender and age

Structural inequalities that combine with disability, such as gender and age, cause further denials of rights. Among Palestinians with disabilities in Lebanon, women, children, and older persons are thus "particularly vulnerable to discrimination, exploitation and violence" (UNRWA, 2017, p. 4). For instance, Palestinian refugee children with disabilities are victims of prevalent

discrimination. They are considered to be distinct non-nationals, are subjected to discrimination, and are denied effective integration into all areas of social life, including education[37].

Elderly Palestinian refugees, aged 60 and over, have high rates of functional disability, chronic disease, and acute illness. A 2015 survey found that, among refugees who had fled from Palestine, the prevalence of functional disability was highest in elderly refugees, and that rate was double that reported in 2010 (Chaaban et al., 2016, p. 94).

Specific sub-groups based on structures of inequalities: Palestinians who have fled from Syria

Palestinian refugees from Syria are one of the most vulnerable groups among Syrian refugees. Around 34,000 Palestine refugees from Syria are displaced in Lebanon as of 2018 (LHF, n.d., p. 2).

A 2013 survey of older refugees from Syria found reports of physical limitations to be **more prevalent amongst Palestinian refugees from Syria than amongst Syrian refugees from Syria**, when controlling for age and sex. Palestinian refugees from Syria reported more difficulty walking (65% vs. 39%), more vision loss (70% vs. 13%), more hearing loss (49% vs. 9%), and more physical inability to leave their home (16% vs. 8%). They also reported much greater need for assistive devices, such as "eyeglasses, hearing aids, hygiene supplies and mobility devices", "as measured by the number of needed items" (Strong, Varady, Chahda, Doocy, & Burnham, 2015, pp. 5–6).

Among Palestinian refugees from Syria, functional disability, chronic disease, and acute illness are **more likely in poor and extremely poor households**. Individuals with disability and chronic illness have lesser opportunities for employment (Chaaban et al., 2016, pp. 190–191).

The prevalence "of functional disability is highest in **elderly refugees**", at 23% in 2015 (Chaaban et al., 2016, p. 190).

Palestinian **children and youth** from Syria have much higher rates on non-attendance of school than Palestinian refugees who fled from Palestine. Among the most common reasons that Palestinian refugees from Syria aged 6 to 18 give is disability or illness (56.6%). In fact, 32% of Palestinian children from Syria who have disabilities are not enrolled in school (Chaaban et al., 2016, p. 165). Youth with disabilities are about twice more "likely to attend vocational training, short courses or informal education than their non-disabled peers", at 4% compared to 2.3% (Chaaban et al., 2016, p. 165).

<u>Syrian refugees who have fled from Syria since 2011</u>

Prevalence of disabilities

A 2017-2018 survey by Humanity & Inclusion found that 22.8% of Syrian refugees have some level of impairment. "**61.4% of households have at least one member with a disability**" (Humanity & Inclusion, 2018, p. 1). Syrian refugee women and girls "have a higher overall disability prevalence compared to men" (Humanity & Inclusion, 2018, p. 1).

A 2017 UN vulnerability assessment, which surveyed only Syrian refugee households registered with UNHCR, found that 14% of households surveyed report having at least one member with a

[37] CRC, 2017, p. 8, §28 (a); JS15, n.d., p. 8; UNRWA, 2017, p. 4.

physical or mental disability, a slight increase from 12% in 2016 (UNICEF et al., 2017, pp. 11–12)[38]. 16% of female-headed household report this, and 13% of male-headed households (UNICEF et al., 2017, p. 111).

The table below presents the share of households who reported having at least one member with a disability – physical, sensorial, mental, or intellectual –, broken down by governorate (UNICEF et al., 2017, p. 12).

Table 5: Share of households of Syrian refugees registered with UNHCR who reported having at least one member with a disability, in a 2017 survey (UNICEF et al., 2017, p. 12)

Governorate	Akkar	Baalbek-Hermel	Beirut	Bekaa	Mount Lebanon	Nabatieh	North	South
Prevalence rate	16%	13%	11%	12%	14%	15%	20%	12%

According to a 2017-2018 survey, problems with mobility are the most prevalent form of disability for adult men and women, followed by anxiety and fatigue (Humanity & Inclusion, 2018, p. 1).

A large number of Syrian refugees with disabilities are persons injured in war (JS15, n.d., p. 9). 71.2% of the Syrians with disabilities "had suffered from illness, injury and malnutrition caused by the conflict" (Humanity & Inclusion, 2018, p. 1).

Children with disabilities make up 2.3% of the Syrian refugees registered with UNHCR (UNICEF et al., 2017, p. 3).

More broadly, according to a UN vulnerability assessment, 66% of Syrian refugee households have at least one member with **special needs** in 2017, compared to 63% in 2016. 46% of households "reported having one or more members with a chronic illness", 34% one or more member with a temporary illness (UNICEF et al., 2017, pp. 11–12). 2.7% of the Syrian refugees registered with UNHCR in Lebanon are over 60 years old. 55% of them are women, 45% are men. One in four Syrian refugees over 60 years old has a mental or physical disability (VASyR cited in LHF, n.d., p. 3).

State of rights, resources, and services for Syrian refugees with disabilities

Discrimination against refugees from Syria is prevalent (CRC, 2017, p. 8, §28 (a)). This poses acute problems for persons with disabilities and for their caregivers, in a context where they have high needs and poor living conditions. In 2017, 80% of Syrian households who have children with disabilities "had an expenditure level that did not meet the Minimum Expenditure Basket threshold", compared to 75% for all Syrian refugee households surveyed in a UN needs assessment (UNICEF et al., 2017, p. 40).

[38] This is based on a 2017 survey of 4,966 UNHCR-registered Syrian refugee households, comprised of 24,415 individuals. It used a two-stage cluster sampling covering all governorates (UNICEF, UNHCR, & WFP, 2017, p. 7).

The association between disability and vulnerability condition the ability of households, including their members with disabilities, to maintain **legal residency** and to "obtain **official documentation** such as birth registration" (UNICEF et al., 2017, p. 40). Registering with UNHCR determines access to many basic services, such as health care. Similarly, those without residency permits cannot travel to Beirut for specialised health care (Baroud, 2017, p. 3).

In relation to **paid work**, Syrian refugees with disabilities are *de facto* excluded from employment (JS15, n.d., p. 10). Consequently, they have to rely on financial and in-kind assistance from aid donors (JS15, n.d., p. 10).

In **health care and rehabilitation services**, Syrian refugees with disabilities have had difficulties accessing "basic healthcare, maternal and child health services as well as specialized services for people with specific needs" (Handicap International, 2016, p. 4). Coverage through humanitarian agencies and the PHC network does not meet all their needs (Baroud, 2017, p. 2).

Financial constraints have been a major barrier to access, as forced displacement has depleted refugee families' financial reserves (Handicap International, 2016, p. 4). For example, 75-90% of the costs in secondary care are subsidised by UNHCR, based on a vulnerability score, but refugees must cover the remaining 10-25%. Many times, this is impossible due to refugees' financial problems (Baroud, 2017, p. 2).The budgets allocated to cover medical care, hospitalisation, and treatments of chronic and incurable diseases, have been at minimal levels (JS15, n.d., pp. 9–10). At the same time, no specialised actions on rehabilitation for Syrian refugees with disabilities are undertaken. This is a major problem especially for those who have recent disabilities as a result of the war in Syria (JS15, n.d., pp. 9–10).

In this context, some of the major obstacles that hinder the access of Syrian refugees with disabilities to health care and rehabilitation services are (HA & HI, 2014):

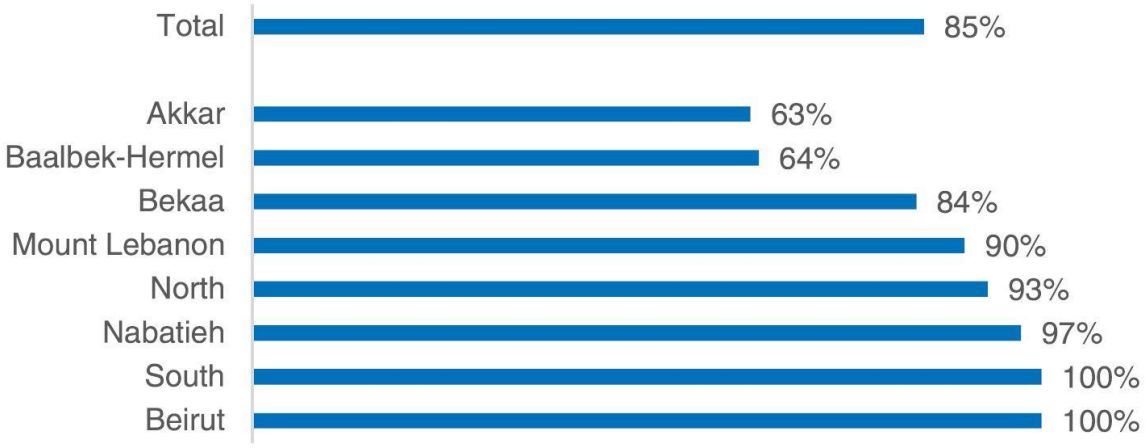
- Increased demands on the health care system, which have led to shortages of drugs and medical supplies, and to staff in primary and secondary health care services being overwhelmed.
- The high costs of treatments for certain chronic conditions (e.g. asthma, diabetes, hypertension, and cardiovascular diseases).
- The lack of information to refugees about available care, both basic and specialised (e.g. physical rehabilitation).
- The absence or deterioration of assistive devices, such as mobility aids (e.g. wheelchairs, crutches) or other specific items (e.g. anti-bedsore mattress). This can worsen a disability and impede access.

Another barrier has been that people with disabilities and impairments have difficulty reaching UNHCR registration points. Mobile registration is available for people who cannot physically go to registration centres. However, the service is provided on a case-by-case basis, and with insufficient coverage. Unless a refugee registers with UNHCR, he/she is excluded from the limited support that does exist (Amnesty International, 2014, p. 20).

Further, one study notes that Syrian refugees with disabilities were significantly more likely than Lebanese with disabilities to report that a lack of trust in health care providers prevented them from accessing health care, due to discrimination and violence experienced in health care institutions (Baroud, 2017, p. 3).

In **shelter and housing**, most Syrian refugees with disabilities lived in informal camps in mid-2015. These camps totally lacked engineering and equipment for adaptation and accessibility. They also do not meet minimum standards of safety and hygiene. Other Syrian refugees with disabilities were forced to live in informal shelters (JS15, n.d., p. 10). However, the situation seems to have improved. For example, among the Syrian refugees with disabilities registered with UNHCR who were surveyed for a UN needs assessment in 2017, 85% reported using disability-adjusted sanitation facilities (UNICEF et al., 2017, p. 31). Still, this varied noticeably by governorate, as shown in the chart below, extracted from (UNICEF et al., 2017, p. 31).

Chart 2. Proportion of surveyed Syrian refugees with disabilities registered with UNHCR who reported using disability-adjusted sanitation facilities, in 2017



As for private accommodation, persons with disabilities encounter unique barriers, because landlords may refuse to rent to them or evict them abruptly due to stigma and discrimination. For example, in cities, multiple families may be sharing an apartment or room in proximity to neighbours. This, combined with the stress of displacement, "can affect the behaviors of some individuals with disabilities" (Rosenberg, 2016, p. 7). Refugees with disabilities and their caregivers have thus reported tensions with neighbours and landlords "over noise that individuals with disabilities sometimes make while in their home" (Rosenberg, 2016, p. 7).

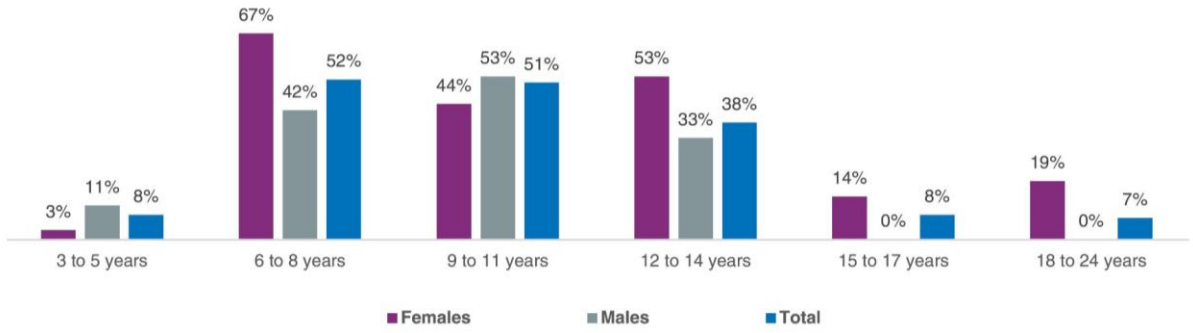
Further, "rented accommodation is largely inaccessible to persons with physical disabilities" (Rosenberg, 2016, p. 8). In turn, this increases their isolation, and reduces their access to services and programmes. In addition, caregivers also report that the overcrowding poses risks to "the safety and dignity of individuals with disabilities, particularly women and girls with disabilities" (Rosenberg, 2016, p. 8).

In **education**, Syrian refugee children with disabilities are deprived of education, let alone good-quality education (HRW, n.d., pp. 5–6, 2016a; JS15, n.d., p. 9)[39]. Compared to Syrian refugee children without disabilities, who are already marginalised, Syrian refugee children with disabilities are out of school in greater proportions across all age groups, from 3 to 17 years old (UNICEF et al., 2017, p. 42).

[39] On education for Syrian refugee children with disabilities, the following paragraphs include reference to a HRW paper: HRW (n.d.). For more details, also see a full report: HRW (2016a, pp. 65–69).

The 2017 survey of UNHCR-registered Syrian refugees details the low enrolment rates among children with disabilities. Total figures range from a maximum of 52% to lows of 7%. Gender- and age-disaggregated figures range from a maximum of 67% for girls aged 6-8, to lows of 0% for boys and young men aged 15-24 (UNICEF et al., 2017, p. 41). The chart below, from (UNICEF et al., 2017, p. 41), present the detailed figures, broken down by gender.

Chart 3. Enrollment rate of for children with disabilities in surveyed Syrian refugee households registered with UNHCR, by age and gender, in 2017



By 2017, “little or nothing had been done to ensure that these children can access education” (HRW, n.d., p. 5). Syrian refugee children with disabilities have nearly no options to get an education (HRW, n.d., p. 5).

Most public schools refuse to enrol Syrians with disabilities (HRW, n.d., pp. 5–6; 2016). Where they do manage to enrol, the schools are inaccessible to children with disabilities, and provide no adequate services (HRW, n.d., pp. 5–6; 2016). The official and sub-contracted services provided to them lack adapted curricula, educational staff trained in disability issues, and appropriate equipment for children with disabilities (JS15, n.d., p. 9).

Syrian refugees have nearly no alternatives to public schools, however. Some residential institutions receive subsidies from the Ministry of Social Affairs to provide education to Lebanese children with disabilities, but this funding does not extend to Syrians. In any case, the quality of education given by these institutions is questionable. Lastly, Syrian refugees cannot afford “either the unsubsidized institutions or [the] private segregated schools created exclusively for children with disabilities” (HRW, n.d., p. 6).

Due to all these barriers in public and private institutions, “some Syrian refugee children with disabilities remain at home, excluded from the education system altogether”. Excluded from mainstream public schools, they cannot access “the same educational resources as Lebanese children with disabilities” (HRW, n.d., p. 6).

International aid

The **quality of assistance that international aid actors provided Syrian refugees has also been poor** in several respects.

One basic problem was that international aid actors **failed to give due attention to disability** issues until very recently. For example, a study by HelpAge and Handicap International conducted in 2013 found that only 1.4% of Syrian refugees in Lebanon who had registered with UNHCR were recorded as having a disability (HA & HI, 2014, p. 6). By mid-2015, UNHCR and its partners still used a non-specialised form to record applications for assistance. It was not

standardised, and did not record the type and degree of disability. It also depended heavily on the statements of the refugees themselves about their disability and needs, without input from trained specialists (JS15, n.d., pp. 9–10).

Specific sub-groups based on structures of inequalities: types of disabilities

The families of **persons with intellectual impairments** "face extreme challenges and additional social isolation as refugees" (UNICEF et al., 2017, p. 40).

Children and youth with intellectual disabilities who are refugees from Syria "have a higher risk of experiencing violence, both within the home and in the wider community" (UNICEF et al., 2017, p. 40). They have often experienced a deterioration in their skills and behaviours compared to their lives in Syria before the war. Their parents attribute this to their children having witnessed war violence. One common manifestation is a change in the affected children's communication and social skills (e.g. children have stopped speaking). Another common manifestation is that the affected children become socially withdrawn, e.g. not wanting to speak with others or to join activities with peers. There are also a few more severe cases. Some young people with intellectual disabilities, who were once independent with their self-care and engaged with peer networks in their community, now need "full assistance with personal hygiene, such as toileting and washing" (WRC & UNICEF, 2018a, p. 40).

Children with intellectual or developmental disabilities are particularly excluded from education services (HRW, 2016b, p. 24).

Specific sub-groups based on structures of inequalities: gender

The risks of gender-based violence are shaped by the location and housing conditions of persons with disabilities. One study on refugees in urban contexts shows that, in cities, "persons with disabilities and their families have less control over where they live, and in what conditions". The lack of stable housing also means families have fewer opportunities to build relationships with neighbours and nearby community-based organisations, and to "develop the social networks that are central to community-based protection" (Rosenberg, 2016, p. 8).

Such isolation disproportionately affects women and girls with disabilities, particularly those with intellectual disabilities. Their families "perceive them to be at greater risk of violence, abuse, and exploitation in the community" (Rosenberg, 2016, p. 8). They believe that all locations outside the home pose a risk. Consequently, women and girls with intellectual disabilities remain "locked up in the house", spending most of the day inside the home, "assisting with housework or watching television and listening to music" (Rosenberg, 2016, p. 8). When families do allow them to go out, they ensure the women and girls concerned remain accompanied at all times. Families also choose the organisations and activities attended very cautiously (Rosenberg, 2016, p. 8).

Boys and men with intellectual disabilities report more freedom of movement in the community, and caregivers are less concerned about gender-based violence against them. However, boys and men with intellectual disabilities "are equally isolated from age-appropriate peer networks, and […] spend most of their day interacting with children" (Rosenberg, 2016, pp. 8–9).

Further, the loss of protective networks increases risks of violence inside the home for persons with intellectual disabilities. As families have less support to turn to for caregiving, parents experience an overload of their capacity, and intense stress levels. As a result, they may adopt negative behaviours towards family members with disabilities (Rosenberg, 2016, p. 9).

Additionally, caregiving women and girls in refugee households in Beirut face significant time constraints and responsibilities in the home. This reduces "their capacity to assist persons with disabilities to attend activities outside the home" (Rosenberg, 2016, p. 9). In turn, this diminishes their access to information about programmes and services, including on gender-based violence. Similarly, caregivers themselves can find it difficult, if not impossible, to attend services or meetings for peer support, when they need to care for someone with a disability full-time inside the home (Rosenberg, 2016, p. 9).

Specific sub-groups based on structures of inequalities: age – children and youth

Syrian refugee **children and youth** with disabilities have multiple and complex needs, which have both medical and social dimensions. Yet, these needs are left unmet (UNICEF et al., 2017, p. 3). Instead, the children and youth concerned are subjected to discrimination and denied effective integration into all areas of social life (CRC, 2017, p. 8, §28 (a)). Indeed, they are amongst the most marginalised groups in the country (UNICEF et al., 2017, p. 3). As a result, the children face protection risks. In particular, they are at risk "of physical violence, both outside and inside the home" (UNICEF et al., 2017, p. 3).

Syrian refugee children with disabilities are acutely affected by the poor availability and quality of basic services. They particularly suffer from inadequate health care services, especially in public hospitals, and "inadequate and insufficient rehabilitation services" (CRC, 2017, p. 8, §28 (b)).

The children and youth concerned are also denied education (CRC, 2017, p. 8, §28 (a)). This has left them "less likely to be enrolled in school" (UNICEF et al., 2017, p. 3). In fact, Syrian children with disabilities have even "been largely excluded from efforts to provide Syrian children access to education" (HRW, 2016b, p. 24). Little or nothing has been done to ensure that they can access education, as noted by 13 humanitarian and disabilities organisations in Lebanon interviewed by Human Rights Watch (HRW, 2016b, p. 24). Financial barriers, such as transportation costs and enrolment fees, are one barrier. Many of the other barriers lie with rejection, neglect, or lack of educational capacities towards children with disabilities, and with discrimination against refugee foreigners. Human Rights Watch documented a number of these issues in 2016 (HRW, 2016b, pp. 24–25).

The lack of education is especially frustrating for children with disabilities "who were able to attend school in Syria" (HRW, 2016b, p. 24). In one example documented by Human Rights Watch, two brothers, who are aged respectively 13 and 18, and who cannot speak or hear, were exceptional students in Syria. However, after they had to leave Syria in 2013, they could not get enrolled into any centres or schools. By 2016, they had "been out of school for three years" (HRW, 2016b, p. 25).

Most public schools refuse to let in Syrians with disabilities. Even where they do, there provide no special services to support these students. Public schools usually fail to "adequately accommodate the needs of all children to ensure they receive quality education on an equal basis with others" (HRW, 2016b, p. 24). Schools reject even simple requests that could be easily accommodated. For example, one school refused to allow a 12-year-old with a developmental disability "to sit in the front row so that he could concentrate better" (HRW, 2016b, p. 24).

Humanitarian actors have only taken limited steps to improve accessibility, mostly making small improvements focused on physical accessibility. For example, as of December 2015, only "7 out of 72 newly rehabilitated schools met physical accessibility standards" (HRW, 2016b, p. 24).

Private schools and providers of informal education, such as NGOs, also widely exclude Syrian children with disabilities. Exclusion takes the form of refusing to enrol them, setting high fees, providing no special services, or having social environments that do not welcome and support these children (HRW, 2016b, p. 24).

Specific sub-groups based on structures of inequalities: age – older persons

Older refugees from Syria are highly vulnerable. They need health monitoring, and targeted assistance. Humanitarian aid may overlook them (Strong et al., 2015).

This was confirmed for example in one 2013 mixed-method study that surveyed 210 older refugees (167 Syrians and 43 Palestinians) who had fled Syria[40]. The study found that many respondents either had disabilities, or had health issues that combined with other problems to end up constituting disabilities. Findings on impairments, health care, and support services, include the following:

- "Two-thirds of older refugees described their health status as poor or very poor" (Strong et al., 2015, p. 1).
- 87% reported difficulties in affording medicines (Strong et al., 2015, p. 1).
- Physical limitations were common. 44% reported difficulty walking. 24% reported vision loss, and 18% hearing loss. Many "reported more than one physical limitation or disability" (Strong et al., 2015, p. 5). "About 10% were physically unable to leave their homes and 4% were bedridden" (Strong et al., 2015, p. 1).
- Most respondents required assistive devices, such as "eyeglasses, hearing aids, hygiene supplies and mobility devices", e.g. walking canes (Strong et al., 2015, pp. 1, 5–6).
- Many saw such assistive devices as unaffordable in Lebanon (Strong et al., 2015, pp. 5–6). Perceived needs for these items were seen as much greater among Palestinian refugees from Syria, as measured by the number of needed items
- Diet was inadequate. Older refugees regularly reduced portion sizes, skipped meals, and limited their intake of fruits, vegetables, and meats. Often, "this was done to provide more food to younger family members" (Strong et al., 2015, p. 1).
- Some 61% reported feeling anxious. Significant proportions "reported feelings of depression, loneliness, and believing they were a burden to their families" (Strong et al., 2015, p. 1).
- 74% indicated depending on humanitarian assistance to varying degrees (Strong et al., 2015, p. 1).

Findings on functional abilities were contrasted (Strong et al., 2015, p. 6):

- 64% of respondents reported being fully independent in performing all six of the following activities: dressing, bathing, using the toilet, transferring positions, maintaining continence, and feeding.

[40] The sample was drawn from a listing of 1,800 refugees over 60 who were receiving assistance from the Caritas Lebanon Migrant Center (CLMC) or from the Palestinian Women's Humanitarian Organisation (PALWHO). Sampling was systematic, and proportional to the population of older refugees in each office surveyed. CLMC and PALWHO social workers collected qualitative and quantitative information from respondents in early 2013 (Strong, Varady, Chahda, Doocy, & Burnham, 2015, pp. 1–2). Study authors calculated a conservative margin of error of ±7.6% for older Syrian refugees, and ±15% for older Palestinian refugees (Strong et al., 2015, p. 2).

- Conversely, 36% reported some functional inability. Various proportions of respondents depended on others for dressing (26%), bathing (26%), using the toilet (22%), transferring positions (21%), maintaining continence (20%), and feeding (12%). 10% were moderately impaired, in that they required help with 2-3 of these activities. 18% were severely impaired, in that they required help with four or more of these activities.
- Variables associated with poorer functional status were: advanced age; dementia; poor vision; difficulty walking; poor reported health status; and larger size of the household.
- There was a trend towards lower functional abilities amongst women and amongst Palestinians, "but this was not statistically significant" (Strong et al., 2015, p. 6).

Lasting effects of violent conflicts

A 10-year longitudinal study of 244 Lebanese civilians who were injured by cluster munitions in 2006 shows that psychological symptoms, especially post-traumatic stress disorder (PTSD), remain high many years after the war. Certainly, the prevalence of PTSD decreased significantly after 10 years, from 98% to 43%. Lower prevalence was significantly associated with being a man, family support, and religion. Conversely, increased prevalence of long-term PTSD was significantly associated with post-incident hospitalisation and with severe functional impairment post-trauma. Among symptoms of PTSD, "negative cognition and mood were more common" after 10 years (Fares et al., 2017, p. 1). The most frequent socioeconomic repercussion among the participants was job instability, at 88%, followed by marital and family problems, at 20% (Fares et al., 2017).

Macro-economic outlook in Lebanon and implications

Prospective planning done by the UN system warns that the medium-term **risks of economic deterioration in Lebanon threaten to generate adverse conditions** that will worsen the situation of persons with disabilities. Specifically, if livelihood opportunities kept shrinking, while competition for work kept increasing, this could further depress wages, increase tensions in communities, "and further degrade living and working conditions, especially for the most vulnerable – the poor, persons with disabilities, youth and women" (UNS, n.d., p. 6, §14).

Foreign aid actors' approaches and their effects on the situation of persons with disabilities

Until 2016-2017, the Lebanese State, but also foreign actors such as the UN, **"had largely overlooked"** the issue of children with disabilities, as acknowledged in a document by the UN system (UNS, n.d., p. 31, §123). For example, until 2016, the UN had not worked "to gather robust data and mainstream the needs of children and youth with disabilities" across its programmes, nor planned "specific interventions to address their needs" (UNS, n.d., p. 31, §123). Similarly, as of mid-2015, UNHCR and its partners used a generic form for Syrian refugees with disabilities to apply to assistance. The form offered no standardised record of the type and degree of disability, and no input from trained specialists (JS15, n.d., pp. 9–10). Consequently, persons with disabilities "are rarely acknowledged and targeted in programming" despite their vulnerabilities and their capacities (Stade et al., 2017, pp. 281–282).

Further, in the aid response to the Syrian crisis, **the contents of adopted approaches have generated shortcomings to the detriment of persons with disabilities**, whether the approaches focused on vulnerability or on resilience. A rigorous external examination of these issues details the problems (WRC, 2017).

To begin, the majority of the aid literature **focuses on vulnerability, and uniformly deem persons with disabilities to be an at-risk group**. Within this, most aid organisations addressing the effects of the Syrian crisis in Lebanon consider persons with disabilities as a group at risk to be prioritised for assistance and services.

Indeed, assessments widely "**consider persons with disabilities as a homogeneous group**" (WRC, 2017, p. 2).

- Vulnerability assessments fail to make distinctions for conditions such as gender or age, and to analyse how factors of vulnerability intersect within these groups. Women, children, or youth with disabilities are not differentiated. As a result, organisations cannot understand how different persons experience protection risks differently (WRC, 2017, p. 2).
- Vulnerability assessments fail to take into account that the vulnerability of persons with disabilities can evolve over time (WRC, 2017, p. 2).
- Even composite models of vulnerability, which are based on a range of proxy indicators, "still ascribe categorical vulnerability to persons with disabilities" (WRC, 2017, p. 2). This is the case e.g. in multipurpose cash assistance.
- Only a few approaches have been better at disaggregating the factors shaping the experiences of persons with disabilities. This has been the case with protection assessments focused on particular groups (e.g. women, children, or youth). They have been better at identifying vulnerability as related to protection risks. They have also sometimes analysed how age, gender, and disability intersect (WRC, 2017, p. 2).

Conversely, **assessments fail to "incorporate an analysis of positive coping or capacity**, as a resilience-based approach would imply" (WRC, 2017, p. 2). Instead, they assume negative capacity, thus remaining primarily within a vulnerability perspective. This holds true even for finer-grained approaches such as the protection assessments discussed earlier. Even these "rarely provide any analysis of what resources, skills and assets people possess that enable them to protect themselves" (WRC, 2017, p. 2).

The external review also found that, as of 2017, **no aid publication considered the resilience of women with disabilities, children with disabilities, and youth with disabilities**. This is part of a larger "lack of research, vulnerability- or resilience-based, that focuses on youth", whether they are with or without disabilities (WRC, 2017, p. 2). This consequently excludes their protection risks and capacities from consideration. As a result, "insufficient information is available on interventions that could mitigate the protection risks of youth, and strengthen their resiliency" (WRC, 2017, p. 2).

These shortcomings stand in contrast to emerging evidence about the positive effects of strengths- and assets-based approaches to resilience, protection, and empowerment for persons with disabilities (WRC, 2017, p. 3). These are explored in the next section.

Mobilisation, advocacy, and capacities, by persons with disabilities or by others

Action by persons with disabilities

Local and national organisations of persons with disabilities "are the in-country experts on the rights of persons with disabilities in Lebanon" (WRC & UNICEF, 2018b, p. 9). They "can provide valuable information on the rights of persons with disabilities in Lebanon, including the disability-specific programs and assistance that may be available" (WRC & UNICEF, 2018c, p. 16). They have individuals with a range of skills and expertise, which can help e.g. raise awareness about disabilities in communities (WRC & UNICEF, 2018c, p. 16).

For example, the Lebanese Association for Self-Advocacy, which centres on persons with intellectual disabilities, has started self-advocacy training for refugees with intellectual disabilities. It has worked with these persons and their caregivers on topics such as expressing emotions and making decisions. The sessions bring together refugees and Lebanese with intellectual disabilities, as well as their caregivers. This highlights their commonalities, and strengthens participants' peer support through this shared identity (Rosenberg, 2016, p. 13).

Lebanon has **a number of diverse associations** of persons with disabilities and their caregivers. The associations address a broad range of impairments and disabilities[41].

Self-led activism by persons with disabilities has a rich history in Lebanon, with mobilisations for the rights of persons with disabilities, but also for broader political goals, including matters of war and peace[42]. Before the civil war, disability was not on the political agenda in Lebanon, and the charitable approach to disability was dominant. Once the civil war broke out, it started leaving thousands of people with impairments. This developed social awareness on disability (Berghs & Kabbara, 2016, p. 279).

The first response to this came from the military and militia organisations in each sectarian community. "These groups, supported by religious and other societal institutions," built medical and rehabilitation institutions for the injured militia men and civilians in their own communities (Berghs & Kabbara, 2016, p. 279). Their response was both institutional and community-based (Berghs & Kabbara, 2016, p. 279).

In the 1980s, a second response began when persons with disabilities, "supported by international NGOs, organised their own programmes and actions" (Berghs & Kabbara, 2016, p. 279). During that period, the movement of persons with disabilities decided to set aside demands for rights and to focus on playing an active role in ending the political violence. Accordingly, associations of persons with disabilities and prominent activists "began to join anti-war and anti-violence campaigns" (Berghs & Kabbara, 2016, p. 279). They carried out many activities, including a blood donation campaign in 1985, and a sit-in at the crossroads between the fighting camps in 1986. The most significant action was the 1987 peace march, which the disability movement organised in collaboration with the non-violence movement. It crossed "the country from north to south in protest against the continuation of violence and militia control" (Berghs & Kabbara, 2016, p. 279).

[41] For a selection of associations of persons with disabilities in Lebanon, see for example: https://www.daleel-madani.org/civil-society-directory?f%5B0%5D=field_intervention_sector_s_%3A15.
[42] Berghs & Kabbara, 2016; Kabbara, 2013; Lakkis et al., 2015.

From the end of the civil war in 1990, the disability movement devised a new strategy based on two pillars. Firstly, it sought to "consolidate disability rights by lobbying for a new law on disability" (Berghs & Kabbara, 2016, p. 279). That was achieved in 2000, although the law is far from being implemented, e.g. in health care, in schools, in public transports, in employment, in integration into mainstream institutions, and into the development of emergency plans to address disasters, war, and other emergencies that have led to forced displacement (Berghs & Kabbara, 2016, pp. 279–280).

Secondly, the disability movement has sought to remain "an 'avant garde' social force working to strengthen social peace and reconciliation and to push for reforms" (Berghs & Kabbara, 2016, p. 279). This has included "actively facing the challenges resulting from the displacement of people due to war in 1993, 1996 and 2006", and challenges posed by "the Syrian crisis and internal sectarian violence" since then (Berghs & Kabbara, 2016, p. 280). Many of the same mistakes made in aid in the 2000s are being made in aid to Syrian refugees and others in Lebanon in the 2010s. The disability community "again finds itself at the **vanguard of peace, non-violence and inclusion for the rights of all people**" (Berghs & Kabbara, 2016, p. 280).

Action by others for the rights of persons with disabilities

Actions for the rights of persons with disabilities

A few service providers, associations, and aid actors have **advocated for the rights of persons with disabilities, and/or carried out activities that have had positive effects** for participating persons with disabilities and their caregivers. In particular, a few organisations have adopted practices that build on the strengths of persons with disabilities, instead of just emphasising their impairments, vulnerabilities, and difficulties. This section highlights a few examples.

Some aid organisations have piloted approaches based on strengths and assets in their programming for youth and adolescent, with successful results. They identify how programming can practically integrate resiliency "to ensure the protection and empowerment of those with disabilities" (WRC, 2017, p. 3). They suggest that it is possible to identify not only vulnerabilities, but also traits of resilience, i.e. skills, capacities, and strategies and approaches for protection, both internally (personal) and externally (environmental). These traits of resilience "not only mitigate risks, but also help facilitate a trajectory […] toward a more positive, sustainable outcome" on the vulnerability-resilience spectrum (WRC, 2017, p. 3).

For example, during training needs assessments conducted in 2017 in Lebanon, children with disabilities and caregivers who had come in for PSS activities and/or services had a positive impact on the communication skills of the participating children with disabilities, on these children's mental and physical health, and on expanding their peer networks. No child or caregiver reported harm from attending PSS activities (WRC & UNICEF, 2018a, p. 37).

Similarly, the persons with disabilities consulted shared that attending activities on how to prevent and respond to gender-based violence "had a positive impact on their mental and physical health[,] and helped them to expand their peer networks" (WRC & UNICEF, 2018b, p. 11). None of them reported harm from attending these activities (WRC & UNICEF, 2018b, p. 11).

Consequently, as international aid actors have increasingly been paying attention to disability, and as positive practices and results have started being documented, the Women's Refugee Commission, in cooperation with Lebanese associations of persons with disabilities, has been able to produce a set of references analysing successful practices. The topic covered in such analyses, guidance, and recommendations are:

- Including disability into the response to the Syrian crisis:
    - Including persons with disabilities into the Syrian refugee response (Pearce, 2013, 2014a).
    - Including women, children, and youth with disabilities in resilience-based approaches that respond to the Syrian crisis (WRC, 2017).
    - Building trust, from outreach to community centres (Pearce, 2014b).
    - Including children with disabilities in child-friendly spaces (Pearce, 2014c).
    - Supporting children with disabilities, their families, and their whole support network (Pearce, 2014d).
    - Using the valuable contributions that persons with disabilities can make in community outreach (Pearce, 2014e).
- Including disability into child protection and/or work against gender-based violence, including in work with Syrian refugees:
    - Building peer networks in urban contexts between refugees with disabilities and persons with disabilities in the host community (Women's Refugee Commission [WRC] & Lebanese Association for Self-Advocacy [LASA], 2017).
    - Case management of survivors and at-risk women, children and youth with disabilities (WRC & UNICEF, 2018b).
    - Guidance on outreach, safe identification, and referral of women, children and youth with disabilities (WRC & UNICEF, 2018c).
    - Disability inclusion in programmes for psychosocial support in Lebanon (WRC & UNICEF, 2018a).

In a different sector, some **individual actors in the private sector** are taking initiatives to employ persons with disabilities and to adapt their workplaces (JS15, n.d., p. 5).

<u>Actions to support caregivers, and to improve their attitudes and behaviours towards persons with disabilities</u>

Professionals in the psychiatry service at Hôtel-Dieu de France, a University hospital, tested a programme of **therapeutic education for caregivers** of three patients with schizophrenia – "a chronic illness that causes considerable functional disability" (Souaibi, Choueifati, Kerbage, & Richa, 2016, p. 677). The participating caregivers were the father and mother in two cases, and the wife in one case. Patients did not participated in the group – this was done with patients' consent. Between March and May 2013, participating caregivers attended 10 sessions, with one hour and a half session per week. They were given information on schizophrenia and its treatment by diverse health professionals from the service (psychiatrist, psychologist, nursing manager, and occupational therapist). They also talked about their own experiences and feelings as caregivers. Their knowledge on schizophrenia was assessed before and after the programme (Souaibi et al., 2016).

The assessment found that the programme had had several positive effects. It led caregivers to acquire new and useful knowledge about schizophrenia. It helped them relieve their distress, and deal with “negative emotions caused by the presence of the disease in a family member” (Souaibi et al., 2016, p. 678). The study authors conclude that therapeutic education for families of patients with schizophrenia is essential in managing the disease, since family is central in patients’ lives in Lebanese society (Souaibi et al., 2016, p. 678).

6. References

Where a reference was available in more than one language, English was prioritised, followed by French, with the Arabic version coming last.

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About this report

This report is based on nineteen days of desk-based research. The K4D research helpdesk provides rapid syntheses of a selection of recent relevant literature and international expert thinking in response to specific questions relating to international development. For any enquiries, contact helpdesk@k4d.info.

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