Removing Barriers

The Path towards Inclusive Access

Disability Assessment among Syrian Refugees in Jordan and Lebanon

Jordan Report

July 2018

Australian Aid

humanity & inclusion

iMMAP

An Australian aid initiative implemented by Humanity & Inclusion and iMMAP on behalf of the Australian Government

The four Study Factsheets and reports can be consulted (https://re.tc/disability_factsheets)
Study Data can be accessed on the Project Dashboard (https://re.tc/disability_dashboards)

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Kids in Zataari camp. © HI/B. Bogaerts, 2014

EXECUTIVE SUMMARY

Objectives

Concerning the lack of disability data in the Syria crisis context, Humanity & Inclusion (HI) and iMMAP conducted the study aimed at the following:

1. Provide statistically reliable prevalence of disability as well as disability disaggregated data indicators on access to services.

2. Increase understanding of the situation of Syrian refugees with disabilities and their households, compared to their peers without disabilities, in relation to the access to services including education, and key barriers experienced in accessing these services.

3. Recommend inclusive actions to be prioritized by humanitarian actors.

Methods

The study conducted a literature review, quantitative data collection as well as qualitative data collection.

Quantitative data was collected from 6,381 persons of randomly sampled 1,159 households in Azraq and Zaatari camps and Irbid between October 2017 and January 2018. In the light of the UN Convention on the Rights of Persons with Disabilities (UNCRPD), the study defined disability as interactions between personal and environmental factors. Disability was measured the level of difficulties a person faces when performing basic activities (referred as "domains") regardless of impairments, using the modified Washington Group's Extended Set (WG-ES) (more precisely, Short Set Enhanced plus fatigue) and Child Functioning Module (CFM).

Twenty-five Key Informant Interviews (KIIs) and 3 Focus Group Discussions (FGDs) were also conducted between November 2017 and January 2018 to elicit deeper insights on the educational situation of children with and without disabilities.

Findings

Prevalence of Disability

- **22.9% of surveyed Syrian refugees aged 2 years and above had disabilities** (1,374 persons out of 6,003 persons): 13.8% in Azraq camp, 23.5% in Irbid and 30.5% in Zaatari camp. Understanding disability as the level of difficulties a person is facing when performing basic activities that could put him/her at risk of not participating in society, the prevalence of disability found by the study was markedly higher than the existing disability statistics at around 2-3% to less than 10%, many of which used questions focusing on a person's medical conditions or impairments.
- The study further found that **62% of sampled households included at least one member with disabilities**. This finding requires humanitarian actors to examine the impact of disability on households and consider the needs to promote appropriate parenting skills and support programs for families.

Causes of Disability

- 29.9% of persons with disabilities reported illness or disease as the primary cause of functional difficulties.
- Among persons who reported illness/disease, injury and malnutrition as causes of their disabilities, **24.7% considered the causes were related to the Syrian conflict**. Among them, walking was the most common activity with which they faced difficulties, followed by anxiety, depression, fatigue and seeing.
- More females (34.6%) than males (24.7%) had disabilities related to illness or disease. Injuries, on the other hand, led to more males having a disability (14.7%) than females (7.1%). This suggests males' higher exposure to risks of injuries in conflicts.

Disability Domains

- The most frequently experienced functional difficulties by adults aged 18 years and above were walking (14.4%), anxiety (11.4%) and fatigue (10.9%). Children aged 5-17 years faced difficulties related to anxiety (9.7%) and depression (5.9%), while children aged 2-4 years experienced difficulties related to communication (2.8%) and controlling behaviors (1.5%).
- The fact that **anxiety and depression are the most common domains for persons aged 5 years and above** may be surprising because often, disability data collection is associated with physical, hearing, seeing and intellectual impairments and rarely with mental health and psychosocial issues (anxiety and depression) or fatigue. A range of stress experienced by Syrian refugees, if not addressed timely and appropriately, could develop to critical conditions, and then to disability. It is particularly worrying that, among children aged **5-17, 9.7% exhibit daily anxiety and 5.9% show depression or sadness on a daily basis**. This data suggests the strong need for humanitarian actors to focus on Mental Health and Psychosocial Support (MHPSS), with careful attention to the young generation.
- **Zaatari: Mental health issues were particularly prevalent in Zaatari camp**. 19.9% of children aged 5-17 in Zaatari experience anxiety daily, higher than corresponding rates in Irbid (7.6%) and Azraq (2.3%). Among adults aged 18+, anxiety was the leading domain affecting 15.0% of its populations in Zaatari, while the most cited difficulty was walking in Azraq and Irbid. This may be related to the nature of Zaatari camp, being established 7 years ago while Azraq is newer, opened in 2014. The relationship between the number of years refugees live in a camp setting and its impact on people's mental well-being needs to be investigated.

Children's Disability by Household Income Level

- **Poorer households are more likely to have children with disabilities (2-17) than households within higher income brackets**. Around 80% of children with disabilities in at least one domain reside within households with a monthly income of 199 JOD or less. This suggests a strong relationship between poverty and disability.

Assistive Devices

- **Persons with disabilities continue experiencing functional difficulties despite assistive devices.** 22.6% of those who use glasses, 19.0% of those who use hearing aids and 71.0% of those who use mobility aids still experience significant difficulties seeing, hearing and walking. The issues could be related to inappropriate fitting of assistive devices at the beginning and lack of longer term support in terms of regular maintenance and repair. Often, projects were only able to distribute the initial device, and not able to cover costs related to repair or maintenance when the devices were damaged or outgrown afterwards.
- By location, **percentage of persons aged 18+ who have difficulties walking even with mobility aids is particularly high in Zaatari (80.4%)** compared to 74.5% in Irbid and 67.5% in Azraq. There is a need to assess the physical accessibility in Zaatari as well as the capacity of established networks of service providers to deliver proper fitting and maintenance.

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Access to Services

(Unit of analysis: households with and without disabilities)

UNHCR Registration

- All surveyed households in Azraq and Zaatari camps are registered with UNHCR.
- Among the 445 households surveyed in Irbid, random sampling found 15 non-registered households with UNHCR (3.4%). Households with members with disabilities showed a slightly higher percentage of registration (98.3% compared to 93.2% among households with no members with disabilities).

Shelter

- All households except for 4 in Zaatari camp had shelters or houses.
- **Inaccessible housing conditions affect both households with and without disabilities.** The percentage of affected households was especially high in Irbid (more than 89%), followed by around 50% in Zaatari and 32% in Azraq.
- The majority of surveyed households (more than 94% across locations) had stable access to electricity, with no major differences between households with and without disabilities, and between locations.
- **Zaatari camp raised particular concerns around feelings of safety**; over one third of households with disabilities (35.9%) worried about being harmed/injured around their shelter compared to 26.1% among households without disabilities, higher than their counterparts in Azraq (23.3% and 15.6% respectively). This result could be related to the higher rates of accessibility concerns in Zaatari than in Azraq.

Latrines

- Zaatari: 13.8% of households with members with disabilities reported that latrines were not always available compared to 9.1% of households without disabilities, despite the majority of families having private toilets. The issue could be related to latrines' functioning or sharing among family members, some of whom might require longer time. More households with disabilities (17.6%) reported latrine accessibility problems than households without disabilities (14.0%).
- Azraq: about 13% of households said that toilets were not always available, with no difference between households with and without disabilities. Considering public toilets in this camp, the rates were unexpectedly low compared to Zaatari. The higher rate of households with disabilities expressed challenges to latrine accessibility (15.1% vs 12.7%).
- Irbid: more than 95% of households with and without disabilities reported that their latrines were available and accessible.
- **In camps, households with disabilities reported a stronger sense of insecurity to use latrines than households without disabilities.** More fears were cited in Azraq than in Zaatari; in Azraq, 22.0% of households with disabilities feared possible harm/injuries and 17.6% feared attacks or harassment, compared to 20.7% and 11.9% respectively in Zaatari.

Water

- Almost 100% of households in Azraq and more than 93% in Irbid confirmed they had enough safe water from reliable sources. The study found no major difference on the basis of disability. Obstacles mentioned in Irbid were availability and the cost of water.
- The percentage was lower in Zaatari at 79.3% (no difference between households with and without disabilities). Most surveyed respondents said the service did not meet families' specific needs, with references to shared water tanks.

Health

- The majority of households had health needs in the last six months. **Stronger needs were reported by households with at least one member with disabilities** than by households without members with disabilities (89.6% vs 82.0%). Needs were particularly high in Zaatari camp, at around 95%.
- When having medical needs, **households with disabilities were less likely to have access to required medical services at hospitals or clinics than households without disabilities** (11.8% vs 7.2%, P<0.05).
- Access to medical services is especially an issue in Irbid. 17.0% of households with disabilities could not access medical services when needed, compared to 11.2% of households without disabilities.
- **In Irbid, the cost of medical services was the major barrier, especially for households with member(s) with disabilities (92.9%)** compared to 72.7% households without disabilities. The cost is also related to transportation, as cited by 38.1% households with disabilities.
- **Unavailability of medical services is the major obstacle to address respondents' medical concerns especially in camps.** Although a number of actors in camps provide medical services free of charge, the specific needs of individuals were not met, leading to refugees' disappointment or frustration. The study found that some refugees had to go outside the camp to look for specific medical services, bearing the costs of transportation and the services.

Food and Cash Assistance

- All households in Azraq had access to food and cash assistance.
- Irbid: more households with disabilities than households without disabilities were receiving services (93.3% vs 89.0% for food assistance and 34.1% vs 19.2% for cash assistance). This could be explained by the effective targeting of vulnerable households including those with persons with disabilities by humanitarian actors, through the inter-agency Vulnerability Assessment Framework. For households who reported not receiving assistance, the main barriers were availability of services, related costs as well as lack of documents.
- Zaatari: reported rates of access to World Food Programme (WFP) vouchers were unexpectedly low (38.7% for families with disabilities and 17.4% for families without disabilities). In terms of cash assistance, more households without members with disabilities reported access (91.7% vs 64.0%), contrary to the finding in Irbid. A further research is needed to elaborate the findings. The majority of households without access to food and cash assistance reported unavailability of the service as the major barrier, and a certain size of households raised lack of information about the services.

Specialized Services

(Unit of analysis: individuals with disabilities)

- 24.7% of respondents with disabilities needed physio, occupational and speech therapies, followed by MHPSS (21.1%), and assistive devices (18.3%).
- However, **25.5% of persons with disabilities were unable to access at least one specialized service despite their needs.** Persons have difficulties with depression and learning domains were more likely to access specialized services, while those with self-care difficulties were less likely to access them (P<0.01).
- The **demand for MHPSS is high among young people aged 5-34**: 13.9% of children aged 5-17 and 25.3% of young people aged 18-34 required MHPSS but could not access this service. Anxiety and depression are key domains prevalent among children aged 5-17 and persons aged 18 years and above. The data implies that there is limited MHPSS for the young generation.
- **MHPSS was particularly inaccessible in Azraq** (51.6%) while in Irbid, different therapies were difficult to access (23.6%) and assistive devices (32.5%) in Zaatari.
- **The main barrier for persons with disabilities to access specialized services in Azraq was the lack of knowledge about available services or support** (41.9%), followed by perceived (or real) unavailability of services (32.3%). In Irbid, the main barrier was costs of services (72.7%) and in Zaatari, costs of transportation to the services (59.7%).

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Livelihood

The study found more difficult economic conditions among families with members with disabilities; less opportunities for work, lower income and higher debt.

- 77.1% of surveyed Syrian refugees aged 18 years and above were not working.
- **83.5% of persons with disabilities were not working, compared to 74.0% of peers without disabilities. Persons with disabilities are less likely to be working than persons without disabilities** (P<0.05).
- Among persons with disabilities that are working, persons who experience difficulties with depression, anxiety and fatigue had higher chances of working (21.1%, 18.7% and 17.9% respectively) than persons who have difficulties with other domains. On the other hand, persons with walking, cognition (remembering and concentration) and upper body functional difficulties were less likely to be working (P<0.05).
- Women have limited chances to obtain remunerated work: only 4.8% of females aged 18+ were working, compared to 45.4% of males aged 18+. Further disaggregation by disability shows that 3.5% of females with disabilities were working compared with 5.5% of females without disabilities. **Gender and disability are the two factors that decrease chance and opportunities for women's to access work.**
- **Among children aged 5-17 years, 2.4% were working** (N=62), including 7 children with disabilities.
- Household income level: One in three households with at least one member with disabilities (29.2%) reported a household cash income in the previous month of 0-49 JOD, the lowest income bracket, compared to 19.5% of households without any members with disabilities.
- Debt level: One quarter of households with disabilities reported having a debt of over 700 JOD, in comparison to 18.6% of households with no members with disabilities. In contrast, the largest group of households with no members with disabilities (39.5%) reported having the lowest debt level of 0-49 JOD, compared to 29.1% of households with members with disabilities.

Education

Persons aged 13 years and above

- **Syrian refugees with disabilities are more likely to have never been enrolled in school and to be illiterate than persons without disabilities (P<0.05): 19.0% of Syrian refugees with disabilities never enrolled in school and cannot read or write, compared to 6.7% among peers without disabilities.**
- Across all age groups, persons with disabilities have higher non-enrolment/illiteracy rates than those without disabilities.
- The gender gap is striking. Non-enrolment/illiteracy rates among females without disabilities are more than double that of their male peers (66.9% compared to 33.1%). When it comes to females and males with disabilities, the rate for females with disabilities is nearly three times higher than that of males with disabilities (74.2% compared to 25.8%).
- More persons in the older generation lost the opportunity to learn.
- In spite of the improved learning opportunities for the younger generation, boys, especially with disabilities, were most at risk of exclusion.

Children aged 6-12 years

- The study found a **very high regular attendance rate** among 1,394 children without and with disabilities surveyed (91.2% and 88.8% respectively), with 17 children who had dropped out and 87 children who had never enrolled. Continuous efforts by the MOE and stakeholders could explain this result. However, these enrolment rates are higher compared to other existing data. The reasons behind this need to be investigated further. Nevertheless, a statistical test confirmed that **children with disabilities are less likely to be attending school than children without disabilities** (P<0.05).
- **Children with disabilities are more likely to never enrol or to drop out of school than children without disabilities** (P<0.05): 10.0% of children with disabilities and 6.9% of children without disabilities never enrolled or enrolled but then dropped out of school.
- Irbid shows the most favourable results with high attendance and low non-enrolment and dropout rates, while Azraq demonstrates the opposite trend.

- **Boys with disabilities are most likely to never enrol in school and least likely to attend education regularly** ($P<0.05$) with higher non-enrolment and dropout rates than girls. This should have been the issue for several years, as the rate of boys currently 13-17 years old, especially those with disabilities, also proved that they were educationally disadvantaged. A higher risk of child labour and more exposure to bullying could be contributing factors to the lower access to education among boys in general, and boys with disabilities in particular.
- Children in schools enjoy different aspects of school activities, but children with disabilities report overall lower rates of enjoyment than children without disabilities. The largest gap is around learning new skills. This poses a question about teachers' capacity to identify children's specific learning needs, some of which could be related to their disabilities, as well as to provide appropriate personalized educational support using tailored learning materials within the mainstream school settings. The interviews with education actors revealed the challenges related to the lack of teachers' capacity and educational materials.
- **Barriers for children attending school:** for children with disabilities in schools, barriers include overcrowded classrooms (25.4% overall, and most cited in Zaatari), distance to school (20.1% overall, particularly concerned in Irbid) and safety (10.1%). Children without disabilities attending schools faced the same issues: distance to school (21.1% again mostly experienced by children in Irbid), safety (11.4%) and overcrowded classrooms (11.2%). The surveyed caregivers in Zaatari were especially overwhelmed with safety fears due to cars and trucks on the way to schools. Physical and verbal abuse by teachers were mentioned in all locations and reported by children who joined FGDs in Zaatari and Azraq camps.
- **Barriers for out of school children:** caregivers of out-of-school children with disabilities cited functional difficulties and psychological distress (20.8% each) and refused entry (12.5%) as the barriers, while for children without disabilities who are not attending school, refused entry (14.3%), financial constraints (13.0%) and overcrowded classrooms (9.1%) were reported. KIIs and FGDs also confirmed that some children, regardless of disability, faced refusal to access education.
- **Priority solutions for children currently attending school to continue: for children with disabilities, 84.3% of caregivers agreed that more recreational activities will help children continue to learn in schools. For children without disabilities, safety inside school** (77.1%) came as the most proposed priority issue to be solved. In Zaatari, the major barrier, which is that of overcrowded classrooms and might be related to bullying and harassment, could be alleviated if comprehensive measures are taken to improve the quality of education and enhance positive relationships between children and with teachers. Teachers' capacities that need to be strengthened would include positive discipline and management of classroom dynamics, which will ultimately reduce instances of bullying.
- **Priority solutions for out of school children to (re-) enrol: for children with disabilities, 83.3% reported that training for teachers to welcome and help every child and to conduct more effective personalized teaching, as well as the provision of appropriate health care, rehabilitation and psychosocial support, will encourage them to enrol children in school** for the first time or to bring children back to school. This suggests the need for comprehensive programming that includes measures at the school level (e.g. teacher training and anti-bullying campaigns) as well as interventions at the community level that create a link between schools and services such as rehabilitation and MHPSS. Children without disabilities will be encouraged to (re-)enrol in school through recreational activities (70.0%), health care, rehabilitation and psychosocial support (65.0%), and safety between home and school (65.0%).
- The findings also suggest that it is important to **take the impact of disability at the household level into careful consideration and to provide the comprehensive family support**. A number of children as well as adult family members were found to have issues with anxiety, depression and fatigue. One of the KII participants rightly proposed that: *"it is necessary to support parents who have children with disabilities by providing psychosocial support and cash [so that they can] support their children."*

Caregivers' perception on inclusive education

- **More than 95% of caregivers believed that all children had the right to education and could learn.** However, a sizable number of caregivers (17.8% and 17.0%) agreed to compromise children's education for child marriage and child labour. Further, caregivers showed relatively low expectations for children's academic progress (34.7%).

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- **Caregivers with disabilities were less likely to assist with the learning of their child at home than caregivers without disabilities** (P<0.05). This suggests that children who have a caregiver with disabilities would receive less support and help with homework at home, which might make them more vulnerable to school drop-out, and so more in need of learning support services. This highlights again the importance of understanding the impact of household-level disabilities in terms of children's educational status and outcomes.
- Caregivers expressed a range of different opinions with regards to inclusion. On the one hand, they showed an overall positive feeling about children's interaction with peers from different backgrounds (74.7%), and belief in children with disabilities' capacity to learn (85.1%). On the other hand, **17.3% of surveyed caregivers agreed that the presence of children with disabilities negatively affects the learning of children without disabilities in the same classroom. 78.9% of caregivers believed that children with disabilities could learn better in special schools with special teachers.** These caregivers' views could be a factor leading to the exclusion of children with disabilities from mainstream schools and learning spaces.
- The study also found **a shared opinion emerging from several interviewees** (caregivers as well as teachers) **which categorizes children with disabilities by types of their impairments and limits their opportunities for inclusion**: *children with physical, visual and hearing impairments can be accepted, and possibly also children with mild intellectual impairments, but children with severe intellectual disabilities cannot.*

A boy in Irbid. © HI/ B. Bogaerts, 2014

Recommendations

1. **Understand disability from a human rights perspective and plan inclusion from the onset of all programs** to ensure the support programs meet the specific needs of 22.9% of the Syrian refugee population who have disabilities at the individual level and of 62% of refugee families that have at least one member with disabilities at the household level.

2. **Build stakeholders' capacity and collect disability data using the relevant Washington Group Questions for the context.** This study used the WG ES and CFM and found their usefulness in terms of their ability to identify persons who have difficulties with mental health and psychosocial issues, and address specific difficulties experienced by children. Application of the WG tools as the standardized disability identification tools as well as proper reporting and data sharing will greatly contribute to the collection and analysis of comparable disability data by different humanitarian actors at a larger scale towards coordinated inclusive programing.

3. **Enhance efforts to consult persons with disabilities, in order to understand their views and provide more tailored services.**

4. **Break fear towards disability, move away from reliance on "disability specialists" and promote disability mainstreaming.**

More specifically, the study points to the following recommendations:

Service providers to:

- Collect **disability data and disaggregate various data by disability** using the WG tools to inform the project design.
- **Identify people and households with disabilities to participate** in the project, through data collection.
- **Establish partnerships with local Community-Based Organizations** (CBOs) **and disability actors** (e.g. **Disabled Peoples' Organizations**/DPOs), to gain a stronger understanding of the true needs of persons with disabilities
- **Use evidence base and design projects with a clear inclusion plan.**
- **Budget for inclusion**: based on the existing and/or newly collected data, allocate specific budget lines dedicated to address key barriers and promote inclusion.
- **Ensure children and youth's access to quality MHPSS services.**
- **Build staff's capacity** on data collection, MHPSS, communications with persons with disabilities.
- **Build education staff's capacities** on **inclusive education and pedagogy with a strong focus on positive discipline** that address corporal punishments and verbal abuse as well as **MHPSS** for children and youth.
- Conduct activities to **promote social cohesion** in order to bring together children with disabilities and their peers without disabilities (e.g. inclusive recreational activities, anti-bullying campaigns), not only at school but also at the community level.
- **Advocate for inclusion**: to modify the built environment and methods of communication; to reduce the costs of health services; and to promote inclusive education.

Communities to:

- Conduct **awareness sessions and outreach** and pioneer community-based initiatives to support **inclusive practices**

Donors to:

- Set the requirements for applicants for funds for **disability inclusive project design.** Specifically, request for partners should include disability disaggregated data and analysis in needs assessments.
- Promote **inclusive budgeting** – e.g. allocation of 5% of the total project budget to inclusion.
- Provide **funding for research and rigorous needs assessments.** Allow partners to **pilot, and scale up or change the direction of their inclusion approach.**
- Adjust the **flexibility of funding** (e.g. re-directing budgets from the one-time distribution of assistive devices towards the regular maintenance and repair of assistive devices).
- Prioritise **multi-year funding** where possible in order to ensure a longer term, more sustainable approach to supporting persons with disabilities.
- In addition to mainstreaming disability into all projects, provide specific funds and support for **MHPSS, inclusive employment and inclusive education.**

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Government and local authorities to:

- **Ensure inclusive actions in national plans for response and resilience** through consultations with persons with disabilities.
- **Earmark budgets to support persons with disabilities** to access various services.

- **Ministry of Education to:**
  - Scale up teacher training programs, develop and roll-out guidelines on inclusive education pedagogy on how to differentiate the curriculum for children with disabilities to ensure that all children can learn to the best of their abilities.
  - Ensure the availability of accessible and inclusive learning materials.
  - Provide infrastructure according to universal design principles.

Kids in Zaatari. © HI/S.Pierre, 2015

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LIST OF ACRONYMS

CBO	Community Based Organizations
CFM	Child Functioning Module
CRPD	Convention on the Rights of Persons with Disabilities
DOS	Department of Statistics
DPO	Disabled People's Organization
FGD	Focus Group Discussions
HI	Humanity & Inclusion
INGO	International Non-Governmental Organization
JOD	Jordanian Dinar
KII	Key Informant Interview
MHPSS	Mental Health and Psychosocial Support
MOE	Ministry of Education
NGO	Non-Governmental Organization
UN	United Nations
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
USD	United States Dollar
WFP	World Food Programme
WHO	World Health Organization
WG	Washington Group on Disability Statistics
WG-ES	Washington Group Extended Set

SECTION 1: INTRODUCTION

1.1 Background

Over the last few decades, understanding of disability has progressed, moving away from the medical model, which views disability through the lens of impairment, and towards a rights-based model, which considers the interactions between an individual and barriers in the physical, social and cultural environments which cause activity limitations and participation restrictions.

The Convention on the Rights of Persons with Disabilities (CRPD), adopted in 2006, has been widely ratified and is a driving force behind this shift in our attitudes and behaviours towards persons with disabilities. The CRPD reaffirms that persons with disabilities should enjoy the same basic rights as persons without disabilities, on an equal basis. These basic rights include the right to participate as active members of society, the right to enjoy fundamental freedoms and to the right to access justice in cases of violation.

One billion people, or an estimated 15 % of the global population (World Health Organization/WHO, 2011), have disabilities. The most vulnerable among these people are those affected by humanitarian emergencies. Article 11 of the CRPD specifically obliges countries to ensure their protection and safety. In recognition of the need to increase the attention given to this issue, the *Charter on Inclusion of Persons with Disabilities in Humanitarian Action was launched at the World Humanitarian Summit in Istanbul in 2016.*

> *"Persons with disabilities are disproportionately affected in situations of risk and humanitarian emergencies, and face multiple barriers in accessing protection and humanitarian assistance, including relief and recovery support."*
>
> Charter on Inclusion of Persons with Disabilities in Humanitarian Action (2016)

The Charter calls for humanitarian actors to place persons with disabilities at the heart of decision-making and to make humanitarian actions responsive to the rights and needs of persons with disabilities.

However, despite all the commitments made at the international level, and the ongoing initiatives to support disability inclusion at local levels, persons with disabilities still face exclusion and discrimination. One of the major reasons behind this is the lack of quality disability data, which is necessary to enable humanitarian actors to assess the situation of persons with disabilities, monitor and evaluate the progress of inclusion within humanitarian programming and policy (CRPD Art. 31, Charter 1.9 and 2.3).

1.2 Objectives and Methods

Objectives

Concerning the lack of disability data in the Syria crisis context, HI and iMMAP conducted the study aimed at the following:

1. Provide statistically reliable prevalence of disability as well as disability disaggregated data indicators on access to services in five locations across Jordan and Lebanon (NOTE: this report is dedicated exclusively to Jordan).

2. Increase understanding of the situation of Syrian refugees with disabilities and their households, compared to their peers without disabilities, in relation to the access to services including education, and key barriers experienced in accessing these services.

3. Recommend inclusive actions to be prioritized by humanitarian actors.

Locations

The study conducted in Jordan targeted three locations: Irbid, Azraq Camp and Zaatari Camp. These three specific locations were selected because of their high concentrations of Syrian refugees and to enable the different camp and host community living contexts to be represented. Amman has the largest number of refugees in host communities. However, Amman was not selected as a study location, due to the greater sample size that would have been required compared to Irbid, as well as the difficulties involved in identifying sample households using random sampling among the refugee hosting households scattered around the city.

Methods

A mixed approach was used combining quantitative and qualitative data collection.

Quantitative Data Collection

Sampling and inclusion criteria

Random sampling was adopted to reflect and compare the experiences of both registered and non-registered Syrian refugees with United Nations High Commissioner for Refugees (UNHCR), as well as of both persons with and without disabilities.

- All the residents in Azraq and Zaatari camps are registered. A random sample of shelters was constituted using available data relating to the structure of the camps.
- Irbid is a city located North of Jordan's capital Amman, and hosts approximately 20% of Syrian refugees in the country (UNHCR, 2018b). As there is no list of unregistered Syrian refugees in the city, the study employed two-stage sampling. The first stage identified 3,600 random locations in the city, taking Irbid's population density into account. Among these random locations, enumerators randomly visited households (including those of Jordanian families) until the Syrian refugee household/family sample size was large enough to enable generalization of statistical results to the entire study population.

Enumerators were instructed to go to the identified locations and interview the household closest to the location. If the father of the household was Syrian, and the potential respondents (the mothers or caregivers of the children of those households) agreed to be interviewed, the enumerators would proceed with the survey. Among the identified Syrian households, information of all members was collected.

Study Population

The full Jordanian sample included a total of **6,381 persons.** This is the sample size that is large enough to represent the total population of Syrian refugees in Irbid and in the two assessed camps (see Annex 1 for further details).

Table 1: Study Population in Jordan by Location

	Total population Size Registered Syrian refugees (as of July 3rd, 2017, UNHCR)	Required Sample Size	Study Population	
			Households	Persons
Jordan		959	1,159	6,381
Azraq	53,610	287	332	1,818
Irbid	136,310	385	445	2,620
Zaatari	80,128	287	382	1,943

Questionnaires

Questionnaires (see Annex 2) were designed to elicit responses relating to the degree of access to different services at the household and individual levels, as well as responses relating to the perceptions of barriers and to the solutions required to increase access to services. In order to examine the differences in these results between persons with and without disabilities, the study needed to define disability and to apply appropriate tools to identify persons with disabilities.

In light of the CRPD, this study **defines disability as resulting from the interactions between personal and environmental factors.** From this perspective, a person with a given medical condition will not automatically be considered to have a disability. For example, a woman with an amputated leg could be a person without a disability if she lives in an enabling environment and is able to participate in society. One way of identifying the people at risk of not participating in society is to understand the level of difficulties a person faces when performing basic activities (hereinafter referred to as "domains" of functioning) *regardless of impairments*, using the Modified Washington Group (WG) Extended Set (or, more precisely, the *Short Set Enhanced* plus fatigue or WS-ES)[1] and Child Functioning Module (CFM). Table 2 shows the age and activity domains covered by each WG tool. For all domains, the **WG recommended cut-off was adopted**[2].

Table 2: Washington Group Tools and Domainsby Age Group

Child Functioning Module		Modified Extended Set
Age 2 to 4	Age 5 to 17	Age 18+
Seeing *		
Hearing *		
Walking *		
Communication *		
	Self Care *	
Learning		
Controlling behaviour		
	Remembering	Cognition (Remembering or Concentrating) *
	Concentrating	
	Anxiety	
	Depression	
Playing	Making friends	Upper body 1&2**
Fine motor	Accepting change	Fatigue

* Domains covered by the Short Set
** Upper body 1 is difficulty raising a 2 litter bottle of water or soda from waist to eye level and 2 refers to difficulty using hands and fingers, such as picking up small objects

[1] The Short Set (with an * mark in Table 2) plus Upper body, Anxiety, and Depression is the WG Short Set Enhanced. In consultation with the WG expert, Fatigue was added in order to take refugees' stressful life conditions into consideration.
[2] For more details, see Analytic Guidelines: Creating Disability Identifiers Using the Washington Group Extended Set (WG-ES) SPSS Syntax (Washington Group on Disability Statistics, October 23rd, 2017), available at http://www.washingtongroup-disability.com/wp-content/uploads/2016/12/WG-Document-6-Analytic-Guidelines-for-the-Washington-Group-Extended-Set.pdf

Section 1: Introduction

The questionnaires were translated into Arabic and reviewed by local experts from HI, the United Nations Children's Fund (UNICEF) and other stakeholders. For the WG-ES, the Arabic-speaking project officer - trained on WG within the framework of the HI Disability Statistics in Humanitarian Action project[3] - examined the Arabic translations of the national statistics offices of Oman, Egypt and Palestine shared by WG, and adopted the Omani translation, which was found to be the most accurate. The study used the CFM in Arabic available on UNICEF's website as it is[4].

These tools were then transformed into an electronic questionnaire to be administered with tablets using the KoBo data collection software. Integrating the questionnaire logic into the KoBo software ensured that the right people were asked the right questions, and that enumerators did not have to manually skip irrelevant questions.

Data Collection

The enumerator teams received 5 days of training and administered the questionnaire on tablets (Table 3). In principle, each team consisted of one male and one female enumerator, in order to ensure quality, gender sensitive interviews.

For children in the households aged 0-17 years old, interviews were conducted chiefly with the mothers or primary caregivers. In these cases, interviews addressed household level questions, as well as individual questions concerning both the mothers or primary caregivers themselves and their children, carefully respecting ethical considerations and advice provided by UNICEF. For the individuals of 18 years or over, enumerators directly asked the WG questions, and, for individuals identified as having disabilities, the additional questions focused on persons with disabilities.

Table 3: Enumerators and Data Collection Period

Location	Number of Enumerators	Data Collection Period
Azraq	12 Syrian refugees (female: 5)	12 Dec 2017 – 7 Jan 2018
Irbid	20 Jordanian (female: 10)	15 Oct 2017 – 2 Nov 2017
Zaatari	12 Syrian refugees (female: 6)	3 Dec 2017 – 14 Dec 2017

Table 4: Question Themes, Unit of Analysis and Respondent

Question Themes (see Annex 2)	Number of Enumerators	Data Collection Period
Basic information relating to household		Caregivers of household children
Access to basic services	Household	Caregivers
WG questions	Individual	• Caregivers: for themselves and for their children aged 2-17 • Adults 18+
• Causes of disability • Access to specialized services	Individual (with disabilities only)	• Caregivers: for themselves and for their children aged 2-17 • Adults 18+
Access to education	Individual	Caregivers
Perception of inclusive education	Individual	Caregivers

Collected data was stored on a secure server and checked daily by the iMMAP field coordinators for inconsistencies. Each household survey took approximately 90 minutes to administer. Exact times varied depending on the number of household members and whether or not they were identified to have disabilities.

[3] https://humanity-inclusion.org.uk/en/disability-statistics-in-humanitarian-action
[4] https://data.unicef.org/topic/child-disability/module-on-child-functioning/

Qualitative Data Collection

Literature Review

A review of existing documents – including reports, summaries, academic and online articles – was conducted in order to understand the situation of Syrian refugees, put the collected quantitative data into perspective and critically analyze this data. Efforts were made to find information focusing on refugees with disabilities in the Jordanian context. While several recent documents provide interesting information, some even dedicating a whole section or chapter to the issues faced by refugees with disabilities (see Section 2), understanding the situation comprehensively and triangulating study findings remains challenging due to the lack of disability disaggregated data and the lack of insights into the real-life experiences of persons with disabilities in different aspects of life.

Key Informant Interviews and Focus Group Discussions

Between November 2017 and January 2018, 25 key informant interviews (KIIs) with stakeholders and 3 focus group discussions (FGDs) with 24 children were conducted in order to elicit deeper insights into the educational situation of children with and without disabilities. Table 5 shows the distribution of participants.

Table 5: KII and FGD Participants in Jordan

KII*				FGD**			
Teachers/ School staff	MOE	NGO	UN	Azraq		Zaatari	
7	4	12	2	6	3	10	5
				Includes 10 children with disabilities			

* MOE Ministry of Education. NGO Non-governmental organizations. UN United Nations agencies.
** Irbid not included. See Limitations

Purposive sampling was used to identify KII participants[5]. Children with and without disabilities who joined FGDs were selected from households identified by the quantitative survey having agreed to participate in further qualitative data collection.

Semi-structured interview guides were used for both KIIs and FGDs. FGDs applied child-friendly methods using animal toys, 'smileys' and picture drawings to encourage children to express their views.

[5] HI approached stakeholders via existing partnerships, as well as via the network of sector coordination working groups.

Ethical Considerations

Ethical considerations were present from the onset of the research design and during the questionnaire administration. During the primary data collection, teams explained the survey's purpose, the collected data's intended use, and the personal data anonymization process. Furthermore, research teams emphasized that participation in the survey was voluntary and that participants could choose to stop at any time, or skip questions that they did not wish to answer. For quantitative data collection, 43 households in Irbid refused to take part in the study, while 3 households in Azraq and 2 households in Zaatari refused to answer certain questions.

Subsequently, research teams gained verbal consent from all household members for quantitative data collection and written consent for KIIs. As for FGDs, both children and their caregivers signed the consent form.

In order to manage expectations effectively, the research team clearly explained that participating in the study would not lead to any direct benefits, nor could the team provide diagnostic or individual case management support. At the end of the interviews, all households were provided with HI contacts to inquire about available services. Information brochures were distributed in camps.

The study team shared and discussed the research objectives and implementation plan with key stakeholders in Jordan, including with UNHCR, UNICEF, and with several NGOs and governmental entities. This took place through individual meetings and presentations delivered during sector coordination working groups. Consultations were also conducted in order to refine the questionnaire. For data collection in Azraq and Zaatari camps in particular, the team followed the Standard Operating Procedures (including assessment tool review by working group members) and obtained required approval.[6]

Data Analysis

All quantitative data collected was fully cleaned and consolidated into a single dataset for both Jordan and Lebanon, including 8,876 rows and 543 columns. In accordance with the analysis plan, thematic analysis was conducted, based on the different sectors that appear as sections of this report, and using different types of disaggregation in order to elicit further meaning (e.g. location, age, gender, disability domain).

Statistical tests were then run for selected variables in order to establish correlation factors. Specifically, descriptive analyses using multivariate analysis statistical hypothesis tests (chi² for variance, independence, regression analyses, etc.) were used in order to describe and compare the various groups considered by the study and validate the statistical relevance of findings. The R statistical computing and graphics language and environment was used for all statistical analyses. All the major statistical results in this report present restricted standard deviations:

- For findings covering both countries: the margin of error is ±2.3 per cent.
- For country-level findings: the margin of error is ±2.7 per cent for Syrian refugees in Jordan.
- For governorate-level findings: the margin of error for Syrian refugees in is ± 4.97 per cent for Zaatari Camp, ±4.91 per cent for Azraq camp, and ±4.5 per cent for Irbid.

[6] See https://data2.unhcr.org/ar/documents/download/60616 This version was revised in October 2017 but the procedures followed by the study team during September and early October 2017 are the same.

Data Validation

A workshop with key stakeholders was conducted in Amman on May 7th, 2018, in order to present findings and discuss in detail how findings relate to contextual realities in each location and how to interpret them accordingly. The workshop also engaged stakeholders in a participatory discussion around the key recommendations arising from the study, targeted towards stakeholders including service providers (NGOs and UN agencies), donors, government agencies and communities. This process enabled results to be 'grounded' into field realities.

1.3 Limitations

- This study is one of the first initiatives in which the WG-ES and CFM are used in the humanitarian context. Therefore, there was no similar research against which findings could be compared or analyzed.
- The quantitative survey relied on the subjective experience and perceptions of Syrian refugees, and did not triangulate or verify the accuracy of responses (e.g. income and debt level, number of days that individuals work a week, regularity of children's school attendance).
- As one of the focuses of this study was the education of children aged 6-12 and given that the CFM was designed for children aged 2-17 years, all questions were asked to children's mothers or caregivers, except for the WG questions for adults. FGDs were conducted to collect the direct views of children. However, due to time and logistical constraints, only 24 children participated, and these FGDs were only organized in Azraq and Zaatari camps, and not in Irbid. More FGDs with children could have been conducted in order to represent their diversity.
- Although WG tools were extensively tested during their global development process, Arabic translations of the study questions were carefully checked, and the whole questionnaire was piloted prior to data collection, thorough cognitive testing was not conducted. Therefore, it remains possible that some questions may not have been clearly understood.
- There were different enumerators in each location. In Irbid, they were Jordanian, while in the Azraq and Zaatari camps, they were Syrian refugees hired through Incentive-based Volunteering and Cash for Work schemes respectively, in accordance with each camp's regulations. All of the enumerators attended the same 5-day training, and daily quality assurance and support were provided by iMMAP field coordinators. However, their interactions with respondents may not have been consistent from one location to another.

SECTION 2: OVERVIEW OF EXISTING EVIDENCE

This section illustrates the overall situations of Syrian refugees with and without disabilities in Jordan in terms of population, disability prevalence and the degree of inclusiveness of various services.

Azraq Camp. © HI/ C.Huby. 2014

2.1 Syrian Refugees with Disabilities in Jordan

Overview

The conflict in Syria continues to drive the largest refugee crisis in the world, with over 5.6 million Syrian registered refugees in the region (UNHCR, 2018a). Jordan is the third largest refugee host country after Turkey and Lebanon, with over 666,000 refugees registered with UNHCR in the country (ibid). As of June 24th, 2018 (UNHCR, 2018b), more than 80% of Syrian refugees reside in Jordanian host communities (e.g. 194,958 in Amman, followed by 139,945 in Irbid), while the remaining population is living in refugee camps, including Azraq camp (41,103 people) and Zaatari camp (78,520 people).

Disability Prevalence

Having ratified the CRPD in March 2008, Jordan is legally obliged to collect disability data (Article 31). As a result of this commitment, the 2015 Population and Housing Census included the WG Short Set on Functioning[7], with the objective of collecting reliable and comparable data (Department of Statistics/DOS, 2015a; DOS 2015b). Applying the WG recommended cut-off, the census found a **disability prevalence rate of 2.7%** of the total sample of 9,180,529 persons aged 5 years and above, which is **much lower than the WHO's global estimation of 15%.** Among the total population, approximately 13% were Syrians. However, data is not disaggregated by nationality[8], therefore disability prevalence among Syrians is not available.

[7] The WG Short Set on Functioning inquires about functional difficulties in six core domains: seeing, hearing, walking, cognition, self-care and communication.

[8] Disaggregation is applied only to Jordanian / non-Jordanian.

Table 6 presents other existing surveys that explored disability prevalence among Syrian refugees. Each survey used different identification methods. Some studies asked if the persons had a disability or not, or any medical condition, while others did not specify what questions they asked to identify persons with disabilities. Even in cases in which WG questions were applied, application was not consistent or reported. As a result, prevalence varies widely from 2-3% (lowest) to 26% (highest).

Table 6: Disability Prevalence from Different Studies in Jordan

	Source	Prevalence	Identification method	Sample size
2014	HI & HelpAge International	25.9% Jordan 23.8% Zaatari 25.3% Irbid	Impairments by 5 activities (moving and reaching/using objects, seeing, hearing, speaking, learning/understanding)	716 persons with impairments found among 3,202 persons for both Jordan and Lebanon (22.4%). Jordan specific size not reported
	Education Sector Working Group	7.2%	Modified versions of WG Short Set	124 children with disabilities among 1,734 children aged 0-17 in Zaatari camp
	UNICEF & Save the Children	4.5%	Impairments (mental, visual, hearing, physical, cognitive, war wounded or communication)	71 children out of 1,587 children aged 7-17 in Zaatari camp
2015	DOS	2.9%	WG Short Set (with recommended cut-off)	9,180,529 persons aged 5 years and above. Nation-wide
	UNHCR	16%	Yes/No for disabilities and chronic illness	7,817 individual Syrian refugees outside camps
2016	UNHCR	27.6%	WG Short Set (Respondents and cut-off: not reported)	From a pilot of WG questions. (At least) one member of 27.55% of 98 households
2017	Nielsen	7.0%	Physical, sensory, mental, intellectual and speech impairments	161 persons among 2,422 household members. Non-camp settings
	Care	5% adults 1.5% children	Not specified	2,184 respondents including 1,447 Syrian refugees in urban settings
2018	UNHCR, 2018c	3.0%	ProGres categories [9]	20,738 Syrian refugees with disabilities among all registered Syrian refugees (as at 17 March 2018)
	UNHCR, 2018d	3.4%	Not specified	1,227 Syrians with disabilities among 36,605 refugees in Azraq camp

[9] ProGres is UNHCR's global refugee database. Impairments include physical (moderate and severe), mental (moderate and severe), visual, hearing and speech impairments

2.2 Inclusiveness of Humanitarian Services

Shelter

In the camps, Syrian refugees live in tents or pre-fabricated caravans, lined up in rows and divided into districts or villages. With the exception of a few villages in Azraq, households in Azraq and Zaatari are supplied with electricity. Public bathrooms have been installed, but due to high demands from refugees, UNHCR and partners in Zaatari have been working to install upgraded prefabs with wider living spaces, private kitchens and private bathrooms (Barakat, 2016).

In host communities, where 80% of Syrian refugees in Jordan live, limited housing supply for low- to middle-income families has been compounded by the influx of a large number of Syrian families, leading to *'increasing rental prices, sub-division of existing units, conversion of outbuildings into rental accommodation, and some limited construction by individuals'* (p.1, MPWH, 2016). Home visits in 2014 found that 47% of refugee households considered that their shelters were unsatisfactory or undignified (UNHCR, 2014). It is possible that the increase in living costs over cumulative years of asylum has aggravated the situation; between 58% and 72% of households reported their housing to be *'bad'* (Abu Hamad et al., 2017). Sharing accommodation with extended families or, sometimes, with unrelated families is common, in apartments with poor facilities: 25% of households were found to lack access to electricity; latrines were found to be non-operational (20%); and about half of the families (46%) suffered from no heating (UNHCR, 2014). The difficulties met when seeking adequate and affordable accommodation in already precarious situations (one in five families rent apartments without a contract) have driven refugee families to constantly move from one place to another. About one in three families in host communities were found to have experienced relocation at least once in the preceding 6 months (Ministry of Public Works and Housing, 2016).

In these desperate conditions, it is not surprising that shelter was the second most important concern among refugee households (11.4%), after concerns relating to livelihoods and securing an income (HI & HelpAge International, 2014).

Health

In these dire living conditions, Syrian refugees are vulnerable to health risks. UNHCR (2015) reported that *'41% of Syrian individuals are part of families with severe health vulnerability, [and] 15% are part of highly health vulnerable families' (p.38).* The impact of the crisis on refugees' mental health is also a grave concern. Care (2017) explained that: 50% of Syrian refugees had lost interest in what they had enjoyed before; 10% were extremely afraid; and 22.9% felt perpetual helplessness to such an extent that they no longer wished to carry on living. Care went on to report that *18.8% felt these feelings so often that they were unable to carry out essential activities for daily living* (p.59).

Although health services to mitigate some of these conditions are free in the camps, the evolving situation in host communities has been exacerbating the problem. Since March 2012, registered Syrian refugees had been able to access public primary health care centers and hospitals free of charge (Nielsen, 2017). However, a policy change in late 2014 has compelled Syrians to pay the same rates as uninsured Jordanians (ibid). Furthermore, a further policy decision in January 2018 now requires that Syrian refugees living outside the camps pay the rate for foreigners at public hospitals (Human Rights Watch, 2018).

Financial constraints are already the major barrier hindering Syrian refugees' access to health services. According to Care (2017), 87.2% of Syrian refugees faced financial burdens preventing them from accessing health services. Another 2017 survey found that households spent 41% of their total income on health care (Nielsen).

For persons with disabilities, health care costs can be even higher. Although basic health care is available, the quality of this health care is considered poor, and persons with disabilities sometimes need to seek better services at their own cost (Curtis & Geagan, 2016). Furthermore, specialized and oftentimes long-term treatments, necessary to treat impairments, injuries or chronic illness, can be very costly and come with additional expenditure such as transportation costs (Abu Hamad et al., 2017; Nielsen, 2017; Amnesty International, 2016; Curtis & Geagan, 2016; HI & HelpAge International, 2014). As a result of these factors, only 38% of persons with impairments reported that they were able to receive appropriate care (Nielsen, 2017).

Financial difficulties are not the only reason behind the lack of access to required services for persons with disabilities. Indeed, information relating to specialized services is not always available or accessible. Furthermore, health care staff's limited capacity and inappropriate attitudes towards persons with disabilities are also negative factors (Abu Hamad et al., 2017; Amnesty International, 2016; Curtis & Geagan, 2016; HI & HelpAge International, 2014). Access to mental health care is another concern. Persons with impairments, injury and/or chronic disease are twice as likely to report signs of psychological distress, with 49% reporting at least one frequent or permanent sign of psychological distress (HI & HelpAge International, 2014).

Food and Cash Assistance

In Jordan, there are three established types of UN food and cash assistance related packages: UNHCR Cash Assistance; World Food Programme (WFP) e-vouchers, targeted at the household level; and the UNICEF Child Cash Grant Programme, focused on improving child wellbeing (Abu Hamad et al., 2017). In addition to assistance from these packages, refugees also seek other sources of income and necessary items, including donations from individuals and support from families overseas (Amnesty International, 2016; Care, 2017).

Due to funding shortages, the value of WFP food e-vouchers provided in 2017 was half that of those provided in 2015. This may have contributed to a recent study's finding that 55% of Syrian refugee households had reported experiencing a food shortage in the preceding month (Abu Hamad et al., 2017). While cash assistance is indeed important and appreciated by the majority of recipients, 26% of surveyed households admitted that the support did not fully meet their needs or alleviate their vulnerability, since they had to prioritize debt repayment over meeting basic day-to-day needs (ibid).

The same study found that although targeting criteria for cash assistance programming do integrate additional weighting for disability, households with members with disabilities did not necessarily receive cash assistance despite their higher expenditure levels, particularly for medical costs. Global research shows that households with at least one member with disabilities spend considerably more on health care than households with no members with disabilities (WHO, 2011). When this fact is not taken into account, and households with members with disabilities do not receive more cash in practice than households without disabilities, it is inevitable that *'cash has less of an effect on the household's depth of poverty'* (p.91, Abu Hamad et al., 2017).

Livelihood

Until recently, Syrian refugees residing in Jordan were not legally permitted to work. They therefore relied on financial and in-kind assistance from humanitarian actors or they engaged in informal work. Citing data from the Ministry of Labour, Abu Hamad et al. (2017) reported that approximately 160,000 Syrian refugees were working in informal employment, which suggests exploitation, or dangerous work conditions without decent pay. The Government of Jordan's Jordan Compact 2016 changed the situation. Indeed, the Jordan Compact committed to issuing 200,000 work permits to Syrian refugees in exchange for billions of dollars of foreign assistance (Barbelet, Hagen-Zanker & Dina Mansour-Ille, 2017). Between 2016 and May 2018, 102,137 work permits were issued to Syrian refugees both in camps and host communities, including 4% to females, for work opportunities mostly in agriculture and manufacturing sectors (Ministry of Labour, 2018). Data is not disaggregated by disability. Therefore, it is not possible to examine the number of Syrian refugees with disabilities who received work permits in comparison to their peers without disabilities.

Despite this progress towards formalizing employment for better working conditions, ensuring decent work opportunities for refugee families continues to be a challenge. According to UNHCR, 85% of Syrian families in the country are living below the poverty line (Middle East Monitor, 2018). On average, Syrian refugee households earn a monthly income of 176 JOD compared to 195 JOD by Jordanian families (Care, 2017). This average Syrian monthly income does not appear to be sufficient to cover high living costs in Jordan for rent, food, healthcare, children's items, etc., in addition to the need to repay debts (Abu Hamad et al., 2017; UNICEF, 2016). The majority of refugee families (88.9%) have debt due to increasing expenditures while income remains limited, and having to borrow money from

neighbours, families, and landlords (Care, 2017). Income and livelihoods were identified as the top major concern among Syrian refugees in Jordan, regardless of whether their households include a member with disabilities or not (HI & HelpAge International, 2014).

One of the negative coping strategies resorted to in order to mitigate financial situations is child labour. The 2016 survey found that the worker-to-population ratio among Syrian children was 3.22, which is higher than for Jordanian and other foreign peers, and that more boys were working (University of Jordan, 2016). The minimum age of employment in Jordan is 16, in accordance with the end of compulsory education (ILO, 2014). However, Terre des Hommes (2016) found that children aged 5 or 6 could be working too, 7 hours a day, 7 days a week. This work could consist of selling items in small shops or on the streets, or working in textile factories, agricultural fields and construction sites; with a very small pay around 3 to 5 JOD per day. Childhood labour can negatively impact children's health, physical development and emotional development, as well as their education. There is an evident lack of further data available on the presence of disability among children who are working in Jordan.

Education

Prior to the conflict, around 2.5 million or over 90% of children in Syria were enrolled in primary school, and almost 70% of boys and girls under the age of 17 were enrolled in secondary education, reflecting the historical emphasis placed on the value of education by Syrian families (World Bank, n.d.; UNICEF, 2016).

In Jordan, access to education has also been high: 98% of Jordanian children go to primary schools (UNICEF, 2018). Embracing the importance of education, the Government of Jordan in partnership with stakeholders has been making tremendous efforts to ensure equal access to education for non-Jordanian children, regardless of their nationality or refugee status. Public schools are open to refugee children free of charge, both inside and outside camps. The double-shift system, which is operated in 209 schools in host communities, has been allowing the increasing number of Syrian children to access schools (Ministry of Planning and International Cooperation, 2018). As a result, the proportion of Syrian refugee children enrolled in formal education drastically increased from 12% in 2012 to 64% in 2016 (Human Rights Watch, 2016). During the 2017-2018 school year, the enrolment rate at the basic education level (grades 1-10) was 66% (No Lost Generation, 2018). Nevertheless, 73,137 Syrian refugee children (i.e. 31% of 233,052 Syrian children aged 5-17) were out of formal and non-formal education (ibid). The number of children with disabilities accounted for in this data was not available.

Thus, disability disaggregated enrolment data is lacking in general. However, a 2015 report found that 51% of boys and 65% of girls with different impairments were attending primary school (Education Sector Working Group, 2015). This finding aligns with the findings of another study conducted in Zaatari camp in 2014, which identified 124 enrolled children with disabilities, and a school attendance of 51-65% (Education Sector Working Group, 2014). Through various education activities, education partners in Jordan enabled 3,601 children with disabilities (48% girls) to enjoy inclusive education programming in 2017 (No Lost Generation, 2018). UNICEF (2018) further reported that 3,911 children with disabilities were enrolled in formal education.

The issues relating to education in and out of schools are monumental. Rapid expansion of school access has come at the cost of education quality. Lack of qualified teachers, overcrowded classrooms, and distance to school are repeatedly responsible for impeding access to quality learning (UNICEF, 2018; Human Rights Watch, 2016; MOE, 2016, NRC, 2016). Although public schools are free, the cost associated with schooling is another obstacle that affects enrolment (Abu Hamad et al., 2017). Household financial hardship compels parents to compromise their children's education and push children, particularly boys, to work (UNICEF, 2016). Bullying and stigmatization of children by teachers or by peers is frequently reported: for example, 78% of families complained about teachers' physical and verbal violence towards their children, 70% of Syrian children were bullied and this experience led 1,600 Syrian children to drop out of school (UNICEF, 2016). Tensions between Jordanian and Syrian children have developed into 'school yard fights that could be quite severe' (UN Women, 2013). Further, Jordanian regulation does not allow children who are aged three years older or above their grade level to enrol in formal schools (Human Rights Watch, 2016). Human Rights

Watch (2016) cited a UNHCR 2014 estimate that this three-year rule had prevented around 77,000 Syrian children from accessing formal education. In response to these problems, the Ministry of Education (MOE), with support from UNICEF, provides a non-formal education program for dropped out children of age 13+, as well as a school-catch-up program initiated in 2016 to facilitate the return to school of children aged 9-12 who have missed school for three years or more (UNICEF, 2017). Informal education services in so-called Makani centers also provide quality learning support for around 42,000 children (Education Sector Working Group, 2018).

All the barriers discussed above can affect every child regardless of disabilities. However, the desk review tried to identify specific challenges faced by children with disabilities in the realization of their rights to education. Overall, the study found a lack of comprehensive data, which constitutes the justification for this study. Nevertheless, several studies did provide valuable insights. One survey showed that 13% of families attributed their children's non-enrolment to 'ill health or disability" itself (Abu Hamad et al., 2017). Another education assessment in host communities reported physical inaccessibility as well as a lack of available specialist education services as reasons for children with disabilities' non-school attendance (Education Sector Working Group, 2015). Other evidence emphasizes parents' concerns regarding teachers' limited training and practices in inclusive education and their fear of taking their children with disabilities into school (HI & HelpAge International, 2014). Bullying and stigmatization based on disability is a major issue. Some parents choose to keep their children with disabilities at home, in apprehension of discrimination against them, as well as of corporal punishment, particularly inflicted upon boys with disabilities (Culbertson, et al., 2015).

Teenager in Ramtha. ©HI/ G. Dubourthoumieu 2013

SECTION 3: FINDINGS

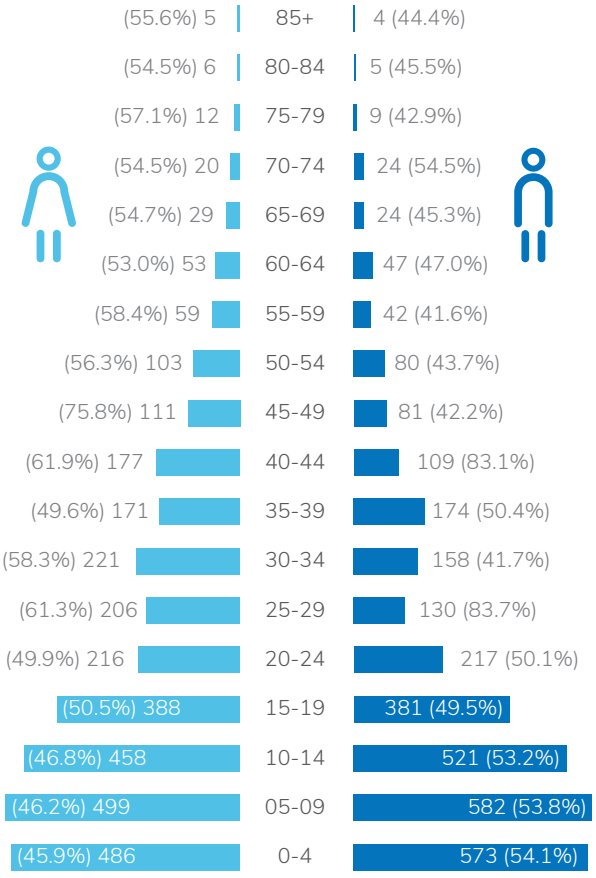
3.1 Demographics

In total, 6,381 persons were surveyed in the study, including 3,161 males (49.5%) and 3,220 females (50.5%) (Table 7). The average household size was 5.5 people. As illustrated in Figure 1, 60.9% of the surveyed population were aged 20 years and below.

Table 7: Number of Surveyed Population and Households, by Location

	Households	Persons 0+	Average household size
Jordan	1,159	6,381	5.5
Azraq	332	1,818	5.5
Irbid	445	2,620	5.9
Zaatari	382	1,943	5.1

Figure 1: Number of Surveyed Populations, by Age and Gender



3.2 Disability

3.2.1 Prevalence of Disability

The study found 1,374 persons with disabilities among 6,003 persons aged 2 years and above, equating to a **disability prevalence rate of 22.9%** (see Table 8 and Figure 2). This finding is markedly higher than the existing disability statistics at around 2-3% to less than 10%, many of which used questions focusing on medical conditions or impairments to identify people with disabilities. Understanding disability as the level of difficulties a person is facing when performing basic activities that could put him/her at risk of not participating in society, the prevalence found by the study is much higher. This urges us to widen the scope of persons of our concern.

When analyzed by location, the highest prevalence of disability was found in Zaatari camp (30.5%) followed by Irbid (23.5%), with the lowest in Azraq (13.8%).

Differences in terms of disability prevalence between Zaatari and Azraq camps could be explained by the set-up of Zaatari camp, as discussed with stakeholders and HI staff who worked in the camps. Indeed, Zaatari was the first camp opened for Syrian refugees in Jordan in 2012 (MPWH, 2016). Located in Northern Jordan just 12 km South of the border with Syria, it was the first settling point for the majority of refugees fleeing the conflict. Due to the large population of refugees with humanitarian needs to which a number of actors responded with allocated funds and resources for years, Zaatari has established a wide range of services. This could have affected the Jordan's government authorities to

Table 8: Surveyed Population aged 2+ and Disability Prevalence, by Location

	Persons 2+	Persons with disabilities 2+	Prevalence
Jordan	6,003	1,374	22.9%
Azraq	1,699	234	13.8%
Irbid	2,476	582	23.5%
Zaatari	1,828	558	30.5%

determine which camp the refugees should be sent to, if the refugees were found to have disabilities, injuries or illness that would require extensive interventions. Stakeholders from Azraq camp further stated that there were cases in which refugees with disabilities in Azraq were transferred to Zaatari for better access to different services.

Disability at the household level

The study found that **62% of the sampled households included at least one member with disabilities.** Of all study locations, households in Zaatari are most likely to have at least one member with disabilities (68.3%). Again, this could be related to the aforementioned contextual factors.

This finding shows a striking difference, for example, from the research by Abu Hamad et al. (2017) which found that 7% of Syrian refugee households included at least one member with disabilities through the traditional yes/no question.[10]

Moving to a rights-based definition of disability means that more households with a member with disabilities are identified. This requires humanitarian actors to examine the impact of disability on households and consider the need to promote appropriate parenting skills and support programs for families. The presence of a family member with disabilities often requires households to provide additional time, physical, emotional and financial efforts for caring and seeking necessary information and services; manage feelings and stress such as the doubt concerning diagnosis and anxiety for future; and address lost opportunities for education or work (Lara & Pinos, 2017). On the other hand, Lara & Pinos (2017) argued that there are a number of positive aspects brought by having family members with disabilities, such as strengthened family cohesion, positive awareness about the needs of others, and enhanced knowledge about and collaboration with support programs and facilitators that exist in society. To mitigate any negative impact and promote positive outcomes, it is extremely important to provide support for family empowerment, which could potentially benefit the wider community (Lara & Pinos, 2017).

Figure 2: Disability Prevalence, by Location

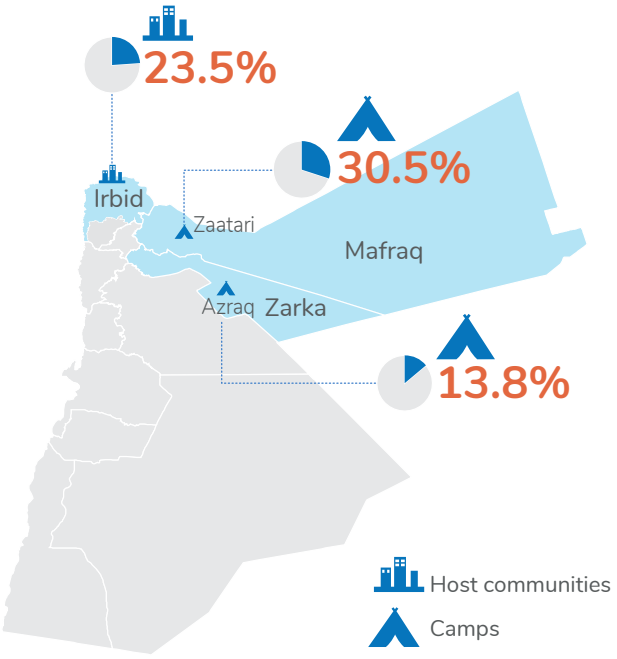
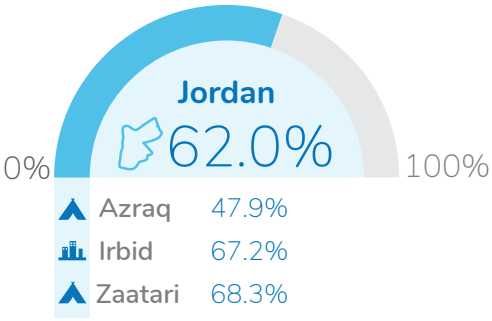


Figure 3: Disability at the Household Level



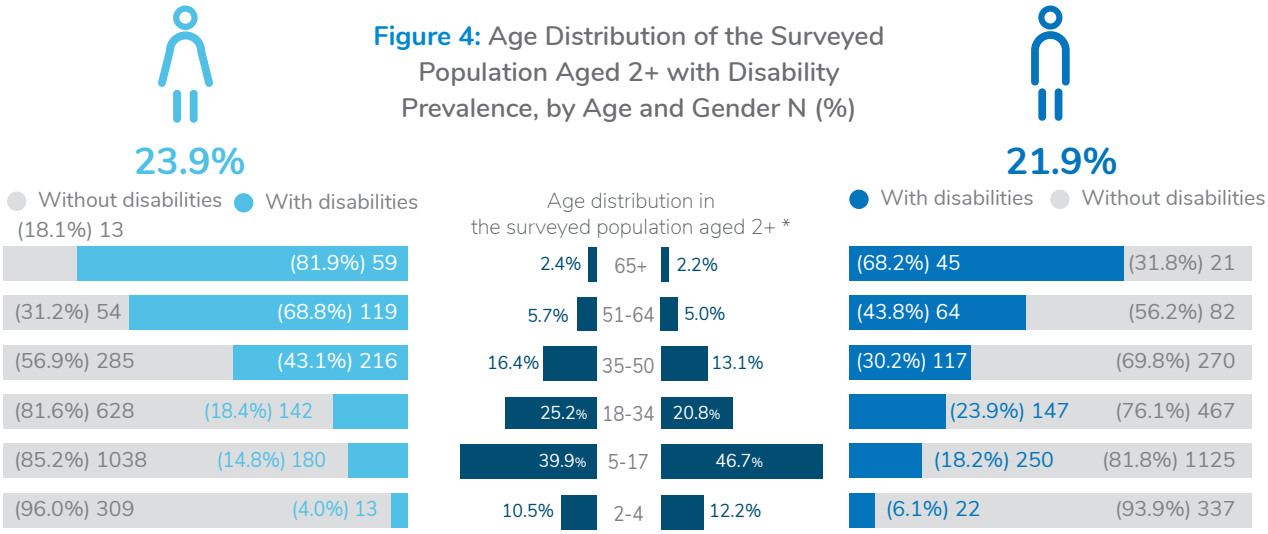
[10] This survey asked if any member of the household had a disability or not. The sample was 2,114 randomly selected households from 4 governorates.

Section 3: Findings

Disability prevalence by age and gender

Among the surveyed population aged 2 years and above, more than 50 % of both females and males were children aged 2-17 years. People aged 51 years and above comprised about 7-8% of the total population (see the population pyramid in Figure 4).

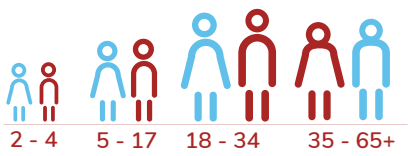
Figure 4: Age Distribution of the Surveyed Population Aged 2+ with Disability Prevalence, by Age and Gender N (%)



*Percentages may not add up to 100% due to rounding

Overall, **females experience slightly higher rates of disability than males.** Among females, the disability prevalence is 23.9%, compared with 21.9% for males. This echoes the global trend that disability prevalence is higher for females than for males (WHO, 2011 p.31).

As Figure 4 shows, **disability increases with age.** Taking also gender into consideration, prevalence of disability is higher among young males than females in age groups 2-34 years; for example, 23.9% among males aged 18-34 years compared to 18.4% among females in the same age group. However, from the 35 years age bracket onwards, more females than males experience disability. The largest gender gap for persons with disabilities is amongst persons aged 51-64 years, where there is a 25 percentage point difference between females and males (68.8% and 43.8% respectively).



Disability prevalence is higher in younger males than females in age groups 2-34 years, and in older females than males in age groups 35 years and above

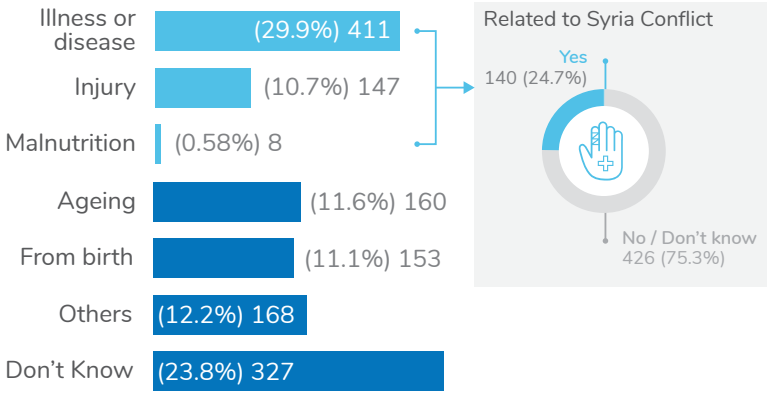
3.2.2 Causes of Disability

The study asked individuals with disabilities about the causes of the difficulties they experienced under the WG questions. As Figure 5 shows, respondents reported illness or disease as the primary cause (29.9%), followed by "I don't know" (23.8%), others (12.2%, many of them related to stress from difficult living conditions, death of family members, etc.), aging (11.6%), from birth (11.1%), injury (10.7%) and malnutrition (0.6%).

Among persons who reported illness/disease, injury and malnutrition as causes of their disabilities[11], **24.7%** (N=140) **considered the causes were related to the Syrian conflict.** The attribution of disabilities to the conflict is a subjective interpretation and no verification was conducted with the respondents. However, the desk review and discussions with stakeholders suggest various relations between disability and conflict; bombing; gunshot; accidents when fleeing from attacks; limited access to emergency health services due to destruction of hospitals, lack or absence of qualified doctors, medical personnel, equipment and medications, among others (see for example, HI & HelpAge International, 2014).

Almost one in three disabilities were acquires as a result of illness or disease

Figure 5: Causes of Disability and Relation to the Syrian Conflict N (%)



Among the 140 persons with disabilities who related the causes of their disabilities to the Syrian conflict, walking was the most common activity with which they faced difficulties, followed by anxiety, depression, fatigue and seeing (Table 9). It is likely that war-related injuries, traumatic experiences and other various daily stressors in exile, caused limitations in these domains.

Table 9: Top 6 Domains Persons with Disabilities Related the Causes to the Syrian Conflict

	Walking	Anxiety	Depression	Fatigue	Seeing	Self-care
Jordan	75	46	41	41	36	12
Azraq	12	5	4	4	7	2
Irbid	37	26	27	28	16	7
Zaatari	26	15	10	9	13	3

Note: Respondents could identify difficulties with more than one domain

Causes of disability by age

Table 10 illustrates that a number of caregivers of children aged 2-17 considered their children had disabilities since birth (60.0% for age 2-4 and 20.7% for age 5-17). For this age group, it is also clear that caregivers did not know the cause of their children's disability (22.9% for age 2-4 and 42.3% for age 5-17).

For adults aged 18 to 64 years, the primary cause of disability was illness or disease, which rises steadily with age (26.0% for the age bracket 18-34, 44.4% for the age bracket 35-50, and 48.1% for the age bracket 51-64). People in the age group 18-50 are also facing a high prevalence of disability related to injuries (15.6% for the age bracket 18-34 and 17.4% for the age bracket 35-50). For persons aged 65 and over, evidently ageing was the leading cause (52.9%).

[11] Among answer choices, causes other than these three (e.g. aging and conditions from birth) are not or less directly attributed to Syria Crisis.

Section 3: Findings

Table 10: Causes of Disability, by Age

Top cause Second cause in each age group

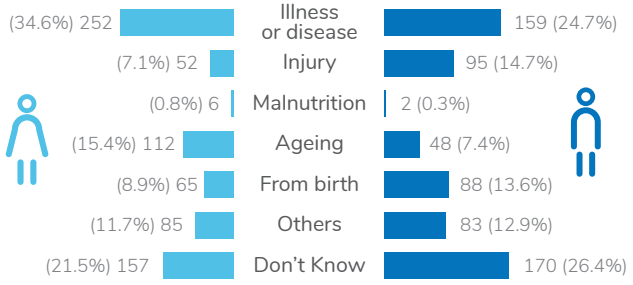
	2-4	5-17	18-34	35-50	51-64	65+
Illness or disease	8.6%	13.3%	**26.0%**	**44.4%**	**48.1%**	38.5%
Injury	2.9%	6.0%	15.6%	17.4%	7.1%	3.8%
Malnutrition	0.0%	0.7%	0.3%	1.2%	0.0%	0.0%
Ageing	0.0%	0.2%	0.3%	12.0%	34.4%	**52.9%**
From birth	**60.0%**	**20.7%**	10.4%	2.1%	2.7%	1.0%
Don't Know	22.9%	42.3%	28.4%	15.0%	2.7%	0.0%
Others	5.7%	16.7%	19.0%	7.8%	4.9%	3.8%

Note: "Other" categories require further investigation

Causes of disability by gender

When disaggregating data by causes of disability by gender (see Figure 6), the study found that more females (34.6%) than males (24.7%) had disabilities related to illness or disease. Injuries, on the other hand, led to more males having a disability (14.7%) than females (7.1%). This suggests males' higher exposure to risks of injuries in conflict. HI and HelpAge International (2014) illustrated their roles in daily activities, such as combatants, fetching food and water, and traveling to check their houses, properties and relatives, could be risk factors.

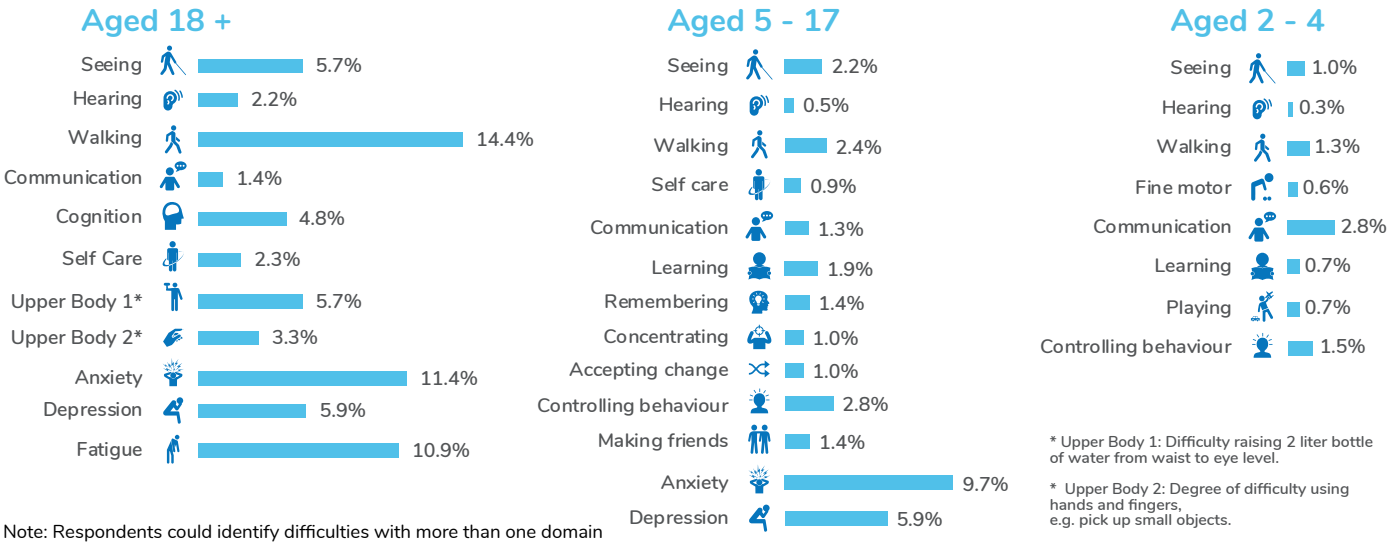
Figure 6: Causes of Disability, by Gender N (%)



3.2.3 Disability Domains

As explained in Section 1, the study asked questions to understand the level of difficulties a person faces when performing basic activities or domains, using the WG tools, depending on the age of the responding household members.

Figure 7: Disability Domains, by Age (%)



Note: Respondents could identify difficulties with more than one domain

As shown in Figure 7, the most frequently experienced functional difficulties by adults aged 18 years and above were walking (14.4%), anxiety (11.4%) and fatigue (10.9%). Children aged 5-17 years faced difficulties related to anxiety (9.7%) and depression (5.9%), while children aged 2-4 years experienced difficulties communication (2.8%) and controlling their behaviours (1.5%).

The fact that **anxiety and depression were the most common domains for persons aged 5 years and above** may be surprising because often, disability data collection is associated with physical, hearing, seeing and intellectual impairments and rarely with mental health and psychosocial issues (anxiety and depression) or fatigue. Syrian refugees experience a range of stress factors in their lives: grief about their lost families; worries about family members remaining inside Syria; tensions with Jordanians in non-camp settings; financial concerns; frustrations regarding difficult living conditions; violence in their communities and many others, on top of uncertainty about the future of their homeland (IMC, 2017; UNICEF, 2016; MHPSS sub working group, 2016; IMC, 2015; HI & HelpAge International, 2014). These traumas could, if not addressed timely and appropriately, develop to critical conditions, and then lead to disability. Recently, IMC found that emotional distress caused reduced functioning in daily activities for 35% of refugees in urban settings and 23% in camps (2017).

It is particularly worrying that, among children aged 5-17, 9.7% exhibit daily anxiety and 5.9% show depression or sadness on a daily basis. Looking further at children's anxiety by location, 19.9% of children in Zaatari experience anxiety daily, higher than corresponding rates in Irbid (7.6%) and Azraq (2.3%).

This data suggests the strong need for humanitarian actors to focus on MHPSS, with careful attention to the young generation. In this regard, a consultation with stakeholders pointed out that one of the challenges could be the distance and expertise gaps between humanitarian actors specialized in mental health and psychosocial support and those specialized in disability.

Disability domains by location and gender

When analyzing the results for adults by location (Table 11), walking was the most prevalent domain in Irbid and Azraq camp. The 16.5% rate in Irbid suggests accessibility problems in urban environments. In Zaatari camp, anxiety was the leading domain affecting 15.0% of its populations aged 18 years and above. Depression was also prevalent in Zaatari (9.0%), higher than in Irbid (5.6%) and in Azraq (2.5%). This may be related to the nature of Zaatari camp, established 7 years ago while Azraq is newer, opened in 2014 (MPWH, 2016). This study is not able to explore further but the relationship between the number of years refugees live in a camp setting and its impact on people's mental well-being needs to be investigated.

Table 11: Disability Prevalence, by Domains, Location and Gender: Adults aged 18 Years and Above

● Top cause ● Second cause in each location

	Seeing	Hearing	Walking	Communi-cation	Cognition	Self-care	Upper Body 1	Upper Body 2	Anxiety	Depression	Fatigue
Azraq	6.3%	1.6%	**10.7%**	1.9%	1.8%	1.5%	3.7%	1.6%	5.3%	2.5%	4.3%
Male	5.2%	1.6%	8.8%	3.2%	1.6%	1.6%	2.6%	1.3%	4.9%	3.2%	4.2%
Female	7.3%	1.6%	12.4%	0.8%	1.9%	1.3%	4.6%	1.9%	5.6%	1.9%	4.3%
Irbid	5.1%	2.4%	**16.5%**	1.0%	4.4%	2.7%	8.5%	2.6%	12.2%	5.6%	13.4%
Male	4.9%	2.9%	15.3%	1.0%	3.7%	2.9%	7.6%	2.7%	11.9%	6.8%	14.1%
Female	5.2%	2.0%	17.4%	1.0%	4.9%	2.4%	9.1%	2.4%	12.4%	4.8%	13.0%
Zaatari	6.0%	2.3%	14.3%	1.4%	7.7%	2.6%	3.3%	5.7%	**15.0%**	9.0%	12.7%
Male	4.8%	2.5%	10.4%	2.5%	4.8%	3.6%	3.6%	3.3%	11.9%	8.9%	10.9%
Female	7.1%	2.0%	17.8%	0.4%	10.2%	1.8%	3.1%	7.8%	17.8%	9.1%	14.2%

Table 11 also presents different difficulties experienced by men and women. Across all locations, females seem to experience higher rates of activity limitations in seeing, waking, cognition, upper body and anxiety while domains such as communication and self-care affect men more, and other domains affect both men and women. Among females in Zaatari camp, 17.8% experienced difficulties walking and another 17.8% with anxiety. One of the largest gender gaps is in relation to walking in Zaatari, where 17.8% of females experience difficulty, compared with 10.4% of males.

Disability domains by age

As disability prevalence increases with age, certain domains linked to ageing are more prevalent across some age groups (Table 12). The study found persons over the age of 40 are more likely to experience difficulties walking, hearing and seeing (P<0.01). The proportion of populations in each age group that experience difficulties walking for example, increased from 4.4% among the 18-34 age group to 63.8% of those aged 65 and over.

Table 12: Disability Prevalence, by Domains and Age

	Seeing	Hearing	Walking	Communi-cation	Cognition	Self-care	Upper Body 1	Upper Body 2	Anxiety	Depression	Fatigue
2-4	1.0%	0.3%	1.3%	2.8%	--	--	--	--	--	--	--
5-17	2.2%	0.5%	2.4%	1.3%	--	0.9%	--	--	9.7%	5.9%	--
18-34	2.3%	0.9%	4.4%	1.3%	3.0%	1.3%	2.0%	1.6%	10.1%	4.8%	7.5%
35-50	7.2%	1.8%	14.5%	1.0%	5.3%	1.2%	4.8%	3.8%	12.3%	7.3%	12.2%
51-64	9.4%	5.3%	36.1%	0.9%	9.1%	3.1%	3.1%	6.9%	16.0%	7.8%	17.9%
65+	21.0%	9.4%	63.8%	5.1%	8.7%	18.1%	31.2%	8.7%	7.2%	2.9%	18.1%

Note: For age groups 2-17, only domains that are common to 18+ are shown in this table. For other domains, see Figure 7.

3.2.4 Children's Disability by Household Income Level

Table 13 highlights that **poorer households are more likely to have children with disabilities than households within higher income brackets.** Overall, around 80% of children with disabilities in at least one domain reside within households with a monthly income of 199 JOD or less. This suggests a strong relationship between poverty and disability[12].

Table 13: Household Income Level of Children with Disabilities, by Age

Total household cash income in the last month	Children with disabilities 2-4 year old		Children with disabilities 5-17 year old	
	Number	*%*	*Number*	*%*
0-49 JOD	16	45.7%	125	29.1%
50-99 JOD	2	5.7%	94	21.9%
100 – 199 JOD	11	31.4%	115	26.7%
200 – 299 JOD	5	14.3%	58	13.5%
300- 499 JOD	1	2.9%	38	8.8%
500 – 699 JOD	0	0.0%	0	0.0%
700 JOD	0	0.0%	0	0.0%
	(total 35)		(total 430)	

[12] See for example: Groce et al., (2011) https://www.tandfonline.com/doi/abs/10.1080/01436597.2011.604520 and Banks, Kuper & Polack (2017) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5739437/

3.2.5 Assistive Devices

Assistive device questions from the WG tool found that, among 6,003 surveyed persons aged 2 and above, 8.8% wear glasses, 0.7% use a hearing aid and 2.8% use mobility aids (Figure 8).

Figure 8: Disability and Assistive Devices

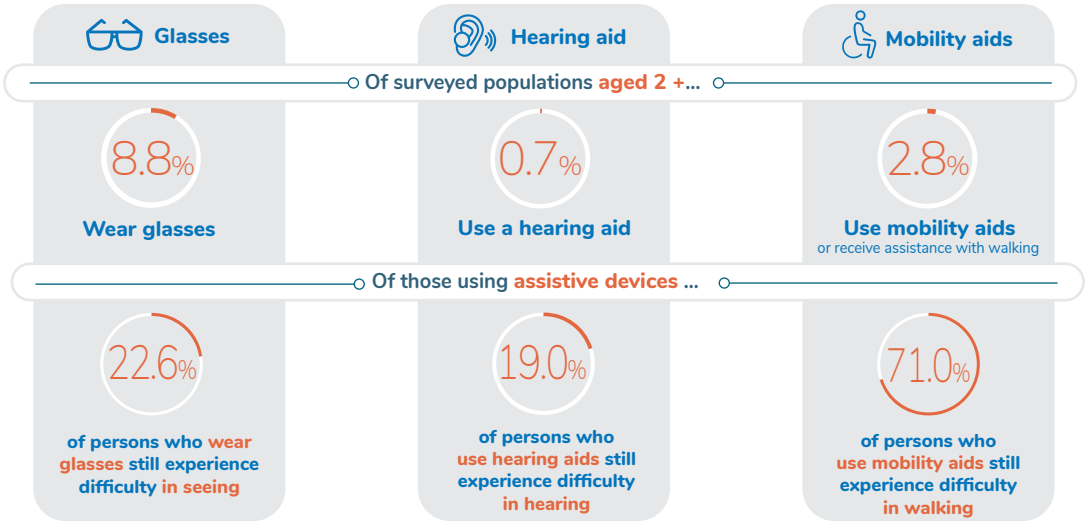


Figure 8 further shows that **users of assistive device face continued difficulties.** 22.6% of those who use glasses, 19.0% of those who use hearing aids and 71.0% of those who use mobility aids still experience significant difficulties seeing, hearing and walking respectively, thereby identified to have disabilities according to the WG recommended cut-off.

HI rehabilitation practitioners confirmed that it is understandable that persons with disabilities who started using assistive devices express activity limitations, comparing the current condition with their performance before acquiring impairments. That being said, the finding implies a deeper issue around inappropriate fitting of assistive devices at the beginning and lack of longer term support in terms of regular maintenance and repair. For example, HI field staff explained cases in which the prescription of glasses were generic and a person could not receive glasses that were aligned with their actual needs. Over time, as their eyesight worsened, the prescribed lenses were no longer suited while chances to obtain new glasses were limited. With regards to mobility aids, key stakeholders working in specialized services programming noted that often, due to the organizations' budgetary constraints, projects were only able to distribute the initial device, and were not able to cover costs related to repair or maintenance when the devices were damaged or outgrown afterwards. The discussion point to be raised here is around the approach adopted by service providers in terms of assistive devices and how this can be tailored in a way that reduces the level of continued difficulty experienced by users.

As a further breakdown by location and age in Table 14 shows, **a sizable population in Zaatari continues facing difficulties seeing and walking**, despite using glasses and mobility aids, compared to other locations: for example, **80.4% of persons aged 18+ have difficulties walking even with mobility aids**. Questions could be posed about the physical accessibility in the camp as well as about the capacity of established networks of service providers to deliver proper fitting and maintenance.

Table 14: Number and Percentages of Persons who Use Assistive Devices and Have Disabilities, by Age and Location

Location		Jordan	Azraq		Irbid		Zaatari	
Age group		2+	2-17	18+	2-17	18+	2-17	18+
Sample Size		6003	1019	680	1271	1205	984	844
Glasses	N who wear glasses	526	25	73	54	221	25	128
	% of the total age population	8.80%	2.50%	10.70%	4.20%	18.30%	2.50%	15.20%
	N who have difficulties even wearing glasses	119	6	16	5	37	8	47
	% of those who wear glasses	22.60%	24.00%	21.90%	9.30%	16.70%	32.00%	36.70%
Hearing Aids	N who use hearing aids	42	5	9	5	6	4	13
	% of the total age population	0.70%	0.50%	1.30%	0.40%	0.50%	0.40%	1.50%
	N who have difficulties even using hearing aids	8	0	1	2	2	0	3
	% of those who use hearing aids	19.00%	0.00%	11.10%	40.00%	33.30%	0.00%	23.10%
Mobility Aids	N who use mobility aids	169	8	40	9	47	14	51
	% of the total age population	2.80%	0.80%	5.90%	0.70%	3.90%	1.40%	6.00%
	N who have difficulties even using mobility aids	120	2	27	5	35	10	41
	% of those who use mobility aids	71.00%	25.00%	67.50%	55.60%	74.50%	71.40%	80.40%

3.3 Access to Services

This section presents data related to access to various services, highlighting the difference between households with at least one member with disabilities (shown as *households with* disabilities) and households without any members with disabilities (shown as *households without* disabilities). Our sample is 1,159 households across three locations in Jordan.

Only for the access to specialized services (3.3.7), the unit of analysis is not households but individuals: the study looks at 1,374 persons with disabilities aged 2 years and above.

3.3.1 UNHCR Registration

All surveyed households in Azraq and Zaatari camps are registered with UNHCR.

Table 15: UNHCR Registration Status in Irbid, by Disability

	Households with disabilities		Households without disabilities	
	Registered	Not registered	Registered	Not registered
Irbid (N=445)	98.3%	1.7%	93.2%	6.8%

Among the 445 households surveyed in Irbid, random sampling found 15 non-registered households with UNHCR (3.4%)[13]. Households with members with disabilities showed a slightly higher percentage of registration (98.3% compared with 93.2% among households with no members with disabilities), implying that their need for associated services might have driven them for registration and regular renewal.

[13] In 2018 the Ministry of Interior and UNHCR launched a 7 month campaign to formalise the status of Syrian refugees who live informally in the host communities (http://www.jordantimes.com/news/local/ministry-unhcr-launch-campaign-regularise-status-syrian-refugees-urban-areas)

3.3.2 Shelter: Accessibility, Electricity and Perceived Safety

In Azraq camp and Irbid, all households reported that they had a shelter or a house. In Zaatari camp, 4 households (2 with member(s) with disabilities and 2 without) were waiting to be provided with a shelter or caravan.

Shelter accessibility

Table 16 on the accessibility of shelter suggests that inaccessible housing conditions affect both households with and without disabilities in Irbid: 89.0% and 89.7% respectively reported it was not easy to move around their houses. This reflects the nature of housing in an urban host community in the country. It particularly causes great challenges for persons with difficulties walking if the house is located on higher floors of an apartment building without a functioning elevator. Among camps, rates of accessibility issues in Zaatari camp are also relatively high, at around half of the sample of households. Azraq presented lower rates of accessibility difficulty but still around 32% of the households felt difficulty moving around their shelters.

Table 16: Accessibility of Shelter/House, by Disability and Location

	Households with disabilities		Households without disabilities	
	Easy to move around	Not easy	Easy to move around	Not easy
Azraq (N=332)	67.3%	32.7%	67.6%	32.4%
Irbid (N=445)	11.0%	89.0%	10.3%	89.7%
Zaatari (N=378)*	45.6%	54.4%	52.1%	47.9%

* There were 382 surveyed households in Zaatari but 4 who reported they did not have their own shelter are excluded from this table

Shelter in Azraq. © HI/ B. Bogaerts, 2014

Electricity

The majority of surveyed households (more than 94% across locations) had stable access to electricity (see Table 17), with no major differences between households with and without disabilities, and between locations. Quite a high level of access to electricity among surveyed populations echoed the finding by Abu Hamad et al. (2017) in which 96% of households had access to electricity.

Table 17: Access to Stable Electricity, by Disability and Location

	Households with disabilities		Households without disabilities	
	Stable	Not stable	Stable	Not stable
Azraq (N=249)*	96.4%	3.6%	94.2%	5.8%
Irbid (N=445)	96.7%	3.3%	93.8%	6.2%
Zaatari (N=378)**	96.9%	3.1%	97.5%	2.5%

* From Village 3 and 6 only ** See note under Table 16

The sample from Azraq excluded 83 families from Village 2 which is one of the later established areas and therefore did not yet have electricity coverage at the time of data collection. Electrification work for Village 2 is ongoing and UNHCR estimates that by June 2018, residents will have access to electricity (UNHCR, 2018d).

Perceived safety

The research also explored whether households fear external factors (attack, harassment or arrest) and fear being harmed or injured in relation to their shelter (Table 18). The findings show that in camps, fears of harm or injuries are stronger than fears of attack, harassment or arrest, and more households with at least one member with disabilities had fears than households without disabilities. Zaatari camp raises particular concerns around feelings of safety; the percentage of households with disabilities that fear attack, harassment or arrest almost doubled compared to households without disabilities (20.5% vs 10.9%); and over one third of households with disabilities (35.9%) worried about being harmed/injured around their shelter compared to 26.1% among households without disabilities. The fear of harm or injuries in particular could be related to the higher rate of accessibility concerns in Zaatari than Azraq.

Table 18: Safety Concerns around Shelter in Camps, by Disability

Fear of attack, harassment or arrest around shelter				
	Households with disabilities		Households without disabilities	
	No fear	Have fear	No fear	Have fear
Azraq (N=332)	87.4%	12.6%	90.2%	9.8%
Zaatari (N=378)*	79.5%	20.5%	89.1%	10.9%

Fear of harm or injuries around shelter				
	Households with disabilities		Households without disabilities	
	No fear	Have fear	No fear	Have fear
Azraq (N=332)	76.7%	23.3%	84.4%	15.6%
Zaatari (N=378)*	64.1%	35.9%	73.9%	26.1%

*See note under Table 16

In Irbid, due to the questionnaire development process, one question was asked including both types of safety concerns (Table 19). The result indicates that Syrian households in a host community felt less safety issues around their houses compared to camps, with no significant difference between households with and without disabilities.

Table 19: Fear of Attack, Harassment, Harm or Injuries around Shelter in Irbid, by Disability

	Households with disabilities		Households without disabilities	
	No fear	Have fear	No fear	Have fear
Irbid (N=445)	94.0%	6.0%	93.2%	6.8%

3.3.3 Latrines: Availability, Accessibility and Perceived Safety

Latrine availability

Table 20 presents how Syrian refugees perceived availability of latrines. In Zaatari, 13.8% of households with members with disabilities reported that their latrine was not always available, compared to 9.1% of households without members with disabilities. The majority of families – 98.4% according to the 2017 research by REACH - in Zaatari have private toilets. The issue therefore could be more related to latrines' functioning or sharing among family members, some of whom might require longer time. Households with and without disabilities in Azraq reported almost the same percentage of unavailability of their latrines (12.6% vs 12.7%) and in Azraq, public toilets are common. In Irbid, 3.4% of households without disabilities reported that latrines were not always available compared to 3.0% of households with disabilities.

Table 20: Availability of Latrines, by Disability and Location

	Households with disabilities		Households without disabilities	
	Available	Not always available	Available	Not always available
Azraq (N=332)	87.4%	12.6%	87.3%	12.7%
Irbid (N=444)*	97.0%	3.0%	96.6%	3.4%
Zaatari (N=382)	86.2%	13.8%	90.9%	9.1%

* One household in Irbid did not answer the question

Households with member(s) with disabilities face greater difficulties in moving around their house and using latrines

Latrine accessibility

In terms of latrine inaccessibility (Table 21), the highest reported rates were found in Zaatari, where 17.6% of households with disabilities reported that their latrines were not accessible, compared to 14.0% of households without disabilities. This suggests that, despite the presence of private toilets for each family, persons in over 10% of households could be struggling to use toilets on a daily basis. Access challenges vary from one person to another, ranging from the width of the door, the slippery floor surface, the space inside to close the door and move around alone or together with caregivers, handrails to keep balance in different positions, the height of the water bowl, to many other aspects (Groce, Bailey, Lang, Trani & Kett, 2011).

Similarly in Azraq, a higher rate of households with members with disabilities expressed challenges relating to latrine accessibility (15.1% vs 12.7%). According to UNICEF (2014), only 12% of WASH centres in Villages 3 and 6 at that time were designed for persons with disabilities and had an access ramp. The study finding could indicate that great progress was achieved in the last few years to the extent that around 85% of the surveyed households in Azraq recognized their latrines were accessible. However, the challenge still remains for about 15% of households. Further assessment of detailed accessibility issues of each household is required to make appropriate adjustments to latrines.

In Irbid, percentages of households who reported inaccessible latrines were much lower: 4.8% of households without disabilities and 3.0% of households with disabilities.

Perceived safety

Table 22 highlights a stronger sense of insecurity among households with at least one member with disabilities to use latrines than households without disabilities. Higher percentages of fears of harassment, etc. in Azraq reflect the common use of public toilets. One in five families in both camps worried that they would be harmed or injured while using latrines, partly linked to accessibility problems illustrated above.

As was the safety concerns around shelter, the question in Irbid asked how households consider safety issues coming from external factors as well as self-imposed risks (Table 23). Interestingly, households without members with disabilities reported a higher rate (10.3%) compared to 7.7% for households with disabilities.

Table 21: Accessibility of Latrines, by Disability and Location

	Households with disabilities		Households without disabilities	
	Accessible	Not accessible	Accessible	Not accessible
Azraq (N=332)	84.9%	15.1%	87.3%	12.7%
Irbid (N=445)	97.0%	3.0%	95.2%	4.8%
Zaatari (N=382)	82.4%	17.6%	86.0%	14.0%

Table 22: Safety Concerns to Use Latrines in Camps, by Disability

Fear of attack, harassment or arrest to use latrines				
	Households with disabilities		Households without disabilities	
	No fear	Have fear	No fear	Have fear
Azraq (N=332)	82.4%	17.6%	87.9%	12.1%
Zaatari (N=382)	88.1%	11.9%	96.7%	3.3%

Fear of harm or injuries to use latrines				
	Households with disabilities		Households without disabilities	
	No fear	Have fear	No fear	Have fear
Azraq (N=332)	78.0%	22.0%	86.1%	13.9%
Zaatari (N=382)	79.3%	20.7%	95.9%	4.1%

Table 23: Fear of Attack, Harassment, Harm or Injuries to Use Latrines in Irbid, by Disability

	Households with disabilities		Households without disabilities	
	No fear	Have fear	No fear	Have fear
Irbid (N=445)	92.3%	7.7%	89.7%	10.3%

3.3.4 Water

The study asked if households *"have enough safe water from reliable sources for drinking, cooking, cleaning and personal hygiene?"* As shown in Table 24, in Azraq, except for only one household with disabilities, all respondents reported that they did have access to water. In Irbid, households with disabilities reported slightly higher rates of no access to enough safe water than households without disabilities (7.0% vs 4.8%). The rates were particularly high in Zaatari: 20.7% of households regardless of disability reported they did not have enough safe water from reliable sources. The difference in perceptions in the two camps is interesting, given that both locations use public water tanks.

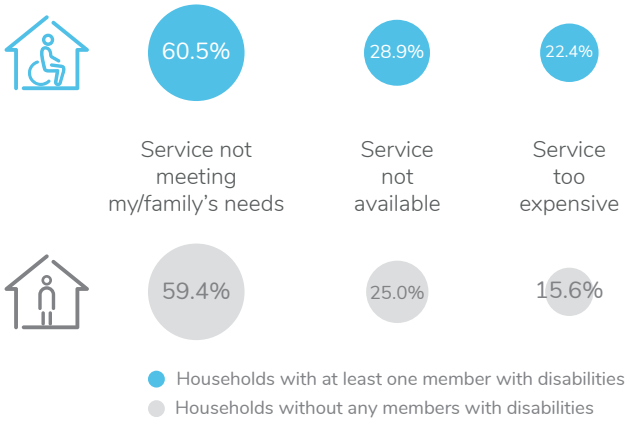
Table 24: Access to Enough Safe Water from Reliable Sources, by Disability and Location

	Households with disabilities		Households without disabilities	
	Have access	No access	Have access	No access
Azraq (N=332)	99.4%	0.6%	100.0%	0.0%
Irbid (N=445)	93.0%	7.0%	95.2%	4.8%
Zaatari (N=382)	79.3%	20.7%	79.3%	20.7%

Barriers to Access Water

The surveyed households who reported that they did not have access to enough safe water shared similar concerns regarding barriers to access water; overall, 60% of the households stated the service did not meet the specific needs of the family, followed by availability and cost of services (Figure 9 and *Jordan Total* of Table 25).

Figure 9: Main Perceived Barriers to Access Safe Water, by Disability



Due to different living conditions, data needs to be disaggregated by location (Table 25). In Zaatari, the top barrier outlined by respondents was *"services not meeting my/my family's specific needs."* This could be related to the several factors. One issue highlighted during the interviews by the respondents concerned the supply of drinking water in tanks for the block, but not through tap water. The respondents said: *"I don't have a tank [for myself],"* *"the public tank [is the barrier],"* *"the public tank is far"*. The amount of water is another concern. The interviewees explained: *"[there is] not enough water,"* and *"water is scarce in summer."* This could be a particular concern for persons with specific difficulties who require additional water supply for their hygiene. Furthermore, the 2017 survey by REACH illustrated that, although 67.8% of households in Zaatari used water delivered by free trucking service for drinking, 32.2% were not drinking water from this service largely due to perceived poor quality of water. Consequently, 32.1% of households reported they had to purchase water.

In Irbid, the perceived barriers were more around availability and cost, indicating the substandard conditions in apartments as well as the need to purchase water which pose an additional burden on their financial status. One household in our study said: *"[the quantity of] water is inadequate and [the water is] not clear. I purchase [water]."*

Water tank in Zaatari ©HI/ B. Bogaerts 2014

Table 25: Main Perceived Barriers to Access Water, by Disability and Location

Multiple answers

Top cause Second cause in each Location

	Azraq*		Irbid				Zaatari				Jordan total	
	N	%	N	%	N	%	N	%	N	%	%	%
Service not available	0	0	16	76.2%	6	85.7%	6	11.1%	2	8.0%	28.9%	25.0%
Service too expensive	0	0	14	66.7%	5	71.4%	3	5.6%	0	0.0%	22.4%	15.6%
Services far away and transportation not available	1	100%	2	9.5%	0	0.0%	1	1.9%	1	4.0%	5.3%	3.1%
Services far away and transportation too expensive	1	100%	4	19.0%	4	57.1%	1	1.9%	0	0.0%	7.9%	12.5%
Services are not meeting my/ family's specific needs	1	100%	2	9.5%	1	14.3%	43	79.6%	18	72.0%	60.5%	59.4%
Sample Size	1		21		7		54		25		76	32

* Only 1 household in Azraq reported no access to safe water

Priority Solutions to Increased Access to Water

When asked about the most important issue to be solved to increase access to water, overall, the surveyed households who reported no access to enough safe water suggested making services tailored to families' specific needs. Reflecting the responses in each location above, this opinion came strongly from Zaatari. Respondents in Irbid highlighted needs to improve availability and reduce costs of water services.

3.3.5 Health

The study found that the majority of households had health needs in the last six months (Figure 10). The needs were stronger among households with at least one member with disabilities (89.6%) than households without members with disabilities (82.0%).

Further analysis by location shows the needs were particularly high in Zaatari camp at around 95% (Table 26). The study found the largest gap in health needs in Irbid between households with and without disabilities (15 percentage point gap between 82.6% and 67.1%).

Figure 10 also demonstrates that, among these families who had medical needs, **households with members with disabilities were less likely to have access to required medical services at hospitals or clinics than households without disabilities (11.8% vs 7.2%), confirmed with statistical significance (P<0.05).** As shown in Table 27, access to medical services is especially an issue in Irbid and more so for households with persons with disabilities (17.0% households with disabilities without access), reflecting the increased medical costs in non-camp settings discussed in Section 2. On the other hand, in camps, humanitarian organizations provide various medical services, free of charge. Therefore, while medical needs are high among camp residents, they have better access to medical services compared to Irbid. Yet again, 8-9% of households with disabilities could not access required health services, compared to 5-7% of households without disabilities.

Figure 10: Needs and Access to Health Services, by Disability

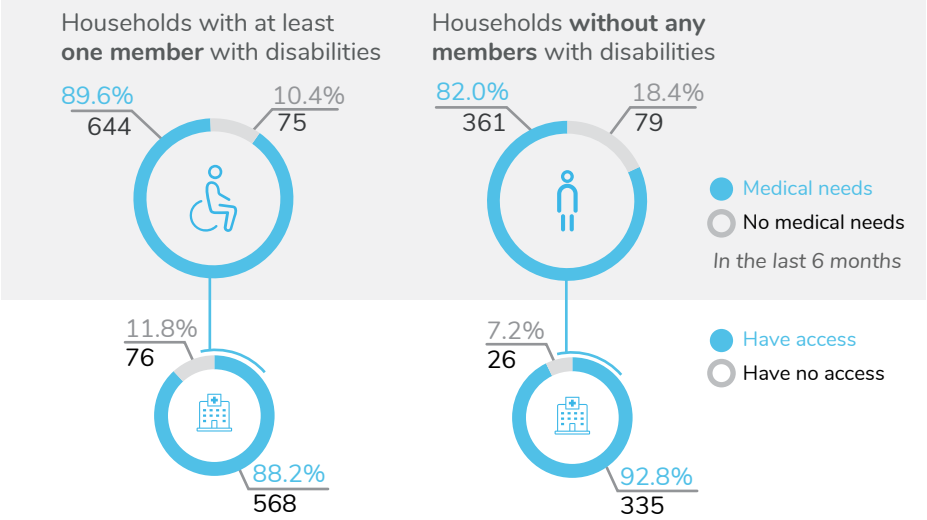


Table 26: Health Needs in the Last 6 Months, by Disability and Location

	Households with disabilities		Households without disabilities	
	Yes	No	Yes	No
Azraq (N=332)	89.9%	10.1%	86.1%	13.9%
Irbid (N=445)	82.6%	17.4%	67.1%	32.9%
Zaatari (N=382)	97.3%	2.7%	94.2%	5.8%

Table 27: Access to Health Services when Needed, by Disability and Location

	Households with disabilities		Households without disabilities	
	Could access	Could not access	Could access	Could not access
Azraq (N=332)	90.9%	9.1%	95.3%	4.7%
Irbid (N=445)	83.0%	17.0%	88.8%	11.2%
Zaatari (N=382)	91.7%	8.3%	93.0%	7.0%

Barriers to Access Health Services

The majority of households stressed the **lack of availability of health services as obstacles** to address their medical concerns. 61.8% and 73.1% households with and without disabilities respectively highlighted service unavailability as a major barrier (Figure 11). In numbers, more households with disabilities were concerned about the availability of services (47 in comparison to 19, see Table 28), suggesting that the diverse medical needs of persons with disabilities were unmet.

Looking by location, this issue was the most frequently raised barrier both in Azraq and Zaatari (Table 28). Although a number of actors in camps provide medical services free of charge, the specific needs of individuals were not met, leading to refugees' disappointment or frustration. One respondent in Azraq said: *"there is no gynaecologist."* Furthermore, *"hospitals are a mess," "[there is no] physical treatment", "medicine is not available"* said another refugee in Zaatari. Interviews with stakeholders indicated that some refugees who could not find the specific medical services inside the camp had to find ways to travel outside the camp, bearing the costs for transportation and the required services.

Figure 11: Main Perceived Barriers to Access Health Services, by Disability

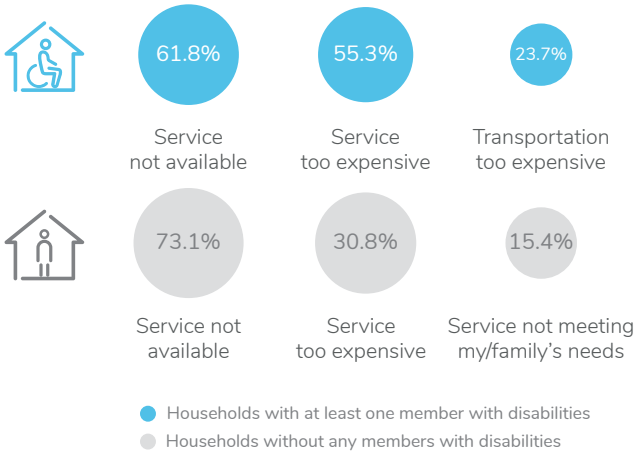


Table 28: Main Perceived Barriers to Access Health Services, by Disability and Location
Multiple answers — Top cause — Second cause in Location

	Azraq				Irbid				Zaatari				Jordan	
	N	%	N	%	N	%	N	%	N	%	N	%	%	%
I don't know where the services are	0	0.0%	0	0.0%	7	16.7%	3	27.3%	0	0.0%	0	0.0%	9.2%	11.5%
I don't have documents	0	0.0%	0	0.0%	7	16.7%	3	27.3%	0	0.0%	0	0.0%	9.2%	11.5%
Service not available	10	76.9%	6	85.7%	24	57.1%	5	45.5%	13	61.9%	8	100.0%	61.8%	73.1%
Service too expensive	0	0%	0	0.0%	39	92.9%	8	72.7%	3	14.3%	0	0.0%	55.3%	30.8%
Services far away & transportation not available	0	0%	0	0.0%	11	26.2%	0	0.0%	2	9.5%	0	0.0%	17.1%	0.0%
Services far away & transportation too expensive	0	0%	0	0.0%	16	38.1%	2	18.2%	2	9.5%	0	0.0%	23.7%	7.7%
Staff not supportive/ do not know how to communicate	0	0%	1	14.3%	8	19.0%	1	9.1%	4	19.0%	0	0.0%	15.8%	7.7%
Services do not meet my/ family's specific needs	4	30.8%	0	0.0%	8	19.0%	1	9.1%	0	0.0%	3	37.5%	15.8%	15.4%
Sample size	13		7		42		11		21		8			

The proportion of households who reported the cost of medical services as a major barrier was markedly high in Irbid, especially among households with member(s) with disabilities (92.9%). This is closely aligned with other recent research on urban refugee households; for example, Care (2017) found that financial constraints were cited by 80.0% of Syrian households as the main obstacle to accessing healthcare. The issue around cost pertains both to the cost of the services themselves, as well as associated costs such as transportation, which was also mentioned by 38.1% of households with member(s) with disabilities. It is common that health services are located far away from home in host communities and consequently public transport is required. Moreover, because buses are not regularly available or accessible, refugees often need to pay taxis which are more expensive.

In Irbid and Zaatari, 19.0% of households with disabilities concerned about the quality of service say that *'staff are not supportive and do not know how to communicate with me/my family"* compared to 9.1% of households without disabilities in Irbid and none in Zaatari. This raises questions for service providers around the demeanour of frontline staff interacting directly with persons with disabilities and their caregivers.

Priority solutions to increased access to health services

When asked about the main issue to be solved concerning access to health services, respondents proposed increased availability of services with reduced cost. Support to the problem that families did not have required documents was raised by 7 families in Irbid.

3.3.6 Food and Cash Assistance

The study asked questions in relation to households' access to food assistance (i.e. WFP e-vouchers[14]) and cash assistance or grant (e.g. UNHCR visa card[15]). In Azraq, WFP, UNHCR and partner humanitarian organizations provide services to all camp residents. Accordingly, all surveyed households reported having access to both services.

In Irbid, the proportion of households who had access to food assistance was around 90%. According to the Food Security Sector (2018), 536,353 individuals in and outside camps received cash based food assistance[16] in the 4th quarter of 2017. This suggests that over 80% of refugee individuals in the country had accessed food assistance in line with our study finding. Regarding cash assistance, about 35% and 20% of households with and without disabilities respectively reported having access. In 2017, UNHCR supported 30,000 of the most vulnerable families in host communities through the monthly cash assistance (UNHCR, 2018e). However, the study could not find the data, disaggregated by disability, about households who benefit from cash assistance in Irbid, specifically to compare with our study finding.

Table 29: Access to Food and Cash Assistance, by Disability and Location

Access to food assistance	Households with disabilities		Households without disabilities	
	Have access	No access	Have access	No access
Irbid (N=445)	93.3%	6.7%	89.0%	11.0%
Zaatari (N=382)	38.7%	61.3%	17.4%	82.6%

Access to cash assistance	Households with disabilities		Households without disabilities	
	Have access	No access	Have access	No access
Irbid (N=445)	34.1%	65.9%	19.2%	80.8%
Zaatari (N=382)	64.0%	36.0%	91.7%	8.3%

[14] The paper vouchers introduced in 2012 have been shifted to the e-vouchers that started in 2014. The electric voucher allows refugees to buy food from local shops in camps and in host communities. The recently launched new programme "Choice" will also allow withdrawal of cash from ATMs (WFP, 2014; WFP, March 25, 2018).

[15] In addition to cash assistance from UNHCR, UNICEF provides the Child Cash Grant

[16] As of December 18 2017, there were 654,903 Syrian registered refugees in Jordan (UNHCR Operational Portal, accessed on June 14, 2018).

Regardless of the number of beneficiaries covered by both schemes, the study found that more households with disabilities than households without disabilities were receiving services in Irbid (93.3% vs 89.0% for food assistance and 34.1% vs 19.2% for cash assistance). This could be explained by the effective targeting of vulnerable households including those with persons with disabilities by humanitarian actors, through the inter-agency Vulnerability Assessment Framework. This is a positive step considering the lower household income and higher debt rates reported by households including member(s) with disabilities (see the Livelihoods section below).

Respondents in Zaatari reported low rates of access to food assistance: 38.7% for families with disabilities and 17.4% for families without disabilities. This finding is unexpectedly low because all refugees in camps are eligible to receive vouchers with which they can buy food in shops (WFP & REACH, 2016). Consultations with stakeholders in the study suggested a possible explanation that households were selling their vouchers to other households, although this needs further exploration. Nevertheless, households with disabilities reported more than double the rate of access to food assistance than households without disabilities. When it comes to access to cash assistance, more households without disabilities reported having access than households with disabilities (91.7% vs 64.0%). Further research is needed to elaborate the findings.

Barriers to access food and cash assistance

As shown in Table 30, more than half of households in Irbid stated the unavailability of the service as the major barrier to access food and cash assistance, with costs of services and transportation as the other major issues. UN agencies and their partners provide free food and cash assistance, but there is a selection process and access to services depends on the households' vulnerability assessment results as well as available funds from supporting organizations. Therefore, households who reported no access to services could be still in the application process (which might require transportation costs) or were not successful. According to Abu Hamad et al., (2017), the selection took an average of 3.5 months; 20% of their survey respondents waited for more than 200 days; and 10% were concerned by long waiting times with high transportation costs. Also in Irbid, 13 households mentioned lack of documents as a barrier to access food assistance and 34 for cash assistance. Furthermore, 22.8% of households with disabilities pointed out unsupportive staff as a barrier, compared to 6.8% of households without disabilities.

In Zaatari, among households who reported not having access to food and cash assistance, the overwhelming majority of households with disabilities and without disabilities (more than 90%) reported that the services were not available. As noted above, humanitarian organizations have the full service coverage in the camps, so factors behind this response from refugee households need further investigation. It is important to note that, especially for cash assistance, 40.4% of households with disabilities and 80.0% of households without disabilities mentioned they did not know where the services were available and who could help, as a reason for not accessing services. Despite humanitarian actors' continuous information dissemination, certain families believe they do not know the necessary information. This also indicates a lack of information about alternative sources of cash support once rejected for UNHCR/UNICEF cash assistance, or the complaints/feedback mechanism.

Table 30: Main Perceived Barriers to Access Food and Cash Assistance, by Disability and Location

Multiple answers

Top cause Second cause in each location

	Irbid				Zaatari			
Food assistance	N	%	N	%	N	%	N	%
I don't know where the services are	2	10.0%	7	43.8%	3	1.9%	5	5.0%
I don't have documents	5	25.0%	8	50.0%	0	0.0%	0	0.0%
Safety fears (injury, harm)	0	0.0%	0	0.0%	1	0.6%	5	5.0%
Service not available	10	50.0%	10	62.5%	155	96.9%	99	99.0%
Service too expensive	6	30.0%	9	56.3%	6	3.8%	2	2.0%
Services far away & transportation not available	1	5.0%	3	18.8%	1	0.6%	0	0.0%
Services far away & transportation too expensive	3	15.0%	8	50.0%	1	0.6%	2	2.0%
Sample size	20		16		160		100	

Cash assistance	N	%	N	%	N	%	N	%
I don't know where the services are	23	11.7%	9	7.6%	38	40.4%	8	80.0%
I don't have documents	24	12.2%	10	8.5%	0	0.0%	0	0.0%
Service not available	105	53.3%	80	67.8%	91	96.8%	9	90.0%
Service too expensive	101	51.3%	67	56.8%	6	6.4%	1	10.0%
Services far away & transportation not available	10	5.1%	2	1.7%	7	7.4%	3	30.0%
Services far away & transportation too expensive	50	25.4%	34	28.8%	5	5.3%	0	0.0%
Staff not supportive/ do not know how to communicate	45	22.8%	8	6.8%	6	6.4%	0	0.0%
Sample size	197		118		94		10	

Priority solutions to increased access to food and cash assistance

When asked about actions to be taken, Syrian families suggested common solutions, in line with the perceived barriers as above. Improved availability of services and cost reductions were the key, with the concern about the cost came more from families with disabilities in Irbid (35.0% for food assistance and 39.1% for cash assistance). Support to required documents was also the demand in Irbid especially for food assistance (37.5% of households without disabilities and 20.0% of households with disabilities). More efforts were requested in terms of information dissemination about the services for cash assistance in particular, by families from Zaatari.

Table 31: Proposed Priority Solutions for Improved Access to Food and Cash Assistance, by Disability and Location

One answer only

Top cause Second cause in each location

	Irbid		Zaatari	
Food assistance	%	%	%	%
Availability of services	20.0%	18.8%	96.3%	98.0%
Cost reduction for services	35.0%	12.5%	0.6%	0.0%
Support to required documents	20.0%	37.5%	0.0%	0.0%
Information about available services	5.0%	12.5%	1.3%	1.0%
Cash assistance	**%**	**%**	**%**	**%**
Availability of services	30.5%	42.4%	86.2%	80.0%
Cost reduction for services	39.1%	34.7%	0.0%	0.0%
Support to required documents	4.6%	8.5%	0.0%	0.0%
Information about available services	4.1%	3.4%	10.6%	10.0%

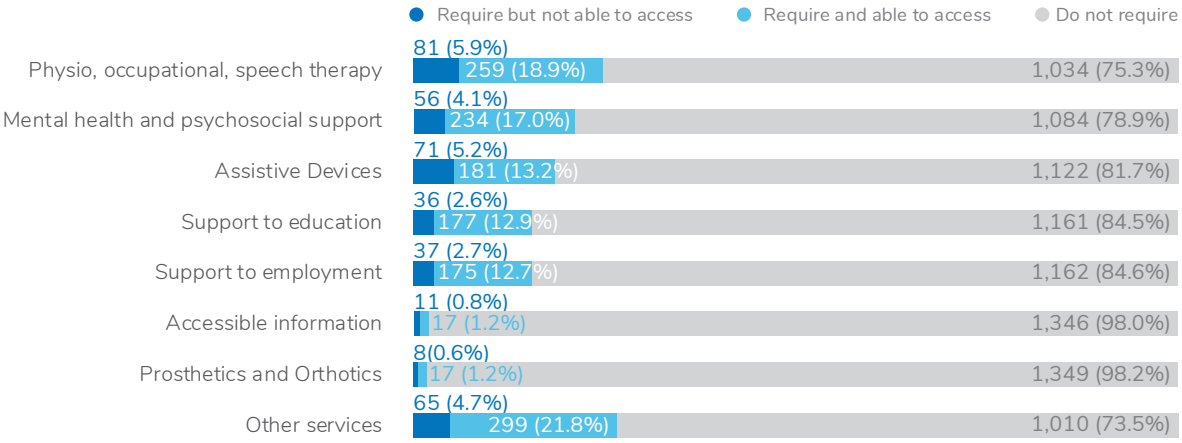
3.3.7 Specialized Services

Note: *the unit of analysis in this section is individuals with disabilities aged 2 years and above*

Persons with disabilities often require certain services varying from prosthetics, orthotics, different assistive devices, and physiotherapy to adopted mainstream services such as mental health and psychosocial support and support to education and employment. On this, when the study asked what service(s) were required, 24.7% of respondents with disabilities mentioned physio, occupational and speech therapies, followed by MHPSS (21.1%), assistive devices (18.3%)[17], support to education (15.5%), support to employment (15.4%), accessible information (2.0%), and prosthetics and orthotics (1.8%). Respondents with disabilities also raised other services including various tests (e.g. glaucoma, tests with magnetic resonance imaging), treatments (e.g. asthma, inflammation, diabetes), surgeries (corneal transplantation, neurosurgery) and medicines.

Figure 12: Specialized Services by Needs and Access

Multiple answers



However, the study found that not all persons with disabilities could benefit from the required services. Overall, 350 out of 1,374, or **25.5% persons with disabilities, were unable to access at least one specialized service despite their needs.** Further statistical analysis proved that, while persons who have difficulties with depression and learning domains were more likely to access specialized services, persons with self-care difficulties were less likely to access them (P<0.01). Persons who experience difficulties with self-care such as washing all over or dressing could potentially include persons with upper body difficulties that could be easily *"visible"* but also those with developmental and/or intellectual difficulties that could be considered complicated to support. A deeper qualitative survey of persons with specific domains of disabilities and the challenges they face in terms of access to specialized services is beyond the scope of this study. However, interviews indicated the strong perception that stakeholders did not have the capacity to support persons with intellectual or mental disabilities: even a specialized teacher in Irbid said *"It is very difficult for children with intellectual disabilities to be included in normal* schools..." (*transcribed exactly as mentioned by the interviewee).* Perceived fears and the actual capacity gap of service providers could limit the chances of persons with certain disabilities to access required services.

As shown in Table 32, 23.1%, 16.0% and 20.3% of persons with disabilities who cannot access the specialized services required physio, occupational and speech therapies, MPHSS and assistive devices respectively. Looking the data by age, therapies were needed but could not be accessed relatively by persons in the age group of 35-64 years. As for assistive devices, 25.3% of the young population in 18-34 years age group required this service but could not access it. This trend increased with age. The **demand for MHPSS is high among young people aged 5-34** (13.9% of children aged 5-17 and 25.3% of young people aged 18-34). As discussed in the previous section, anxiety and depression are key domains prevalent among children aged 5-17 and persons aged 18 years and above.

[17] Several assistive devices were also mentioned under "other" category. When these are included, the need for assistive devices becomes the most demanded specialized service.

The data implies that there is limited MHPSS for the young generation. Indeed, various actors provide psychosocial support services for children (e.g. Makani centers run by UNICEF partners where girls and boys aged from 5 to 24 years can join) (UNICEF, n.d.). However, it would be worth reviewing the inclusiveness, age sensitiveness as well as the coverage of ongoing MPHSS.

Table 32 also presents the limited access to services for persons with disabilities who need it, by location. MHPSS was particularly inaccessible in Azraq (51.6%) while in Irbid, different therapies were difficult to access (23.6%) and assistive devices (32.5%) were difficult to access in Zaatari.

Table 32: Key Specialized Services Needed but not Accessible by Persons with Disabilities, by Age and Location

	Physio, occupational, speech therapy		MHPSS		Assistive Devices	
	N	%	N	%	N	%
2-4	2	13.3%	1	6.7%	2	13.3%
5-17	8	7.9%	14	13.9%	5	5.0%
18-34	20	23.0%	22	25.3%	22	25.3%
35-50	27	36.5%	11	14.9%	13	17.6%
51-64	16	34.8%	6	13.0%	17	37.0%
65+	8	29.6%	2	7.4%	12	44.4%
Total	81	23.1%	56	16.0%	71	20.3%
Azraq	5	16.1%	16	51.6%	10	32.3%
Irbid	57	23.6%	26	10.7%	36	14.9%
Zaatari	19	24.7%	14	18.2%	25	32.5%

Barriers to access specialized services

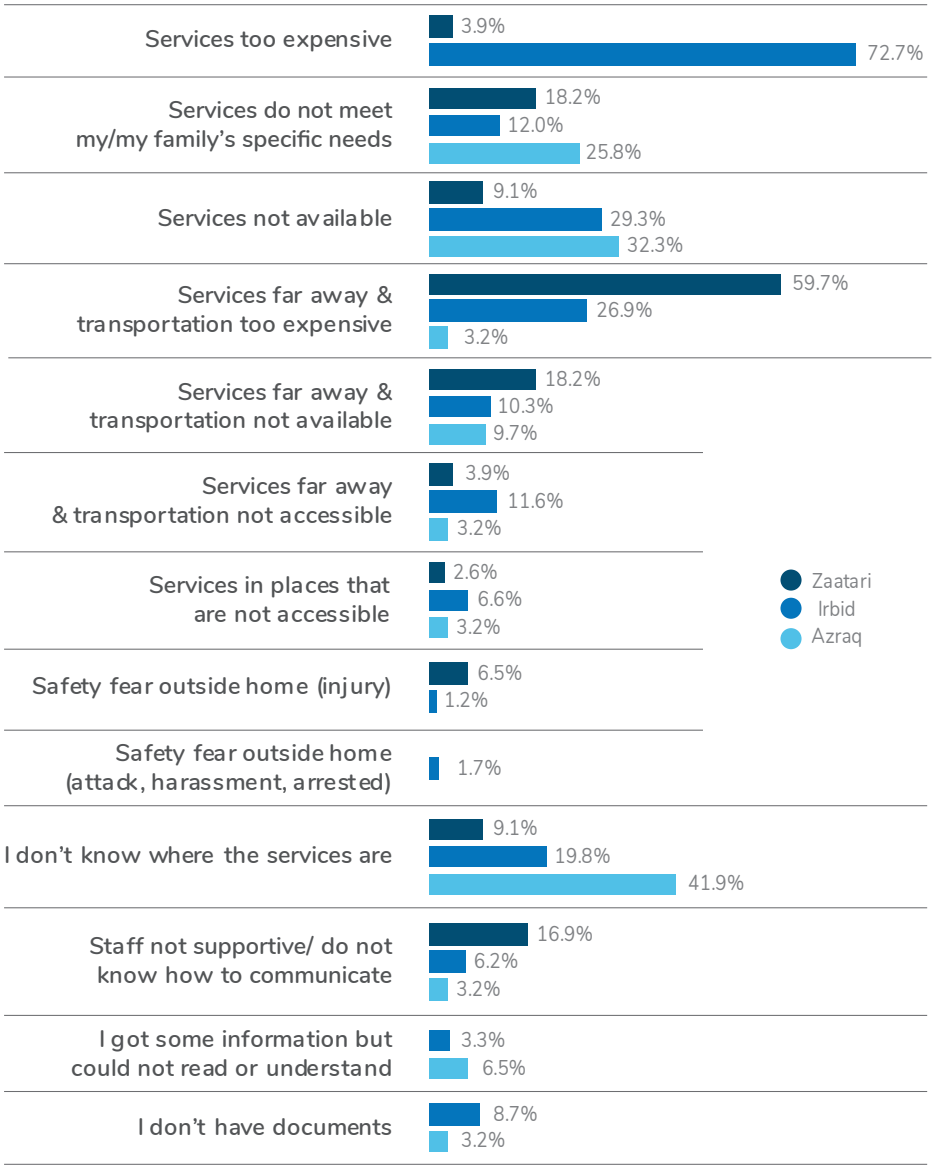
Barriers to access specialized services cited by persons with disabilities who could not access required services varied among locations, as displayed in Figure 13.

In Azraq, the main barrier was lack of knowledge about available services or support (41.9%). The second barrier is the perceived (or real) unavailability of services (32.3%), which could also be linked to the limited knowledge about available services.

In Irbid, the main barrier outlined by persons with disabilities who were unable to access required specialized services was related to costs, including costs of services (72.7%) and costs of transportation (26.9%). Limited availability of services was also mentioned as a barrier by the respondents (29.3%). Again, service unavailability could be linked to the fact that numbers of respondents (19.8%) admitted they did not know where the services or support was available. In addition to the cost, accessibility of transportation also emerged in Irbid (11.6%) implying the issues around the design of the buses or taxis, routes from home to bus or taxi stops, and /or attitudes of the drivers.

The cost of transportation to services came out as the main barrier (59.7%) in Zaatari, along with responsiveness of the services to the specific needs (18.2%) and the availability of transportations (18.2%). The latter could suggest that persons with disabilities were seeking specialized services outside the camp. Alternatively, this could refer to the available services within the camp which were however perceived to be located far away from the caravans, and were therefore inaccessible.

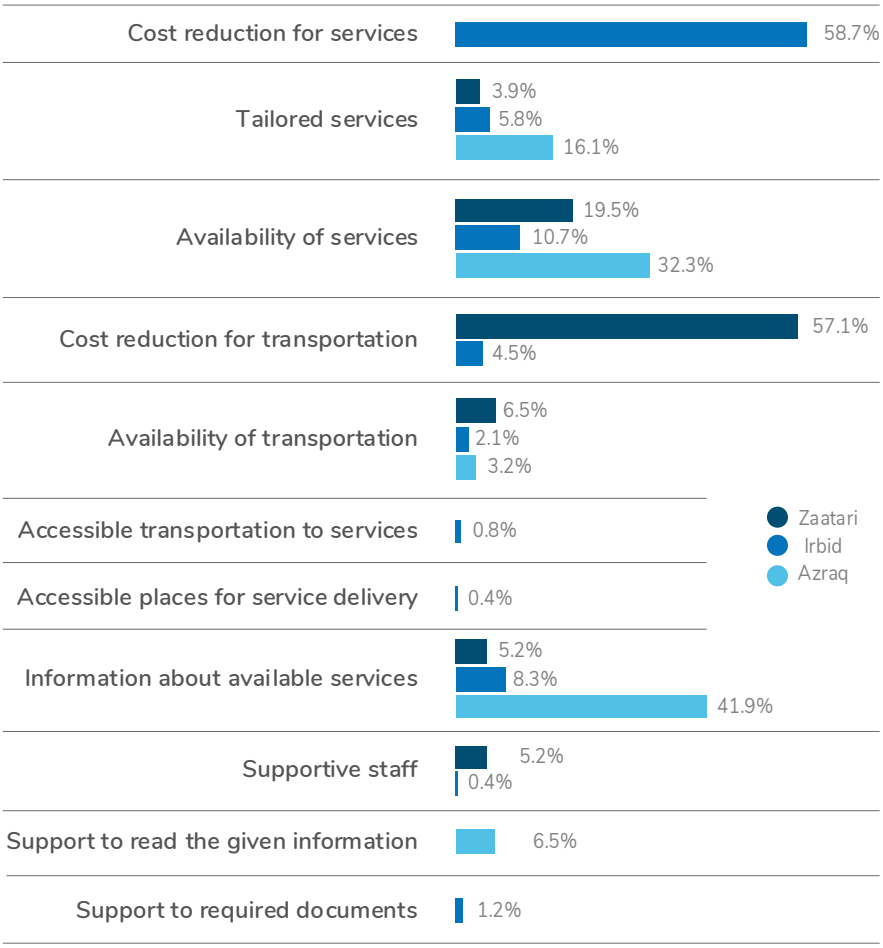
Figure 13: Main Perceived Barriers to Specialized Services, by Location
Multiple answers



Priority solutions to increased access to specialized services

Respondents with disabilities were further asked to choose only one issue to be solved as a priority (Figure 14). Their overall opinions corresponded to the perceived barriers above. In Irbid, 58.7% of the respondents voted cost reduction for services, while in Zaatari, cost reduction was requested for transportation (57.1%) in particular. People with disabilities in Azraq demanded information about available services (41.9%); it is interesting that 6.5% persons with disabilities in this camp asked for support to read the information, which links to the highest illiteracy rate (35.2%) among persons aged 13 years and above within our sample compared to other locations (to be discussed in the Education section below). Moreover, the figure shows that a sizable number of respondents in all locations asked more services to be available and flexible to meet individuals' specific needs.

Figure 14: Proposed Priority Solutions for Increased Access to Specialized Services
One answer only



3.4 Livelihood

3.4.1 Work Status

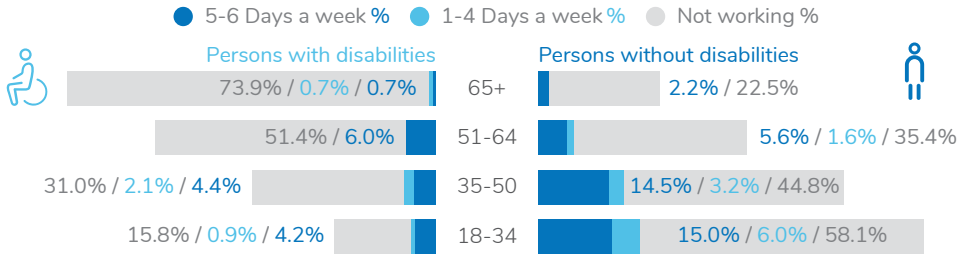
Overall, 77.1% (2,105 persons) among the 2,729 surveyed Syrian refugees aged 18 years and above were found not working. When breaking down by disability, 83.5% of persons with disabilities were not working, compared with 74.0% of peers without disabilities. The study confirmed that **persons with disabilities are less likely to be working than persons without disabilities (P<0.05).**

83.5%
Of persons with disabilities aged 18+ are not working

74.0%
Of persons without disabilities aged 18+ are not working

Figure 15: Work Status of Persons Aged 18+, by Disability and Age

Note: Length of the bar in this chart is proportionate to the percentage of persons with and without disabilities in each age group. Percentages are shown as the proportion of persons with and without disabilities with each work status among the total population of each age group.



Azraq showed the highest rate of persons not employed (79.9%) while the rate was 76.1% for Irbid and 73.6% for Zaatari.

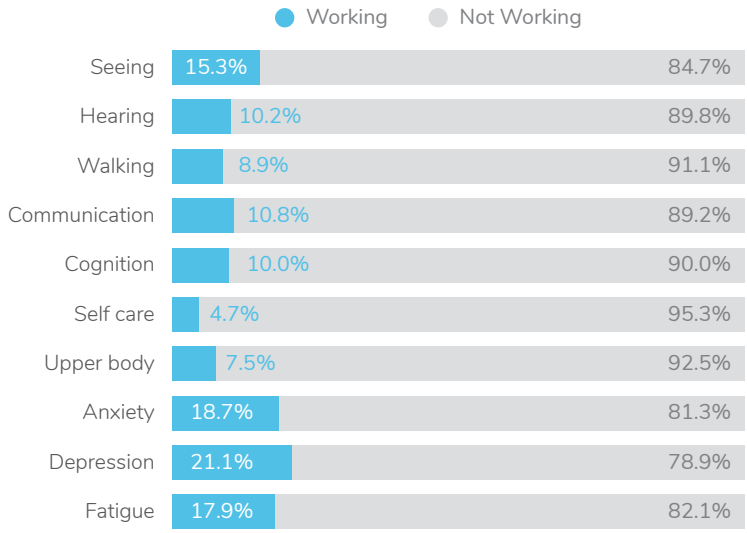
Table 33 shows that the percentages of persons with disabilities that are not working are constantly higher than their peers without disabilities in all age groups. When looking at employed persons, persons without disabilities in the 35-50 age bracket show the highest rate of working either 1-4 days or 5-6 days a week (total 28.2%). This age group also presents the largest gap among persons with and without disabilities, where 23.2% of persons without disabilities are working, compared to 11.7% of persons with disabilities.

The table also shows an interesting finding; while persons with disabilities are less engaged in work, in the 18-34 years age group, the rate of persons with disabilities who were working 5-6 days per week among persons with disabilities (20.1%) was slightly higher than 19.0% for persons without disabilities. It is a positive finding that some persons with disabilities were indeed working. As Figure 16 shows, among persons with disabilities working, persons who experience difficulties with depression, anxiety and fatigue had higher chances of working (21.1%, 18.7% and 17.9% respectively) than persons who have disabilities with other domains. This could be the reflection of the situation where persons with anxiety and depression would not necessarily require environmental modifications to work, compared to other impairments. In fact, the study confirmed that, of the surveyed domains, persons with walking, cognition (remembering and concentration) and upper body functional difficulties who sometimes require some adjustments to work environments or equipment were less likely to be working (P<0.05)[18].

Table 33: Work Status of Persons Aged 18+, by Disability and Age

	Persons with disabilities				Persons without disabilities			
	Total	Not working	1-4 days	5-6 days	Total	Not working	1-4 days	5-6 days
18-34	289	218	13	58	1,095	804	83	208
		75.4%	4.5%	20.1%		73.4%	7.6%	19.0%
35-50	333	275	19	39	555	398	28	129
		82.6%	5.7%	11.7%		71.7%	5.0%	23.2%
51-64	183	164	0	19	136	113	5	18
		89.6%	0.0%	10.4%		83.1%	3.7%	13.2%
65+	104	102	1	1	31	31	0	3
		98.1%	1.0%	1.0%		91.2%	0.0%	8.8%

Figure 16: Percentage of Persons with Disabilities Aged 18 Years and Above, Working and Not Working, by Domains



[18] Self-care shows lower rate 4.7% than walking, cognition and upper body, but due to its small sample, the statistical analysis did not yield the result.

Work permits

Among 150 persons with disabilities who were working, 39 said they had work permits (26%) compared to 31% for adults without disabilities (147 out of 474). Work permits for Syrian refugees in Jordan are still a new initiative, introduced in 2016. It could be possible that some respondents in camps might have answered positively for their work under the incentive-based volunteering program in Azraq camp and the cash for work scheme in Zaatari camp.

Work status by disability and gender

Among persons aged 18+ who are working

11.7% are females

88.3% are males

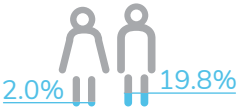
The study revealed limited chances for women to obtain remunerated work; among the sample aged 18 years and above (1,516 females and 1,213 males), 4.8% of females were working, compared to 45.4% of males. This is in line with the 2017 study by UN Women which found that, among 303 Syrian women who were 18 years old and above, 6% were employed while 94% were unemployed. While women's responsibilities at home as well as objections from the family are common reasons that prevent women from working, perceived lack of employment opportunities that meet women's preferences, conditions or educational backgrounds are equally significant factors (UN Women, 2017). The same study claimed that in fact, 57% of women wanted to work if they had appropriate opportunities.

Overall, females constituted 11.7% of the total working population. Figure 17 shows the breakdown by disability, gender as well as by age. The study confirmed that males without disabilities aged over 18 were more likely to be working than other groups (P<0.01).

Figure 17: Persons with and without Disabilities who are Working, by Age and Gender

5-17

18-50



51+

	Female	Male	Female	Male	Female	Male
Number of persons working	2	60	68	509	5	42
With disabilities + without disabilities	(0+2)	(7+53)	(16+52)	(113+396)	(3+2)	(18+24)
Total population	1,218	1,375	1,271	1,001	245	212
With disabilities + without disabilities	(180+1038)	(250+1125)	(358+913)	(264+737)	(178+67)	(109+103)

Further looking through the lens of gender and disability, just over one third (35.1%) of males with disabilities aged 18 and above were working, compared to half (50.0%) of their male peers without disabilities. Similarly, 3.5% of females with disabilities and 5.5% of females without disabilities were working. **Gender and disability are the two factors that decrease chances and opportunities for women to access work.**

Child labour

In order to gain an insight into trends around children and work, the study sample included children aged 5-17 years. Among the full sample of children in this age group (N=2,593), **2.4% or 62 children were working**: 28 in Zaatari, 19 in Irbid and 15 in Azraq. 45 of them (72.6%) were working 5-6 days a week while the rest were working 1-4 days a week. This represents 9.0% of the total sample of 686 persons who were working, aged 5 years and above (Figure 18).

2.4%

Of children aged 5-17 years are working (N=62)

Among the 62 children identified as working (Table 34), 11.3% had disabilities (N=7, in domains related to anxiety, depression and controlling their behaviours). Furthermore, the study found three children (4.8%) who worked with a work permit, two of which were 17 years old. However, one was reported to be 14 years old which is below the legal working age of 16 years in Jordan[19].

3.4.2 Household Income

The study explored households' income level, asking households to classify their 'total cash income in the last month.' As the enumerators did not specify further, it is possible that households understood *"total cash income"* in different ways; for example, some might have considered cash assistance as cash income, whereas others may have only considered income from renumerated work as cash income.

Figure 18: Age Distribution of Persons Aged 5+ who are Working

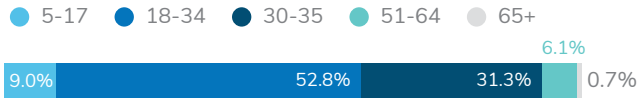
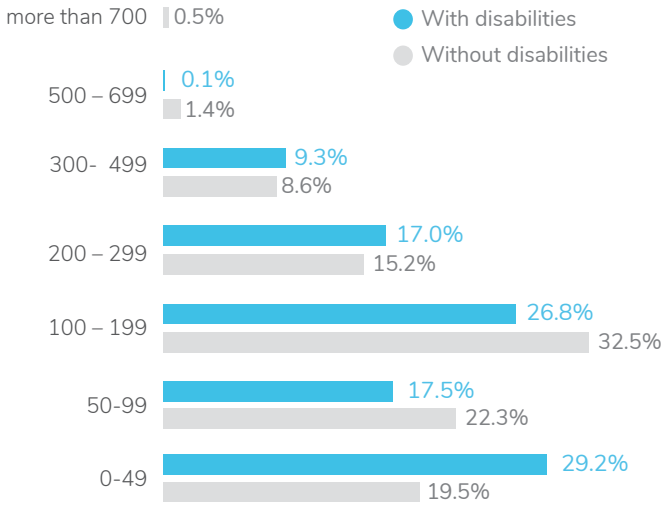


Table 34: Work Status of Children Aged 5-17, by Disability

Children with disabilities				Children without disabilities			
Total	Not working	1-4 days	5-6 days	Total	Not working	1-4 days	5-6 days
430	423	3	4	2,163	2,108	14	41
	98.4%	0.7%	0.9%		97.5%	0.6%	1.9%

Figure 19: Household Income Level (JOD), by Disability



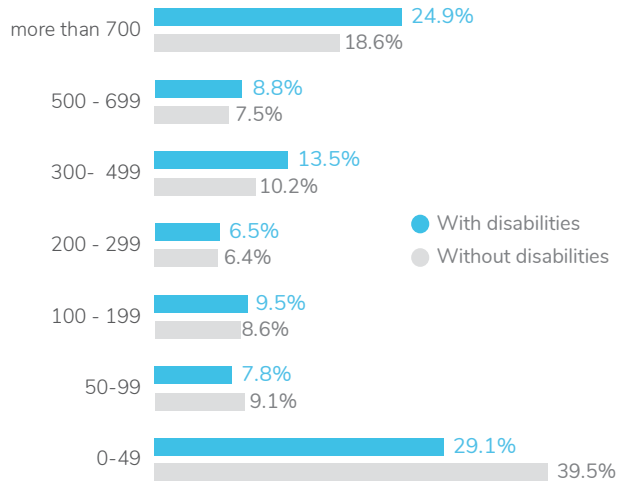
[19] According to the Center for Strategic Studies of the University of Jordan (2016), child labor in Jordan is defined as: i) All children in employment under the age of 16 years; ii) Children aged 16 -17 years employed for more than 36 hours per week; and iii) Children under the age of 18 years engaged in designated hazardous work.

As shown in Figure 19, one in three households with at least one member with disabilities (29.2%) reported a household cash income in the previous month of 0-49 JOD, the lowest income bracket, compared to 19.5% of households without any members with disabilities. Among the households with no members with disabilities, the most commonly reported income bracket was 100-199 JOD. According to the research conducted with urban refugees by Care (2017), the average reported income for Syrian refugees was 176 JOD monthly. In our study, more than 70% of households, regardless of having family members with disabilities, earned very low wages - under 199 JOD per month. This suggests a dire economic situation for Syrian refugees, considering the multiple expenses incurred with rent and the general cost of living.

3.4.3 Household Debt

Households were also asked about the 'total debt accumulated since their arrival in the country'. The findings around debt show that one quarter of households with member(s) with disabilities report having a debt of over 700 JOD, in comparison to 18.6% of households with no members with disabilities. In contrast, the largest group of households with no members with disabilities (39.5%) reported having the lowest debt level of 0-49 JOD, compared to 29.1% of households with members with disabilities.

Figure 20: Household Debt Level (JOD), by Disability



It may be helpful to analyze reported income and debt together to consider the living conditions of families that have members with disabilities. While the majority of Syrian refugee families live below Jordan's poverty line (Middle East Monitor, 2018; Abu Hamad, et al, 2017) and increasing living costs affect all families regardless of disability, medical costs for specific surgeries, ongoing therapies and transportation for specialized services as well as loss of earnings in case family members need to give up work to provide daily support and care specifically impact households with members with disabilities. It could be possible that households reported a low income of 0-49 JOD considering cash income as the cash left over once they have paid off their outstanding monthly debts.

Overall, the study suggests more difficult economic conditions of families with members with disabilities; less opportunities for work, a lower income and higher debt. The study did not explore the type and conditions of work, the household expenditure related to disability, and the coping mechanisms adopted manage their low earning and high debt, and further qualitative exploration will be needed.

3.5 Education

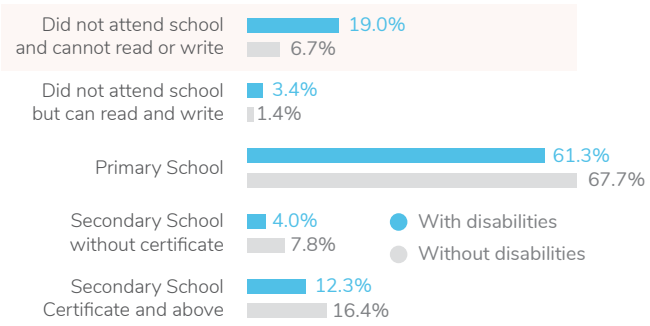
The study placed a particular focus on education for children of primary school age, considering the extreme lack of disability disaggregated information at the school level. This section first provides findings about the education level of surveyed persons aged 13 years and above, then explores the education status and level of children aged 6-12, in terms of enrolment, experiences in schools, barriers and priority solutions. It also discusses the perceptions of caregivers on inclusive education. Data is disaggregated by disability as well as by location, gender and age, as relevant.

3.5.1 Education Attainment: Persons Aged 13 Years and Above

The quantitative survey found that 19.0% of Syrian refugees with disabilities never enrolled in school and cannot read or write, compared to 6.7% of people without disabilities. **Statistical tests confirmed that Syrian refugees with disabilities are more likely to have never enrolled in school and to be illiterate than persons without disabilities (P<0.05)**[20].

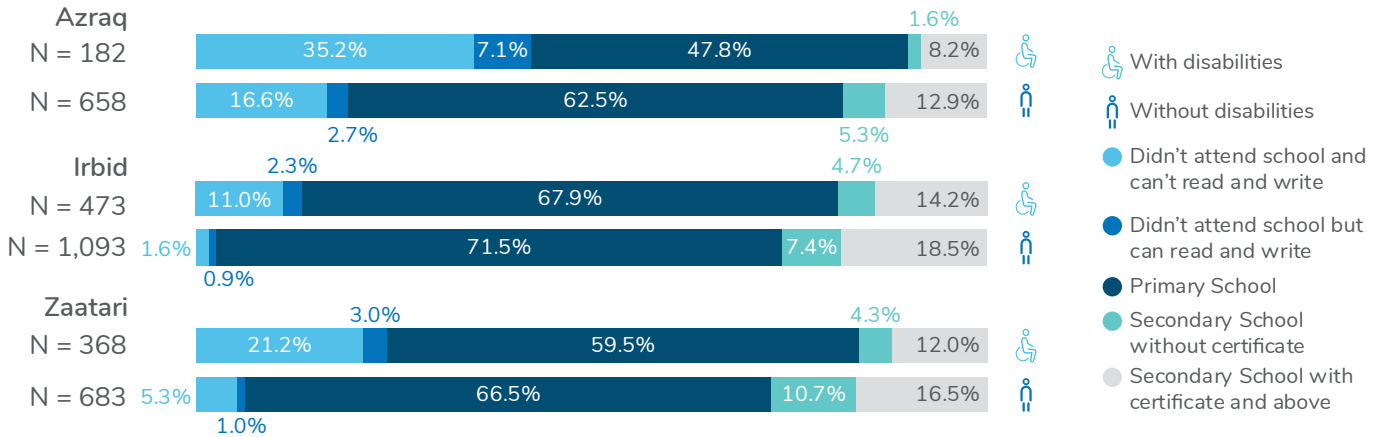
On the other hand, 16.4% of persons without disabilities and 12.3% of persons with disabilities had completed secondary education with certificate and a higher level of education. Overall, this is in line with UNICEF's (2016) finding that about 16% of Syrian refugees in Jordan have a secondary school education level and above.

Figure 21: Education Attainment of Persons Aged 13 Years and above, by Disability



Disaggregation by location highlights that Azraq had the highest rate of non-enrolment and illiteracy: 35.2% of persons with disabilities and 16.6% of persons without disabilities reported not being able to read and write with no schooling history.

Figure 22: Education Attainment of Persons Aged 13 Years and above, by Disability and Location



[20] This is in line with the literacy rates in Syria before the crisis. Garakani T (2012) reported adults' literacy (age 15+) in 2010 was 84.2%, or 15.8% illiteracy rate.

Further analysis of persons who never enrolled and cannot read and write, by disability, age and gender, illustrates some trends (Table 35).

1. Across all age groups, persons with disabilities have higher non-enrolment/illiteracy rates than their peers without disabilities.

2. The gender gap is striking. Non-enrolment/illiteracy rates among females without disabilities are more than double that of their male peers (66.9% compared to 33.1%). Considering females and males with disabilities, the rate for females with disabilities is nearly three times higher than that of males with disabilities (74.2% compared to 25.8%). Older women are much more likely than older men to be illiterate or to have never gone to school.

3. More persons in the older generation lost the opportunity to learn. Almost half of persons aged 65 years and above were not able to read or write (44.1% of persons without disabilities and 45.2% of persons with disabilities). Before the crisis, the education system in Syria was quite developed with a high enrolment rate (Al Hessan, 2016; UNICEF, 2016), but old people do not seem to have benefited from this system.

4. In spite of the improved learning opportunities for the younger generation, boys, especially with disabilities, were most at risk of exclusion. Overall, the rates of non-enrolment/illiteracy decrease as age goes down: however, for boys with disabilities in the 13-17age bracket, the percentages leaped (10.5%). Furthermore, while more women were likely than men to have lost chances to go to school, when it comes to the 13-17age bracket, more boys with and without disabilities are disadvantaged than girls.

Table 35: Number and Percentage of Persons 13+ who Never Enrolled in School and Cannot Read and Write, by Disability, Age and Gender

	13-17	18-34	35-50	51-64	65+	Total	Gender balance
Without disabilities	10	63	54	21	15	**163**	
	1.6%	*5.8%*	*9.7%*	*15.4%*	*44.1%*		
Male	8	23	13	3	7	**54**	33.1%
Female	2	40	41	18	8	**109**	66.9%
With disabilities	12	22	50	63	47	**194**	
	10.5%	*7.6%*	*15.0%*	*34.4%*	*45.2%*		
Male	8	11	14	5	12	**50**	25.8%
Female	4	11	36	58	35	**144**	74.2%

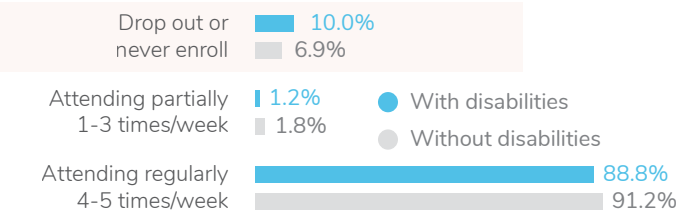
3.5.2 Education: Children Aged 6-12 Years

Enrolment

The study found a very high regular attendance rate among 1,394 children without and with disabilities surveyed (91.2% and 88.8% respectively). Continuous efforts by the MOE and stakeholders could explain this result. However, these enrolment rates are higher compared to that of other existing data: for example, No Lost Generation (2018) reported 66% for Grades 0-10 (note: enrolment rate at primary school level was not available); and *"20% of children under the age of 18 remain out of school"* (p.18 Abu Hamad et al., 2017). The reason behind the high enrolment in our study needs further investigation. This said, a statistical test confirmed that **children with disabilities are less likely to be attending school than children without disabilities (P<0.05).**

The study also confirmed that **children with disabilities are more likely to never enrol in or to drop out of school than children without disabilities (P<0.05)**: 10.0% of children with disabilities and 6.9% of children without disabilities never enrolled or enrolled but dropped out of school. In total, the study found that 17 and 87 children across three locations dropped out and never enrolled respectively. Reasons for non-enrolment are discussed in detail below. Box 1 shows one of the factors: stigma.

Figure 23: Enrolment of Children 6-12 Years, by Disability



Box 1: Stigma towards Children with Disabilities

"Children with disabilities receive a lot of stigma. Some parents don't allow their children to leave their home…I saw a child with intellectual disabilities [and his] parents didn't allow him to leave his room because of shame"

Project Manager, INGO, Zaatari

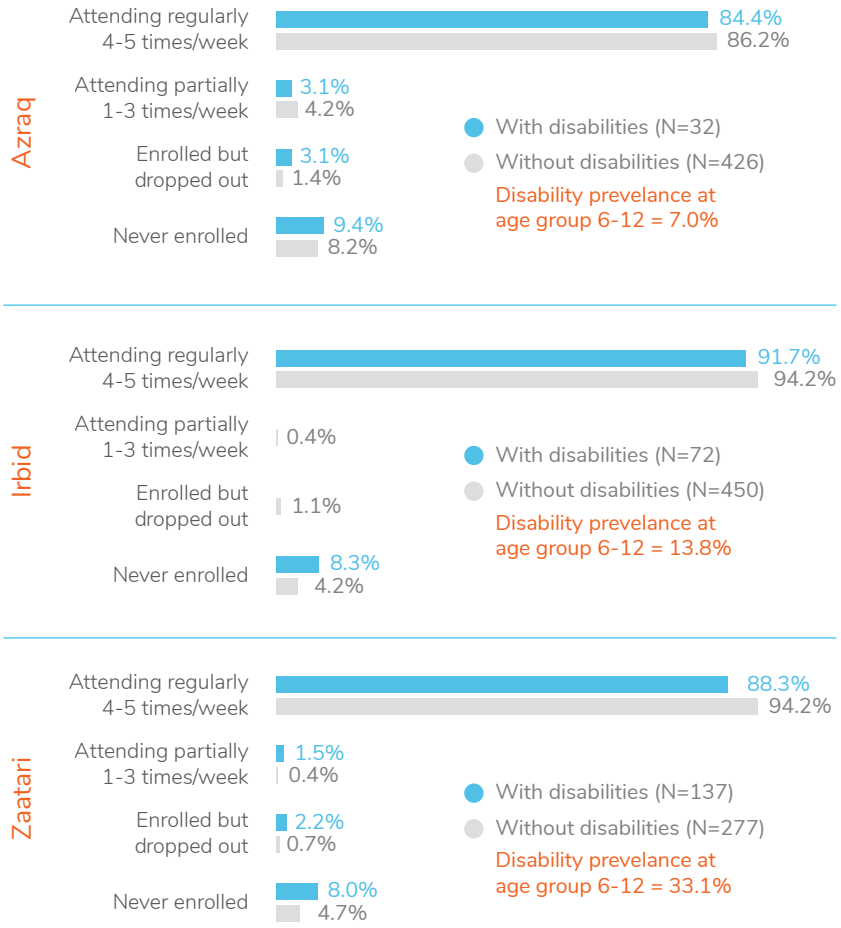
"In camps, parents of children with disabilities are afraid of stigma… [and] of not being accepted by the services, and that their child will be refused. There should be more awareness…and support…because Syrian refugees are under a lot of pressure."

Field Officer, INGO, based in Amman

Enrolment by location

When considering data by location, Irbid shows the most favourable results with high attendance and low non-enrolment and dropout rates, while Azraq presents the opposite trend: a total of 12.5% among children with disabilities and 9.6% among children without disabilities dropped out of or never enrolled in school. The biggest difference in regular attendance (4-5 days/week) was found among children in Zaatari; 88.3% of children with disabilities went to school regularly compared to 94.2% of their peers without disabilities.

Figure 24: Enrolment of Children 6-12 Years, by Disability and Location



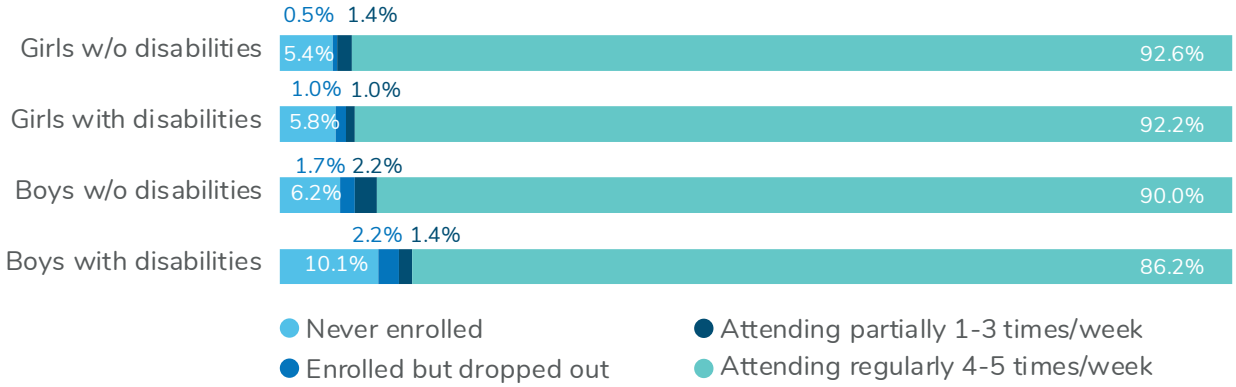
Enrolment by gender

Further analysis of enrolment by disability and gender shows that **boys with disabilities are most likely to never enrol in school and least likely to attend education regularly** (P<0.05), as shown in boys' higher non-enrolment and dropout rates than girls' (Figure 25). This should have been the issue since several years ago, as the data for boys currently aged 13-17 years, especially those with disabilities, also proved that they were educationally disadvantaged (Table 34 above). The desk review and consultations with stakeholders suggest that higher risk of child labour and more exposure to bullying could be partly contributing to the lower access to education among boys in general, and boys with disabilities in particular.

Better educational opportunities for girls were expected as Abu Hamad et al. (2017) reported that *'girls are slightly more likely to be enrolled than boys (81% vs 78%)'* (p.77). Among girls, there was no large enrolment difference by disability; 92.2% of girls with disabilities and 92.6% of girls without disabilities attend school 4-5 times per week. Interestingly, girls with disabilities were attending schools more than boys with and without disabilities.

Boys with disabilities are most likely to never enroll

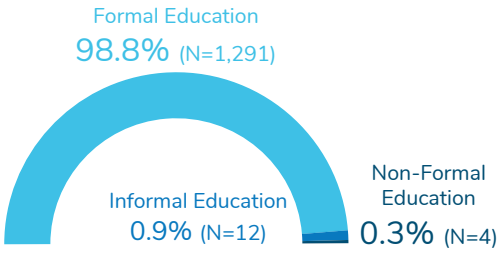
Figure 25: Enrolment of Children Aged 6-12 Years, by Disability and Gender



Our study found a low number of children who had enrolled in but subsequently dropped-out of education (17 children out of 1,394 children). Among these children, 23.5% had disabilities (N=4). More boys (N=13) than girls (N=4) dropped out, and Azraq hosted the highest number of children who dropped-out (N=7). In terms of drop-out age, the most common age for boys was later in the primary school at 11 years (N=3) and 12 years (N=3), whereas for girls it was 10 years (N=2).

Type of education [21]

Figure 26: Type of Education



Among children currently or previously attending schools, formal education was the most common type of education, reported by 98.8% of caregivers of children in the sample. This is in line with another study which found that 95% of Syrian refugee children in schools enrolled in a public school (Abu Hamad et al., 2017). It is important to keep in mind that children could be enrolled in more than one education program. In this case, it could be possible that caregivers reported formal education as the appropriate response to the enumerators, even if the child was actually receiving other types of education. Informal education and non-formal education were reportedly attended by 0.9% and 0.3% of children respectively. The recent data from the MOE, however, reported that at least 29,247 Syrian refugee children aged 5-17 years were attending non-formal education only, constituting about 13% of total Syrian refugee children in the same age group (No Lost Generation, 2018).

Among children with disabilities who currently or previously attended education, 99.1% were attending formal education, slightly higher than 98.7% of children without disabilities.

The study found no children with disabilities attending special schools, which is not surprising given the low number of special schools within the survey sites (none in Azraq and Zaatari) and a few only in Irbid. As the study presents below, 78.9% of surveyed caregivers thought that children with disabilities could learn better in special schools. While caregivers shared a belief that special schools would provide better quality education than mainstream schools, this is not based on special schools' actual experience.

[21] The study defined the type of education as below:
Formal education: Structured learning with the formal curriculum, with the MOE certificate upon completion.
Non-formal education: Less structured and may or may not be guided by the formal curriculum. In Jordan, NFE includes an alternative learning pathway such as the Catch-up program for children aged 9-12 years and the Drop-out program targeting adolescents aged 13+. Both are certified by the MOE.
Informal education: less structured uncertified learning support activities conducted at the community level, including psychosocial support, life skill activities, etc. An example is the Learning Support Service (LSS) offered as part of the UNICEF Makani program. No MOE certificate delivered.

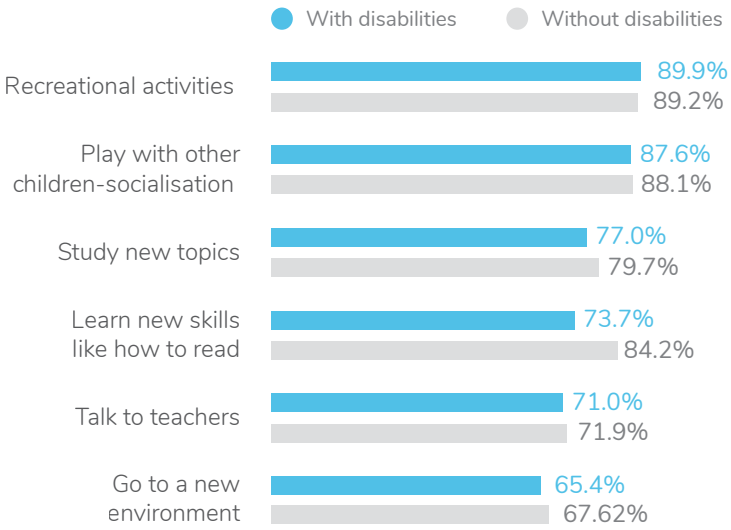
Experiences by Children Attending School

Figure 27 shows the aspects of school which children with and without disabilities who were attending schools enjoyed (currently or previously for those who dropped-out). Unsurprisingly, children liked fun activities such as sports, games, singing and dancing, and playing with their peers, while they did not rate studying and talking to teachers as highly, in terms of enjoyment. Overall, children with disabilities report lower rates of enjoyment across all school activities, with the exception of recreational activities.

The largest gap is around learning new skills such as how to read and write; 84.2% of children without disabilities reported enjoying this aspect, compared to 73.7% of children with disabilities. This poses a question about teachers' capacity to identify children's specific learning needs, some of which could be related to their disabilities, as well as to provide appropriate personalized educational support using tailored learning materials within mainstream school settings. While the MOE does not yet have the official inclusive education policy, some initiatives have been undertaken in partnerships with stakeholders such as teacher training on inclusive education, and establishment of *"resource rooms*[22] " in some schools.[23] However, despite an overall aspiration for inclusive education among teachers and actors in the education sector, interviews revealed various challenges – in particular related to teachers' capacity and lack of educational materials. It is important to note that in Jordan, persons with subject-related degrees can become teachers without pre-service training.

The study also found several positive efforts towards inclusive education, which could have contributed to the above-mentioned enrolment data. At the same time, further efforts are required for the full realization of inclusive education. For example, the exact quote from the assistant teacher below shows the idea that learners with disabilities need to be ready in order to join *"normal"* schools or classrooms, which is rejected by the fundamental principle of inclusive education.

Figure 27: School Activities Enjoyed by Children in Schools, by Disability



"I did not receive any training about inclusive education. [...] Syrian [assistant teachers] do not receive many trainings, [unlike] Jordanian teachers, [but we sometimes receive it] from NGOs. Teachers need [training on] special methods for children with disabilities, different methods like motivating and rewarding children with disabilities".

Assistant teacher (Syrian refugee), MOE school, Zaatari.

"A teacher in regular schools may have 40-50 students and focus on a certain group of students who are good... A teacher treats disabled students in a bad way that makes them frustrated. In addition, there is discrimination against Syrian students".

Special teacher, NGO, based in Amman.

"Some of the schools lack necessary educational tools, educational approaches and appropriate curriculum that fit students with disabilities".

Camp Coordinator, international NGO (INGO) in Azraq.

[22] The Hashemite Kingdom of Jordan (2017) reported that there were 900 resource rooms in formal schools across the country that provided remedial and educational support for children with specific needs. However, the information from the field indicates that they are not always functional for the intended purpose.

[23] From the interview with the Director of Special Education, MOE, November 21st, 2017.

"It is good for children with disabilities to go to regular school. [In my school] there is a special room or 'resource room', a special teacher and special tools like hearing and seeing devices from Mercy Corps, for children with physical and mild intellectual disabilities. At the beginning, it was difficult for [children] to be included. After they receive special education from a special teacher in the resources room, they improved and then they could be included in normal classroom.*

Our principal has a big role to make the school inclusive. The principal supports children with disabilities and she always conducts activities for them and makes them participate in school activities. For example, there was a child who was hyperactive; at the beginning it was difficult to include her in a normal classroom, but the teacher and I supported her and made her participate in school activities. We also sent her to the [school] library to read stories. Now she improves and is included in a normal* classroom".*

Female assistant teacher, Syrian, with 5 years of experience in Syria and 2 years in Jordan. Public school, Zaatari

"[One day, we had] activities in my school playground. [Then] I noticed some children were watching the activity from outside the school premise. They were not my students. I therefore [approached them] and asked why they were not in the school. The reason was their parents. I took their names, informed Save the Children, [who then] contacted their parents and the [children] came to school".

Female school principal, Zaatari

"There was a boy [using] a wheelchair [who] was not going to school. The school made a ramp for him and some children helped him to go to school. Now he regularly attends school".

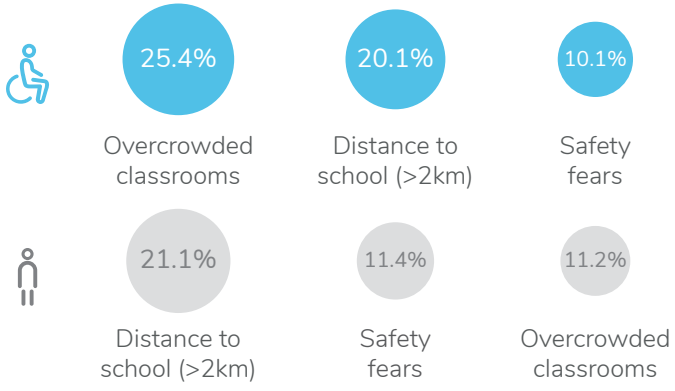
10 year old boy who has difficulty walking, Azraq

*Transcribed exactly as mentioned by interviewee.

Barriers for Children Attending School

The study examined risk factors that put children at risk of dropping-out of school. When caregivers of children with disabilities who are currently attending school were asked to give three concerns in order of priority, overall, 25.4% cited overcrowded classrooms as the major concern for the first priority, followed by distance to school (20.1%) and safety fears of movements outside home (10.1%) (Figure 28. A detailed breakdown can be found in Annex 3). For children without disabilities, caregivers were concerned about distance to school (21.1%), safety issues (11.4%) and overcrowded classrooms (11.2%).

Figure 28: Three Major Perceived Barriers Mentioned as the 1st Priority to Education for Children in School, by Disability



Note: first to third frequently raised barrier as the 1st prioritized barrier.

Section 3: Findings

It is important to examine data by location due to differences in each context (Table 35). For children with disabilities, overcrowded classrooms were a particular concern for caregivers in Zaatari camp, for both boys and girls. The issue could be about the lack of space due to overcrowding that affects children with disabilities' mobility (see Box 2) but also about the limited attention teachers could pay to individual children. Distance to school was the major problem for children in Irbid, stated by 42.4% of girls with disabilities and 25.0% of boys with disabilities, suggesting several aspects such as difficult mobility in the community setting (e.g. dangerous road with traffic, uneven grounds) and safety en route. In Azraq, the number of responses was small (N=18)[24] and the concerns ranged from safety fears, children's psychological distress and health conditions, to poor quality of teaching that affects children's academic progress.

Box 2: Physical Conditions at School in Zaatari Camp

"It is very difficult for children with disabilities to enrol in regular schools because the schools are not accessible."

Project Manager, INGO, Zaatari

"The classroom space is insufficient for children [who use] wheelchairs"

Teacher, MOE School, Zaatari

"The school is new and accessible for children with disabilities. We have ramps, special toilets and large classrooms"

School Principal, MOE school, Zaatari

Among children without disabilities, the 21.1% rate shown in Figure 28 concerning distance to school across three locations was largely skewed by results from Irbid where half the caregivers of girls (51.4%) and one in three caregivers of boys (34.2%) referred to this issue (Table 36). Safety fears were highlighted by caregivers in Zaatari for boys and girls, and also in Azraq. Overcrowded classrooms emerged as a disabling factor for children without disabilities who are attending school in Azraq.

Table 36: Top Rated Perceived Barrier as the 1st, 2nd and 3rd Priority for Children in School, by Location, Gender and Disability

	Azraq	Irbid	Zaatari
Girls with disabilities	(total sample =10) 1. Health condition (N=2, 40.0%) 2. One response each for 5 different barrier 3. Toilet not clean (N=2, 40.0%)	(total sample =36) 1. Distance to school (N=14, 42.4%) 2. Financial constraints & inaccessible toilets (N=3 each, 12.5%) 3. Financial constraints & school time (N=4 each, 20.0%)	(total sample=50) 1. Overcrowded classrooms (N=18, 40.0%) 2. Bullying from Syrian peers (N=12, 26.7%) 3. Bullying from Syrian peers (N=19, 44.2%)
Boys with disabilities	(total sample =18) 1. Safety fears & psychological distress (N=3 each, 23.1%) 2. Health condition (N=5, 38.5%) 3. Bullying, inaccessible toilets, safety fears (N=2 each, 15.4%)	(total sample =30) 1. Distance to school (N=7, 25.0%) 2. Distance to school (N=7, 29.2%) 3. Financial constraints (N=7, 35.0%)	(total sample=73) 1. Overcrowded classrooms (N=21, 32.3%) 2. Bullying from Syrian peers (N=17, 27.4%) 3. Bullying from Syrian peers (N=27, 44.3%)
Girls without disabilities	(total sample =185) 1. Health conditions (N=45, 33.8%) 2. Health conditions & safety fears (N=23 each, 19.0%) 3. Overcrowded classrooms (N=33, 28.0%)	(total sample =212) 1. Distance to school (N=94, 51.4%) 2. Financial constraints (N=56, 34.4%) 3. Financial constraints (N=27, 18.1%)	(total sample =123) 1. Safety fears (N=24, 27.3%) 2. Bullying from Syrian peers (N=23, 28.4%) 3. Bullying from Syrian peers (N=19, 24.4%)
Boys without disabilities	(total sample= 200) 1. Health conditions (N=32, 22.9%) 2. Overcrowded classrooms (N=25, 19.2%) 3. Overcrowded classrooms(N=21, 16.2%)	(total sample= 214) 1. Distance to school (N=64, 34.2%) 2. Financial constraints (N=44, 27.2%) 3. Financial constraints (N=37, 25.3%)	(total sample= 139) 1. Safety fears (N=26, 23.9%) 2. Bullying from Syrian peers (N=31, 30.1%) 3. Bullying from Syrian peers (N=23, 25.3%)

Note: the same barriers could be mentioned more than once if they were most frequently cited as the first, second or third major concern by different caregivers. Children who said "no difficulties" were excluded from the calculation of percentages. "Others" is not ranked

[24] Of total 28 respondents, 10 did not report any problem

The above table also shows additional trends in each location.

Azraq (Note: 29.5% of caregivers of both children with and without disabilities who are currently enrolled reported no problems about their children's education)

- Health conditions and psychological distress affect the learning of all children regardless of disability. This could be related to a (perceived or real) lack of health and/or psychosocial support services for children within the camp.
- Bullying, nicknaming and/or intimidation from Syrian peers was also an issue, raised by approximately 10% of caregivers of boys and girls without disabilities. A 6 year old boy without disabilities explained, *"I know a child in my neighbourhood who does not go to school because he stole pens from the teacher and hit other children. Then he was dismissed…."* Another boy, 7 years old, without disabilities admitted: *"I don't like maths and I don't like the maths teacher. I don't like the boys who make problems and hit others".*

  For children with disabilities, the sample was small: 1 girl out of 5 and 1 boy out of 13 mentioned the problem. Bullying in schools could be linked with the safety fears and crowdedness, which are discussed below for Zaatari.
- None of the respondents mentioned financial difficulties for schooling in Azraq.

Irbid (Note: 12.4%, ditto)

- Financial constraints were the second major unanimous concern following distance to school, possibly due to secondary costs of education such as transportation to and from school. Interestingly, the percentage of caregivers who concerned this barrier was higher for boys (19.8%) than girls (12.0%). Assuming the costs for books, clothes, bags and transportation for schools are equal for boys and girls, this data might reflect caregivers' expectations for boys to bring financial contributions to households.
- The third frequently raised concern was overcrowded classrooms, cited by approximately 12% of caregivers (not appearing in the table).

Zaatari (Note: 20.3%, ditto)

- As in Azraq, among 385 respondents in Zaatari, only one mentioned the financial reason as an obstacle for children already in schools.
- The surveyed caregivers in Zaatari were overwhelmed with safety fears for movements outside home, bullying and overcrowded classrooms. One of the aspects of safety fears found in our study was around the traffic that affects all children (over 90% of respondents who raised *"other"* reasons came from Zaatari and the majority mentioned this); *"the road to school [is not safe],"* and *"cars, water trucks and garbage trucks on the way to school [could be dangerous]"* was another fear expressed by a number of caregivers. Some also said *"[there are] dogs on the way to school that attack children."* Others concerned time: *"[the child] comes back home late from school."*

While it is not about *"movement,"* the study also found other aspects of safety issues that bothered caregivers: bullying, harassment, violence and negative influence from Syrian peers. One mother explained *"[I worry about] abuse and violence from other children in schools." Others said "[I am afraid] my child will learn bad behaviours from other kids – older ones."* And this could be compounded by overcrowded classrooms where children accumulate frustration from physical proximity and tensions with peers. In Zaatari, 18.3% of caregivers of boys without disabilities complained about bullying, compared with 14.8% for girls without disabilities, 10.8% of boys with disabilities and 6.7% of girls with disabilities.

Section 3: Findings

Finally, while the quantitative data did not show a significantly high percentage, physical and verbal abuse by teachers were mentioned in all locations. FGDs with children in Zaatari and Azraq illustrated that this is the common practice across different grades.

"Once, the teacher hit me. I should do the homework. [I draw what I don't like about the school]... this is a teacher, hitting a boy with a stick. The flag says 'no violence'"

A boy without disabilities, 12 years old, Zaatari

"I don't like English because the English teacher shouts, hits children and teaches them by force".

A girl without disabilities, 9 years old, Zaatari

(Picking a picture of a face 😠) "[This is my feeling] – angry – because the teacher hit me".

A boy with difficulty seeing, 11 years old, Zaatari

"I know some children go home before the class ends because some teachers hit them".

A boy with visual difficulties, 10 years old, Azraq

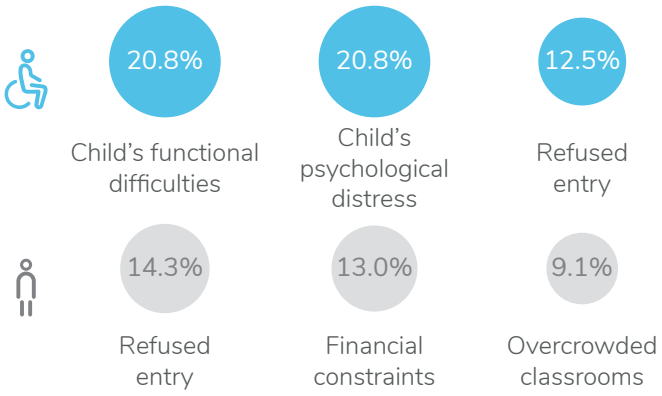
"My friends do not like school because the teacher hits them. One of them cannot read".

A boy with anxiety, 9 years old, Zaatari

Barriers for Children who Dropped-Out of or Never Attended School

For children who had either never enrolled in education, or enrolled but subsequently dropped-out, their caregivers were asked about the main barriers which prevented children from enrolling in or going back to schools. The total sample size here is 104 with the following disaggregation: N= 45 (4 children with disabilities and 41 children without disabilities) in Azraq, N= 30 (6 and 24) in Irbid and N=29 (14 and 15) in Zaatari. As shown in Figure 29 (details available in Annex 3), functional difficulties and psychological distress are the main barriers for children with disabilities being out of school (20.8%) followed by refused entry (12.5%). Refused entry was the leading obstacle for children without disabilities (14.3%), followed by financial constraints (13.0%) and overcrowded classrooms (9.1%).

Figure 29: Three Major Perceived Barriers Mentioned as the 1st Priority to Education for Out of School Children, by Disability



Note: first to third frequently raised barrier as the 1st prioritized barrier

Due to the smaller sample size, it is very difficult to infer certain factors that hinder children's access to education that can be generalized for the concerned population, by location, gender and disability (Table 37). This said, we can observe barriers that are common for children attending schools (e.g. psychological distress, health conditions and financial constraints) as reasons for children's withdrawal or non-enrolment in education. Furthermore, respondents of children with and without disabilities – especially in Azraq - frequently mentioned *"refused entry"* as a barrier. In principle, all children are entitled to access education. However, in reality, children cannot enrol if they have missed three or more years of education (in this case the MOE certified Catch-Up Program is available). Furthermore, school principals hold the power to make admission decisions. One female assistant teacher at the public school in Zaatari camp said: *"there was a girl with autism who came to my school. The principal refused to include her in the school because she [might] disturb other students. I don't know where she went after she left. [I think] the girl should be in a special school."* A 10 year old boy without disabilities in Zaatari who joined FGD was not enrolled, and explained: *"I do not go to school because the school did not accept me. My father and mother went to school to talk to the teacher, but the school refused to enrol me."*

Table 37: Top-Rated Perceived Barrier as the 1st, 2nd and 3rd Priority for Children Out-of-School, by Disability, Location and Gender

	Azraq	Irbid	Zaatari
Girls with disabilities	(total sample =1) 1. Psychological distress (N=1) 2. Health condition (N=1) 3. Functional difficulties (N=1)	(total sample =3) 1. Financial constraints, health condition & not learning due to inappropriate school time (N=1 each) 2. 2. Overcrowded classroom & distance to school (N=1 each) 3. 3. Financial constrains & teachers not caring my child (N=1 each)	(total sample=3) 1. Refused entry (N=2) 2. 2. Refused entry, safety fears & health conditions (N=1 each) 3. 3. Refused entry, health conditions & functional difficulties (N=1 each)
Boys with disabilities	(total sample =3) 1. Health condition & Functiona difficulties (N=1 each) 2. Health condition & refused entry due to functional difficulties (N=1 each) 3. Health condition & inaccessible classroom (N=1 each)	(total sample =3) 1. Functional difficulties (N=2) 2. Health condition & functional difficulties (N=1 each) 3. Bullying & financial constraints (N=1 each)	(total sample=11) 1. Psychological distress (N=4) 2. Psychological distress (N=3) 3. Psychological distress (N=3)

Table 37: Continues

	Azraq	Irbid	Zaatari
Girls without disabilities	(total sample =16) 1. Refused entry (N=3) 2. Refused entry (N=3) 3. Refused entry (N=3)	(total sample =11) 1. Financial constraints (N=5) 2. Distance to school (N=3) 3. Financial constraints, overcrowded classrooms & not learning due to poor quality of teaching (N=1 each)	(total sample =6) 1. Refused entry & overcrowded classrooms (N=2 each) 2. same as 1. 3. same as 1.
Boys without disabilities	(total sample= 25) 1. Refused entry (N=3) 2. 2. Refused entry (N=4) 3. 3. Refused entry (N=6)	(total sample= 13) 1. Financial constraints (N=5) 2. 2. Distance to school (N=3) 3. 3. Overcrowded classrooms (N=2)	(total sample= 9) 1. Refused entry (N=3) 2. 2. Refused entry (N=3) 3. 3. Refused entry (N=3)

Note: the same barriers could be mentioned more than once if they were most frequently cited as the first, second or third major concern by different caregivers. Some respondents mentioned only 1st, or, 1st and 2nd priorities.

Priority Solutions for Education

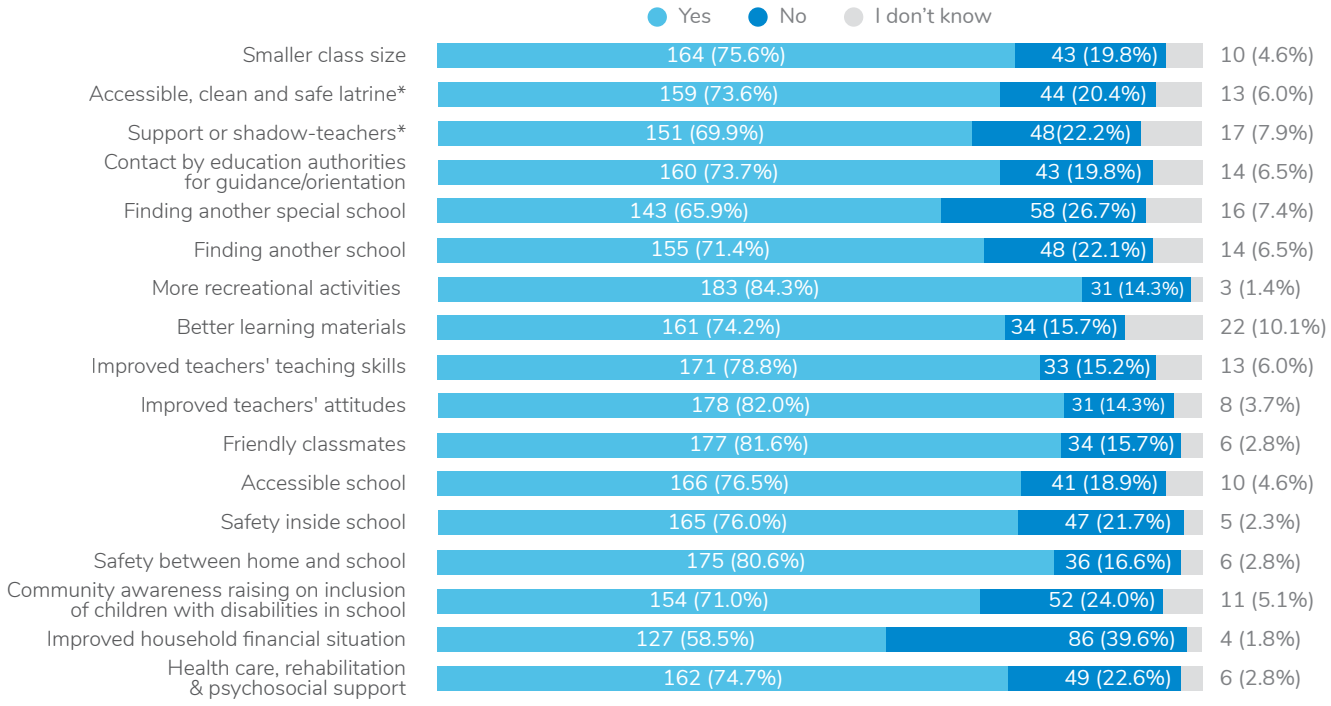
As above, the study revealed a number of barriers that put 1290 children who are currently attending school from our sample at risk of drop-out of, as well as prevent 104 children from enrolling in or going back to school. The following section explores solutions proposed by caregivers, stakeholders as well as children themselves to ensure children at school pursue their schooling and children outside school will come back or enrol for the first time.

Friendly classmates
Safety between home and school
More recreational activities
Welcoming attitudes of teachers

For children currently attending school to continue

For children with disabilities (sample total N=217, Figure 30), 84.3% of caregivers agreed that more recreational activities will help children continue learning in schools, followed by training to improve teachers' attitudes (82.0%), awareness-raising activities to encourage classmates to be friendlier to each other (81.6%) and safety between home and school (80.6%).

Figure 30: Proposed Priority Solutions for Children with Disabilities Attending School to Continue Education



Note: * 1 response missing

Caregivers of children without disabilities (total N=1,073, Figure 31), on the other hand, proposed to focus on safety inside school (77.1%), safety between home and school (75.7%), more recreational activities (75.1%) and welcoming attitudes of teachers (73.9%).

Safety between home and school
Safety inside school
More recreational activities
Welcoming attitudes of teachers

Figure 31: Proposed Priority Solutions for Children without Disabilities Attending School to Continue Education

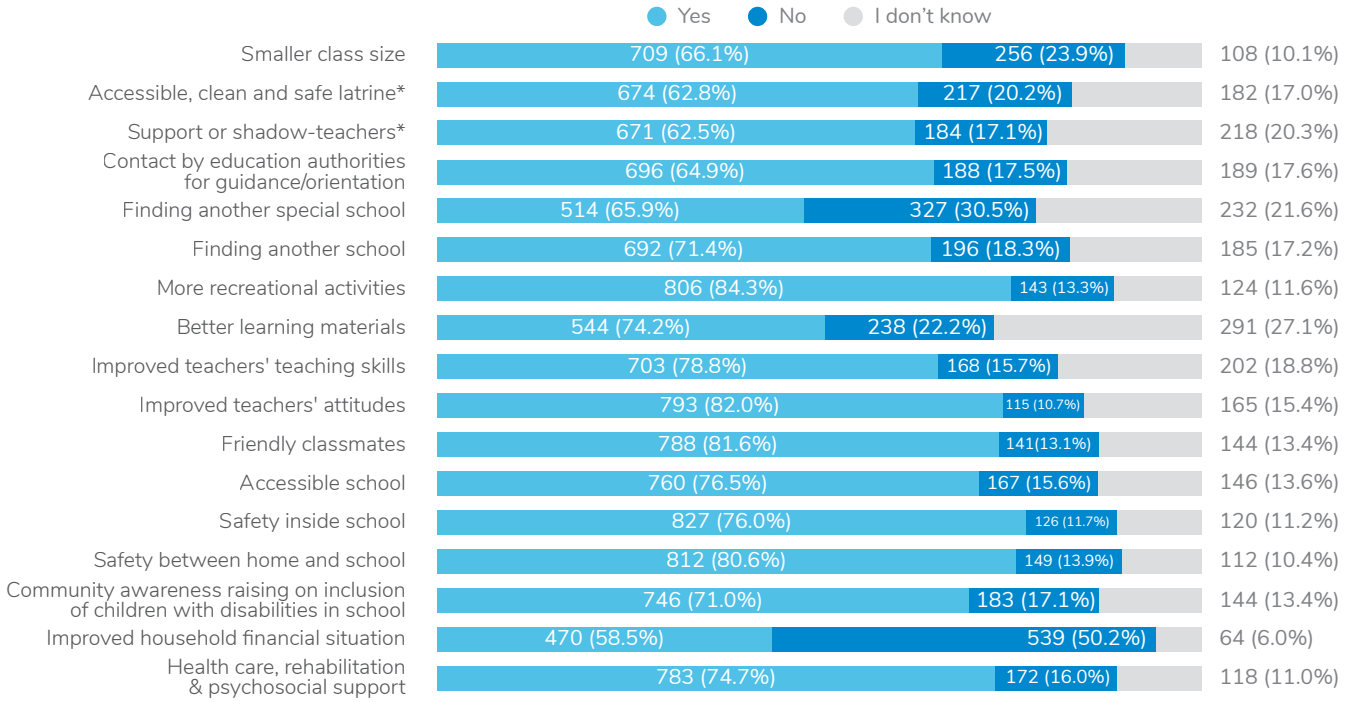
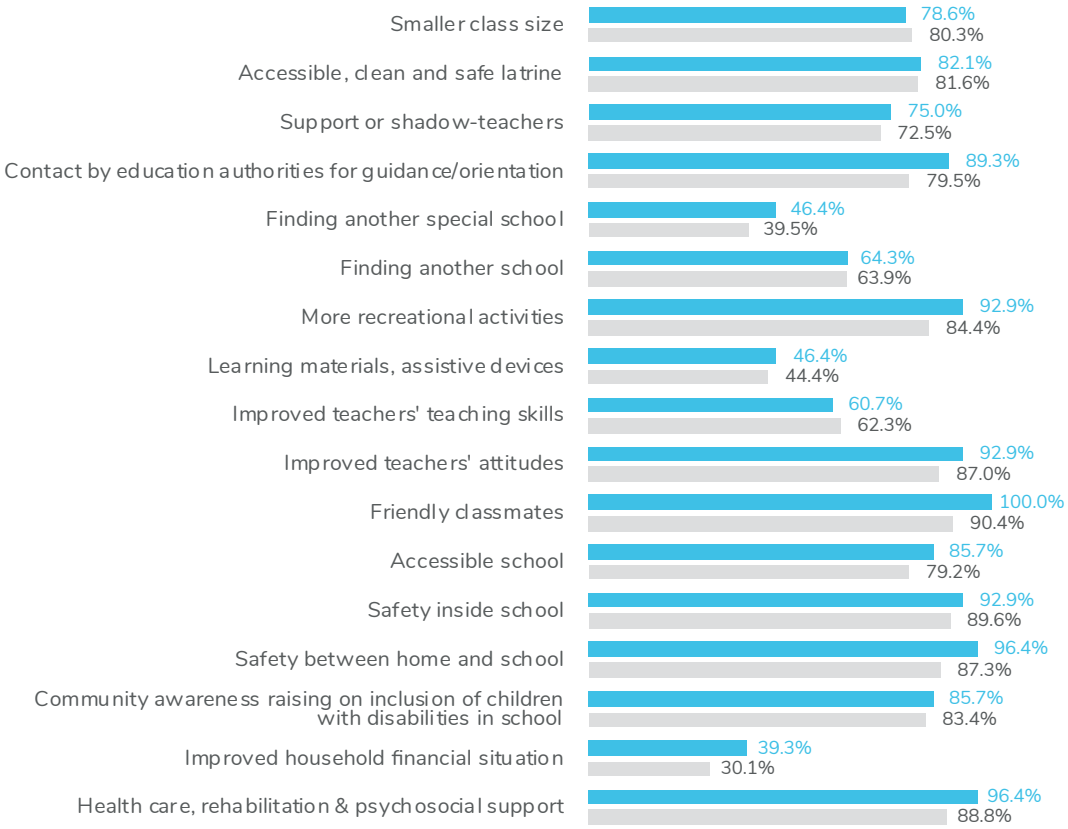


Figure 32 shows the data breakdown by disability for Azraq. Overall, needs for solutions came more strongly from caregivers of children with disabilities. In particular, all of them supported the idea to conduct awareness-raising sessions to encourage classmates to be friendlier to each other. In line with the barriers identified, the vast majority (96.4% each) also suggested to ensure access to appropriate health related care and improved safety en route to school. Children without disabilities also agreed to take measures for more friendly classmates (90.4%) and improved safety inside school (89.6%). This indicates the persistent bullying or any form of harassment that children are facing every day. They further asked for healthcare, rehabilitation and psychosocial support (88.8%). For both children with and without disabilities, support for financial difficulties at home was not considered as the priority solution compared to other issues.

Figure 32: Percentage of Caregivers in Azraq, Agreeing to Different Solutions to Ensure Children Continue Attending School, by Disability

(N=28 for children with disabilities and N=385 for children without disabilities)



In Irbid (Figure 33), when caregivers were asked what will encourage you to send/continue sending your child to school, the study received overall lower rates of agreement than in other locations, because certain number of caregivers said they don't know. This could be due to the complicated nature of living conditions and challenges which made it difficult to determine what could really solve the problem.

As said above, more recreational activities (78.8%), improved teachers' teaching skills (75.8%) and safety between home and school (75.8%) were the most supported solutions cited by caregivers of children with disabilities. Caregivers of children without disabilities also considered that improvement of safety inside school and between home and school were the priority (67.6% each) as well as to make school accessible (63.4%). Although financial constraints was mentioned as the key obstacle for children in schools, needs for solutions on this issue did not come out stronger. It could be possible that focusing on more enjoyable and safe learning experiences in classrooms will be more effective than targeting the household financial conditions in order to retain children in schools.

In Zaatari (Figure 34), caregivers of children with disabilities asked for learning materials or assistive devices (87.0%), more recreational activities (85.4%), improved teachers' attitudes as well as their teaching skills (84.6% each) and friendly classmates (82.1%) in order for them to continue attending school. These responses suggest that the major barrier, which is that of overcrowded classrooms and might be related to bullying and harassment, could be alleviated if comprehensive measures are taken to improve the quality of education and enhance positive relationships between children and with teachers. The need to strengthen teachers' capacities would include positive discipline and management of classrooms dynamics, which will ultimately reduce instances of bullying.

Figure 33: Percentage of Caregivers in Irbid, Agreeing on Different Solutions to Ensure Children Continue Attending School, by Disability

(N=66 for children with disabilities and N=426 for children without disabilities)

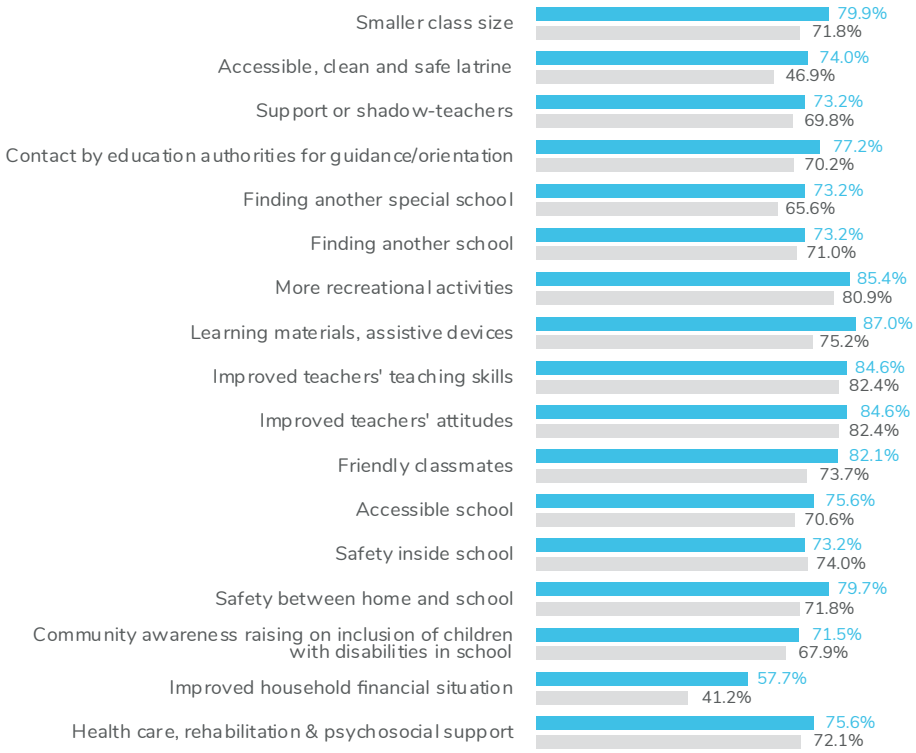
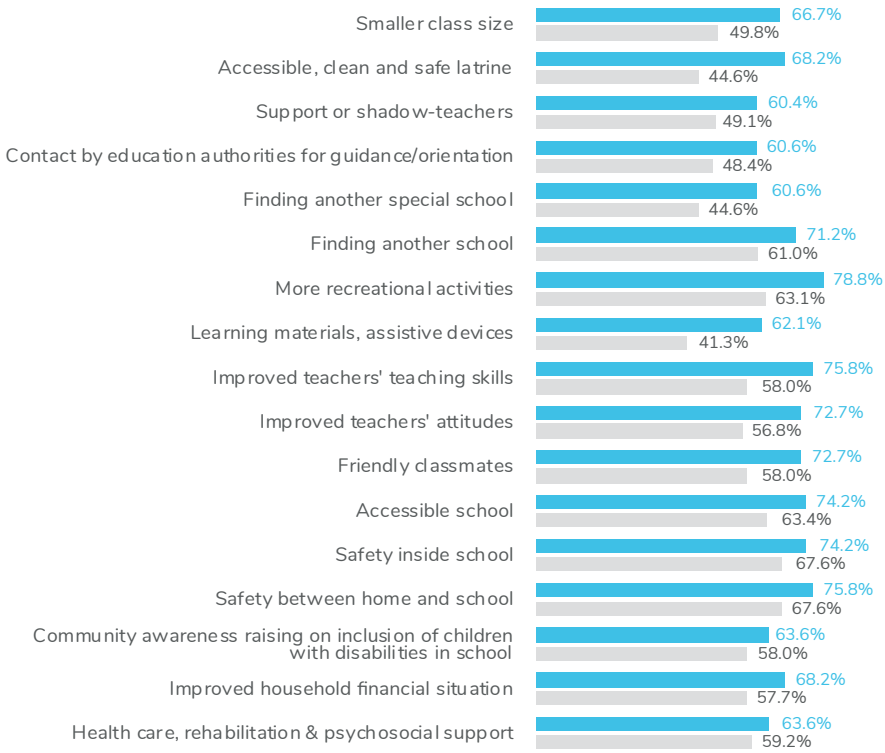


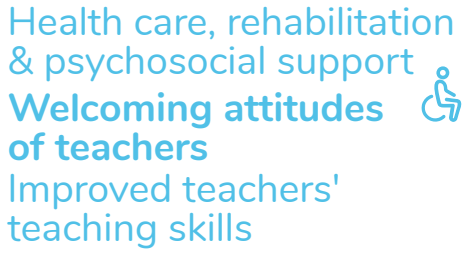
Figure 34: Percentage of Caregivers in Zaatari, Agreeing on Different Solutions to Ensure Children Continue Attending School, by Disability

(N=123 for children with disabilities and N=262 for children without disabilities)

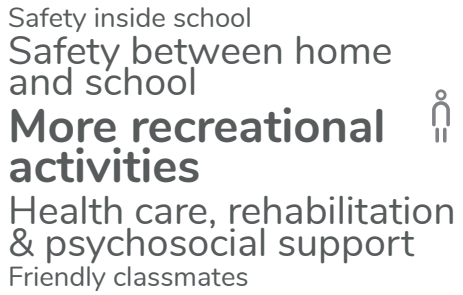


For out of school children to (re-)enrol

Among caregivers of children with disabilities, 83.3% reported that training for teachers to welcome and help every child and to conduct more effective personalized teaching, as well as the provision of appropriate healthcare, rehabilitation and psychosocial support, will encourage them to newly enrol or bring children back to school. Moreover, 79.2% proposed safety inside school, safety between school and home, and friendly classmates. This suggests the need for a comprehensive programming that includes measures at the school level (e.g. teacher training and anti-bullying campaigns) as well as interventions at the community level that create a link between schools and services such as rehabilitation and MHPSS.



The study further finds that caregivers of children without disabilities preferred recreational activities (70.0%) as an encouragement for (re-) enrolment of their children in school – this is favoured by caregivers in camps (Table 38). They also said that they would be motivated if healthcare, rehabilitation and psychosocial support and safety between home and school are ensured (65.0% each). For Irbid, it is important to keep in mind that measures to address households' financial conditions would be needed.



It is understandable that caregivers of children with and without disabilities frequently mentioned factors inside schools although their children are not currently enrolled, because some of them have previous experiences (especially those who have children who dropped-out) and they also hear stories about schools from relatives and families. It is therefore important to ensure quality and safe learning experiences for those currently attending school, so that the positive impact of this will, through community networks, eventually reach caregivers who do not send their children to school.

Table 38: Top Three Proposed Priority Solutions for Children Out of School to Access Education, by Location and Disability

	Azraq	Irbid	Zaatari
Children with disabilities	(total sample =4) All below were agreed by 3 respondents each • Health care, rehabilitation & psychosocial support • Community awareness raising • Safety between home and school • Safety inside school • Friendly classmates • Improved teachers' attitudes • Support or shadow-teachers	(total sample =6) All respondents agreed with all solution ideas	(total sample=14) • Improved teachers' teaching skills (N=12) • Health care, rehabilitation & psychosocial support (N=11) • Improved teachers' attitudes (N=11)
Children without disabilities	(total sample =41) • More recreational activities (N=31) • Safety inside school (N=31) • Safety between home and school (N=30)	(total sample =24) • Improved household financial situation (N=17) • Health care, rehabilitation & psychosocial support (N=15) • Safety between home and school (N=12)	(total sample=15) • More recreational activities (N=14) • Improved teachers' attitudes (N=13) • Improved teachers' teaching skills (N=12) • Learning materials and assistive devices (N=12)

Indeed, teachers' capacity-building is critical to improve the quality of education, not only for children with disabilities but also for other children in mainstream classrooms. Having disability prevalence among the surveyed children aged 6-12 at 17.3%, it is not logical to set-up special rooms for all concerned children. One special teacher in Zaatari camp suggested: *"teachers need training on how to support children with different disabilities, different methods, how to make an appropriate environment for children with disabilities [and] inclusive education."* It is important to highlight that increasing all teachers' capacity on inclusion and inclusive education pedagogy (such as positive encouragements and discipline for all) will not only help better learning for every child with different learning needs but will also address corporal punishment as found by the study that made children reluctant to go to school.

Teacher training also needs to address the key study finding of the high prevalence of issues around mental wellbeing among children. A female assistant teacher (Syrian) in Zaatari pointed out: *"teachers should receive trainings to support children with mental health issues."*

Furthermore, schools need to take an active role to reach-out and talk to parents who have children out of school, as suggested by a 12 year boy with no disabilities in Zaatari : *[Children are not coming to school because] the mother and father do not want them to go to school. The teacher should go to the children's house and talk to their father and mother. The teacher should tell the parents that the child would like school and want to learn."* An interviewee in Azraq (a team leader, INGO) also suggested the community wide solution: *"If people with disabilities play and make friends without disabilities, the inclusion process can be enhanced."*

The study findings also suggest that it is important to take the impact of disability at the household level into careful consideration and provide the comprehensive family support. For example, our data suggested a number of children as well as adult members of the family have issues with anxiety, depression and fatigue. One of the KII participants rightly proposed that: *"it is necessary to support parents who have children with disabilities by providing psychosocial support and cash [so that they can] support their children"* (an education officer, INGO in Irbid). Furthermore, one 11 year old boy in Azraq, who has difficulties remembering, seeing and anxiety, highlighted a critical issue of child labour which requires a holistic family approach: *"there is a boy who doesn't want to go to school because he works to help his father."* Another issue emerged from FGDs and required solutions were about domestic violence. When asked his feeling by choosing a picture of different facial expressions, a 10 year old boy in Zaatari said: *"this is the feeling – sad- because my father hit me."*

During FGDs in camps, children were also active in proposing several solutions. Some were related to what adults should do (e.g. teachers' improved discipline) but they also suggested what children themselves can do.

"The teacher should not hit children. When they stop hitting children they will go to school".

A 10 year old boy with disabilities seeing, Azraq

"If a boy cannot write, his father should teach him at home so that he can go to school. My father teaches me at home".

A 6 year old boy without disabilities, Azraq

"We should give the children a pencil and a notebook to help them write and learn".

A girl with no disabilities, 9 years old, Azraq

"We should go to the children's homes and convince the parents to let them go to school".

A boy, 9 year old who has anxiety, Zaatari

We should talk to the parents of the children who don't like school".

A 9 year old girl without disabilities, Azraq

Caregivers' Perceptions on Inclusive Education

Finally, the study examined the perceptions of caregivers (N=1,159) on inclusive education by asking a series of statements to specify the extent to which they agree, disagree or are neutral about the statement.

In general, the vast majority of caregivers agreed that all children had the right to education and could learn (95.4%, Statement 1) and that education was important for future prospects (95.3%, Statement 2). However, a sizable number of caregivers (17.8% and 17.0%) agreed to compromise children's education for child marriage and child labour (Statement 3 & 4). Furthermore, caregivers showed relatively low expectations for children's academic progress (for Statement 6: 34.7% agreed vs 45.4% disagreed). Belief in education is high but nevertheless is fragile, and could be easily affected by extremely difficult living conditions.

Whilst 83.7% of caregivers agreed to assist with the learning of their child at home (Statement 5), it emerged through correlation analysis that caregivers with disabilities were less likely to assist with the learning of their child at home than caregivers without disabilities ($P<0.05$). This suggests that children who have a caregiver with disabilities would receive less support and help with homework at home, which might make them more vulnerable to school drop-out, and so more in need of learning support services. This highlights again the importance of understanding the impact of household-level disabilities in terms of children's educational status and outcomes.

95% of caregivers believe in the importance of education for every child.

However, around 30% have low expectations for children's academic progress.

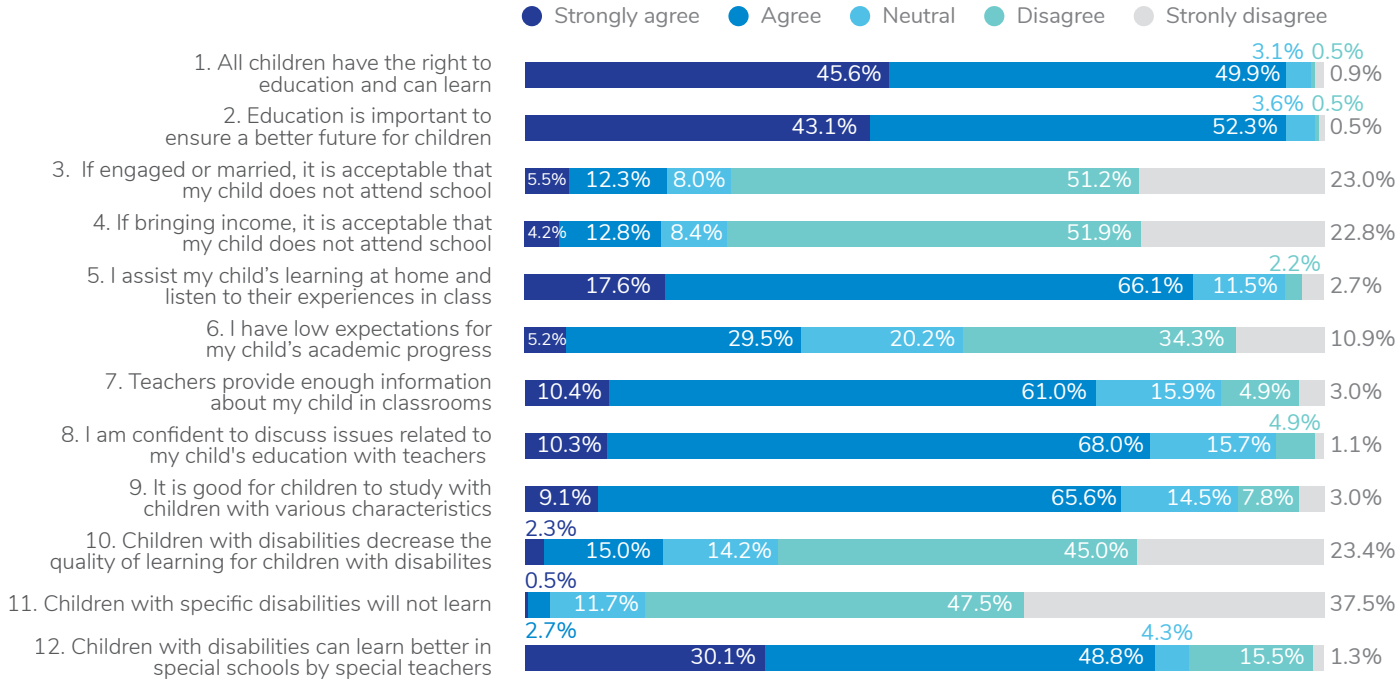
Caregivers' perceptions on teachers are mostly favourable. The majority of caregivers (71.4%) agreed with Statement 7 on teachers' information-sharing about how their children were doing in classrooms. Furthermore, 78.3% felt confident to discuss issues related to their child's education with the teachers (Statement 8).

With regards to inclusion, caregivers expressed a range of different opinions. On the one hand, they expressed an overall positive feeling about children's interaction with peers from different backgrounds (Statement 9, 74.7%). They also believed in children with disabilities' abilities to learn (Statement 11, 85.1%). On the other hand, 17.3% of caregivers agreed that children with disabilities negatively affect the learning of children without disabilities in the same classroom (Statement 10). Further, without knowing the reality of special schools (see discussion above), a high proportion of caregivers (78.9%) believed that children with disabilities could learn better in special schools with special teachers. These caregivers' awareness could be a factor leading to the exclusion of children with disabilities from mainstream schools and learning spaces. Similarly to teachers, this finding highlights a lack of awareness about the positive effects of inclusive education, and a lack of experience of a truly inclusive school.

The study found another correlation that caregivers with disabilities were more likely to disagree that it is acceptable for their child not to attend school if the child contributes to the household income ($P<0.05$). This may reflect the greater emphasis ascribed to ensuring children can have an education, which caregivers with disabilities may have been deprived of themselves.

Except two correlations noted above, the study found no significant correlation between caregivers' perceptions and their disabilities or their children's disabilities.

Figure 35: Caregivers' Perceptions on Inclusive Education (N=1159*)



* Sample of Irbid is 445. However, due to an error in Kobo, Irbid' sample is 196 only for Statement 12.

As said, 85.1% of caregivers disagreed or strongly disagreed with Statement 11 children with specific disabilities will not learn. On the other hand, 37 caregivers (3%) strongly agreed or agreed with the statement. The study further asked these caregivers with what types of impairments they thought children won't learn and they expressed that children with intellectual disabilities (48.6%) and psychosocial disabilities (29.7%) would not learn, compared to lower percentages for hearing, physical and visual disabilities (13.5%, 13.5% and 10.8% respectively). This perception echoes the opinions of principals and teachers identified during the interviews. One Jordanian teacher in a special school in Irbid said:

Some persons with disabilities such as visual disability can be included in normal schools because the child does not have big problems receiving information and making friends... he/she can be accepted [by] other children without disabilities. [However,] it is very difficult for children with intellectual disabilities to be included in normal* schools because that will have negative academic and social effects on [...] their peers without disabilities.*

* Transcribed exactly as mentioned by the interviewee

Section 3: Findings

As such, the study found a shared opinion emerging from several interviewees which categorizes children with disabilities by types of their impairments and limits their opportunities for inclusion: children with physical, visual and hearing impairments can be accepted, possibly also children with mild intellectual impairments, but children with severe intellectual disabilities cannot. Global studies and practices have been proving various inclusive educational approaches that ensure learning for children with severe impairments in least restricted environments. Awareness and experiences on truly inclusive schools was limited in the study sample.

In addition to the 12 statements above, the study also asked if the caregivers would prioritize any of their children to receive education when needed. Among 1,159 caregivers, the vast majority disagreed to make such a choice, indicating their wish to ensure an education for all their children, while 22 admitted that they would. When asked criteria, these caregivers mentioned; equal response for girls and boys (11 each); 13 chose young children over old ones; and 14 said children with disabilities over 8 who would chose children without disabilities.

A girl in North Jordan. © HI/S.Hughes, 2013

SECTION 4: CONCLUSIONS AND RECOMMENDATIONS

The study explored the prevalence of disability among Syrian refugees in Irbid, as well as Azraq and Zaatari camps, and provided a number of insights into the level of access to different services that are crucial for their lives, associated barriers as well as required solutions, with statistical data disaggregated by disability. The findings highlighted a number of aspects to be taken into consideration by the humanitarian and development stakeholders in the protracted Syrian crisis.

1. **Understand disability from a human rights perspective and plan inclusion from the onset of all programmes**

   The study applied the rights-based model of disability by using the WG tools to identify persons with disabilities regardless of their impairments. People with disabilities identified were people at risk of not participating in society (including humanitarian action). Using this rights-based understanding of disability, the study found that 22.9% of Syrian refugees have disabilities, which is much higher than the 2-3% prevalence from existing surveys that used the medical approach to disability, and the WHO's global estimate of 15% (WHO, 2011). Furthermore, 62% of households have at least one family member with disabilities. These findings indicate that, without an inclusive perspective from the very beginning and throughout all stages of actions, support programs will not be able to address the specific needs of the larger number of individuals as well as households who have members with disabilities than the current assumption.

2. **Build the capacity of stakeholders and collect disability data using the relevant Washington Group Questions for the context**

   Review of the existing knowledge suggested that, in spite of efforts of various humanitarian actors to collect disability data, the methods and applications greatly varied, which made it very hard to compare the results and establish a comprehensive assessment of the actual situation. This study used the WG ES and CFM and found a two-fold usefulness. First, persons in this particular humanitarian context experience mental health and psychosocial issues such as anxiety and depression, which can be identified by these tools (note that these domains are not covered by the WG Short Set). Second, children experience difficulties with daily activities in different manners than adults who can be identified by CFM (again, the WG Short Set is not designed for children). It is necessary for humanitarian actors to discuss the application of the WG ES and CFM instead of the WG Short Set, taking into consideration the operational feasibility.

   It is also important to stress that, while the WG tools help the identification of persons with disabilities, an assessment of the barriers of the specific contexts requires additional questions to be asked. As done by this study, a barrier analysis and qualitative survey could be combined with the WG tools to help directly link the results of the survey with the designing of inclusive interventions.

   This being said, building the capacity of humanitarian actors on disability, inclusion and disability data collection is crucial. Application of the WG tools as the standardized disability identification tools as well as proper reporting and data-sharing will greatly contribute to the collection and analysis of comparable disability data by different humanitarian actors at a larger scale towards coordinated inclusive programming.

3. **Enhance efforts to consult persons with disabilities, in order to understand their views and provide more tailored services**

   The study found that households with disabilities were not more disadvantaged than their peers without disabilities to access certain services such as shelter, water and food assistance, probably due to efforts by humanitarian actors to target vulnerable families. Still, more work needs to be done to improve the quality of services to address issues that affect all such as accessibility of housing. On the other hand, the study revealed that households and persons with disabilities face more difficulties to access water, health services, specialized services, work and education, than their peers without disabilities. Quite often, they stated unavailability and costs of services as barriers to access, despite the presence of free services, due to lack of documentation, limited knowledge about available services and associated costs such as transportation. Other obstacles they complained about include inflexible services that do not meet their specific needs and unsupportive staff, and they proposed more tailored services. Humanitarian actors are required to improve the ways they work to be more inclusive,

in order to ensure the equitable access to services for persons with disabilities. This requires a better understanding of perceptions and experiences of persons with disabilities. Direct consultations with the concerned people will be useful.

4. **Break fear towards disability, move away from reliance on "disability specialists" and promote disability mainstreaming**
During the consultations and interviews, a number of stakeholders showed genuine interest in inclusion. This is very positive. At the same time, the study found a common feeling that they were not confident to take actions and required specialists to intervene. There were also opinions about inclusion depending on the types of disabilities. While it is true that specialized organizations are needed for specific services, mainstreaming is required for wider inclusion.

The following more specific recommendations address different actors in humanitarian contexts to strengthen inclusive actions. These recommendations incorporate the study findings as well as the outcomes of the workshop organized by the study team on May 7, 2018 in Amman, during which various stakeholders reviewed the study findings and discussed actions to be taken by humanitarian actors.

Service providers[25]

Project design

- Collect **disability data and disaggregate various data by disability** using the WG tools, alongside gender, age and location, in order to capture a fuller picture of the situation and vulnerabilities of persons and households with disabilities in the underserved areas, and inform the project design. Build on the existing data without reinventing the wheel.
- (Through data collection) **Identify people and households with disabilities to participate** in the project.
  - Introduce common definitions and systems for the registration of people with disabilities using the WG questions (e.g. UNHCR registration)
- **Establish partnerships with local CBOs and disability actors** (e.g. DPOs, specialized NGOs). Conduct home visits and participatory and inclusive focus group discussions. This will contribute to:
  - **Gain a deeper understanding about the specific needs of identified persons and households with disabilities** as a whole at this early stage of the project cycle. Concerning education, conduct friendly and accessible consultations with children to listen to their views and opinions.
  - Enhance the ownership and sustainability of the projects.
- **Use evidence-base and design projects with a clear inclusion plan**: for example, children with disabilities for inclusive education, order people for literacy classes, females with disabilities in relation to livelihoods/work. Link proposal writers with field staff in order to ensure that needs are effectively translated into project proposals.
- **Budget for inclusion**: based on the existing and/or newly collected data, allocate specific budget lines dedicated to address key barriers and promote inclusion. For example, the study findings suggest the needs to address the **costs of services** (e.g. specific health services that are not available in the camps), **transportation costs** to reach services (especially in the host community setting) and the **costs for maintenance of assistive devices**. Explore subsidies for specialized services which are often not affordable for refugee households. Also budget costs for **accessible services** in terms of **accessible facilities** (e.g. shelters and latrines), **accessible information** dissemination, and **awareness-raising and training for staff**

[25] An umbrella term referring to organisations operating to provide services for Syrian refugees in Jordan. This could include UN agencies, international and local NGOs, CBOs, DPOs and local public and private entities

Project implementation

- Continue the established partnerships with CBOs and disability actors (DPOs, NGOs) to support existing services to be inclusive, and raise the awareness of community members and family members about inclusion and available services.
- **Ensure children and youth's access quality MHPSS services** either through support to access existing services (referral, financial support, etc.) or through ad-hoc programming aimed at filling the gaps of the existing MHPSS systems of services (enhance the coverage among age groups, geographical coverage and quality through capacity-building and financial support or through direct provision if necessary). Enhance coordination and exchange of expertise between actors specialized in MHPSS and in disability/inclusion.
- Engage persons with disabilities as '**role models**' in order to motivate and inspire other persons with disabilities. Hiring persons with disabilities within staff teams will also ensure service providers 'walk the talk' of inclusion.
- **Strengthen coordination** between different stakeholders to respond to gaps in inclusiveness of service provision. Ensure data and information sharing between different sectors, services and levels (e.g. staff in the main office in the capital and staff in the field) for smoother referrals.
- Move away from a focus on impairments of persons with disabilities as a homogeneous group, to a focus on the **abilities and skills of each individual**. For example, schools and employers should not screen-out persons with disabilities depending on their types of disabilities.
- Develop **practical guidelines** around how to support persons with disabilities, keeping in mind that there are a number of existing tools.
- Conduct a full **mapping of available services** *(particularly in relation to cash assistance services and specialized services)*, translate into fully accessible user-friendly formats and disseminate the information, targeting households who have persons with disabilities.
- Pilot the inclusion approach while critically examining and recording whether the project is effectively addressing vulnerable populations' needs. Use results as a rationale for further funding from donors.

Capacity building of staff

(throughout the project cycle)

- Conduct awareness sessions and training for frontline staff around disability; e.g. **data collection using the WG tools and data analysis; MHPSS**; and **communication skills** with persons with disabilities and their family members.
- Within education programming in particular:
  - Build the capacity of teachers and school principals on **inclusive education and pedagogy** with a strong focus on **positive discipline** that addresses corporal punishments and verbal abuse as well as **MHPSS** for children and youth.
  - Train school principals to plan and organize **outreach for out-of-school children**, in partnerships with CBOs/DPOs and community members. In order to address specific family needs, utilize the referrals to different services. Pay particular attention to boys with disabilities who are most educationally excluded.
  - Conduct activities to promote **social cohesion** in order to bring together children with disabilities and their peers without disabilities (e.g. inclusive recreational activities, anti-bullying campaigns), not only at school but also at the community level.

Advocacy

- Advocate to relevant public institutions, humanitarian organizations and donors to **modify the built environment** including public transportation, infrastructures and schools, as well as methods of communication, in order to ensure equitable access to services and information.
- Advocate to the government to further **reduce the costs especially of health services**.
- Advocate and collaborate with the MOE and education sector actors to promote inclusive education through actions such as;
  - Developing and implementing an **inclusive education policy, national strategy** and/or action plans.
  - Developing and implementing the **teacher training curriculum** on inclusive education, including a psychosocial support component.
  - Increasing the **ear marked budget** given for children with disabilities' education.
  - Improving **schools' accessibility**.
  - Developing **accessible learning materials/aids**.

Communities

- Conduct **awareness sessions and outreach** to ensure that community members are aware of key services offered by service providers and no persons with and without disabilities are excluded from access to required services. Utilize strong and active community leaders/members (with disabilities) to promote inclusion within the community.
- Create/ join established **community networks** linked with DPOs, engage with service providers and any other relevant stakeholders in community meetings, identify specific barriers facing persons with and without disabilities and remove identified barriers.
- Pioneer community-based initiatives to support **inclusive practices**; for example, accompanying children with and without disabilities to and from school to ensure children will not face safety issues (e.g. traffic, harassment).

Donors

- In the calls for proposals, set the requirements for applicants for d**isability inclusive project design**. Specifically, request for partners to include disability disaggregated data and analysis within needs assessments.
- Add a 'weighting' for disability inclusion while screening the proposals, in order to support funding decisions based on inclusiveness.
- Promote **inclusive budgeting** – e.g. whatever the sectoral focus of the project, allocate 5% of the total project budget to inclusion such as improving accessibility of services, staff's capacity-building and communities' awareness-raising towards disability inclusion. Partners then have the dedicated funding to ensure inclusion activities are implemented. In particular, allow funding for **cash for transportation** or enable the provision of direct transportation within budget lines.
- Provide **funding for research and rigorous needs assessments** in which persons and households with disabilities are fully engaged and consulted. This ensures funding is invested based on real needs. Also allow partners to **pilot, and scale-up or change the direction of their inclusion approach** based on the pilot results, to better meet the needs of persons with disabilities.
- Adjust the **flexibility of funding**: e.g. shift the budgets from the one-time distribution of assistive devices towards the **maintenance and repair of assistive devices**.

- Prioritize **multi-year funding** where possible in order to ensure a longer term, more sustainable approach to supporting persons with disabilities. This is based on the observation that many projects have a short term funding and consequently result in regular 'breaks' in service, preventing the continuity of access.
- In addition to mainstreaming disability into all projects, provide specific funds and support for **MHPSS, inclusive employment and inclusive education**.

Governments and local authorities

- **Ensure inclusive actions in national plans for response and resilience** through consultations with persons with disabilities.
- **Earmark budgets to support persons with disabilities** to access various services.
- Ministry of Education to:
  - Scale-up **teacher training** programs, develop and roll-out guidelines on **inclusive education pedagogy** on how to differentiate the curriculum for children with disabilities to ensure that all children can learn to the best of their abilities.
  - Ensure the availability of **accessible and inclusive learning materials**.
  - Provide **infrastructure according to universal design principles** within schools so that children with disabilities can enjoy full and equal access. In practical terms, this means a full appraisal of schools to assess the gaps in accessibility and the formation of development plans to address these gaps.

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ANNEXES

Annex 1: Household Sampling Methodology

1. Sample size calculation assuming a simple random sample survey

The formula for calculating the sample size is (Unicef 2006):

$$n_{h1} = \frac{(z_{\alpha/2})^2 P(1-P)k}{e^2 r\hat{\eta}}$$

- n_h is the parameter to be calculated and is the sample size in terms of number of households per unit;
- $Z_{(\alpha/2)}$ is the statistic that defines the level of confidence desired, for 95% confidence interval the z-statistic to use should be 1.96;
- P is an estimate of a key indicator to be measured by the survey, is our "prior guess" of the true prevalence (.224) based on;
- r is the proportion of the total population upon which the indicator, P, is based. In this survey 15% is used.
- e is the margin of error to be attained at unit level. In this survey 5% of marginal error is used.
- $\hat{\eta}$ is the average household size (6 persons per household);
- k is an adjustment for potential loss of sample households due to non-response, if non adjustment is necessary $k=1$. In this survey 10% non-response rate is used.

$$n_{h1} = \frac{(1.96)^2 (0.224)(1-0.224) (1.1)}{(0.05)^2 (0.15)(6)} \approx 327 \quad \textit{Households/unit of Analysis}$$

2. Design effect correction to sample size calculation, due to cluster sample survey design

The design effect (*DEFF*), is an adjustment that should be used to determine survey sample size. This value is defined basically as the ratio of the actual variance, under the sampling method actually used, to the variance computed under the assumption of simple random sampling (Kalton, 1979; Henry, 1990; Frongillo, 1996; US Census Bureau, 2001)

ρ is the intra class correlation coefficient (ICC), the value

$$DEFF = [1 + (m-1)\,\rho]$$

of ρ is near zero for many variables and frequently inversely related to the size of the PSU because larger clusters tend to be more diverse. The design effect it has been suggested in many surveys at household level to consider at 1.5, according to accepted estimates from other surveys in the country. This gives us less sample at unit of analysis level as per below:

$$n_{h2} = (327)\,(1.5) \approx 491$$

Households/unit of Analysis

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Annex 2: Questionnaire

Arabic version available upon request

Enumerators												
Enumerator 1 (name and surname):	Mobile											
Enumerator 2 (name and surname):	Mobile											
Date of Visit:												
Time of Visit:		Start								End		
Household information:												
Address GPS data		Longitude						Latitude				
Address		Governorate District										

Introduction & Consent

Hello, my name is (name 1) and next to me is my colleague (name 2). We are from Handicap International[26] and we are working to improve lives of vulnerable populations. We are now conducting a survey to understand your and your family members' situation, functional difficulties, and difficulties you may have faced in accessing services in general and inclusive education for children in particular. Understanding factors that affect access to essential services for you and other Syrian refugees will help us improve the ways we deliver services. Your household is randomly selected for this interview with Syrian refugees in (location name).

Do you understand the objective of this survey?
☐ YES
☐ NO (If NO clarify the above again).

The interview will take about one hour and a half. Because there are questions about your child(ren), it would be good to ask all questions to their mother or the child(ren)'s primary caregiver (do not read this note: caregiver in case a mother is deceased or not living with children), except for one set of questions for adults who are 18 years old or above.

All the information we obtain will remain strictly confidential and be kept by HI and its partner iMMAP only. Reports will be presented completely anonymously and will not include information such as names, ages and addresses.

Participation is voluntary and you are free to refuse to participate. When you agree to participate, you may stop at any time or skip any questions that you don't wish to answer.

There is no direct benefit, money or compensation provided to you for participating in this survey. When your family member has specific issues, I am not able to assess or diagnose the situation. But if you are interested, I will provide you with the information about some services we will talk about.

Do you understand the consent and confidentiality?
☐ YES
☐ NO (If NO clarify the above again).

Do you agree to participate in the interview?
☐ YES Thank you for agreeing to participate (go to the questions below).
☐ NO (If NO, stop the interview. Thank the person).

[26] At the time of data collection. Humanity & Inclusion becomes new name of Handicap International on January 24, 2018

Household data

Name of mother/caregiver

Contact information

Telephone(s):
Alternative phone(s):

UNHCR registration

☐ YES
☐ NO

ACCESS TO BASIC SERVICES

Now, I will ask you about your household's conditions and access to basic services.

Housing

- Does your family have a shelter or house? Yes / No
- Does the house have stable electricity? Yes / No
- Is it easy to move around the shelter/house? Yes / No
- Do you have any fear of attack or harassment around your shelter/house? Yes / No
- Do you have any fear of getting harmed or injured around your shelter/house? Yes / No

Health

- Did you or another member of your household have any medical need in the last 6 months? Yes/No
- (If yes), were you or any of your family members able to access medical services at hospitals/clinics? Yes/No
- If no, why? If No Go to reasons and enabling factors

Safe water

Does your family have enough safe water from reliable sources for drinking, cooking, cleaning and personal hygiene? If no, why?

Yes

No
Go to reasons and enabling factors*

Latrine

- Is the latrine you use accessible to all of your family members? (for Irbid, ask only this)
- Is the latrine available anytime during the day, evening and night? Yes / No
- Do you have any fear of attack or harassment when using/ going to use the latrine?
- Do you have any fear of getting harmed or injured when going to use the latrine?

Food assistance

Does your family have World Food Programme food e-vouchers? If no, why?

Yes

No
Go to reasons and enabling factors*

Cash assistance

Does your family receive any cash assistance or grant (e.g. UNHCR visa card)? If no, why?

Yes

No
Go to reasons and enabling factors*

Household Income size

What is your household total cash income in the past month?

Jordan	Lebanon
700JOD – above	700.000 LBP – above
500 – 699JOD	450.000 – 699.000 LBP
300 – 499JOD	300.000 -449.000 LBP
200 – 299JOD	150.000- 299.000 LBP
100 – 199JOD	75.000- 149.000 LBP
50-99JOD	0-74.000 LBP
0-49JOD	

Household debt

What is your total amount of debt accumulated since your arrival to Jordan/ Lebanon up to now?

REASONS FOR NOT ACCESSING SERVICES

If NOT able to access any services listed above, WHY? Main reasons (multiple answers) READ LIST

- ☐ I do not know where the service or support is available or who can help
- ☐ I got some information but could not read or understand
- ☐ I do not have documents to access services (eg UNHCR card, visa, ID)
- ☐ Safety fears for movement outside home (attack, harassment, arrest)
- ☐ Safety fears for movement outside home (harm, injuries)
- ☐ Services are not available
- ☐ Services are too expensive
- ☐ Services are far away and transportation is not available
- ☐ Services are far away and transportation is too expensive
- ☐ Services are far away and transportation is not accessible (e.g. does not have a lift, handrail)
- ☐ Services are delivered in places that are not accessible (e.g. does not have a ramp, wide door)
- ☐ Services are delivered in places that are not gender sensitive (not comfortable for women or men)
- ☐ Staff are not supportive and/or do not know how to communicate with me/my family
- ☐ Services do not meet my/my family's specific needs
- ☐ Other (specify)

ENABLING FACTORS TO FACILITATE ACCESS TO SERVICES

Among the reasons mentioned, what will be the most important issue which, if solved, will help you access services? (specify one reason)

Individual data

Now I will ask about each of your family members and their status

Name	Age	Work	Education
What is the name of your family member and their relationship?	How old is (name)?	Has (name) worked in the past 7 days to bring an income to your household, with or with-out a work permit (Jordan) / a legal residency permit (Lebanon)? (ONLY for those 5+)	What is the highest level of education (name) attended (or is currently attending)? (ONLY for those 13 +) For persons aged 6-12 years old, refer to separate Qs
1.			
2.			
....			

FUNCTIONAL DIFFICULTIES

Now, I am going to ask you additional questions about your ability to do different activities, and how you have been feeling.

Note: Review individuals' name and age, and use the Washington Group (WG) Children Functioning Module (CF-M) 2-4 for children aged 2-4; the CF-M 5-17 for children aged 5-17, and the WG Extended Set of Functioning (ES) Light set for adults aged 18+. Results will be recorded for each individual.

ACCESS TO SPECIALIZED SERVICES

Only for individuals who responded "a lot of difficulty" or "cannot do at all," and other cut-off conditions for at least one domain of WG questions (WF-ES, CFM 2-4 & 5-17)

What is the cause of (name)'s functional difficulties? (Select one)

☐ From birth ☐ Injury ☐ Illness or disease ☐ Ageing ☐ Malnutrition ☐ Others (specify) ☐ Do not know

In case of Injury, Illness or disease, or Malnutrition, ask:

Is this condition due to Syria crisis related incidents since 2011?

☐Yes ☐No ☐ Do not know ☐Refuse to answer

Is [name] able to access the specialized services needed? What are those services? (Select as many as appropriate).

YES	☐ Prosthetics and Orthotics ☐ Assistive Devices (cane, walking stick, walker, crutches, wheelchair, hearing aids…) ☐ Physiotherapy, occupational therapy, speech therapy, ☐ Accessible information (sign language, Braille texts, large print) ☐ Mental health and psychosocial support (e.g psychotherapy, counselling) ☐ Support to employment: (e.g accessible career guidance, employability skill training) ☐ Support to education : (e.g trained (para) teacher, modified learning materials ☐ Others .
NO	

Reasons for not accessing services (answer category: same as * above)
If NO, WHY is it difficult to access the given services? Main reasons (multiple answers) READ LIST.

Enabling factors to facilitate access to services
Among those the reasons above mentioned as problems, what will be the major issue to be prioritized, and help you access services? (specify one reason)

ACCESS TO EDUCATION (for children 6-12 years old, with & without FUNCTIONAL DIFFICULTIES)

Now, I would like to ask you about (NAME)'s educational status.

Your children's education status (per child)

Name	Gender	Age	Status	This is an instruction directed at HI enumerators: do NOT read aloud If currently attending or enrolled in school before
	☐ M ☐ F		☐ Attending partially 1-3 times/week ☐ Attending regularly 4-5 times/week ☐ Never enrolled ☐ Enrolled but dropped out (at age of _____) , in grade ___)	Type of school ☐ Public (government) ☐ Private Type of education ☐ Formal education - Ministry of Education (MOE) certificate obtained a. Regular school b. Double shifted school – morning shift c. Double shifted school – afternoon shift ☐ Non-Formal education (catch up) - MOE certificate obtained ☐ Informal education (delivered by Community-Based Organizations [CBOs], educational activities) - NO MOE certificate ☐ Specialized (special needs) a. special unit in mainstream school (resource room) (select the type of school to which the special unit belongs) ☐ Formal education - MOE certificate obtained a. Regular school b. Double shifted school – morning shift c. Double shifted school – afternoon shift ☐ Non-Formal education (catch up) - MOE certificate ☐ Informal education (delivered by Community-Based Organizations [CBOs], educational activities), NO MOE certificate b. Special schools If attending → go to 1, 2 & 4 If not → go to 3 & 4

1. (For a child **attending** school/learning spaces) What does (name of the child) tell you that (name of the child) likes most about the school/learning space?
Per Child: READ LIST. Select/record as many as mentioned.

☐ To play with other children (socialization)
☐ To participate in recreational activities such as sports, games, singing and dancing, music.... (socialization)
☐ To study new topics (learning, topic)
☐ To learn skills such as how to read and write, or do calculations (learning, skill related)
☐ To talk to teachers (interaction)
☐ To go to a new environment and have a change from home (home related reasons)
☐ Others (specify)

2. (For a child attending school/learning spaces) What are your concerns about (name of the child)'s learning and experience at school/learning space? Per child. READ LIST. Select/record as many as mentioned.
→ Among identified, what are the 3 major issues? Please select.

- ☐ Child's psychological distress which significantly affects his/her ability to learn
- ☐ Child's health condition reduce attendance or ability to learn or participate in learning
- ☐ Child's functional difficulties affects his/her learning
- ☐ Financial constraints (fees, transport, materials)
- ☐ Distance to school (>2km) / Safety fears for movement outside home
- ☐ Overcrowded classrooms / Inaccessible classrooms / Inaccessible toilets / Toilets not clean and safe
- ☐ Physical and/or verbal abuse from teachers/staff / Teacher/staff do not care about my child
- ☐ Bullying, nicknaming, intimidation and violence from children from host communities
- ☐ Bullying, nicknaming, intimidation and violence from children from the refugee community (Syrian peers)
- ☐ Not learning or progressing due to:
  - ☐ Poor quality of teaching
  - ☐ Lack of personalized support for my child's learning (e.g. support teacher, sign language interpreter)
  - ☐ Poor quality of learning materials
  - ☐ Lack of accessible learning materials
  - ☐ Limited learning time at school/learning spaces
- ☐ School time not appropriate
- ☐ Not applicable (no difficulties)
- ☐ Other (specify)

3. If your child was **never enrolled in or dropped out of school**, what are the reasons? Per child. READ LIST. Select/record as many as mentioned.
→ Among the reasons identified, what are the 3 major issues? Please select.

- ☐ Child marriage/engagement (if this is mentioned, specify at which age _____)
- ☐ Education is not important (cultural, not useful)
- ☐ Missed 3 or more years of education
- ☐ Fears for non-completion of primary education or non-continuation to secondary/further education with valid certificate, despite investment
- ☐ Lack of documentation (ID/school records/UNHCR Card, visa etc)
- ☐ Refused entry (general) / Refused entry due to functional difficulties
- ☐ Fears of community stigma (for child and family)due to enrolling a child with functional difficulties in school
- ☐ Helping with house chores / Helping with economic activities for the household

(THE LIST CONTINUES: THE SAME ANSWER CHOISES UNDER 2 ABOVE)

4. What will encourage you to send/ send again/ continue sending your child to school? READ LIST and answer 'yes', 'no' or 'do not know' to each.

☐ My child gets appropriate health care/ rehabilitation/ psychosocial support	Yes / No / Do not know
☐ Household financial situation improves	Yes / No / Do not know
☐ School admission criteria changed and my child is encouraged to enrol/ re-enrol	Yes / No / Do not know
☐ Community awareness raising sessions undertaken to sensitize people to the idea of children with disabili-ties being in school	Yes / No / Do not know
☐ Safety mechanisms put in place from home to school/ learning space	Yes / No / Do not know
☐ Safety mechanisms put in place inside school/ learning space	Yes / No / Do not know
☐ Nearby school/ learning spaces become accessible	Yes / No / Do not know
☐ Other students are encouraged to be friendly	Yes / No / Do not know
☐ Teachers are trained to welcome and help every child	Yes / No / Do not know
☐ Teachers are trained to teach more effectively every individual child	Yes / No / Do not know
☐ Learning materials or aids OR assistive devices (e.g mobility aids) are available	Yes / No / Do not know
☐ More recreational activities	Yes / No / Do not know
☐ Find another school/ other learning spaces	Yes / No / Do not know
☐ Find special school/ learning space with special needs education teachers	Yes / No / Do not know
☐ Education, social or other authorities contact me in person for orientation/ orientation visits with children	Yes / No / Do not know
☐ Support or shadow-teachers are assigned	Yes / No / Do not know
☐ Latrines become accessible, clean and safe	Yes / No / Do not know
☐ Smaller class size	Yes / No / Do not know
☐ Other (specify)	

I will read some statements about education. Please tell me to what extent you agree with the statements. There is no right or wrong answer.

Awareness about inclusive education as a principle and in reality

1. All children have the right to education and all children can learn	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
2. Education is important to ensure a better future for children	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
3. If I have to choose, I prioritize among my children who will access ed-ucation according to gender, disability and age	No	Yes boy or girl	Yes With disabilities or without	Yes Order or younger	
4. If my child(ren) are engaged or married, it is acceptable that s/he does not attend school/learning spaces	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
5. If my child(ren) are contributing to income of the household, it is ac-ceptable that s/he does not attend school/learning spaces	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
6. I assist my child(ren)'s learning at home and listen to what they expe-rience in classrooms	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
7. I have low expectations for my child(ren)'s academic progress	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
8. Teachers provide enough information about my child(ren)'s situation in classrooms, curriculum, homework, class activities, exam, etc	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
9. I am confident and comfortable to discuss any issue related to my child(ren)'s education with teachers and/or staff from the school/learning space	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
10. It is good for children to study with children from different back-grounds and with various characteristics	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
11. Children with disabilities in a classroom will decrease the quality of learning for children without disabilities	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
12. Children with specific disabilities will not learn	Strongly disagree	Disagree	Neutral	Agree If agree somehow, which disability? ☐ Intellectual ☐ Psychosocial ☐ Visual ☐ Hearing ☐ Physical ☐ Communication	Strongly agree
13. Children with disabilities can learn better in special schools educated by specially trained teachers	Strongly disagree	Disagree	Neutral	Agree	Strongly agree

Annexes

Thank you so much for your participation in the survey. Do you have any questions?

If you agree, at another time, I am keen to talk to your child about their opinions and experiences about education. Do you agree? (if yes) If so, I will contact you to make an appointment. Confirm the telephone number.

If you are interested, I have information brochures about different services.

Thank you.

END

Annex 3

The 1st, 2nd and 3rd Perceived Barriers Facing Children in School, by Disability (See Figure 28)

for each column for children without disabilities: First, Second, Third

for each column for children with disabilities: First, Second, Third

	Children without disabilities				Children with disabilities			
Barriers	1st	%	2nd	3rd	1st	%	2nd	3rd
Bullying, nicknaming, intimidation & violence from Syrian peers	66	7.9%	89	81	13	6.9%	30	50
Bullying, nicknaming, intimidation & violence from chil-dren from host communities	3	0.4%	9	7	2	1.1%	3	0
Child's functional difficulties affect learning	2	0.2%	5	14	1	0.5%	0	1
Child's health condition reduce attendance or ability to participate learning	87	10.4%	46	24	6	3.2%	5	1
Child's psychological distress which significantly affects their ability to learn	58	6.9%	10	11	9	4.8%	3	1
Distance to school (>2km)	177	21.1%	40	35	38	20.1%	12	7
Financial constraints (fees, transport, materials)	59	7.0%	100	65	7	3.7%	10	14
Inaccessible classrooms	7	0.8%	10	10	0	0.0%	1	0
Inaccessible toilets	19	2.3%	38	43	2	1.1%	8	3
Not learning or progressing due to poor quality of teach-ing	14	1.7%	15	15	3	1.6%	4	7
Not learning or progressing due to poor quality of learn-ing materials	12	1.4%	0	8	0	0.0%	0	0
Not learning or progressing due to inappropriate school time	0	0.0%	0	0	0	0.0%	0	0
Not learning or progressing due to lack of accessible learning materials	1	0.1%	0	1	0	0.0%	0	0
Not learning or progressing due to limited learning time at school/learning spaces	0	0.0%	3	3	0	0.0%	1	0
Not learning or progressing due to lack of personalized support for my child's learning (e.g. support teacher, sign language interpreter)	1	0.1%	15	7	0	0.0%	1	2
Overcrowded classrooms	94	11.2%	107	94	48	25.4%	16	12
Physical and/or verbal abuse from teachers/staff	22	2.6%	17	15	5	2.6%	22	8
Safety fears for movement outside home	96	11.4%	71	49	19	10.1%	8	8
School time not appropriate	11	1.3%	15	24	1	0.5%	1	4
Teacher/staff do not care about my child	24	2.9%	20	31	2	1.1%	11	4
Toilets not clean and safe	8	1.0%	63	78	1	0.5%	3	5
Other*	79	9.4%	87	97	32	16.9%	34	35
Total	840	100%	760	712	189	100%	173	162
Not applicable (no difficulties)	233		313	361	28		44	55
Total sample	1073		1073	1073	217		217	217

* Over 90% of "other" concerns came from Zaatari: see analysis on page 64.

Annexes

The 1st, 2nd and 3rd Perceived Barriers Facing Children Out of School, by Disability (See Figure 29)

for each column for children without disabilities: First, Second, Third

for each column for children with disabilities: First, Second, Third

Barriers	Children without disabilities				Children with disabilities			
	1st	%	2nd	3rd	1st	%	2nd	3rd
Bullying, nicknaming, intimidation & violence from Syr-ian peers	0		1	1	0		0	1
Bullying, nicknaming, intimidation & violence from children from host communities	0		0	0	0		0	1
Child marriage/engagement*	0		0	0	0		0	0
Child's functional difficulties affect learning	1		1	0	5	20.8%	3	4
Child's health condition reduce attendance or ability to participate learning	0		0	0	2		5	2
Child's psychological distress which significantly af-fects their ability to learn	1		1	1	5	20.8%	3	3
Distance to school (>2km)	4		7	2	1		1	1
Education not important*	2		0	0	0		0	0
Fears for non-completion of primary education or non-continuation to secondary/further education with valid cer-tificate, despite investment*	0		0	0	0		0	0
Fears of community stigma due to enrolling a child with disability in school (for child and family)*	0		0	0	0		0	0
Financial constraints (fees, transport, materials)	10	13.0%	2	1	1		0	2
Helping with house chores *	0		0	0	0		0	0
Helping with economic activities for the household *	1		1	1	0		0	0
Inaccessible classrooms	1		0	0	1		0	1
Inaccessible toilets	0		0	0	1		1	1
Lack of documentation *	1		2	1	0		0	0
Missed 3 or more years of education *	1		0	0	0		0	0
Not learning or progressing due to poor quality of teaching	1		0	1	0		0	0
Not learning or progressing due to poor quality of learning materials	0		0	1	0		0	0
Not learning or progressing due to inappropriate school time	0		0	0	1		0	0
Not learning or progressing due to lack of accessible learning materials	0		0	1	0		0	0
Not learning or progression due to limited learning time at school/learning spaces	0		0	0	0		0	0
Not learning or progressing due to lack of personal-ized support for my child's learning (e.g. support teacher, sign language interpreter)	0		0	0	0		0	0
Overcrowded classrooms	7	9.1%	5	6	1		3	0
Physical and/or verbal abuse from teachers/staff	0		1	0	0		0	0
Refused entry (general)*	11	14.3%	12	14	3	12.5%	2	2
Refused entry due to functional difficulties *	1		0	0	2		1	0
Safety fears for movement outside home	0		0	0	0		2	0
School time not appropriate	0		0	0	0		0	0
Teacher/staff do not care about my child	1		2	2	0		0	1
Toilets not clean and safe	0		0	0	0		0	0
Other	34		38	40	1		3	5
Total	77	100%	73	72	24	100%	24	24
Not applicable (no difficulties)	3		7	8	0		0	0
Total sample	80		80	80	24		24	24

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