



People for development

DISABILITY INCLUSION AT AVSI LEBANON

Overview and Key Insights

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LIST OF ACRONYMS

CBID	Community-based Inclusive Development
CERD	Center for Educational Research and Development
CWD	Children with Disabilities
EDNA	Emergency Disability Needs Assessment
FCRM	Feedback, Complaint, and Response Mechanism
HDN	Humanitarian-Development Nexus
IEP	Individualized Education Plan
ITS	Informal Tented Settlement
KII	Key Informant Interview
MEHE	Ministry of Education and Higher Education
MHM	Menstrual Hygiene Management
MoSA	Ministry of Social Affairs
MTSS	Multi-tiered System of Support
NARPD	National Association for the Rights of Persons with Disabilities
NDA	National Disability Allowance
OPD	Organization of Persons with Disabilities
PHC	Primary Healthcare Centers
PSA	Psychosocial Approach
PWD	Persons with Disabilities
RECU	Reach, Enter, Circulate, Use
SDC	Social Development Center
SOP	Standard Operating Procedures
TVET	Technical and Vocational Education and Training
UNCRPD	United Nations Convention on the Rights for People with Disabilities
WASH	Water, Sanitation, and Hygiene

1. Introduction

1.1 Strategic Framework

Disability inclusion is a fundamental and integral component of humanitarian and development programming at AVSI. This commitment is derived from a profound understanding that effective and equitable aid delivery necessitates empowerment and reach to all individuals, particularly marginalized groups. Aligned with the *United Nations Convention on the Rights of Persons with Disabilities* (UNCRPD)¹ and rooted in AVSI's core values emphasizing human dignity and person-centered holistic development, disability inclusion is mainstreamed across all departments, activities, and phases of the project cycle, from needs assessment and design through implementation, monitoring, and evaluation. This report provides a detailed articulation of AVSI's multifaceted approach, presents significant achievements in 2024, identifies current operational challenges, and outlines upcoming strategic priorities for Lebanon, featuring an innovative initiative to enhance inclusive accountability.

AVSI's inclusion framework is predicated on an overarching *twin-track approach*, which combines mainstreaming across all universally designed services with the provision of specific targeted support and reasonable accommodations. This dual strategy aims to ensure the equitable participation of *persons with disabilities* (PWD) and to systematically address and dismantle barriers at multiple socio-ecological levels through context-specific adaptations and interventions. The strategic framework adopted aligns with AVSI's *psychosocial approach* (PSA), which recognizes the dynamic interaction between individual experiences and social conditions.

1.2 Sector Positioning and Interagency Networks

AVSI plays a leading cross-sectoral role in mainstreaming disability inclusion in Lebanon through proactive coordination, applied technical expertise, and innovative, sustainable solutions. As a founding member of the *Inclusion Task Team* within the *National Education Sector*, AVSI helped develop the group's terms of reference and work plan, grounded in evidence collected of barriers to inclusive education. In response to the 2024 conflict escalation, the Task Team examined the exclusion, neglect, and abuse faced by PWD and advocated for inclusive approaches within emergency education responses.

AVSI's inclusion specialist also contributes actively to the *Emergency Task Force for Persons with Disabilities*, convened by Lebanon's disability alliance network. This 42-member Task Force, composed of institutional agencies and ministry representatives, has mapped available services, coordinated inter-sectoral aid referrals, and launched disability-inclusive amendments to the *National Emergency Response Plan* (NERP), with AVSI leading the education component. As part

¹ United Nations. (2006). *Convention on the Rights of Persons with Disabilities*.

of its technical contributions, AVSI developed an *Emergency Disability Needs Assessment* (see annex 7.1) for internally displaced PWD. Designed for use by non-specialists, the tool integrates Washington Group questions with a triage approach to identify urgent *water, sanitation, and hygiene* (WASH), health, and protection needs. The tool was adopted by all UNICEF partners across Lebanon for use during the emergency response.

Collaboration remains central to achieving sustainable progress in disability inclusion, particularly in Lebanon's complex and volatile environment. AVSI engages in interagency coordination at local, national, and regional levels. This includes grassroots WhatsApp groups in South Lebanon and Nabatieh, which connect caregivers, non-governmental and *community-based organizations* (CBOs) to facilitate referrals and financial support; national health, protection, and education sector working groups. A key initiative has been the mapping of disability actors, thematic sub-groups, community-based *organizations of persons with disabilities* (OPDs), and relevant government units, enabling timely referrals and improved response mechanisms.

Moreover, the AVSI inclusion specialist contributed to three national consultative workshops throughout the development of the *National Policy for Inclusive Education for Children with Special Educational Needs* in 2023², led by the *Ministry of Education and Higher Education* (MEHE) with support from UNICEF and the European Union. Public and private disability stakeholders who participated were tasked with ensuring that the policy reflects ground-level realities.

These interagency efforts reinforce cross-sectoral mainstreaming, facilitate the exchange of good practices, identify barriers and emerging gaps, and strengthen collective advocacy. As a cornerstone of AVSI's inclusion strategy, this collaborative role enhances service delivery, informs resource allocation, supports policy development, and promotes inclusive humanitarian coordination for greater impact.

2. Contextual Challenges in Lebanon

Despite significant progress in mainstreaming disability inclusion in Lebanon over the years, remaining systemic gaps impede equitable access to services and full participation of PWD in society.

² Ministry of Education and Higher Education. (2023). *National policy on inclusive education for children with special needs in Lebanon*. Center for Educational Research and Development.

2.1 Institutional Procedures and Structural Coordination

- Legal Framework and Enforcement:** While Lebanon has legal provisions pertaining to disability, particularly *Law 220/2000*³, implementation and enforcement remain fragmented and inconsistent. While the development of a national inclusive education policy represented a key step forward in the ratification of this legislation, implementation remains limited. Furthermore, while the *Ministry of Social Affairs (MoSA)* issues disability cards and supports access to some services, there is no standardized referral mechanism between schools and health providers. This leads to significant delays in assessment, rehabilitation, and follow-up care, especially for marginalized children in remote areas. In terms of livelihood, there is no enforcement of the 220/2000 law, which mandates a 3% employment quota for PWD in public and private institutions. Insufficient anti-discrimination legislation and clear accessibility standards across sectors continues to impede the full realization of rights for PWD. There are currently no penalties for non-compliance and no oversight mechanisms. Most schools, health facilities, and workplaces remain physically inaccessible with very minimal provision of reasonable accommodations.
- Intervention Protocols:** The absence of clear and regulated *standard operating procedures (SOPs)* for disability support, particularly in terms of assistive device provision and rehabilitation services, significantly compromises both quality and safety. SOPs should cover minimum qualifications for specialists, standardized assessment tools, decision-making criteria for device selection, customization requirements, delivery protocols, caregiver training, and structured follow-up.

There have been numerous process variations detected among organizations. For example, orthopedic assessments are conducted by medical doctors, physical therapists, or orthopedic technicians using physical examinations and/or diagnostic imaging. Since inaccurate specifications in orthotic prescriptions can hinder mobility development, exacerbate misalignments, or cause skin sores, the 'Do No Harm' principle is counterproductively compromised⁴. This is also commonly seen in hearing aids provided that are either incompatible or are not properly recalibrated after 30 to 40 days to ensure auditory input is optimized and not distorted. Failure to provide the correct type of hearing aid with diligent follow-up has often been shown to result in discontinued use, selling the device, distress, and impaired language acquisition. Additionally, failure to train beneficiaries or caregivers on basic device care, battery replacement, cleaning, and safety checks leads to preventable breakdowns, injury, or device abandonment. Practical standards are made further ambiguous by inconsistent institutional regulation as well as

³ Republic of Lebanon. (2000). *Law No. 220 on the Rights of Persons with Disabilities*. Official Gazette, Issue No. 6.

⁴ World Health Organization. (2017). *WHO standards for prosthetics and orthotics*.

unclear professional or educational requirements of specialists providing various therapy and rehabilitation services. Without unified official SOPs in place, interventions are vulnerable to error, inefficiency, and harm.

- **Inter-Sector Mainstreaming:** A harmonized approach to disability mainstreaming across all sectors yet to be adopted, which impedes the delineation of a clear referral pathway (see section 2.2), limits systemic progress towards full inclusion, and leads to inadequate consideration of cross-cutting needs. In practice, some sectors continue to address disability in an ad hoc manner, often relying on isolated short-term initiatives rather than universal planning or budgeted integrated strategies. The absence of cross-sectoral disability inclusion working groups or technical monitoring units limits institutional learning and operational coherence.

In the WASH sector, infrastructure frequently fails to meet accessibility standards. For example, latrines installed in collective shelters during the conflict were constructed with narrow entrances, on stairs without ramps, and insufficient turning radius, making them inaccessible to individuals with mobility impairments. Similarly, hygiene and dignity kits distributed rarely accommodate the specific requirements of PWD such as incontinence briefs and pads, long-handled hygiene aids, or reusable user-friendly menstrual underwear with lateral openings. In parallel, there are minimal guidelines for adapting *menstrual hygiene management* (MHM) information sessions to accommodate women and girls with disabilities (see annex 7.3). In the health sector, public *primary healthcare centers* (PHCs) are often physically inaccessible due to architectural barriers. Even when services are available, communication and information remain exclusionary. These sector-specific gaps are compounded by the absence of shared inclusion standards, indicators, and accountability mechanisms.

2.2 Resources and Data Management

- **Funding and Resources:** Disability inclusion efforts in Lebanon are increasingly constrained by significant and compounding funding shortfalls. In recent years, there have been major funding reductions in humanitarian aid from key donor governments. The 2023 USAID funding freeze led to the immediate suspension of programs and funding pipelines within an already declining humanitarian financing landscape. As disability inclusion is often deprioritized in emergencies where lifesaving needs dominate, it is one of the first areas to face cuts. Additionally, The MoSA faced longstanding budgetary constraints that hinder its ability to provide benefits to disability card holders, with the exception of a newly launched *National Disability Allowance*, a minimal monthly sum of \$40 USD only eligible to PWD between ages 18 and 28 years old⁵. Since MoSA is largely

⁵ Ministry of Social Affairs. (2023, April 26). *The Ministry of Social Affairs introduces a social protection programme for people with disabilities in Lebanon*. International Labour Organization.

responsible for supporting Lebanese citizens, while the humanitarian system primarily covers non-Lebanese populations, disparities in the distribution of aid and services contributes to rising social tensions. In a 2024 emergency response assessment conducted by AVSI Lebanon⁶, several organizations who provided specialized services and assistive devices for PWD in the South and Nabatieh governorates terminated support due to funding cuts; even though it was also reported that a large number of individuals were identified with newly acquired disabilities as a result of the conflict with limited options for referral (see annex 7.4).

- **Demographic and Prevalence Data: Sex, age, and disability disaggregated data (SADDD)** by geographic location in Lebanon remain critically lacking and largely unreliable due to the use of varying operational definitions of disability and incompatible screening tools for identification. This was further exacerbated after the economic crisis in Lebanon, as PWD no longer received valuable benefits from the MoSA through disability cards, leading to reduced registration and underreporting, which contributes to the systemic “invisibility” of many PWD who remain uncounted. Incomplete and heterogeneous data impedes effective needs assessments, resource planning, and inclusive service delivery. In the absence of comprehensive disability data, needs assessments often overlook those with the most complex or intersecting impairments. For example, many inclusive programs primarily distribute corrective eyeglasses to individuals with common visual impairments that can be fully corrected. While vision correction is an important health service, its use as a proxy indicator for disability inclusion is misleading. It inflates coverage statistics without addressing the needs of those facing structural exclusion, such as persons requiring assistive technology, personal assistance, accessible transportation, or inclusive education and employment pathways. The result is a continued exclusion of those most at risk of being left behind.
- **Referral Pathways:** The absence of a functional and widely recognized referral system, with guidelines for informed consent, data protection, eligibility criteria, response timelines, tracking, and feedback mechanisms creates critical delays and inefficiencies in service provision. Without a unified system, referrals are often made inconsistently, leading to fragmented care and reinforcing the misconception that inclusive services are unavailable. Service providers may lack visibility into available services while PWD frequently remain unidentified or unserved, particularly those with complex or multiple needs. In many projects, it becomes evident that some individuals receive duplicate services, while others are excluded because such services are not listed in existing service maps or referral directories. Additionally, informal tracking and follow-up prevent timely confirmation of service uptake and limit opportunities for case monitoring and cross-

⁶ AVSI (2024). Situation Report. *Emergency response in Lebanon: Insights on needs and gaps*.

sector coordination. This undermines accountability, inflates costs, and erodes trust among PWD and caregivers.

2.3 Accessibility Barriers

- **Information and Service Directory:** Persons with sensory, learning, or intellectual disabilities are often unable to access information about available services independently. Standard communication materials often lack accessible formats such as audio messages, local sign language interpretation, and visual aids. As a result, PWD are excluded from critical information related to health services, protection mechanisms, education opportunities, and aid distributions. This also increases reliance on caregivers or intermediaries, undermining the autonomy and dignity of PWD and raising privacy and protection concerns.
- **Infrastructure and Environment:** Many institutions and facilities such as schools, universities, community centers, healthcare centers, *social development centers* (SDC), government buildings, municipal offices, and *informal tented settlements* (ITS), remain physically inaccessible. Common barriers include the absence of ramps or elevators, narrow doorways, uneven or unstable terrain, and non-adapted WASH facilities.

Even where rehabilitation efforts have been made, they are often partial or not functionally practical. For example, while a ramp may be added at a building entrance, the facility may still lack accessible toilets or sufficient turning radius within rooms. In other cases, ramps are constructed with inappropriate slope ratios or without proper handrails, making them unsafe or unusable. The implications of such environmental inaccessibility are wide-ranging. Structural investments in accessible infrastructure must consider the entire journey of the user. Without such holistic planning, interventions remain incomplete and largely symbolic, and they fail to create sustainable inclusion for PWD.

- **Transportation:** Transportation is a major barrier to inclusion for PWD in Lebanon due to high costs and inadequate infrastructure. Public buses are inaccessible, and there are minimal pedestrian options as sidewalks are limited and often broken or obstructed, especially outside urban areas, which are prerequisite for tactile guiding systems on pavements or accessible pedestrian signal systems at crosswalks. Alternatively, wheelchair-accessible vehicles are extremely limited and expensive. As a result, persons with disabilities face severe mobility restrictions that limit their access to education, employment, health care, and community life.
- **Emergency Preparedness:** Lebanon's NERP does not account for the specific needs of PWD during crises. As seen during the recent armed conflict, PWD were largely overlooked, resulting in exclusion from accessible shelters, municipal evacuation

initiatives, equitable aid distribution, access to critical information and security alerts, which increased risk of injury, illness, and even death. It was reported that many PWD were left behind in high-risk areas in the South governorate and Beirut suburbs (see annex 7.4). In several documented cases, PWD experienced serious health deterioration due to interrupted access to essential medication, equipment, or care. Families with PWD were either not admitted to collective shelters or were later removed because their needs were perceived as too demanding. CWD in shelters were especially vulnerable. Some reportedly faced corporal punishment due to behavioral expressions, often linked to sensory overstimulation in overcrowded and noisy environments. Caregivers of children with developmental disorders, such as autism, also reported eviction threats unless they controlled their children's behavior. In one documented instance, a caregiver resorted to pharmacological sedation⁷. The lack of inclusive emergency preparedness and risk mitigation has shown to result in greater exposure to injury, illness, neglect, and trauma.

2.4 Social Marginalization

- **Stigma and Discrimination:** Although progress has been made in awareness-raising, stigma and discrimination against PWD continues to restrict social inclusion, service access, and overall well-being. Common misconceptions and the perception of familial burden contribute to exclusion, isolation, and emotional distress, particularly in community and institutional settings. Charity and medical models of disability, wherein PWD are regarded as pitiful or defective, perpetuate social stigma and discourage self-identification and disclosure. Discriminatory practices reduce participation in public life, employment, and education, undermining the principles of dignity, autonomy, and equal opportunity.
- **Older Persons with Disabilities:** Lebanon has the highest demographic of people over 60 years old in the MENA region, accounting for 11% of the population. Older PWD experience compounded marginalization due to the intersection of ageism and ableism. They are often excluded from disability programming, underrepresented in aging services, and overlooked in policy planning. A recent needs assessment found that an alarming 40% of older PWDs did not receive any humanitarian assistance during the conflict escalation in September 2024, which then further increased to 61% of older PWD who reported not having received any aid after November 2024⁸. Results reflect common challenges faced by older PWD, namely limited access to assistive devices, inadequate long-term assistance, and a lack of integrated healthcare that addresses both age-related and pre-existing disabilities. Their social isolation, reduced mobility, and economic

⁷ AVSI (2024). Situation Report. *Emergency response in Lebanon: Insights on needs and gaps*.

⁸ HelpAge International. (2025). *Needs assessment of older people in Lebanon after the Israel–Lebanon cross-border escalation of September–November 2024*.

vulnerability further exacerbate exclusion, underscoring the need for targeted, cross-sectoral interventions that uphold dignity and autonomy.

- **Public Representation and Leadership:** PWD remain significantly underrepresented in leadership roles across government, civil society, and the private sector. Their exclusion from public decision-making processes limits their influence on policies and services that affect their lives, reinforcing systemic ‘invisibility’ and marginalization. This barrier directly opposes *Article 29* of the UNCRPD.
- **Employment Opportunities:** Employment barriers for PWD persist due to inaccessible workplaces, exclusionary hiring practices or employer bias, and limited access to inclusive *Technical and Vocational Education and Training* (TVET). These challenges contribute to disproportionately high unemployment rates and ongoing economic exclusion, undermining financial independence, and increasing vulnerability. They also lead to an overreliance on informal or charitable employment models that are highly susceptible to exploitation and abuse.

2.5 Education

- **Dropout Rates:** There is substantial evidence in the literature demonstrating significantly higher dropout rates among CWD compared to peers. This widely reported trend is driven by a range of intersecting barriers including inaccessible school environments, lack of individualized support and accommodations, social stigma and bullying, and economic burden linked to tuition costs, transportation, assistive devices, or specialist support, making sustained attendance unfeasible. In low socio-economic status communities, a prevailing discriminatory perception recorded is that CWD have limited potential; therefore, education is often regarded as futile. Instead, CWD are withdrawn from school at an early age and directed towards exploitative activities, such as begging or informal child labor, to contribute financially to the household. Nevertheless, inclusive formal and non-formal education services at AVSI have shown an average retention rate of 97% from 2022 until 2024, which reflects the impact of technically robust program design on mainstreaming disability⁹.
- **Inclusive and Specialized Schools:** Following the recent scale-up of the MEHE initiative to strengthen inclusive education in Lebanon with the support of UNICEF, there are 110 officially established inclusive public schools scattered across Lebanon. However, for many CWDs, attendance requires long commutes that are costly or unsafe, particularly for children in rural areas, undocumented refugees, or residents of conflict-affected zones.

⁹ AVSI (2024-2025). Activity Info Database.

To make matters more challenging, the recent conflict caused severe damage to key infrastructure in the country, particularly in the South of the country and in the southern suburbs of Beirut. For example, the only inclusive school in the Marjayoun district, Khiam primary public school in Khiam (right), has been largely destroyed. AVSI is planning rehabilitation works to support the safe return of its diverse student body (below).



Khiam Primary Public School



Damaged books and debris



Discussion with school principal

Despite notable developments in Lebanon’s inclusive education framework, in practice, CWD are still systematically excluded. Even in public schools designated as inclusive, in 2023, it was reported that CWD only represent 0.5% of the students enrolled¹⁰. In particular, children with severe intellectual, developmental, or sensory disabilities are frequently refused admission, citing ill-equipped infrastructure, insufficiently trained staff, or limited capacity to provide individualized support. As a result, these children are either diverted to institutional care or remain confined without access to formal education or pathways for social participation.

In parallel, specialized schools that cater to children with severe disabilities are limited in number, concentrated in urban centers, often unaffordable for low-income families, and tend to operate at or beyond full capacity. These institutions lack coordination under a unified framework, leading to marked disparities in both service quality and pedagogical approaches. For example, fragmented sign language instruction further disrupts continuity of learning across settings, language development, communication, interpreter training, and consequently, inclusive education. Overreliance on segregated schooling reframes the right to education as a form of ‘special care’, which in turn reinforces dependency and perpetuates stigmatization.

¹⁰ Humanity and Inclusion. (2023). *Inclusive education in Lebanon: Briefing paper*.

- **Teacher Capacity and Bias:** There is an evident gap in the overall capacities of teachers to apply inclusive teaching strategies in the classroom. Many have reported little confidence in identifying CWD and adapting learning material to accommodate diverse needs. Alongside rigorous and evidence-based pre-service and in-service training, teachers require technical support from specialists, such as special educators. Furthermore, while teachers' attitudes towards inclusion have shown improvement over the years, biases among educators and administrators continue to obstruct inclusive education, which directly impacts efficacy of inclusive education programs. Teachers who perceive disability inclusion as overly expensive, difficult, time-consuming, detrimental to overall academic standards, cumbersome, or unnecessarily laborious are less likely to implement effective strategies regardless of training. As a result, learners with disabilities are excluded from meaningful participation, assigned irrelevant tasks, or left without appropriate support, contributing to academic disengagement, behavioral difficulties, and early dropout. Capacity building, supplementary support, and positive attitudes form a necessary combination widely recognized in literature positioning teachers as central actors in the success of inclusive education.

2.6 Protection

- **Violence, Abuse, and Exploitation:** PWD are more likely to experience violence, abuse, neglect, and exploitation due to communication barriers, dependency on caregivers, limited mobility, and social isolation. These risks are particularly acute for individuals with intellectual or psychosocial disabilities who may be unable recognize abuse, understand their rights, or report violations independently, as distress signals can be more easily misunderstood or ignored. CWD are also more likely to face abuse and exploitation, including child labor, early marriage, and forced begging. In the absence of appropriate behavioral support, incidents of corporal punishment, physical restraint, and overmedication are frequently documented. Exclusion from protective environments, such as schools, safe shelters, and community-based programs, further increases long-term exposure to harm, trauma, and social marginalization. The lack of targeted safeguarding measures for PWD across sectors results in inadequate response, which perpetuates cycles of abuse and impunity.
- **Family Separation and Institutionalization:** CWD are at significantly higher risk of family separation and institutionalization due to absence of caregiver support, perceived familial burden, and displacement, particularly during emergencies and protracted crises. Placement in boarding institutions or residential alternative care is associated with exposure to neglect, abuse, and poor developmental outcomes. The lack of family-centered support services further contributes to institutional reliance and, in some cases, abandonment. During the conflict for example, AVSI found that PWD in the South and

Nabatieh governorates, mostly dependents within their households and not the decision-makers, reported a sense of helplessness and deep fear of being left behind and forgotten (see annex 7.4).

- **Disclosure and Reporting Harm:** The lack of available confidential reporting mechanisms that are readily accessible to PWD further compounds vulnerability and protection risks by limiting opportunities for safe disclosure of violations, filing complaints, or seeking redress. Standard hotlines and reporting mechanisms rarely accommodate diverse communication needs. Additionally, most systems are not designed to allow for third-party or proxy reporting, which is often essential for individuals with limited autonomy or who fear retaliation. The absence of inclusive channels not only deters reporting abuse, exploitation, and neglect, but also results in underrepresentation of PWD in accountability data. This limits opportunities for redress and adaptation of programs based on feedback. Without inclusive safeguarding and feedback mechanisms, the principle of "do no harm" cannot be upheld, and protection violations may persist unaddressed.
- **Intersectional Vulnerability:** Multiple and intersecting factors such as gender, age, refugee or stateless status, disability type, and socio-economic deprivation compound the exclusion and marginalization experienced by PWD. Women and girls with disabilities are at significantly greater risk of gender-based violence. Older PWD, particularly those living alone or in informal settlements, also frequently face barriers to accessing age-appropriate inclusive health, nutrition, and protection services. Finally, refugees and displaced PWD may avoid seeking services altogether due to legal insecurity, discrimination, or fear of arrest. These intersecting vulnerabilities exacerbate protection risks, increase invisibility within response mechanisms, and contribute to chronic neglect across the humanitarian-development nexus (HDN). Without targeted and intersectional approaches, inclusive services risk failing to reach those most at risk.

2.7 Health

- **Disability-Specific Healthcare Services:** PWD face significant challenges accessing long-term health services and medical care. Public and non-governmental health systems and programs often prioritize acute and life-saving interventions, while chronic care and rehabilitation are underfunded or excluded altogether¹¹. As a result, consumable yet essential medical supplies such as colostomy bags, urinary catheters, oxygen concentrators, adult incontinence products, and specialized feeding tubes are inconsistently available or completely absent from service delivery packages. Similarly, access to maintenance medication for noncommunicable conditions related to

¹¹ World Health Organization. (2011). *World report on disability*.

disabilities, such as epilepsy, spasticity, or mental health disorders, is unreliable and expensive. Moreover, non-emergency medical interventions, such as cochlear implants, orthopedic corrections, oral and maxillofacial surgeries (e.g., cleft lip/palate repair or glossectomy to improve speech and swallowing), are rarely covered by national health systems or humanitarian funds, despite their critical role in restoring function and preventing secondary complications. These systemic gaps reduce quality of life, increase risk of hospitalization, and undermine the autonomy and participation of PWD in daily and community life, particularly in contexts of displacement or extreme poverty. Following the conflict, the loss of medical and therapeutic services has exacerbated the conditions of CWD in the Nabatieh governorate, as confirmed by school directors, caregivers and teachers interviewed by AVSI in May 2025. Findings also confirmed the emergence of disabilities directly linked to the conflict, including traumatic brain injuries, limb loss and hearing impairments resulting from war-related violence (see annex 7.6).

- **Disability Competence Among Health Professionals:** Health professionals often lack the training, awareness, and competencies required to provide inclusive and rights-based care to PWD. Medical and nursing curricula frequently omit modules on disability rights, etiquette, inclusive communication, or rehabilitation principles. This gap reinforces harmful stereotypes, such as viewing disability solely through a medical or charity lens, rather than a human rights-based approach. In practice, this translates into dismissive attitudes or inadequate accommodations. Research indicates that healthcare workers may underestimate pain, disregard consent, or deprioritize treatment for PWD, especially those with intellectual or psychosocial conditions¹². Without systematic capacity building and supervision, health professionals remain ill-equipped to uphold inclusive standards of care, perpetuating exclusion, medical neglect, and long-term disparities in health outcomes for PWD.

3. AVSI Approach: Mainstreaming and Intervention

AVSI's commitment to disability inclusion is operationalized through a series of interconnected and technically robust strategic pillars, each designed to foster an environment characterized by equity, dignity, and meaningful participation. The pillars listed below align with the Humanitarian-Development Nexus (HDN)¹³ by addressing both immediate needs and long-term systemic barriers, promoting continuity between emergency response and sustainable development outcomes.

¹² World Health Organization. (2022). *Global report on health equity for persons with disabilities*.

¹³ United Nations Office for the Coordination of Humanitarian Affairs. (2019). *The humanitarian-development nexus*.

3.1 Capacity Building

The efficacy of AVSI's disability inclusion strategy is contingent upon the capabilities of human resources. Consequently, the organization prioritizes rigorous, evidence-based training and practical workshops for staff and stakeholders. Training packages are meticulously designed to combine relevant theoretical knowledge with practical skills applicable in specific contexts.

Investment in these areas ensures personnel possess up-to-date information, sensitivity, and practical tools necessary for effective inclusive practice across all operational sectors, including education, WASH, protection, and livelihoods. This continuous professional development cultivates a culture of competence, empathy, and technical proficiency, which enhances the quality and inclusivity of interventions.

Key Training Domains:

- **Foundations of Disability Inclusion:** presenting the rights-based model, principles of the UNCRPD, intersectional vulnerability, and disability etiquette.
- **Accessibility Assessment and Rehabilitation:** using the *Reach, Enter, Circulate, and Use* (RECU) framework for evaluating physical accessibility of infrastructure (e.g., schools, centers, public spaces) and identifying low-cost practical adaptations in accordance with international accessibility standards and national regulations.
- **Identification, Intervention, and Referral:** applying Washington Group screening tools to identify PWD based on functional limitations, developing action plans for practical support, and using referral mechanisms and pathways.
- **Community-Based Inclusive Development (CBID):** supporting grassroots, locally driven, inclusive development by mobilizing communities, families, and OPDs by building local capacity, promoting disability rights, and fostering sustainable, community-led support systems for PWD¹⁴.
- **Accommodations and Adaptations:** implementing pragmatic accessibility solutions for barrier removal in various areas, such as communication, mobility or self-care, to promote equitable and meaningful participation.
- **Universal Design for Learning (UDL):** creating inclusive learning environments to include flexible ways for students to access content (e.g., text, audio, visuals), engage with activities (e.g., choice in tasks or group work), and demonstrate understanding (e.g., drawings, written reports, or oral presentations). Instead of retrofitting for individual

¹⁴ UNICEF. (2021). *Engaging with organizations of persons with disabilities in humanitarian action*.

needs, the research-based UDL framework anticipates learner diversity by building options that support different abilities, interests, and learning styles¹⁵.

- **Individualized Education Plans (IEP):** designing tailored educational plans to address unique learning needs of students with disabilities who require more intensive intervention provided at Tier 3, beyond the general support provided at Tier 1 or the small groups targeted at Tier 2 within a *Multi-Tiered System of Support (MTSS)*. Personalized goals include a combination of environmental accommodations (e.g., extra time, preferential seating), instructional adaptations (e.g., reducing length of task, adjusting response modality from written to oral), and content modifications (e.g., simplifying lesson objectives, reverting to prerequisite skills) to ensure meaningful access to learning. Typically, about 1% to 5% of students in an inclusive classroom could benefit from IEPs applied through collaboration between members of a multidisciplinary team that includes educators, specialists, and families.¹⁶

3.2 Screening and Assessment

Reliable, internationally recognized, and contextualized Washington Group tools are employed for consistent identification of PWD of all ages nationwide, such as the contextualized *Washington Group Short Set Questions* in Levantine Arabic, adapted specifically for Lebanon by the Center for Educational Research and Development (CERD), which is integrated in all AVSI outreach forms. Assessment of disability is done through the Washington Group Short Set of question. Also, the *Child Functioning Module* is filled for students between 4 and 17 years old referred to the inclusion team for case confirmation within education programs in Beirut, Mount Lebanon, Beqaa, Nabatieh, and the South. These tools are globally recognized for their capacity to generate comparable data on disability across diverse contexts, focusing on functional limitations rather than medical diagnoses.

Coupled with key informant interviews and naturalistic observation, this approach facilitates the nuanced identification of disabilities across multiple domains such as communication, mobility, self-care, sensory processing, learning and cognition. Structured data collection is further augmented by needs-based screenings, such as vision tests, audiograms, or orthopedic assessments, conducted by qualified professionals to ensure a comprehensive and precise understanding of individual needs, functional abilities, and specific barriers encountered. This granular understanding informs the design of responsive and effective interventions.

¹⁵ CAST. (2024). *Universal Design for Learning Guidelines version 3.0*.

¹⁶ MTSS Center. (2025). *Special education and MTSS*. American Institutes for Research.

3.3 Specialized Services

AVSI offers a range of specialized rehabilitation services delivered by qualified contracted professionals for targeted support of PWD. In 2024, 263 specialized services were provided for Lebanese and Syrian CWD, enrolled in formal and non-formal education, between ages 4 and 15 years old in Beirut, Mount Lebanon, Beqaa, Nabatieh, and the South. These services play a critical role in facilitating program participation, promoting functional independence, and improving quality of life. Rehabilitation and therapeutic interventions include speech and language therapy, occupational therapy, and physiotherapy. Specialized services also encompass special education support, such as orientation and mobility training for individuals with visual impairments and local sign language instruction for individuals with hearing impairments.

These services are either center-based, provided within educational centers of AVSI or partners through pull-out sessions, or clinic-based, provided at a third-party clinic usually covering cost of transportation. While clinic-based interventions allow beneficiaries and caregivers to share scheduling preferences and encourage more active engagement, prior experience has shown that center-based intervention is more cost-effective, less operationally demanding, encourages collaboration between specialists and teachers in educational settings, enhances quality control and monitoring, improves attendance rates, and reduces protection concerns associated with limited supervision during transportation and at clinics. These interventions significantly contribute to the empowerment of PWD by equipping them with essential communication tools, critical life skills, and foundational support necessary for accessing broader opportunities.

3.4 Assistive Devices and Technologies

AVSI also provides assistive devices and technologies to substantially facilitate learning, foster greater independence, and ensure equitable participation for PWD of all ages. In 2024, devices were distributed in Beirut, Mount Lebanon, Beqaa, Nabatieh, and the South. In alignment with global initiative such as the Global Cooperation on Assistive Technology¹⁷, AVSI aims to provide devices that are appropriate, user-centered, and meet specific individual needs by contracting qualified technicians and service providers who adhere to standard guidelines for assignment, follow-up, and calibration. Assistive devices and technologies include mobility aids (e.g., wheelchair, orthosis) to enable greater physical autonomy, sensory aids (e.g., hearing aid, corrective eyeglasses) to improve visual and auditory perception, WASH aids (e.g., bathroom commode, toilet chair) to facilitate safe and dignified hygiene practices, and digital accessibility tools (e.g., screen reader, speech-to-text software) to enhance communication and access to resources. Provision of these technologies is typically accompanied by training for users and caregivers on maintenance to ensure long-term benefit and sustainable impact.

¹⁷ World Health Organization. (2014). *Global Cooperation on Assistive Technology (GATE)*.

3.5 Parental Engagement

Recognizing the pivotal role of caregivers in the well-being, development, and advocacy for CWD, AVSI often integrates supplementary support groups using the *Parental Engagement Curriculum for Caregivers of Children with Disabilities* developed by UNICEF in 2021. The sessions aim to disseminate information on disability rights and available services, encourage exchange of practical strategies and coping mechanisms for everyday challenges, and foster collective advocacy efforts to champion the rights and inclusion of their children. Significantly, these sessions also offer critical psychosocial support, cultivating a sense of solidarity and reducing isolation by building resilient communities of empowered caregivers who can draw upon shared experiences and mutual encouragement. This active engagement reinforces community capacity and contributes to the establishment of influential networks driving sustainable social behavioral change, consistent with family-centered practice models in disability services¹⁸.

3.6 Accessibility Rehabilitation

AVSI undertakes minor rehabilitation works to enhance the physical accessibility of essential community infrastructure, such as educational institutions and community centers. These interventions are guided by site assessments that evaluate barriers according to the RECU framework to implement reasonable and cost-effective adaptations where appropriate. All upgrades comply with accessibility standards from *International Organization of Standardization under 2154 - Accessibility and Usability of the Built Environment*¹⁹ as well as pertinent national guidelines and regulations from the *Lebanese Code for Accessibility in Buildings* issued by the Order of Engineers and Architects and the Ministry of Public Works and Transport²⁰. Examples include the installation of ramps with compliant gradients and handrails, widening of doorways, and modification of bathroom facilities to include accessible toilets, grab-bars, and sinks. These minor adjustments (> 2% of total project budgets²¹) represent important steps toward creating safer, more inclusive, and dignified environments by implicitly increasing community sensitization to accessibility considerations, visibility, and participation of PWD.

¹⁸ Dunne, L., Godfrey, R., & Vance, M. (2019). *Supporting families of children with disabilities: Evidence-based practice in early intervention*.

¹⁹ International Organization for Standardization. (2021). *ISO 21542:2021 – Building construction: Accessibility and usability of the built environment*.

²⁰ Order of Engineers and Architects. (2016). *Code for accessibility for persons with disabilities in buildings and facilities*.

²¹ Humanity and Inclusion, & HelpAge International. (2018). *Humanitarian inclusion standards for older people and people with disabilities*.

4. Achievements and Insights

4.1 Factsheet: 2024 at a Glance



Inclusive activities delivered were adapted for equitable access and meaningful participation.

During conflict escalation in September, AVSI activated Rapid Response Mechanisms within emergency programs to promptly address the emerging needs of PWD.

- Non-Formal Education
- Retention Support
- Cash Assistance
- School Accessibility Upgrades
- Art Therapy
- CBO Localization
- SDC Support & Capacity Building
- Digital Literacy & STEM Programs
- Recreational Activities
- MHPSS
- MHM Awareness

4.2 Inclusive Accountability

As part of an ongoing commitment to inclusive and rights-based programming, AVSI developed an accessible communication video to support equitable access to the *Feedback and Complaint Response Mechanism* (FCRM). With a focus on universal design, the video incorporates local sign language interpretation, captions, voiceover narration, and visual aids to ensure information is accessible to a wide range of users, including persons with disabilities (see annex 7.2). This initiative reflects a broader effort to strengthen inclusive accountability across all AVSI programs. It aims to improve the collection of feedback from diverse perspectives to inform adaptive programming. It also seeks to identify and address accessibility gaps and barriers through evidence-based adjustments, and to promote the autonomy and self-advocacy of persons with disabilities. Additionally, it contributes to reducing challenges related to fear, stigma, or reliance on intermediaries in reporting protection concerns, supporting earlier identification of potential risks. Importantly, the initiative reinforces AVSI's organizational commitment to disability inclusion and to recognizing persons with disabilities as rights-holders with meaningful contributions to make. It is also designed to foster trust, visibility, and a sense of belonging among persons with disabilities, while encouraging their active participation, as well as that of caregivers of children with disabilities.

4.3 Gender and Disability

To promote the equitable participation of girls and women with disabilities across all programming, MHM sessions were specifically adapted for girls and women of reproductive age with disabilities in Nabatieh, Lebanon (see annex 7.3). Targeted sessions were held in two specialized schools catering to students with various disability types and age groups. Prior to delivery, WASH officers and the inclusion specialist conducted consultations with school directors to establish the specific needs of each group. To strengthen accessibility and meaningful participation, facilitators employed multimodal teaching approaches such as tactile storybooks, sequencing cards illustrating hygiene routines, and WhatsApp-linked audio guides in colloquial Lebanese Arabic to reach participants with low literacy or visual impairments. Sessions also incorporated demonstrations with menstrual dolls and practice materials to normalize menstruation and reduce anxiety among participants with intellectual and developmental disabilities. Adapted MHM kits were distributed, including reusable menstrual underwear with lateral Velcro openings. The presence of caregivers, who often reported keeping girls with disabilities home during menstruation, was leveraged to reinforce skills at home through structured visual routines and gradual transfer of responsibility, while peer support activities were introduced to reduce stigma and foster social inclusion. These combined adaptations sought not only to address immediate hygiene needs but also to advance dignity, independence, and the long-term participation of girls and women with disabilities in education and community life.

5. Recommendations and Future Directions

AVSI adopts a rights-based twin-track approach that centers PWD as active participants. This strategy builds on over a decade of inclusive service delivery in Lebanon across both emergency response and longer-term systems strengthening, ensuring that disability inclusion efforts are technically rigorous and contextually relevant. Notable contributions to policy, national strategy, and infrastructural accessibility reflect a humanitarian-development nexus approach.

To overcome ongoing challenges moving forward, system-level initiatives should be prioritized:

- **Procedural standardization and transversal regulation** across humanitarian sectors and governmental ministries should be developed to uniformly guide accessible communications, infrastructure rehabilitation, identification and referral, and provision of specialized services and assistive devices. This requires close intersectoral collaboration to ensure safe and gender-sensitive disability inclusion that holistically addresses intersectional vulnerabilities. Established standards should then be embedded into national frameworks and response protocols.
- **Strengthening disability data systems** is another critical step toward harmonizing and centralizing key information needed to identify service gaps, inform interventions, promote transparency, and enhance accountability. This can be achieved by collecting and reporting SADDD, using standardized tools such as the Washington Group sets, training data collectors to avoid biased phrasing and ensure inclusivity, establishing a multisectoral centralized referral platform to facilitate continuity of support, and disseminating information through accessible channels.
- **Targeted protection interventions** build on these structural foundations to address the diverse and intersecting vulnerabilities of PWD. Peer support networks, safe disclosure spaces, and caregiver capacity building are also critical to psychosocial wellbeing and resilience, particularly for older persons and women with disabilities who face compounded discrimination and isolation. To mitigate protection risks, accessible and confidential reporting mechanisms, legal aid support, advocacy campaigns, and capacity building on identification and response to protection risks through an intersectional lens should be developed to counteract abuse within households and institutions. Concurrently, *Mental Health and Psychosocial Support* (MHPSS) interventions must explicitly consider barriers such as stigma, inaccessibility, and information gaps. Services must be adapted and decentralized to accommodate diverse needs and scale up home-based or mobile options to expand reach.

- **Strategic investment in inclusive education** is the central to sustainably mainstreaming disability inclusion, as it instills values of diversity and lays equitable foundations for active participation in society. Accessible and supportive environments cultivate empathy, reduce stigma, improve academic performance, and expand employment prospects. In this way, education functions as a strategic entry point for fostering social cohesion, economic inclusion, and generational transformation. Enhancing inclusive education in Lebanon requires dedicated resources for specialized support staff, capacity building, bias sensitization, caregiver engagement, targeted vocational programs, and accessibility rehabilitation. Nevertheless, achieving meaningful inclusion is contingent upon bridging the expertise of specialized institutions with the reach of inclusive schools through partnerships that promote collaboration, knowledge exchange, resource sharing, and mutual commitment to establishing pathways that progressively transition CWD into mainstream formal education.
- **Continuity of care and access to consumable supplies** are crucial to PWD, although many initiatives with short funding cycles and vertical priorities only offer immediate relief (e.g., outbreak control or trauma care). Universal health coverage principles must be adopted to ensure equal access to preventive, curative, rehabilitative, and palliative care services for PWD across the lifespan. Caregivers should receive basic training to reduce risks of complications and institutionalization. Additionally, developing a sustainable system for the uninterrupted reliable provision of essential health and WASH supplies is imperative for preserving safety, functioning, and participation of PWD. These include medications for chronic conditions, inclusive WASH items, and medical supplies (see section 2.7). To ensure dignified and equitable access for those unable to reach health facilities, flexible delivery systems, such as door-to-door distribution or home-based follow-up.
- **Empowering and institutionalizing OPDs** is paramount to upholding the UNCRPD principle “nothing about us without us” and ensuring efforts are grounded in lived realities, responsive to need, and technically robust²², as it is PWD themselves who are most knowledgeable of their own needs. This is achieved by strategically embedding the community-based actors in all aspects of program design, planning, delivery, monitoring, and evaluation. By establishing formal participatory mechanisms, underpinned by budgeted long-term partnerships rather than ad hoc consultation, OPDs will be empowered to lead with authority, represent diverse perspectives, and drive systemic change across policy and practice.

²² UNICEF. (2021). *Engaging with organizations of persons with disabilities in humanitarian action*.

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7. Annex

7.1 Emergency Disability Needs Assessment (2024)

7.2 Accessible Video on FCRM (2025)

7.3 Inclusive Menstrual Health Management Guidelines (2022)

7.4 Emergency Situation Report: Needs and Gaps (2024)

7.5 Key Informant Interview with NARPD (2025)

7.6 Multisectoral Needs Assessment (2025)