Including disabled children in psychosocial programmes in areas affected by armed conflict

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Children with disabilities are more vulnerable to violence, as well as more likely to experience psycho-social problems in situations of armed conflict than children with no disabilities. All children who live in conflict affected areas have the same rights to psychosocial support, as enshrined in the Convention on the Rights of the Child (CRC), and in the case of disabled children, additionally the Convention on the Rights of Persons with Disabilities (CRPD). However, children with disabilities are often over looked in psychosocial programmes. In this article, the authors examine the reasons behind this observed exclusion and suggest ways to increase the participation of children with disabilities.

Introduction: disability as a social construct

Various definitions of disability exist. The most commonly used is the International Classification of Functioning, Disability and Health (ICF) (WHO, 200l). This framework not only explains disability as a social construct, but also gives direction for the levels and types of interventions that are needed in order to:

1) Ensure that children with disabilities are included in psychosocial programmes during, or after, conflict situations; and

2) Minimise the stress on the disabled child and his or her relatives.

The ICF describes the impact of a disease, disorder or disaster on an individual in terms of functioning, disability and health (WHO, 2000). The ICF thus uses three levels of disability (the generic term): impairment, activity limitation and restriction in participation. In the context of childhood disability due to war these may be understood as:

- *Impairment* (the signs and symptoms of pathology). A primary impairment may take the form of an amputation as a result of, for example, a landmine blast. Contractures of the hip may be a secondary impairment. The physical impact of the blast or the loss of family members may also have psychological consequences, like depression.
- *Activity Limitation* (is best conceived as observed activity). These are difficulties that an individual may have in executing activities (often as a result of an impairment), such as, personal care, mobility, communication, and behaviour. In the case of a child injured by an explosion, it is the limitation of walking, as a result of amputation of the leg that leads to activity limitation. The psychological impact of this impairment, with the corresponding depression, may result in sadness due to activity limitation.

- *Participation Restriction* (best conceived as social roles and status) are the problems an individual may experience in a life situation, such as: social relationships, education, play and community life. In other words, participation restriction is - often - the social consequence of impairment or activity limitation, and is experienced as social exclusion. In our example of a child with an amputation, who is unable to walk well, he/she may be excluded from play or attending school. The child with depression and resulting sadness may isolate him/herself from playing with other children; or may be scared to go out of his/her home, and as such restricts him/herself in participation in those activities of his/her peers.

The ICF also acknowledges the *contextual factors* to be of immediate importance to the experience of disability. The contextual factors are divided in two areas of influence: the personal factors and the environmental factors. The ICF classification highlights the importance of the contextual factors when considering the consequences of disease, disorder and disaster. Contextual factors can be both positive and negative. Therefore, they can act as both *barriers* and as *facilitators* of rehabilitation interventions, and, as a result, cannot and should not be overlooked. In this article, the authors argue that organisations involved in designing and implementing psychosocial programmes can influence certain contextual factors to accommodate children with disabilities.

The view on integration and rehabilitation of people with disabilities is moving away from a rigid interpretation of the *'medical'* model and moving towards the fundamental construct of disability that has been proposed for many years by disability lobby groups. That construct is termed the *'social'* model of disability. The fundamental difference between these two models is that proponents of the social model suggest that the person's impairment is not the cause of the restriction of activity, but rather it is the way society is organised that discriminates against the disabled community. The proponents of the social model think that, if society would accept and accommodate disabled people, both physically and in societal attitudes, disability as a concept would be made redundant (Barnes, 2005 - listed as 2003 in references).

Rights of children with disabilities

Children with disabilities have the same rights as children with no disabilities, as enshrined in the *UN Convention on the Rights of Children* (article 2):

'States Parties shall respect and ensure the rights set forth in the present Convention to each child within their jurisdiction without discrimination of any kind, irrespective of the child's or his or her parent's or legal guardian's race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status' (CRC, 1989).

The CRC also promotes the right of all children, who have experienced armed conflict, to psychosocial rehabilitation (article 39):

'States Parties shall take all appropriate measures to promote physical and psychological recovery and social reintegration of a child victim of: any form of neglect, exploitation, or abuse; torture or any other form of cruel, inhuman or degrading treatment or punishment; or armed conflicts. Such recovery and reintegration shall take place in an environment which fosters the health,

self-respect and dignity of the child.' (CRC, 1989).

However, disabled children continue to face challenges in realising those rights. In May 2008, the *UN Convention on the Rights of Persons with Disabilities* (CRPD) entered into force. This convention provides a detailed elaboration of the measures needed to realise those rights (Save the children, 2009). Article 11 affirms the right of people with disabilities to be protected in situations of risk, including situations of armed conflict:

'States Parties shall take, in accordance with their obligations under international law, including international humanitarian law and international human rights law, all necessary measures to ensure the protection and safety of persons with disabilities in situations of risk, including situations of armed conflict, humanitarian emergencies and the occurrence of natural disasters.' (CRPD, 2008).

The International Disability and Development Consortium (IDDC) task group on '*Conflict and Emergencies*' have clarified what Article 11 means in practice (IDDC, ~~nd~~). Three of these recommendations are listed below:

- *Persons with disabilities and children with disabilities need to be considered as a key target group across all intervention processes from identification, assessment and planning, delivery of support programmes, monitoring and evaluation.*
- *Local organisations of persons with disabilities, and parents of children with disabilities, together with NGOs working in the field of disability should be involved and consulted by humanitarian agencies to ensure the needs of persons with disabilities are recognised.*
- *Action and care is needed by humanitarian aid agencies to pro-actively seek-out persons with disabilities to ensure they are registered and supported in a humanitarian situation, as they are often hidden away and/or not easy to identify.*

Children with disabilities have a right to be heard (article 12 CRC and article 7 CPRD). It is essential that the views of disabled children are taken into account when developing psychosocial programmes for children affected by armed conflict. Programmes should be developed in partnership with these children, who share their anxieties, struggles, hopes and dreams. The motto '*Nothing about us, without us*' used for many years by Disabled People Organisations (DPOs), applies here too. Many child focused development and aid organisations claim to have a *Child Rights Based Approach*. One can't help but wonder how this relates to the apparent lack of inclusion of disabled children in most psychosocial projects and programmes.

Impact of war on disability

'Millions of children are killed by armed conflict, but three times as many are seriously injured or permanently disabled by it.' (UN Study on the Impact of Armed Conflict on Children, 2006).

War has both a direct and an indirect impact on the lives of children and adults (Miles & Medi, 1994). Examples of direct impact include physical injuries from weapons, or psychological problems derived from witnessing horrific events. Examples of indirect impact include the breakdown of health services and lack of food security. Illnesses such as malaria, TB and meningitis are treated late, or not at all, which could also result in disability. Additionally, lack of food production and food security – a frequent result of civil conflict and war - has severe consequences for the nutritional status of children. Malnutrition increases and

specific nutritional deficiencies (for example iodine, vitamin A) may not be addressed (Richman, 1995). This, in turn, could lead to irreversible impairment and subsequent disability.

According to researchers, children with physical, sensory, intellectual or mental health impairments are at an increased risk of becoming victims of violence. While the amount of research available on this population is extremely limited, particularly for disabled children in the developing world, current research indicates that violence against disabled children occurs at annual rates at least 1.7 times greater than their able bodied peers (UNICEF, 2005). An example of the increased vulnerability of children with a disability to violence is found in a study on children with language impairment in Nebraska, USA. These children were 3.4 times more likely to face sexual violence than other children (Sullivan & Knutson, 2000). Another study from the United Kingdom concludes that all disabled people are at twice the risk of being physically or sexually abused, compared to their able bodied peers (Calderbank, 2000).

Based on the few available studies, it becomes evident that the risk of violence of disabled children under *'normal'* circumstances, with the consequent physical, psychological or emotional problems, is already higher than that for children with no disability. Living as a disabled child in a conflict situation makes the child even more vulnerable. For example, children with disabilities like epilepsy, learning difficulties and communication difficulties are more likely to develop emotional and mental health problems during situations of armed conflict (Healthlink Worldwide, 1999).

Children with disabilities often fail to survive during times of conflict because of lack of treatment, starvation, and because they are simply not able to escape the conflict area (Miles & Medi, 1994). When families try to run away from war, it is likely that disabled children may have greater difficulties in terms of movement, and fewer chances to reach safety than other children. Parents, who lack access to advice concerning handling and managing their children with (severe) disabilities, with the added problems of living in a conflict situation, will find it more difficult to ensure that these children survive. This means that while the incidence of disability may increase in conflict situations, the prevalence of children with disabilities may not (Maslen, 1997).

Psychosocial interventions for children with disabilities in war affected areas

'Disability and conflict' is a topic that is increasingly gaining an interest from various development organisations. In 1997, Handicap International organised a one-day seminar *'Disability and Conflict'* for International Disability and Development Consortium (IDDC) members. In 2000, IDDC organised an international seminar on *'Disability and Conflict'* in Cyprus (Stubbs, 2000). However, very little is documented on how children with disabilities are included in psychosocial interventions. In the next paragraphs, the few available reports on this topic will be described.

Save the Children has published an inventory on the documentation about children with disabilities in areas of armed conflict and displacement, focusing on the following topics: prevention; protection; participation; and rehabilitation (Åhlén, 1997). These four topics are also listed by Healthlink Worldwide (1999) as among the types of interventions available for children with disabilities, in situations of armed conflict:

1. *Prevention:* including primary prevention (prevention of the onset of disability) as well as secondary prevention (early identification of disabilities);
2. *Protection:* families need to be supported to meet their children's needs;
3. *Participation:* children with disabilities should be included in play groups and cultural and leisure activities;
4. *Rehabilitation:* including physiotherapy, occupational therapy and mobility training.

Special mention is made of the right to *psychosocial rehabilitation* for children with emotional and mental difficulties.

Psychosocial programmes for children in war affected areas vary widely in their aims, scope, target groups, and duration. One could describe *'psychosocial'* as a continuum from more *curative*, therapeutic, mental health kinds of interventions, to *preventative*, community based, holistic programmes (Euwema et al., 2008). An example from one end of this spectrum is a counselling session with children or a therapy group, while examples from the other end can include things like restoring education facilities, or creating parent support groups. Although the preference of the authors of this article is for the preventative approach, for the sake of argument, psychosocial programmes in the broadest sense are meant here, since, in either case, disabled children are mostly not reached.

Rädda Barnen (Save the Children Sweden, xxxx) published a report to promote inclusion of children with disabilities in all programmes directed at children in armed conflict (Persson, 1997). The report analyses the different chapters of the *United Nations High Commission for Refugees (UNHCR) Policy on Refugee Children*. Chapter 4 deals with psychosocial wellbeing of children. It recommends that field staff should be made aware of the importance of working towards inclusion of children with disabilities in all activities. Unfortunately, the report does not give examples of how to achieve this. The Inter-Agency Standing Committee *'Guidelines on Mental Health and Psychosocial Support in Emergency Settings'* (IASC, 2007) recognize that people with pre-existing disabilities are at increased risk of various problems in emergencies. The inclusion of people with disabilities is mentioned in various domains of humanitarian action, such as the provision of shelter, food and sanitation, and community mobilization and support. Several Early Childhood Development activities are listed to facilitate social support for young children and their caregivers (Action sheet 5.4). One of the recommended actions is to *'include children with special needs in care activities, games and social support at the community level'*. However, the IASC Guidelines do not elaborate on methodology.

In field studies conducted by the Women's Commission for Refugee Women and Children (2008a) the participants pointed out that refugee women and disabled children were excluded from psychosocial support. This could be explained by the exclusion of people with disabilities in society in general, because of social stigma (Mueser et al, 2003). In some cultures, disability is seen as a result of witchcraft or a divine punishment for sin. Parents' feelings of shame and guilt may lead to hiding their disabled children from the outside world (and these children then also remain out of sight in psychosocial interventions). Other reasons disabled children are not being included are that parents can be fearful for their children with disabilities. They may be afraid that other people will not treat their child properly, and are reluctant to leave their child with other people.

The Women's Commission for Refugee Women and Children has also published a *Resource Kit* for field staff working with refugees and conflict affected populations (Women's Commission, 2008b). The resource kit provides practical ideas on how to improve services and protection for people with disabilities and how to enhance their inclusion and participation in community affairs. In the section *'Access to mainstream services'* the following questions are listed in the field of psychosocial programs:

- *Are people with disabilities included in existing psychosocial/counselling and support programs?*
- *Are there specially trained counsellors/community workers to work with people with disabilities and their families? Are they trained in sign language/Braille/other forms of communication?*
- *Can community workers make referrals to locally available psychosocial services for people with disabilities?*

In the section *'Specialized Services for People with Disabilities'* the following ideas are listed (among others):

- *Encourage home visits by social workers/disability workers to people with disabilities and their families or caregivers to provide counselling and psychosocial support.*
- *Help set up support groups for families or caregivers of children and adults with disabilities.*
- *Promote full and inclusive participation of people with disabilities in decision making, planning, design, management and implementation of camp activities as a key strategy toward ensuring psychosocial wellbeing* (Women's Commission, 2008b).

Mainstreaming and the 'twin-track approach'
Voluntary Services Overseas defines mainstreaming as:

'The process of engaging in a structured way with an issue as an organization, at workplace, programme and policy levels, in order to address, an avoid increasing, the negative effects of that issue' (VSO, 2006, p. 8).

Mainstreaming has been used by many organisations to address issues such as gender and HIV/AIDS. Mainstreaming disability is not an end in itself, but a means to achieve disability equality by removing environmental barriers that violate disabled peoples' basic human rights (Miller and Albert, 2005).

The Department for International Development in the UK has adopted a *'twin-track'* approach to disability (DFID, 2000). The *'twin-track'* approach addresses the special needs of people with disabilities, and at the same time, promotes the active inclusion of people with disabilities in all areas of development. In light of including children with disabilities in psychosocial programmes, this *'twin track'* approach could also be used. This means on the one side supporting special initiatives that are specifically directed at the psychosocial wellbeing of disabled children, while on the other, treating disability as a cross-cutting issue in mainstream psychosocial programmes. In summary: the *twin-track approach* means including disabled children *where possible in mainstream programmes,* but also organise and initiate *special programmes where needed.*

How to include children with disabilities in psychosocial activities
War affected children with disabilities remain largely excluded by psychosocial and, for that matter, other programmes[1]. The causes for this gap are multi-fold, as described earlier. The question now is how this situation could change? The importance that this change occurs cannot be over

emphasized; children with disabilities, and especially those with intellectual disabilities, are the most vulnerable in (post) conflict situations. If international and national organisations are serious in their attempts to support the healthy development of children in war affected areas, inclusive care for these children needs to be a top priority.

Children with disabilities are often '*invisible*' to service providers. Field workers of aid organizations need to actively identify children with disabilities and assess their situation. When assessing the needs of children and their communities, organisations should ensure that they see and meet disabled children. An integral part of their preparation, or training, should focus on how to include children with disabilities in programming. A lot can be done in proper design and preparation of an intervention.

As Harris & Enfield (2003) note in their guidelines for good practice in emergencies, an emergency '*is not the moment to start deliberating for the first time every about access for disabled people.*' (Harris & Enfield, 2003).

For example, one of the authors of this article was involved in setting up a psychosocial programme in Kosovo in 2000. International and national staff members were very busy organising creative art workshops for children in schools. No one thought about reaching disabled children in the community. One person in the team had a background in working with children with disabilities, and convinced colleagues of the necessity to include them, and encouraged the team to work with disabled children. It was the first time that national staff worked with disabled children and it demanded training and raising of awareness to '*convince*' them. Once the staff started working with children with disabilities, they enjoyed it. Since then, the national team continue to include disabled children in their target

groups, and later even organised integrative activities for disabled children and children with no disabilities, and teacher training.

The importance of a dedicated staff member working on disability issues is also illustrated by the work of Oxfam in Kosovo (Harris & Enfield, 2003). In addition, the team had undergone training in disability rights before the crisis. In the training manual '*Disability, Equality and Human Rights*' key challenges are listed for aid and development agencies to support people with disabilities:

- *Agencies and individuals need to become more aware of how their current practice, directly or by omission, contributes to discrimination against disabled people.*
- *Agencies and individuals need to actively engage with disabled people and their organizations, to learn from them, and to work together with them to overcome the barriers to equal participation.*
- *Agencies should adopt positive approaches to participation, and ultimately to recruitment, which allow disabled people to become colleagues and programme partners, not just beneficiaries.* (Harris & Enfield, 2003).

Another example comes from Bosnia. Hastie (l997) describes the challenges of developing an integrated project for children with disabilities. Initially, attitudes of professional staff working at a Support Centre for children with disabilities and non-professional staff in an Arts and Music Centre in Bosnia prevented an integrated approach. Oxfam developed a Disability Strategy Plan that included a disability policy for the office, and awareness training for staff. These examples illustrate the need for organisations to include disability in the training programmes of their staff. Only in this way

will the inclusion of disabled children in psychosocial programmes be ensured.

Even in conflict situations, it is possible to train teachers, community workers and leaders to be sensitive to the needs of children with disabilities (Richman 1993; Healthlink Worldwide 2000). Child-to-child programmes, in which children help each other, can also be used to promote integration of disabled children. For example, the Child-to-Child Trust has published the book '*Child-to-Child and Children Living in Camps*', which lists ideas for children to help children with disabilities in refugee camps (Hanbury, 1995). Organisations implementing psychosocial programmes in war affected areas would also benefit from collaborating closer with DPOs and other organisations supporting people with disabilities.

National and international staff members, as well as volunteers, who work directly with children often ask how they can include disabled children in their work. Strategies do not need to be costly or time consuming.

Once people see how easy it can be to include disabled children in activities, they usually no longer ignore them. Initial resistance may have to do with fear and insecurity on the part of staff members themselves. To overcome this, training and first hand experience is needed. It is the responsibility of national and international organisations to create and stimulate opportunities for their staff to gain such positive experiences. In the opinion of the authors, some other key factors to make psychosocial programmes for (disabled) children in war affected areas successful include:

1. First (and this is very obvious): a relevant number of the target group reached by a certain psychosocial programme needs to consist of disabled children. This

should therefore *always* be a target. Organisations need to actively seek out children with disabilities to ensure their participation (IDDC, nd).

2. Staff needs to be made aware of how their current practice contributes to discrimination against disabled children (Harris & Enfield, 2003; Hastie, 1997) and of the importance to include children with disabilities in their work (Persson, 1997).

3. Organisations need to ensure participation of disabled people and children in design, implementation and evaluation of psychosocial projects (Harris & Enfield 2003; Women's Commission, 2008b).

4. A good psychosocial programme for children in war affected areas allows space for flexible adaptation of its target groups and goals. By this we mean that a project should never be too fixed in advance, or inflexible. The psychosocial problems and needs of children in a certain community or region cannot be completely known beforehand. Allowing an intervention to change its objectives and methods along the way will better guarantee that it is open for the inclusion of disabled children. Child-to-child programmes can also help to promote the integration of children with disabilities (Hanbury, 1995).

Conclusions and recommendations

Children with disabilities are more at risk of experiencing psychosocial problems than children with no disabilities, especially in conflict situations. Despite this sad fact, children with disabilities are often not included in psychosocial programmes because of (organisational) negligence, (negative) attitudes and stigma. Disabled children who

have experienced armed conflict have the right to psychological recovery and social integration. Therefore, psychosocial programmes for children in war affected areas that fail to reach disabled children, fail. This should be the prerogative of organisations and institutions when they plan, monitor and evaluate psychosocial interventions. A joint statement to this effect by the larger organisations active in delivering psychosocial support to children in war affected areas could be a meaningful step.

Including children with disabilities in psychosocial programmes is not an easy process. Organisations working in this field must first become really committed to the inclusion of children with disabilities. An organisation needs to look at its own practices, structures and policies to see what factors hinder the inclusion of disabled children. Sensitisation and training of staff is important to overcome attitudinal barriers that disabled children face. Children with disabilities need to be included in the design, implementation and evaluation of psychosocial projects to ensure their participation. We recommend a flexible adaptation of psychosocial programmes to be able to adjust to the needs of these children.

Unfortunately, documentation on how to include disabled children in psychosocial programmes is scarce. The authors call on NGOs and academic institutions to become involved in research which will study and document experiences of disabled children in conflict situations. Such documented experiences can, and should, form the basis for the development of disability-friendly psychosocial programmes. This may have a ripple effect - that the inclusion of children with disabilities in psychosocial programmes will have a positive impact on the inclusion of people with disabilities in the wider context as well.

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[1] We are not referring here to organisations that specifically address the needs and rights of the disabled, like Handicap International or the Leonard Cheshire International. Their psychosocial programmes of course always include disabled children!

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Uncited references

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