Disability and Inclusion Assessment in Raqqa Governorate, Syria

Raqqa Governorate, Syria
July 2019

THIS REPORT WAS PREPARED FOR CHEMONICS INTERNATIONAL INC. BY DR. ALAA SEBEH AND DR. BRENDA SINCLAIR WITH CONTRIBUTIONS FROM THE INJAZ PROJECT TEAM.
Acknowledgments

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A. Introduction

The prolonged Syrian crisis has precipitated mass displacement, economic collapse, and an education crisis with an estimated 1.75 million Syrian children out of school. Moreover, the use of explosive weapons and indiscriminate attacks during the conflict has killed or injured thousands of children. While there are no accurate or comprehensive statistics on the number of children with disabilities in Syria, UNICEF estimates over 1.5 million people, including children, are now living with permanent, war-related impairments.

As children with disabilities are less likely to have the resources, services and social support required to attend school, they are most at risk of exclusion from education. According to the UNICEF regional director of the Middle East and North Africa, “Without access to services, schools and assistive products, like wheelchairs, many children with disabilities face a very real threat of exclusion, neglect and stigmatization1.”

Respecting the rights of children with disabilities and affording them the same freedoms and rights as other children is something that governments are obliged to do, in accordance with the UN Rights of the Child and Convention on the Rights of People with Disabilities (CRPD)2.

Since the Fall of 2017, the Chemonics Injaz project has been supporting local community-based organizations (CBOs) to operate non-formal child education centers (child centers3) that provide psychosocial support and remedial literacy/numeracy to children, including those with disabilities. Within the Raqqa Governorate, child centers are located in Ain Aiesa IDP camp, Raqqa City, Tabqa City, Karama, Al Mansoura, and Journiyeh. Injaz also supports a child center in the Abu Khasab IDP camp within the Deir Ezzor Governorate. The goal of the centers is to facilitate re-enrollment of children into formal primary schools affiliated with local councils.

At the beginning of the assessment, in October 2018, there were reportedly a total of 166 children with disabilities enrolled in three of the 11 child centers and three additional child centers were planning on enrolling more children with disabilities from their target communities.


3 The Injaz project coined the term ‘child centers’ to refer to CBO facilities that provide remedial and psychosocial programming to children.
B. Executive Summary

Chemonics conducted a Disability and Inclusion Assessment in October 2018 with dual aims framed by the following research questions:

1) What percentage of children within the target population (child centers, wider communities, IDP camps) have difficulties functioning and participating in daily activities?
2) To what extent is each child center ‘inclusive’ and promoting inclusive education?

The first aim was to identify the actual number, types and severity of functional difficulties among children targeted by the Injaz project. Using two internationally recognized instruments for measuring functional skills, the assessment identified children within 11 child centers, four surrounding communities, and two IDP camps who have difficulty functioning and participating in daily activities, such as educational activities within the child center and basic tasks within their home and communities.

The second aim was to assess the status of inclusive education within each child center as a baseline to measure future progress. The participatory self-assessment facilitated child centers to identify the main barriers, facilitators and resources available for creating inclusive learning environments. Child centers used the results of the assessment to develop intervention plans that address the inclusion gaps and fulfill the rights of children with disabilities to access education and to ensure their inclusive participation in all center activities. The action plans were developed in collaboration with the child protection and inclusion committees and will guide future child center interventions.

The assessment will provide the Injaz project and its donors with recommended interventions to design inclusive programs and provide implementers with a snapshot of the current status of children with disabilities in child centers to inform future activities. The results will inform Injaz intervention plans at both the programmatic and individual levels. Identified children will be categorized by type and severity of the difficulty, age group (5-9, 10-14, 15-17), and gender.

Note that the Disability and Inclusion assessment was not intended as a research project, but rather as a baseline assessment to identify the number of children with functional difficulties and the extent of inclusiveness within child centers for an inclusion project under the broader Injaz project. It also intended to build the capacities of child center staff and promote continuous assessment and action planning among child center communities.

B1. Sample size

All children within each target group participated in the assessment. A total of 11,902 children, aged 5 to 17 participated in the study. Among the target population, 2,038 were enrolled in child centers (excluding IDPs), 6,113 were children in the surrounding communities not enrolled in child centers, but who may be in formal schooling or out of school, and 3,751 were children living in two IDP camps (Ain Aesa, Raqqa Governorate and Abu Khashab, Deir Ezzor Governorate) and may or may not have been enrolled in the two child centers within the camp.

B2. Instruments

To respond to the first research question, two internationally recognized tools developed by the Washington Group were used to identify children with disabilities in IDP camps, child centers, and communities. The Washington Group Short Set of Disability Questions (WGSS) was used to assess 3,751 children in IDP camps, while the UNICEF/Washington Group Child Functioning Module (CFM) was administered to 8,151 children in child centers and communities (2,038 in 11 child centers and 6,113 in neighboring communities).

As recommended by the Washington Group who developed the instruments for this study, the disaggregation of data by these variables is important to inform the development of policies, plans and for understanding the scope of disability.
While the CFM tool is more comprehensive than the WGSS tool (13 domains versus six), the WGSS tool was selected for the IDP target group due to its brevity, ease of administration, and appropriateness for the emergency context. Thus, the results are comparable across all groups for the six common domains, but the WGSS may have underestimated the total number of children with disabilities within the IDP camps given it is a shorter version of the CFM tool.

The **WGSS tool** captures the degree of severity and difficulty experienced with performing basic functions within six domains (e.g., walking, seeing, hearing, remembering and concentrating, self-care and communication). The responses are grouped into four categories: no difficulty, some difficulty, a lot of difficulty, and cannot do at all.

The **Child Functioning Module**, developed jointly by the Washington Group and UNICEF in 2017, is an expanded version of the WGSS tool, and includes functional difficulties in 13 domains. These domains are: seeing, hearing, walking, self-care, communication (being understood inside or outside the household), learning, remembering, concentrating, accepting change, controlling behavior, making friends, anxiety and depression. The CFM also captures the frequency of difficulties related to psychosocial conditions. The responses are scored according to the same categories as the WGSS (no difficulty, some difficulty, a lot of difficulty, cannot do at all).

The WGSS tool was administered to caregivers or children themselves, if they were old enough to express themselves, while the CFM tool was administered to child center facilitators (teachers) who work closely with each child providing them with remedial education and psychosocial support and thus are very much aware of their capabilities.

For the second research question, the **Index for Inclusion** was used to measure the inclusiveness of child centers and was applied in all 11 child centers. The **Index for Inclusion**, developed by two British educators to make schools more inclusive, is a very detailed set of indicators for characterizing the inclusivity of a school or education center. The tool was applied in 11 child centers with ‘Child Protection and Inclusion Committees’, established for the purpose of this assessment. The participatory assessment provides a comprehensive overview of the extent of inclusiveness within the child center according to three dimensions: 1) creating inclusive cultures, 2) producing inclusive policies, and 3) evolving inclusive practices. During the self-assessment, all center stakeholders reflect on their environment against a set of criteria and determine the extent to which they agree or disagree with whether their child center meets the inclusiveness indicator. The process is intended to raise awareness about the principles of an inclusive child center as well as promote discussion and action planning to make their child centers more inclusive. The participatory approach also intended to build capacity of child centers to conduct periodic/continuous self-assessment and action planning in the future.

**B3. Key findings from Disability Assessment**

For the purposes of this assessment, a child is considered as having a disability if they have a *lot of difficulty* or are unable to do a basic function in any one of the domains included in the Child Functioning Module or in the WGSS Disability Questions. This definition is the cut-off threshold recommended by the Washington Group on Disability Statistics. In addition to these criteria, children aged 5-17 years who have “daily” episodes of anxiety or depression were also considered to have a functional difficulty. The percent and number of children identified as having a functional difficulty in each target group are presented below.

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5 The Index for Inclusion in the Arabic World was developed based on the original English version Index published in the UK by Centre for Studies on Inclusive Education (CSIE). UNESCO introduced the tool to the Syrian MoE in 2004.

6 The Washington Group recommendation for international reporting is to use “a lot of difficulty” as a threshold for identifying persons with a disability. Therefore, persons who report “a lot of difficulty” or “unable to do” for at least one domain are considered to have a disability. http://www.washingtongroup-disability.com/washington-group-questions-disability-continuum/
Child centers. Of 2,038 students assessed in child centers with the Child Functioning Module, 12 percent (250 children) had functional difficulties in at least one of the 13 domains. The most common types of disability among these children was difficulty with communication and hearing, particularly within the 15-17 year old age group.

Among 50 youth (15-17 years old) surveyed in child centers, 34 percent have difficulty hearing, 40 percent have difficulty communicating and 50 percent have trouble making friends. Furthermore, depression, anxiety and difficulty learning were more prevalent in older children. There were no notable differences in results by gender.

Communities. Out of 6,113 children assessed in communities with the Child Functioning Module, 12 percent (734 children) had functional difficulties in at least one of the 13 domains. The most common types—identified in four to five percent of children—were anxiety and difficulty communicating and seeing. There were no significant differences in terms of gender or age.

IDP camps. IDP children had the lowest rates of functional difficulties among the three target groups, which may be due to the limited number of domains within the WGSS instrument and its lack of sensitivity to developmental and psychosocial conditions. Of the 3,751 children assessed in the two IDP camps, 4.4 percent (165 children) had functional difficulties in at least one of the six WGSS domains. In terms of the severity, 3 percent of IDPs (113 children) had mild disabilities in four of the six categories (hearing, walking or climbing stairs, remembering or concentrating, and communicating); one percent (30 children) had a lot of difficulty seeing, even with glasses, and walking or climbing stairs; and less than one percent of IDPs had severe disabilities. Fifteen children were unable to do a basic function at all.

Conclusion. Among all 11,902 children surveyed in child centers, surrounding communities and two IDP camps, 10 percent (1,165) had a functional difficulty in at least one domain.

B4. Key findings from Inclusion Assessment

Dimension A: Inclusive Cultures. Most elements of a positive inclusive culture and inclusive values exist within child centers. Making everyone feel welcome, collaborating with one another, and treating each other with respect was valued by over 80 percent of respondents. Staff seek to remove barriers to learning and promote equal participation of all students in all child centers activities. However, staff, children and management lack a shared vision, philosophy and commitment to inclusion in 40 percent of child centers. Moreover, 85 percent of respondents were not satisfied with the extent of local community participation in center activities. They were also dissatisfied with the extent of awareness and accessibility of local resources.

Dimension B. Inclusive Policies. While the majority of respondents agreed that they have inclusive policies, most centers have codes of conducts and non-violence classroom management norms, but not written inclusive education policies. Thus, there was not a clear understanding of this dimension; more awareness raising is needed for an accurate assessment.

Dimension C. Inclusive Practices. The majority of stakeholders agreed that instruction is planned based on students’ diverse learning needs and that students learn collaboratively building on each other’s knowledge and diversity. Yet, outside of the classroom, not all students partake in extracurricular activities. Less than half of respondents fully agreed that centers effectively mobilize resources to support children with disabilities, including developing resources to support children with disabilities’ learning and participation, or constructing tests that contribute to the achievement of all students.

7 Youth comprised two percent of the total sample. Therefore, these results are not generalizable beyond the child centers assessed.
Conclusions. Based on the results of the inclusion assessment, additional awareness-raising and capacity building is needed to improve the degree of inclusiveness across the three dimensions. Child centers, in particular, 1) need to develop a shared vision and inclusive development plan, 2) to establish inclusive education policies to help support the implementation of the plan, and 3) to improve inclusive education practices inside and outside of the classroom to support children with disabilities to equally participate in the classroom and in all child center activities (See illustrative actions in textbox).

It is important to note that most responses to the Index for Inclusion assessment referred to special education classes for children with hearing difficulties. There is a misconception among child center staff that all children with disabilities require specialized types of education and consequently, the few numbers of children with disabilities enrolled in the child centers are mostly placed in special education classes regardless of their needs, types and levels of disabilities. However, through participating in the disability and inclusion assessment and process for developing inclusive education plans, perceptions have begun to change and child centers have already taken steps to become more inclusive. The self-assessment tremendously contributed to raising awareness among child center staff and local community stakeholders about inclusive education and paved the way for future actions in this regard.

Despite the capacity building activities prior to and during the assessment, there is still the need for continued training and support provision for the child center management and staff. This could be provided through Training of Trainers (ToT) workshops and dissemination of simplified resource materials in Arabic. The consultant who led this assessment has provided some follow-up technical support through the Whatsapp group, which has facilitated exchanges of successes and lessons learned.

B4. Recommendations

1. Expand the utilization of the UNICEF/Washington Group Child Functioning Module among teachers to identify children with functional difficulties in child centers, to all child center communities, and council-affiliated schools, pending access. This is crucially important for the identification of children who are at risk of not fully and effectively participating in child center activities due to functional limitations so that appropriate accommodations can be made.

2. Provide Child Protection Officers and Inclusion Committees with additional training and support to expand their roles in implementing inclusive education plans and sustain these committees. They can contribute to early identification of children with disabilities, establishing and supporting a referral system within the CBO network for those who would need more specialized interventions, and supporting the inclusion of children with special education needs in extracurricular and PSS activities.

3. Increase awareness within child centers about the principles of inclusive education, the benefits and how inclusive child centers can provide strong models in their respective communities for promoting inclusion. Develop an evidence-based model of inclusive education that would serve as an entry point to encourage young children to respect differences and accept diversity within a society affected by the presence of violent extremist ideologies.

4. Conduct an out-of-school survey to identify the number of children excluded or who have dropped out and the explanatory reasons. Such research would be helpful for identifying possible barriers to their inclusion in education services, for developing context-relevant interventions to support the inclusion of all excluded and disadvantaged children, not only children with disabilities, and for increasing enrolment of out-of-school children in both child centers and formal schools.

What does inclusive education look like?

- Teaching is planned with the learning of all students in mind.
- Lessons encourage participation of all students.
- All students partake in activities outside the classroom.
- Student difference is used as resource for teaching and learning.
5. Share findings of the out-of-school survey (Recommendation #4) with child center staff and jointly develop concrete interventions to address the barriers. For instance, child center staff may mobilize caregivers of enrolled students to conduct outreach to parents of out-of-school children and increase their awareness of the education and psychosocial services provided by child centers, including for children with disabilities.

6. Consider the need for a twin-track approach to inclusive education during humanitarian actions. On the one hand, education programs should be adapted to be more inclusive and accessible to all children, including children with disabilities. On the other hand, humanitarian interventions should aim to directly address the disability-related needs of children and adolescents with disabilities – for example, by providing assistive devices for children and adolescents with disabilities to support their participation in education. This assessment identified the number of children with disabilities. Further assessment is necessary to identify the specific needs of children with disabilities (e.g., assistive devices, accessible education materials, transportations).

7. In the future, Disability and Inclusion Assessments should include persons with disabilities in meaningful roles, such as advisors, enumerators, and partners. Their experience and perspective can inform the whole process and could lead to their support/involvement in implementing education interventions.

B5. Next Steps

Injaz project staff plan to review findings with partners and facilitate consultations to determine how best to expand inclusion and respond to the issues and recommendations specific to the child centers raised in this report. Children identified on the UNICEF/Washington Group Child Functioning Module as having "some difficulty" or higher levels of difficulty in relation to vision, hearing, walking or other domains should be referred for further assessment and services as available. Child centers' managers will work closely with relevant community resources to identify the out of school children, dropouts and support the inclusion of all excluded and disadvantaged children, not only children with disabilities, and will coordinate with schools to re-enroll children in formal education. Addressing inclusive education and establishing referral and support systems will require a coordinated response. Injaz will share the recommendations with local councils that manage schools in the Raqqa Governorate, as well as with donors and humanitarian actors through various international and regional forums and platforms; among these is the United Kingdom Forum for International Education and Training (UKFIET) Conference in September 2019.
C. Background

C1. Overview of Disability Statistics

Globally, 15 percent of the world’s population lives with a disability\(^8\). A recent assessment on disability in Syria among adults in western Aleppo, Idlib and Raqqa governorates indicated an average prevalence rate of 30 percent, double the global average\(^9\). It also found an average of 45 percent of surveyed persons injured during the Syria crisis are expected to sustain a permanent impairment (e.g. amputation, spinal cord injury, brain injury).

There is no accurate or comprehensive data on the number of children with disabilities in Syria, yet UNICEF estimates 1.5 million people, including children, are now living with permanent, war-related impairments\(^10\). The use of explosive weapons and indiscriminate attacks during the conflict has killed or injured thousands of children. During the first two months of 2018 alone, 1,000 children were reportedly killed or injured\(^11\). An estimated 3.3 million children inside Syria are exposed to explosive hazards, such as landmines, unexploded ordinance or improvised explosive devices\(^12\). As a result, there is an unspecified number of children who may be suffering injuries from the war and living with disabilities.

An estimated 1.75 million Syrian children are out of school, yet no data is available on how many of these children have disabilities and may be facing barriers to education due to societal norms, stigmatization and neglect.

C2. Injaz Project

The Injaz project, funded by the U.S Department of State’s Bureau of Near Eastern Affairs (NEA), provides structured psychosocial programming and remedial education to address the socio-emotional and learning needs of internally displaced and local children, including children with disabilities, with the aim of preparing them to enter formal schools. The centers accommodate children with disabilities who are unable to access mainstream schools due to their special needs or because there are no formal schools operating in the area\(^13\). Injaz delivers its education program through 11 child centers operated by community-based organizations (CBOs) in northeast Syria, primarily in Raqqa Governorate.

Injaz also provided support to a limited number of formal schools, according to priorities communicated by the respective local councils. Injaz funded local CBO partners to provide some light rehabilitation of schools to help accommodate children with disabilities, including wheelchair ramps to enter schools, wheelchair-accessible toilet facilities, and handrails on the sides of hallways to support children with physical disabilities\(^14\).

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\(^12\)Ibid.
\(^13\)This regulation is valid for child centers in cities or suburbs, not for child centers in IDPs.
\(^14\)Unfortunately, local education authorities in Raqqa and Deir Ezzor Governorates do not allow external foreign entities to engage in other aspects of inclusive education, such as policy development, instructional materials, teacher training, sensitization among the student population, and community awareness and outreach.
The inclusion of children with disabilities in Injaz child centers was a grassroots initiative led by Syrian CBOs. CBO partners informed Injaz management that they wanted to serve children with disabilities who were not enrolled in school, or who could not enroll due to lack of adequate facilities such as, wheelchair ramps and braille instruction. In November 2017, one Community-Based Organization- CBO (Partner I) enrolled 13 children with disabilities in one dedicated classroom at their child center. During the year of 2018, two more CBOs (New Horizons and Partner E) began engaging children with disabilities. As of October 2018, the three aforementioned CBOs dedicated 9 classrooms and 23 staff to a total of 166 Children with disabilities.

Between January and October 2018, the three CBOs made 58 referrals to specialized organizations in the region, after which 38 children with disabilities were provided with assistive technologies. During the assessment, three additional CBOs (Partner K, Partner G, and Partner B) declared their intention to allocate resources and start new programs for children with disabilities.

The Injaz program strives to address the needs of children with disabilities through creating inclusive centers with the goal of creating a model for other humanitarian actors working in the education sector.

D. Purpose of the Assessment

The purpose of the Disability and Inclusion Assessment was to respond to the following two research questions:

1) What percentage of children within the target population (child centers, wider communities, IDP camps) have difficulties functioning and participating in daily activities?

2) To what extent is each child center ‘inclusive’ and promoting inclusive education?

Using two internationally recognized instruments for measuring functional skills, the main objective of the Injaz disability assessment was to identify the number, types and severity of functional difficulties among children enrolled in the targeted child centers, in their respective districts and in IDP camps. It aimed to identify children who have difficulties functioning and participating in daily activities, including educational activities within the child center, and basic tasks within their homes and communities.

The assessment also aimed to assess the status of inclusivity within each child center as a baseline to measure future progress. The findings of the disability and inclusion assessment will be used to support child centers with developing intervention plans aimed at increasing access for children with disabilities and ensuring their inclusive participation in center activities.

The results will be used at the programmatic level to inform program design and future activities. It will provide the Injaz project and its donors with recommendations for interventions to design effective and responsive programs as well as provide implementers with a snapshot of the current status of children with disabilities in child centers to inform future activities. Identified children will be categorized by type and severity of the difficulty, age group (e.g., 5-9, 10-4, 15-17), and gender15

E. Sample Size and Characteristics

The assessment was carried out for all children within each target group, including all children in each child center and all children within selected communities and IDP camps through a door-to-door survey. A total of 11,902 children aged 5 to 17 participated in the study. The target population included all 2,038 children enrolled in the child centers (excluding IDPs), 6,113 children in communities surrounding four child centers (Partner E, Partner H, Partner G, and New Horizons), who may be enrolled in formal schooling or out of

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15 As recommended by the Washington Group who developed the instruments for this study, the disaggregation of data by these variables is important to inform the development of policies, plans and for understanding the scope of disability.
school, and 3,751 children living in the two IDP camps (Ain Aesa, Raqqa Governorate and Abu Khashab, Deir Ezzor Governorate) who may or may not be enrolled in the two child centers within the camp.

We had originally planned to reach children in all child center communities. However, due to lack of permits from local governance authorities to conduct wider surveys, surveyors were only able to reach communities surrounding four child centers.

Among the 2,038 children enrolled in the child centers, excluding the centers in the IDP camps, 53 percent (1,088) were boys and 46 percent (950) were girls. Students ages ranged from 5 to 17 years old. Overall, 42 percent were in the youngest age group (5 to 9), over half (56%) were in the adolescent age group between 10 to 14 years old, and two percent (50) were in the oldest age group (between 15 to 17 years old).

Of the 6,113 children in communities adjacent to the child centers, the gender ratio was the same as for students enrolled (53% boys; 46% girls). Age composition of community children were also similar with 41 percent in youngest age group (5 to 9), 51 percent in the adolescent age group (10 to 14), and 8 percent in the oldest age group (15-17).

Among the 3,751 children surveyed in the two IDP camps, 54 percent were boys and 46 percent were girls. Age distribution was slightly different with the greatest percentage of students in the youngest group (48%) followed by 42 percent in the adolescent group and 11 percent in the oldest age group.

### Exhibit 1: Distribution of Sample by Type and Gender

<table>
<thead>
<tr>
<th>Sample Type</th>
<th>Total</th>
<th>Boys</th>
<th>Girls</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child Centers</td>
<td>2,038</td>
<td>1,088</td>
<td>950</td>
</tr>
<tr>
<td>Children in Communities Surrounding Four Child Centers*</td>
<td>6,113</td>
<td>3,270</td>
<td>2,843</td>
</tr>
<tr>
<td>IDP Children in two IDP camps**</td>
<td>3,751</td>
<td>2,015</td>
<td>1,736</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>11,902</td>
<td>6,373</td>
<td>5,529</td>
</tr>
</tbody>
</table>

*Partner E, Partner H, Partner G, and New Horizons
**Ain Aesa, Raqqa Governorate and Abu Khashab, Deir Ezzor Governorate

### Exhibit 2: Distribution of Sample by Type and Age

<table>
<thead>
<tr>
<th>Sample Type</th>
<th>5-9</th>
<th>10-14</th>
<th>15-17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child Centers</td>
<td>42%</td>
<td>56%</td>
<td>2%</td>
</tr>
<tr>
<td>Children in Communities Surrounding Four Child Centers*</td>
<td>42%</td>
<td>51%</td>
<td>8%</td>
</tr>
<tr>
<td>IDP Children in two IDP camps**</td>
<td>48%</td>
<td>42%</td>
<td>11%</td>
</tr>
</tbody>
</table>

F. Assessment Methodology
As illustrated in Exhibit 3, Injaz utilized three tools for data collection. To respond to the first research question, two internationally recognized tools developed by the Washington Group were used to identify children with disabilities in the IDP camps, child centers, and communities. The Washington Group Short Set of Questions on Disability was applied in the two IDP camps in Raqqa and Deir Ezzor (3,751 children) and the Child Functioning Module was administered to all 11 child centers and four adjacent child center communities (8,151 children). The WGSS tool was selected for its brevity, ease of administration and appropriateness for the emergency context, while the comprehensive CFM tool was selected for use with child centers and their surrounding communities. For the second research question, the Index for Inclusion tool was designated and applied in the 11 child centers (2,038 children).

The WGSS and CFM tools both use a functional approach that asks questions about the level of difficulty people have doing various daily activities. This method provides an accurate approximation (proxy) to identify most people with disabilities – because people who cannot do certain activities like ‘walking’ or ‘hearing’ are experiencing impairment and may face barriers participating on an equal basis with other people and are therefore considered as having or being at risk of having a disability. A functional approach also avoids use of the word ‘disability’ and therefore mitigates under-identification due to stigma.

### Exhibit 3: Instruments and Target Groups

<table>
<thead>
<tr>
<th>Instruments</th>
<th>Target Population</th>
<th>Sample Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Washington Group Short List of Questions on Disability (WGSS)</td>
<td>Two IDP Camps</td>
<td>3,751</td>
</tr>
<tr>
<td>Child Functioning Module</td>
<td>11 Child centers and 4 child center communities*</td>
<td>8,151</td>
</tr>
<tr>
<td>Index for Inclusion</td>
<td>11 Child Centers</td>
<td>2,038</td>
</tr>
</tbody>
</table>

*Partner E, Partner H, Partner G, and New Horizons*

A description of each of the tools is provided below. Limitations of the methodology are detailed in Section G4.

#### F1. The Washington Group Short Set of Questions on Disability

The 'Washington Group Short Set of Questions on Disability' (WGSS) is an internationally recognized tool designed to identify (in a census or survey format) people with a disability. The WGSS questions ask whether people have difficulty performing basic universal activities (walking, seeing, hearing, etc.) that fall under six domains: 1) vision, 2) hearing, 3) mobility, 4) remembering and concentrating, 5) self-care, and 6) communication. The responses are grouped into four categories designed to capture the degree of severity and difficulty experienced, including: no difficulty, some difficulty, a lot of difficulty, and cannot do at all.

The WGSS tool was used to identify all children with disabilities in the two IDP camps in which Injaz has child centers (Ain Aesa, Raqqa Governorate and Abu Khashab, Deir Ezzor Governorate). The door-to-door community survey was confined to two existing IDP camps due to its practicality and feasibility as well as the limited time and resources. The survey was administered to parents/caregivers or to children old enough to express themselves.

#### E2. The Washington Group/UNICEF Child Functioning Module
The Child Functioning Module—published in July 2017 jointly by the UNICEF and the Washington Group on Disability Statistics—assesses a broad range of childhood disabilities covering 13 domains. The Child Functioning Module provides a series of questions to identify the sub population of children that are at greater risk of experiencing limited social participation due to functional limitations.

Two versions of the modules were developed by the UNICEF and Washington Group, one for the age range of 2 to 5 and the other for the age 5 to 17. The latter was used in this assessment. It assesses functional difficulties in the following 13 domains: seeing, hearing, walking, self-care, communication (being understood inside or outside the household), learning, remembering, concentrating, accepting change, controlling behavior, making friends, anxiety and depression. The responses are scored on a graded scale ranging from: 1) “no difficulty”, 2) “some difficulty”, 3) “a lot of difficulty” and 4) “unable to do”.

The Child Functioning tool was implemented in all 11 child centers and in four child center communities. The tool was administered with each child center teacher. The enumerator asked the teacher questions exploring children’s actual experiences and the difficulties that they encounter. In the communities, the survey was administered to parents/caregivers and to children old enough to express themselves.

**E3. The Index for Inclusion**

The Index for Inclusion is an internationally recognized tool known for its flexible and participatory approach. It engages all relevant stakeholders—teachers, facilitators, volunteers, managers, children, youth and parents/caregivers—in a reflective and participatory self-assessment process based on a very detailed set of indicators for characterizing the inclusivity of the child center. The tool facilitates stakeholders to identify the barriers, strengths and resources for inclusion, and then facilitates them to develop an action plan for mitigating the barriers and developing facilitating measures. Child centers implement the inclusion action plans in partnership with surrounding communities. It is the best ‘learning’ tool for engaging all stakeholders in the process, which was among our main objectives. Through this participatory approach, child centers learn how to conduct self-assessments and develop context-relevant solutions; the capacity building is as important as the assessment itself since child centers can then continue to conduct periodic assessments and update their action plans. There is a lot of evidence in the inclusive education literature that has proven the efficiency and success of this approach.

The Index for Inclusion was applied in 11 Child Centers with ‘Child Protection and Inclusion Committees’, established for the purpose of this assessment, but which could play a role in the future. The participatory assessment provides a comprehensive overview of the extent of inclusiveness within the child center according to three dimensions: 1) creating inclusive cultures, 2) producing inclusive policies, and 3) evolving inclusive practices. The tool was administered in a participatory fashion with stakeholders in a group setting, but the responses were reflected on individually. The Index of Inclusion provides examples of an inclusive education system that stakeholders reflect on and decide on the extent to which they agree or disagree that their child center meets the inclusiveness indicator.

The process is designed to help stakeholders reflect on the current situation and stimulate brainstorming and discussions on the ways forwards to implement inclusive education in the child centers. Each member of the team who uses the Index for Inclusion needs to answer on her/his own, after the group discussion, whether he/she fully agrees with the indicator, agrees to some extent, disagrees to some extent, fully disagrees, or needs additional information to make an informed decision. As the inclusion topic was

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16 Note that the CFM was designed to be asked to the parent or primary caregiver to avoid teacher bias. However, in humanitarian and conflict contexts, it is very difficult to obtain the required permissions to enter communities and conduct surveys; thus, it was not feasible to interview all caregivers or parents. The data is reliable since child center facilitators have close relationships with children and are more aware of the psychosocial and developmental difficulties the children may have due to the psychosocial activities and the personal interactions facilitators have with children.
completely new for child center committees, it was decided to begin with an initial discussion of the indicators/questions, provide any clarification, and then allow a few minutes for individual reflections and responses. Thus, responses may have been influenced by their peers or discussion may have helped them to reflect more deeply on their own beliefs. The scores, however, were recorded as a collective, aggregate score rather than individual scores, which were aggregated for an overall child center score.

There are various versions and adaptations of the Index for Inclusion tool. For this inclusion assessment, we selected an Arabic version, originally developed by Save the Children UK in the Middle East and North Africa (MENA) region for use in Kindergarten classrooms 17. It had been applied in Egypt and was shortened/adapted for use in the Sudanese context. Drawing from the Sudanese shorter version consisting of 44 indicators, the Disability and Inclusion consultant selected the most relevant questions and adapted them to better reflect the child center context. He re-designed the questionnaires, the layout, and the sequencing of all items. Adhering to the original tool’s standards, the adapted tool was designed to investigate the cultures, policies and practices of the child centers. The revised tool was presented during the training to the child center and management staff to validate its content. Participants were given two days to review and the project officers were in charge of collecting their contributions or modifications. In the end, all suggested modifications were approved with no further adaptation.

G. Training and Data Collection

Due to limited time and resource constraints, the team decided to use full-time staff from the Injaz project in Berlin and from partner CBOs to collect the data and information. CBOs’ Child Protection Officers, Trainers and mobile teams served as data collectors.

G1. Training

Using a cascade-training model, the Disability and Inclusion Consultant trained trainers and education staff at Injaz-supported child centers on survey and inclusion tools. The training workshops were conducted remotely during the month of September 2018. Injaz held a three-day training of trainers (TOT) on inclusion assessment tools for 24 child center staff, including Child Protection Officers (CPOs) and Psychosocial (PSS) facilitators from all Injaz-supported CBOs. During the training, facilitators provided an overview of the content and purpose of the surveys, reviewed each of three instruments with participants question by question, provided guidance on interviewing techniques, and facilitated practice interviews. The trainees, in turn, trained their colleagues in the 11 respective child centers to utilize the three tools for each of the target populations. The training of the inclusion assessment committees at child centers took place at all supported child centers.

Injaz team held three meetings with child center managers and child protection officers (CPOs) of all Injaz-supported CBOs to introduce the tools as a prelude to a series of training sessions on this topic with the aim to raise awareness amongst relevant child center staff (CPOs, center managers, PSS trainers) and enhance the process of inclusion at these centers.

G2. Preparation for Inclusion Assessment

17 The adaptation of the tool to the Arabic context was an extensive process for two years implemented by Save the Children (SC) UK in 2005. The instrument was translated, adapted and pilot tested in Lebanon, Morocco and Egypt. The final version was published in 2006. The Injaz Disability and Inclusion Consultant was the Regional Disability Adviser of SC UK and was in charge of this project; thus, he is very familiar with the tool and was easily able to adapt it further to the Syrian context.
Immediately following the ToT, ‘Child Protection and Inclusion Committees’ were established in each child center in order to conduct the Index for Inclusion assessment. It was suggested that committees be comprised of the following stakeholders: the center manager, two facilitators, a parent who has a child with a disability, a representative from the local community (or board member), a disability specialist from any civil society/program serving persons with disabilities (if any exist), and a child from the center (but only if his/her participation is not symbolic). The center managers and Injaz officers made the final selection of the committees.

Though sustainability of these committees is not guaranteed, it was thought that establishing such committees during the scope of this assessment and providing them with technical and motivational support would likely strengthen their capacities and lead to their sustainability if members are well motivated and realize the impacts they can make. The final committees selected by the survey team consisted of child center managers and representatives of teachers/facilitators, caregivers, local communities, and specialists who work with children with disabilities. The main role of these committees was to assess the extent to which the child centers policies, attitudes and practices were inclusive. It is envisaged that these committees would continue working on supporting the identified children either through the child center resources or referring those in need to specialized NGOs, or relevant services in the local community. It is also expected that these committees will maximize the utilization of internal and external resources for the benefit of children who are mostly excluded and disadvantaged.

G3. Data Collection

Data collection was carried out from September 10 through October 14, 2018. There was a total of 11 teams, one team from each child center. The assessment teams initiated the assessment in all child centers, Ain Aesa and Abu Khashab IDP camps, and in four communities surrounding the child centers. The Child Protection and Inclusion Committees met several times to assess each dimension in their respective center using the Index for Inclusion instrument as described above.

Data were collected through designated paper forms and then entered into smart phones using KOBO software. The data was verified and completed by the third week of October. In the last week of October, the data was analyzed and tabulated using SPSS. The Disability and Inclusion Consultant oversaw the data collection processes and disability determination.

G4. Assessment Limitations

One limitation of the assessment is that we used two distinct instruments to identify disabilities—the CFM with children in the child centers and communities, and the WGSS tool for children in IDP camps. While the CFM is more comprehensive than the WGSS tool, the WGSS tool was selected for use in IDP camps because it is more appropriate for emergency contexts and rapid assessments, such as baseline surveys. Due to its brevity and ease of administration, the WGSS tool is recommended for census or large-scale door-to-door surveys. The CFM instrument is an expanded version of the WGSS and includes the same six domains plus additional domains, so the results are comparable across both groups for those six common domains.

Secondly, due to the complexity of disability\(^{18}\), the WGSS questions were not designed to measure all aspects of difficulty in functioning that people may experience, but rather those domains of functioning that are likely to identify a majority of people at risk of participation restrictions. As a result, it may miss a

\(^{18}\) According to the UN Convention on the Rights of Persons with Disabilities (CRPD), there are a range of disabilities that include “those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others” (Article 1). Available at: http://www.washingtongroup-disability.com/washington-group-question-sets/short-set-of-disability-questions/
significant number of children with developmental or psychosocial limitations. The WGSS may have underestimated the total number of children with disabilities within IDP camps.

Because of limitations in securing necessary approvals from local governance authorities, time and resource constraints, the WGSS survey was restricted to two IDP camps and CFM survey only reached four of the targeted 11 child center communities. Hence, these results are not generalizable to other IDP camps or communities. In the future, with time and local governance authorities’ clearance, Injaz could implement the Child Functioning Modules in all child center communities.

Another limitation is that data was collected through child center staff and Child Protection and Inclusion Committees rather than professionally trained data enumerators. This approach could have caused biased responses or inaccurate responses due to the learning curve associated with applying a new tool. Therefore, the Index for Inclusion results should be interpreted as a generous self-assessment. Most committee members made ambitious statements regarding the inclusivity of their center, envisaging the ideal scenario or reflecting on previous Injaz interventions. For instance, they stated that they already have ‘written’ policies for inclusion; however, in reality, they meant the code of conduct and non-violent classroom management norms co-developed with technical assistance from the Injaz team. However, engaging child center staff in the assessment also contributed tremendously in building the capacities of the center teams and stakeholders. It developed a sense of ownership of the results of the inclusion assessment, contributed to their analysis of the current situation, and facilitated the development of action plans.

As the inclusion topic was a new concept for most child center committees, it was important to discuss the indicators as a group, provide clarifications and allow participants to brainstorm ideas collectively as well as individually. Thus, the responses reflect a consensus score rather than aggregated individual scores since the members of the Child Protection and Inclusion Committees worked collectively to agree on certain scores for each indicator, instead of scoring individually. In the future, they will likely be able to respond individually now that they’re familiar with the indicators and process.

The Index for Inclusion has the potential to identify, describe and categorize the existing barriers and facilitators to inclusion of children with disabilities. This was done within each child center during the participatory self-review of their current policies, practices, attitudes and physical environment. Each center was required to include these barriers and facilitators in their report of the findings of the self-review, and to develop an action plan for mitigating the barriers and facilitating inclusive measures. However, the documentation of the processes and the final reporting of each center varied in quality and were delayed to the extent that we could not include such analysis in the baseline report. The exercise, however, was meaningful since each child center now has an understanding of the existing barriers and facilitators. A programming follow-up is needed to ensure the best utilization of this information to promote inclusion.

H. Findings and Analysis

H1. Results for Child Centers and Communities (Child Functioning Module)

The CBO Child Protection Officers assessed 2,038 children in all 11 child centers using the Child Functioning module and 6,113 children in surrounding four communities. A child was considered as having a functional difficulty if they scored A LOT OF DIFFICULTY or CANNOT DO AT ALL in any one domain. This definition is the cut-off threshold recommended by the Washington Group on Disability Statistics. Injaz had introduced some preliminary inclusion topics during their trainings with child center staff to develop codes of conduct and with teachers while developing classroom norms, but did not cover the dimensions in the Index for Inclusion tool. Thus, some staff may have confused previous knowledge with the indicators and dimensions. The Washington Group recommendation for international reporting is to use “a lot of difficulty” as a threshold for identifying persons with a disability. Therefore, persons who report “a lot of difficulty” or “unable to do” for at least one domain are considered to have a disability. http://www.washingtongroup-disability.com/washington-group-questions-disability-continuum/
addition to these criteria, children aged 5-17 years who have “daily” episodes of anxiety or depression were also considered to have a functional difficulty. The percentage of children reported as having a functional difficulty was **12.3 percent** among all children surveyed aged 5 to 17 years old, including both child centers and surrounding communities with no differences between the two groups.

**Child Center Results**

As noted above, 12.3 percent of children in child centers had functional difficulty in at least one domain, according to child center facilitators surveyed. None of the students had difficulty walking. Five percent had difficulty hearing and communicating. Anxiety and depression were reported for 3 to 4 percent of children. The percentage of children with functional difficulties in the other domains (seeing, self-care, learning, remembering, concentrating, accepting change, controlling behavior and making friends) averaged between one and three percent.

**Exhibit 4: Percent of children in child centers with functional difficulty for the indicated domains**

<table>
<thead>
<tr>
<th>Domain</th>
<th>Percent of Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Difficulty in at least one domain</td>
<td>12</td>
</tr>
<tr>
<td>Depression</td>
<td>3</td>
</tr>
<tr>
<td>Anxiety</td>
<td>4</td>
</tr>
<tr>
<td>Making Friends</td>
<td>3</td>
</tr>
<tr>
<td>Controlling Behavior</td>
<td>2</td>
</tr>
<tr>
<td>Accepting Change</td>
<td>1</td>
</tr>
<tr>
<td>Concentrating</td>
<td>1</td>
</tr>
<tr>
<td>Remembering</td>
<td>1</td>
</tr>
<tr>
<td>Learning</td>
<td>2</td>
</tr>
<tr>
<td>Communication</td>
<td>5</td>
</tr>
<tr>
<td>Self-Care</td>
<td>2</td>
</tr>
<tr>
<td>Walking</td>
<td>0</td>
</tr>
<tr>
<td>Hearing</td>
<td>5</td>
</tr>
<tr>
<td>Seeing</td>
<td>2</td>
</tr>
</tbody>
</table>

There were no significant differences in functional difficulties reported by sex, as illustrated in Exhibit 5.

**Exhibit 5: Percent of boys and girls in child centers with functional difficulties**
According to the results by age group in Exhibit 5, older children aged 15 - 17 had significantly higher functional difficulties compared with younger children in 12 of the 13 domains. Among 50 youth surveyed in child centers, 34 percent have difficulty hearing, 40 percent have difficulty communicating and 50 percent have trouble making friends. Depression, anxiety and difficulty learning were also reported as being more prevalent in older children.
There were stark differences in results by age group. While the percentage of children with a functional difficulty in at least one domain was 10 percent for the 5 to 9 year old age group and 11 percent for the 10 to 14 age group, it increased to 64 percent among children in the 15 -17 year old age group. As noted above, the greatest challenges for youth were making friends and communicating, which could be natural challenges that emerge as children mature or could be due to the conflict, crisis and economic situation. More research is necessary to explain this trend.
Community-level Results

Among the 6,113 children surveyed in surrounding communities, 12 percent (734 children) reportedly have a functional difficulty in at least one domain. The domain with the highest percentage of children was 

Exhibit 7: Percent of children in child centers with functional difficulty in 1 domain by age group
anxiety with 5 percent of children reportedly having this functional difficulty, followed by difficulty communicating and seeing (4 percent). Depression was reported for 3 percent of children in the communities. For the other domains, the percentage of children with the functional difficulty hovered around 2 to 3 percent.

Exhibit 8: Percent of children in surrounding communities with functional difficulty for the indicated domains

<table>
<thead>
<tr>
<th>Domain</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>3</td>
</tr>
<tr>
<td>Anxiety</td>
<td>5</td>
</tr>
<tr>
<td>Making Friends</td>
<td>3</td>
</tr>
<tr>
<td>Controlling Behaviour</td>
<td>3</td>
</tr>
<tr>
<td>Accepting Change</td>
<td>2</td>
</tr>
<tr>
<td>Concentrating</td>
<td>2</td>
</tr>
<tr>
<td>Remembering</td>
<td>2</td>
</tr>
<tr>
<td>Learning</td>
<td>3</td>
</tr>
<tr>
<td>Communication</td>
<td>4</td>
</tr>
<tr>
<td>Self-Care</td>
<td>3</td>
</tr>
<tr>
<td>Walking</td>
<td>0</td>
</tr>
<tr>
<td>Hearing</td>
<td>3</td>
</tr>
<tr>
<td>Seeing</td>
<td>4</td>
</tr>
<tr>
<td>Children with difficulty in at least one domain</td>
<td>12</td>
</tr>
</tbody>
</table>

There was a slightly higher percentage of boys with a functional difficulty in at least one domain. The differences were negligible.

Exhibit 9: Percent of boys and girls in surrounding communities with functional difficulties

21 Anxiety is identified through the question: HOW OFTEN DOES (name) SEEM VERY ANXIOUS, NERVOUS OR WORRIED? WOULD YOU SAY: DAILY, WEEKLY, MONTHLY, A FEW TIMES A YEAR OR NEVER?. Only if child is anxious on “daily” basis is the child identified as having anxiety.
Children in surrounding communities were more homogeneous than children in child centers, with differences of one to two percent between age groups. As gender and age ratios were similar across groups, further research is necessary to better understand this result.
As illustrated in Exhibit 10, the percentage of children in surrounding communities with a functional difficulty in at least one domain was 12.4 percent for the youngest age group (5-9), 11.8 percent for the 10-14 year old age group, and 14.4 percent for the oldest age group (15-17).
H2. IDP Results (WGSS tool)

The table in Exhibit 12 illustrates the findings from the door to door community survey to identify all children with disabilities living in the two targeted IDP camps in Raqqa and Deir Ezzor Governorates. Based on IDP responses to the short set of questions in Exhibit 9, of the 3,751 IDP students surveyed, 96 percent did not have any difficulty doing any of the basic functions (hearing, seeing, walking, remembering or concentrating, self-care, or communicating). Among those with difficulties, about 3 percent had some difficulty, one percent had a lot of difficulty, and less than one percent could not do one of the basic functions at all.

### Exhibit 12: IDP Responses to Washington Short Set Survey Questions

<table>
<thead>
<tr>
<th>Difficulty</th>
<th>No Difficulty</th>
<th>Yes, Some Difficulty</th>
<th>Yes, A Lot of Difficulty</th>
<th>Cannot do at all</th>
</tr>
</thead>
<tbody>
<tr>
<td>Difficulty seeing (even if wearing glasses)</td>
<td>3600</td>
<td>96.3</td>
<td>95</td>
<td>2.5</td>
</tr>
<tr>
<td>Difficulty hearing (even if using a hearing aid)</td>
<td>3598</td>
<td>96.2</td>
<td>108</td>
<td>2.9</td>
</tr>
<tr>
<td>Difficulty walking or climbing stairs</td>
<td>3564</td>
<td>95.3</td>
<td>117</td>
<td>3.1</td>
</tr>
<tr>
<td>Difficulty remembering or concentrating</td>
<td>3575</td>
<td>95.6</td>
<td>125</td>
<td>3.3</td>
</tr>
<tr>
<td>Difficulty with self-care, such as washing all over or dressing</td>
<td>3598</td>
<td>96.2</td>
<td>99</td>
<td>2.6</td>
</tr>
</tbody>
</table>
Exhibit 13 shows the results for IDP children reporting difficulty in performing one of the functions. As illustrated, about 3 percent of students had some difficulty in four of the six categories: hearing, walking or climbing stairs, remembering or concentrating, and communicating. One percent of children had a lot of difficulty seeing even if wearing glasses, and a lot of difficulty walking or climbing stairs. Under 1 percent of children could not do any of the six functions.

IDP children are considered to have a functional difficulty if they reported having a lot of difficulty’ or cannot do at all one of the basic functions. Of the 3,751 IDP children surveyed, 4.4 percent of IDP children (165 children) have a functional difficulty, with 3 percent (113) having a mild disability (some difficulty) and 0.6 percent (45) having a severe disability (30 have A Lot of Difficulty and 15 Cannot Do At All).

H3. Inclusion Results (Index for Inclusion)

A snapshot of the indicators and results for the Index for Inclusion instrument is shown in Exhibit 13. These percentages reflect a consensus score rather than aggregated individual scores since the members of the Child Protection and Inclusion Committees worked collectively to agree on certain scores for each indicator, instead of scoring individually. As the inclusion topic was completely new for child center committees, it was important to discuss the indicators as a group, provide clarifications and allow participants to brainstorm ideas collectively as well as individually. As the objective of the instrument is to conduct a self-assessment in a collective way in order to identify the barriers and work together to develop and implement inclusion plans, this deviation in the implementation was not seen as problematic by the center management teams.

DIMENSION A: - Creating inclusive cultures
This dimension measures the extent to which child centers build inclusive communities and establish inclusive values, such as setting high expectations for all students, sharing a philosophy of inclusion, treating each other with respect, removing barriers to learning and participation, and striving to minimize discriminatory practices.

According to the respondents, most of the elements of positive inclusive cultures exist in the child centers. Over 90 percent of stakeholders reported that the center is a friendly and welcoming place for everyone, including students and staff. The majority fully agree or agree to some extent that students help each other, staff collaborate with each other and staff and center management work well together. Moreover, most stakeholders report there are high expectations for all students and students are equally valued. Supervisors link what happens to the center with the lives of children at home. Staff and students treat one another with respect, staff seeks to remove barriers to learning and participation in all aspects of the centers; and, the centers strive to minimize all forms of discrimination.

On the other hand, only 60 percent of the respondents agreed that staff, center management teams and children themselves share a philosophy of and commitment to inclusion. Also, nearly half of the respondents did not fully agree that there is good partnership between center staff and caregivers. Similarly, half of the participants agreed only to a certain extent that there are linkages between the learning processes and center activities with children’s lives at home. Moreover, 85% of respondents were not satisfied with the extent of local community participation in center activities. They were also dissatisfied with the extent of awareness and accessibility of local resources.

**Exhibit 14: DIMENSION A - Creating inclusive cultures and establishing inclusive values**

<table>
<thead>
<tr>
<th>Dimension A: Create integrative cultures</th>
<th>I fully agree</th>
<th>I agree to some extent</th>
<th>disagree</th>
<th>I want more information</th>
</tr>
</thead>
<tbody>
<tr>
<td>A / 1/1 Efforts are made to make everyone feel welcome and a friendly environment</td>
<td>96.3%</td>
<td>3.7%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A / 1/2 Children help each other</td>
<td></td>
<td></td>
<td>42.6%</td>
<td>55.5%</td>
</tr>
<tr>
<td>A / 1/3 Facilitators/supervisors collaborate with each other</td>
<td>59.3%</td>
<td>40.7%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A / 1/4 Facilitators/supervisors and children treat each other with mutual respect</td>
<td>64.8%</td>
<td>35.2%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A / 1/5 There is a good partnership between supervisors and parents</td>
<td>42.5%</td>
<td>50%</td>
<td>5.6%</td>
<td>1.9%</td>
</tr>
<tr>
<td>A / 1/6 Facilitators/ supervisors link what happens to the center to the lives of children at home</td>
<td>29.6%</td>
<td>63%</td>
<td>5.6%</td>
<td>1.9%</td>
</tr>
<tr>
<td>A / 1/7 There is good cooperation between the facilitators and the child centers administrators</td>
<td>74.1%</td>
<td>25.9%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A / 1/8 Local communities participate in center activities</td>
<td>3.7%</td>
<td>53.7%</td>
<td>31.5%</td>
<td>11.1%</td>
</tr>
</tbody>
</table>

**DIMENSION B: Producing inclusive policies**

This dimension assesses the extent to which policies benefit all students and all forms of academic and behavioral support is organized for diversity. For instance, special educational needs policies should be inclusive so that all children may participate in classes and activities, but they should also receive the
specialized support they need to succeed. Education buildings should be made accessible for all students, barriers to attendance should be reduced, and bullying should be minimized.

In general, around two-thirds of respondents confirmed that the child centers are committed to promoting inclusive education and organizing the necessary support for diversity. About half (52%) agreed that all new staff are oriented to the inclusion policies when they first join the centers. The majority agreed that their center seeks to admit all students from its locality, helps them get settled into the centers and that the center makes its buildings physically accessible to all people. Three-quarters of respondents agreed that barriers to attendance have been reduced for children with disabilities. Over half (63%) agreed that 'special educational needs' policies are inclusive policies.

However, only half agreed that staff development activities help staff respond to student diversity. One-third agreed that all forms of support, including interventions to promote diversity and ensure participation of children with disabilities, are coordinated while 41 percent agreed to a certain extent. The data collected was quantitative, not qualitative, and therefore did not capture more contextual data.

**DIMENSION C: Evolving inclusive practices**
This dimension measures to what extent the child center orchestrates learning and mobilizes resources so that they support inclusion. For instance, teachers should be concerned with supporting the learning and participation of all students, and should plan instruction according to students’ diverse learning needs. Students should be encouraged to be actively involved in all aspects of their education, and student difference should be used as a resource for learning. Staff are expected to identify local resources to support teaching and learning, including through engaging the participation of students, parents/caregivers and local communities in the classroom or center activities.

Over 80 percent of respondents agreed that teaching lessons are planned with the learning needs of all students in mind. Three-quarters agreed that lessons encourage the participation of all students. Over half of respondents agreed that student diversity is used as a resource for learning, that staff expertise is fully utilized, and that students learn collaboratively. The tools did not collect qualitative data to enable a more nuanced understanding of these findings.

Conversely, 44 percent did not fully agree that the centers mobilize resources to support children with special education needs. In fact, only 39 percent agreed that staff develop resources to support CWD learning and participation; and another 36 percent did not fully agree that the testing and examinations contribute to the achievements of all students. Astonishingly, 71 percent of respondents did not fully agree that all students partake in extra-curricular activities (informal PSS activities) outside of the classroom, indicating that CWD are often excluded from such activities.

H3.1 **Analysis of the Index for Inclusion results**
The results should be viewed in light of how the child center staff perceive themselves. According to the Injaz team, they see their child centers as the only child center providing education services to children with disabilities in Raqqa and Deir Ezzor Governorates within the last 5 to 10 years. Even before the conflict began, there were no comparable initiatives. Possibly, there is also a lack of relevant knowledge and insights into other (“more advanced”) initiatives in other similar communities or countries. We further recognize that most of the engaged field staff have a need for recognition and appreciation of their efforts, and thus, they tend to overestimate the impact of their initiatives. However, under all circumstances, it is known that inclusive education is based on quality education and vice versa. As long as quality participatory education is provided in these child centers, it would be relatively easy to introduce and expand inclusive education, if technically supported during the initial period.
I. Conclusions

C1. What percentage of children within the target population have difficulties functioning and participating in daily activities?

Based on the Washington Group definition of a disability, 10 percent of all 11,902 children surveyed have a functional difficulty in at least one domain. Within the target groups, the percentages of students with difficulties was 12 percent in child centers (250 CWDs), 12 percent in surrounding communities (734 CWDs), and only 4.4 percent (165 CWDs) in IDP camps.

The percentage of IDP children with functional difficulties in at least one domain was much lower than might have been expected – one-third of children with disabilities in child centers and communities. This result could be due to different tools administered, and the number and types of domains covered in each instrument. The WGSS tool focuses on physical abilities and cognitive functions, while the Child Functioning Module includes these domains, plus other functions, such as controlling behavior, learning, accepting change, making friends, anxiety and depression. It may be useful to administer the Child Functioning Module with IDP children to cross-examine the results of this assessment.

At the time of the assessment, child centers had reported having 166 children with disabilities across three centers. Thus, the actual number is higher than originally estimated. This may be due to how child centers were identifying children, perhaps giving more weight to the physical impairments rather than the social or emotional difficulties, such as trouble communicating or having anxiety. However, through engaging child center staff in the participatory assessment, capacity has been built in better understanding the definitions and classifications of children with functional difficulties for each target group.

C2. To what extent is each child center ‘inclusive’ and promoting inclusive education?

The Index for Inclusion Assessment conducted in the 11 child centers revealed the existence of a positive, welcoming and inclusive environment, as reflected in the above findings. However, most of the positive answers were referring to existing services in special education classes. There was a misconception that children with disabilities require specialized types of education rather than mainstreaming and accommodations. As a consequence, the few children with disabilities enrolled in the child centers were mostly placed in special education classes regardless of their needs, types and levels of disabilities.

Based on the results of the inclusion assessment, additional awareness-raising and capacity building is needed to overcome some of the misconceptions around the needs of children with disabilities and to improve the degree of inclusiveness across the three dimensions. Child centers, in particular, 1) need to develop a shared vision and inclusive development plan, 2) to establish inclusive education policies to help support the implementation of the plan, and 3) to improve inclusive education practices inside and outside of the classroom to support children with disabilities to equally participate in the classroom and in all child center activities.

The engagement of child center staff in the Disability and Inclusion Assessment was the first step in raising their awareness about inclusive education, building their capacities, and motivating them to continue learning. As a result, staff perceptions have changed and child centers have already begun taking steps to become more inclusive. CBOs ran a competition on how best to include and serve children with disabilities in their centers. Four Child Centers (Partner K, Partner G, and Partner B) decided to expand their services to include children with disabilities. Inclusive actions within these centers included hiring new staff, training existing staff and adding new classrooms. Other child centers decided

22 A child is considered as having a functional disability if they have a lot of difficulty or cannot do at all a basic function in any one of the domains included in the Child Functioning Module and WGSS Disability Questions.
to move some children with disabilities from specialized classes to mainstream classes. Partner E and Partner G employed an additional Braille and additional Sign Language Instructor.

Despite the capacity building activities prior to and during the assessment, there is still the need for continued training and support provision for the child center management and staff. This could be provided through Training of Trainers (ToT) workshops and dissemination of simplified resource materials in Arabic (manuals, audio visual materials, exchange visits, linking with any specialized NGOs, etc). The consultant who led this assessment has provided some technical support through the Whatsapp group, which has facilitated increased enrolment for children with disabilities, further discussion and exchanges of successes and lessons learned.

J. Recommendations

The following recommendations are provided to the Injaz project for strengthening the inclusiveness of child centers and capacities of the center staff to address the special needs of children with disabilities:

1. **Expand the utilization of the UNICEF/Washington Group Child Functioning Module** among teachers to identify children with functional difficulties in child centers, to all child center communities, and council-affiliated schools, pending access. This is crucially important for the identification of children who are at risk of not fully and effectively participating in child center activities due to functional limitations so that appropriate accommodations can be made.

2. **Provide Child Protection Officers and Inclusion Committees with additional training and support to expand their roles in implementing inclusive education plans and to sustain these committees.** They can contribute to early identification of children with disabilities, establishing and supporting a referral system within the CBO network for those who would need more specialized interventions, and supporting the inclusion of children with special education needs in extracurricular and PSS activities.

3. **Increase awareness within child centers about the principles of inclusive education, the benefits and how inclusive child centers can provide strong models in their respective communities for promoting inclusion.** Develop an evidence-based model of inclusive education that would serve as an entry point to encourage young children to respect differences and accept diversity within a society affected by the presence of violent extremist ideologies. Child centers should promote the broader understanding of inclusive education which acknowledges that all children can learn, regardless of their abilities, disabilities, gender, socioeconomic status, psychosocial or health needs, with a specific focus on those who are vulnerable to marginalization and exclusion. Initial awareness-raising and training should emphasize that inclusive education is a process to find better ways of responding to diversity and appreciate differences. It is mainly concerned with the identification and removal of barriers to learning and participation, and is seen as part of a wider strategy to promote an inclusive society.

4. **Drawing on best practices from the DFID-funded Chemonics Manahel project in Northwest Syria, DFID should support the Injaz team to conduct an out-of-school household survey** to identify the number of children excluded or who have dropped out and the explanatory reasons. Such research would be helpful for identifying possible barriers to their inclusion in education services, for developing context-relevant interventions to support the inclusion of all excluded and disadvantaged children, not only children with disabilities, and for increasing enrolment of out-of-school children in both child centers and formal schools.

5. **Share findings of the out-of-school survey (Recommendation #3) with child center staff and jointly develop concrete interventions on how they can help address the barriers.** For instance, child center staff may mobilize caregivers of enrolled students to conduct outreach to parents of out-of-school children and increase their awareness of the education and psychosocial services provided by child centers, including for children with disabilities.
6. **Consider the need for a twin-track approach to inclusive education during humanitarian actions.** On the one hand, education programs should be adapted to be more inclusive and accessible to all children, including children with disabilities. On the other hand, humanitarian interventions should aim to directly address the disability-related needs of children and adolescents with disabilities – for example, by providing assistive devices for children and adolescents with disabilities to support their participation in education. This assessment identified the number of children with disabilities. Further assessment is necessary to identify the specific needs of children with disabilities (e.g., assistive devices, accessible education materials, transportations).

7. **In the future, Disability and Inclusion Assessments should include persons with disabilities in meaningful roles, such as advisors, enumerators, and partners.** Their experience and perspective can inform the whole process and could lead to their support/involvement in implementing education interventions. This was not possible in the current assessment due to the lack of any programs or services for persons with disabilities. Therefore, the Injaz team would need to identify persons with disabilities who could serve in such roles and would need to build their capacity to participate as partners and contributors.