A study of mainstream education opportunities for disabled children and youth and early childhood development in Iraq.

Report

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Volume 1

Table of Contents

ACKNOWLEDGEMENTS (alphabetical order)

1.   INTRODUCTION

This report presents the major findings from the UNICEF commissioned research into mainstream educational opportunities for disabled children and young people and early childhood development in Iraq together with recommendations arising from the research. A model for training primary school teachers and providing professional development for qualified and practicing teachers is also attached to this report (Volume 3). The training model for teachers is entitled: *Inclusive schools for Iraq*.

This report is the final stage of our consultation and analysis strategy. The report not only aims to describe the research findings and table recommendations for consideration and action, but it is also offered to:
   o   Encourage further support to those working on the ground in Iraq consistent with the key findings of the research;
   o   Encourage those in decision-making positions in government and community organisations to act on the recommendations given the urgency of the issues for establishing mainstream opportunities for those disabled children and youth who are excluded from education in Iraq;
   o   Sustain the engagement of those who will continue to address the issues identified in this research.

The research team suggests that this report should provide the basis for follow-up discussions between the senior cross-government officers who previously met in Erbil in December 2010 to discuss the interim findings from the research.[1]

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[1] The delegates at this consultation meeting are listed in the Appendix 1 'Stakeholder Consultation Meeting Erbil December 2010'.

Divided into eight sections, this final study consultation document comprises:
- The background to and objectives and overview of the research, including definitions of key terms used in the research;
- Description of the research methodology, including an explanation of data collection, consultations and analysis;
- Findings from the household survey of early childhood development and childhood disability;
- Discussion of the findings in relation to developing inclusive education in Iraq;
- Report recommendations; and
- References.

2. STUDY BACKGROUND, OBJECTIVES & OVERVIEW

2.1 Study Background

At the outset of this report, it is important to acknowledge the unique context of Iraq and the difficulty that people face in conducting everyday life in a country that has endured protracted war, international sanctions and the associated extreme levels of suffering and poverty. Our meetings with people in Iraq and consultations at key stages of this research constantly reminded us that many of the things we take for granted living outside of Iraq do not apply when thinking about education reform for Iraq. The destruction of Iraq's education and health infrastructure and the assassination and forced exile of so many Iraqi professional people, including teachers, doctors, nurses, academics and senior civil servants, means that it is more precise to describe the task as rebuilding rather than reforming education.

These circumstances underline the urgency and scale of the tasks confronting Iraq in undertaking the provision of both the early childhood development and educational infrastructure, including buildings, health workers, social workers, teachers, classroom assistants, and instructional materials and the transformation in thinking about disability to promote mainstream opportunities for an inclusive education. At this point in time, according to our observations, education in Iraq is predominantly characterised by the separation of disabled children and youth from mainstream education. Where disabled children and youth are included in their neighbourhood schools, support for their participation and transition to further educational opportunities or employment are extremely limited.

Early childhood care and education services are extremely under developed in Iraq. This represents a major risk with respect to child wellbeing and educational outcomes. The UNESCO Education for All (EFA) Dakkar Framework for Action, adopted by the World Education Forum in Senegal in 2000, establishes early childhood care and education as its first priority, and commits to: (i.) Expanding and improving comprehensive early childhood care and education, especially for the most vulnerable and disadvantaged children. The present gap in support for early childhood care and education has been identified in our current study and there is a need for the Iraqi government to bring early childhood care and education forward in its planning. Early childhood care and education is also a first step in building an inclusive education system.

While the context of Iraq is extremely challenging, it may also be seen as an opportunity. There is an opportunity to reconsider how the education system, commencing with provisions for early childhood care and education can be designed in a more inclusive way. There is no reason to adhere to old structures that divide special and regular education. Building two systems of schooling is extremely costly, and so wasteful of scarce resources. It also divides communities and makes it far more difficult for disabled children and young people to experience optimal educational opportunities and be connected with the local community. Adhering to inclusive education ideas, models and practices is an acknowledgement of research from around the world that tells us that disabled people's education, employment and life chances are improved when they experience an inclusive rather than a segregated education system (Crawford, 2004; Ainscow & Miles, 2008; Slee, 2010).

As stated in the Phase One Report submitted to UNICEF in April 2010,[2] there has been a growing international movement of advocacy for the rights of disabled people. There are

presently 148 country signatories to the United Nations Convention on the Rights of Persons with Disabilities and Optional Protocol (United Nations, 2006) and, of these, 90 have been ratified. Article 24 of the convention specifically addresses the importance of an inclusive mainstream education as a gateway to employment opportunities, civic membership and authentic life choices for children and young people with disabilities. Throughout the world the opportunities of disabled children and young people are compromised through ongoing stigmatisation and marginalisation, which accrue from prejudice, shame and inferior educational provision and opportunities.

Presently Iraq does not give force to legislation that effectively protects the rights of disabled people, nor has it embarked on a national education strategy to raise disability awareness to change social attitudes and institutional structures and policies that obstruct or compromise the participation of disabled people in regular community activities such as education and employment. It is also important to acknowledge that Iraq has not yet declared an intention to sign and ratify the United Nations Convention on the Rights of Persons with Disabilities and Optional Protocol (United Nations, 2006). Although the Disability and Special Needs Bill has been drafted, it awaits final approval from the Council of Ministers. This report recommends legislative reform as a precondition to support local initiatives to improve the mainstream education opportunities of children and young people in Iraq.

Inclusive education is often misunderstood and there are many different interpretations around the world. It is seen by some as a process of strengthening the capacity of an

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[2] CARA (2010) *A study of education opportunities for disabled children and youth and early childhood development in Iraq. Phase One Report*, London, Council for Assisting Refugee Academics, page 4.

education system to reach out to all learners in the community. It is an overarching principle to guide all educational policies and practices, starting from the belief that education is a basic human right and the foundation for a more just society. Inclusive education takes the *Education for All* (EFA) (UNESCO, 1994) agenda forward by finding ways of enabling schools to serve all children in their communities, with a particular focus on those who have traditionally been excluded from educational opportunities – such as learners with special needs and disabilities, children from ethnic and linguistic minorities, children living in poverty, nomadic communities, refugee and homeless children and so on. Inclusive schools offer a more cost-effective means of achieving EFA. The Salamanca Statement declared its commitment to *Education for All* children in their neighbourhood school[3], by recognising the necessity and urgency of providing education for all children and young people 'within the regular education system.' It asserts that children with special educational needs *'must have access to regular schools'*.

This report acknowledges that the introduction of early childhood development programmes and inclusive education requires a process of reform where ideals are not instantly achieved in circumstances of scarce resources. There must be a progressive transition of support and training to existing child and child-health services and to neighbourhood schools to enable them to provide the conditions to support and educate all children. The recommendations of this report therefore acknowledge the extreme context of Iraq and they frame national and local interventions to establish support for early childhood development and systematically build more inclusive educational opportunities for disabled children and young people.

Making education inclusive: increasing educational opportunities for disabled children and young people in Iraq Of course legislative reform will not in itself produce the changes required to education in Iraq. The very basic elements of educational infrastructure such as more and safe buildings, qualified teachers, classroom assistants and instructional materials are also required to support a transition to inclusive education.

International sanctions from 1990 isolated Iraq from changing global attitudes to, and the growth in advocacy for, regular educational provision for disabled children and young people. Inclusive education is a process involving the transformation of schools and other centres of learning to cater for all children – including boys and girls, students from ethnic minorities, those affected by illness and pandemic, homeless and refugee children, and those with disabilities and difficulties in learning. It recognises that education takes place in many contexts, both formal and non-formal, and within families and the wider community. Consequently inclusive education is central to the achievement of high quality education for all learners and the development of more inclusive communities.

If disabled children do not have the opportunity to develop their potential during the critical years of childhood, their families are at risk of becoming poor. Making education more inclusive is a key feature of the United Nations Convention on the Rights of Persons with

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[3] See Salamanca Statement and Framework for Action on Special Needs Education, UNESCO (1994) *Final Report: World conference on special needs education: Access and Quality.* Report for UNESCO (Paris); Slee, R. (2010) *The Irregular School.* Abingdon, Routledge.

Disabilities and Optional Protocol (United Nations 2006). Iraq is not yet a signatory, but the Disability and Special Needs Care Bill is in the process of becoming law. Inclusive education is a precondition of the broader goals of social justice and social inclusion and contributes to the Millennium Development Goals of eradicating extreme poverty and achieving universal primary education.

The right of all children to education, including disabled children, has been enshrined in the 2005 Iraq Constitution (see Article 32 and Article 34):

2005 Iraqi Constitution: Articles 32 & 34

Article 32: The State cares for the handicapped special-need people and ensures their rehabilitation for their reintegration into society. This shall be regulated by law.

Article 34: First: Education is a fundamental factor in the progress of society and is a right guaranteed by the State. Primary education is mandatory and the state guarantees to combat illiteracy. Second: Free education at all stages is a right for all Iraqis. Third: The State encourages scientific research for peaceful purposes that serve humanity. And it supports excellence, creativity, invention and the different aspects of ingenuity. Fourth: Private and public education is guaranteed. This shall be regulated by law.

However, Iraq faces major challenges in the development of an education system that is inclusive of all children. These difficulties are not only due to isolation from the international movement of '*Education for All*', but also reflect the degradation of Iraq's specialist human capital through the mass departure of trained professionals, and the near complete collapse of educational and health infrastructure as a consequence of protracted conflict, international sanctions, hyperinflation and poverty. This report recognises the extreme conditions under which Iraq is struggling to rebuild public health services and educational capacity.

'Daily life for the majority of Iraqis is still associated with a lack in basic necessities including electricity, water, sanitation, food, access to employment, education and health services.' CARA Phase One Report, 2010.

Poor school attendance has been an enduring problem for Iraq. This is hardly surprising given the destruction and dilapidation of infrastructure (buildings, equipment and curriculum materials), the dwindling numbers of teachers and the poor state of security. Ministry of Education statistics reveal that in 2007 only 30% of Iraq's 3.5 million school-aged children were attending classes. This stands in contrast to the previous school year when 75% attended regularly.[4] Al-Obaidi and Budosan report increased rates of absence amongst

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[4] Baker, Ismael & Ismael (2010) page 130.

disabled children.[5] Our interviews support the general perception that school attendance for disabled girls is even less likely.

Reforming public services such as health and education continues to be compromised by the impacts of pervasive threats to security. COSIT (2008) has recognised the importance of structural reform and reducing corruption as crucial to Iraq's economic growth and stability. The present division of fiscal and administrative responsibilities in Iraq compromises the development of a planning ethos and strategic capacity with clear articulations within and between Ministries. This predicament was reported in the CARA Phase One Report:

'Two complementary laws: 1976 Mandatory Education Law (Article 9 [modified][1]) – a first step towards inclusive education in primary school grades 1 to 4 – and Modified 1980 Social Care Act No 126[1] went some way towards clarifying ministry roles and responsibilities, whereby the Ministry of Education (MoE) became responsible for the education of those with special needs who were not included in Act 126, and MoLSA for the institutional care of the disabled (e.g. institutions dedicated to specific disabilities such as visually or hearing impaired) and orphanages.

Albeit important milestones, these two laws did not reflect the complexities associated with disability and special needs care and education, despite the growing number of disabled in Iraq as a consequence of war.

They also promoted division rather than coordination between the ministries and failed to impact in any systematic or meaningful way on Iraq's school and care systems. This failure reflects to a great extent Iraq's economic state due to the debilitating nature of the UN sanctions through the 90s, the resulting paucity of training and modern teaching aids, the loss of specialist teachers and the lack of investment, degradation and insufficiency of school buildings and equipment.'

CARA Phase One Report, 2010.

This failure was confirmed by the Phase 1 visits to state schools undertaken by Dr Al-Hashemy in the four study governorates (see Section 10, CARA Phase One Report).

2.2   Scope and Objectives

The paucity of data relating to the prevalence of childhood disability and to early childhood development across Iraq impedes efforts to develop systematic policies, programmes and support services. Responding to the need for detailed information to add to existing data available from government departments and other stakeholder organisations, UNICEF commissioned this research with the following objectives:

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[5] Al-Obaidi and Budosan (2011) page 38.

__Early Childhood Development__ (0 - 8 years, ie. excluding 8 year olds*)*

To provide recommendations and guidelines that will inform the development of a comprehensive national strategy and policy on early childhood development to support improved coordination, institutional and human capacity, the expansion of services and the quality of early childhood development programmes, in addition to improving budget allocation awareness and raising awareness of early childhood development issues.

Although early childhood development (ECD) provision should be argued for all children, it is important to acknowledge the role it has to play in supporting inclusive education. ECD programmes refer to a range of educational, health diagnostic and support services, and to public education about early child development, nursery and pre-school education provisions. Early diagnosis and attention childhood development needs is critical to school readiness, inclusion and achievement.

__Education Opportunities for Disabled Children and Youth__ (0 - 18 years, ie. excluding 18 year olds) The development of contemporary and inclusive policies, strategies, programming approaches and initiatives to improve the quality of education for children with disabilities and ensure their inclusion at the primary education level.

Pursuant to the development of contemporary and inclusive policies, strategies, programming approaches and initiatives to improve the quality of education for children with disabilities and to ensure their inclusion at the primary education level, a 'baseline assessment' to establish prevalence of children with physical, mental or other disabilities, description of 'situation' and 'conditions' for disabled children, and current support levels was necessary. To achieve the research objectives the team engaged in a household survey to ensure the equal representation of young children attending school and those not attending school. In addition to the large-scale household survey, the research also employed a series of representative semi-structured interviews and focus group discussions. The interviews and focus groups were representative of stakeholders including those involved in education, social care, parents, disabled persons, government and community.

The inclusive education component of this research provides baseline findings as the foundation for the larger UNICEF project to increase mainstream education opportunities for disabled children and young people.

UNICEF Implementation Project Objectives

Objective 2. Capacity building of the government to implement the new policies and initiatives for children at all levels: central, directorate, district, community, and school in a phased manner in selected pilot locations.

Objective 3. Implementation of new policies and programmes through direct support of 30 targeted schools in 4 governorates by the end of 2010.

2.3   Key Terms

There are often both fundamental and subtle differences in the way groups of people working in different disciplines and contexts use the same language. This is exacerbated as researchers work across Arabic, Kurdish and English. We recognise this is an important issue for effective communication between stakeholders in the current research. Therefore, to aid common understanding of the issues under discussion, a glossary of key terms follows:

Early Childhood Development (ECD) is used in the study to refer to the ordered emergence of interdependent skills of sensor-motor, cognitive-language, and social-emotional functioning with a focus on children under 8 years of age and particularly on the first years of life when development is most rapid.

Inclusive Education refers to the practice of including all children in their neighbourhood school regardless of impairment. Inclusive education is an education aspiration and strategy, where barriers to access, participation and success in schooling are systematically dismantled through the reform of curriculum (what we teach), pedagogy (how we teach – instruction and assessment), and the physical and cultural arrangement of schools. Here we embrace Education For All (EFA) as mobilised through UNESCO and UNICEF and represented in the Millennium Goals.

Impairment refers to a difficulty in physical or mental functioning that is long standing. Within the questionnaire the word 'difficulty' is used to refer to impairment because less stigma is attached to the term.

Disability refers to the interaction of personal impairment with aspects of relevant social contexts. Identification of disability therefore is a twofold process:

i. Identification of an impairment (described in the survey as a 'difficulty' that is longstanding); *and*

ii. Identification of a setting in which the person is unable to participate on equal terms with other users because their impairment is not accommodated. In the terms of this survey the context of particular interest is educational.

> *Examples*
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> *i.* A person who has a leg missing (due to birth defect, or accident, or an act of war) who is given an effective prosthesis (false leg) and consequently can function in the full range of social settings (home, community, education), is not considered to have a *'disability'*. In this case, the person does not experience *'disability'* due to access to appropriate rehabilitation.
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> *ii.* A person whose leg muscles do not function, who is provided with a wheelchair, is still unable to access environments where there are physical barriers to wheelchair use. For example because of a lack of smooth streets, or due to steps in front of or inside buildings that cannot be climbed while using a wheelchair. This person is therefore 'disabled' in these environments.

Disablement and Enablement refer to a society's responses to impairment, illness, or difference. In other words a society may enable or disable people with impairments, illnesses, or differences through its culture, organisation, beliefs and practices by changing physical arrangements such as architecture and cultural values such as assumptions about what is normal, communities may become more or less disabling, more or less enabling.

Cognitive impairment refers to developmental delay in attaining typical levels of intellectual functioning. This is often due to incomplete formation of physical structure of the brain or of neurological function that occurs for a wide variety of reasons which may be known or unknown (for example: hydrocephalus, Down's syndrome).

Mental health difficulties refers to impaired cognitive functioning due to illness that may be temporary or ongoing (for example: psychosis, depression, anxiety disorders, obsessive compulsive disorders and so on).

Confirmed risk of mental health difficulties In this study we used the Strengths and Difficulties Questionnaire to stream for mental health issues, an instrument that has been confirmed by other studies as being sufficiently sensitive to identify many children who have a confirmed diagnosis of mental illness, in that their overall score lies in the 'abnormal' or 'probable diagnosis' range (Goodman, 1997; Goodman et al, 2000). For the purposes of this study, children who score in the 'abnormal/probable' range are labelled 'confirmed risk' of mental health difficulties.

Sensory impairment refers to difficulties with vision and/or hearing caused by incomplete development of 'sensory equipment' (the ear or eye) or of the regions of the brain that interpret sensory signals from these organs, or post natal damage of these due to illness or trauma. Such impairments may be relatively minor, leaving the individual with some residual sight or hearing, or profound where the individual has no functional vision and or hearing.

Household refers to <u>all persons</u> accommodated within a single dwelling where this is their only, or main residence. It is important to be clear that **'household' is not equivalent to 'family'**.

Nuclear Family refers to a family comprising mother, father and all their children.

Extended Family refers to a family that comprises varying combinations of mother, father and all their children together with other relatives such as grandparents, uncles, aunts, and cousins.

Situation refers to the geographical, religious and civil attributes of the location where interviewed households reside. It encompasses aspects of environmental characteristics (such as access to potable water), cultural characteristics (such as lifestyle guidance from civil and religious authorities) and civil characteristics (such as the extent of educational provision or rehabilitative support available).

Conditions refers to the current living conditions of the household interviewed. It encompasses aspects of household specific configurations including: the household and its amenities, adult educational levels, household income and access to key assets such as transport.

Current support refers to support received aimed at, or likely to impact on, optimum child development and educational opportunity and achievement. Support may comprise paid or unpaid elements and may involve family, household, community, statutory or voluntary actions (including NGO and religious organisations) or financial aid.

Status of young children and families refers to the development of young children (0-8) and '*conditions*' and '*current support*' experienced by children and their families in the household as defined above.

Vulnerability refers to a state of high exposure to certain risks combined with reduced ability to protect or defend against risks and cope with negative consequences. A person can suffer from multiple or cumulative vulnerabilities. It is possible to distinguish between types of vulnerability:
- Environmental (living in high-risk area)
- Structural (attributes such as gender, race, impairment, illness, occupation or social class and status)
- Role (relationships involving high or significant degree of commitment – marriage or tenancy)

Disadvantage occurs when structural obstacles (created by society) inhibit access to resources, benefits and opportunities. 'Obstacles' derive from power relationships and the relative value society gives each group. The structural causes (structural vulnerability) that underlie disadvantage include: race, ethnicity, gender, religion, indigenous or national origin, socio-economic status, level of education attainment (qualifications), disability, and geographic location.

Building refers to a relatively permanent structure that has a roof and walls, and may have several levels. A building may comprise a single or many dwellings

Structure refers to the manner in which a building is constructed, reflecting the materials used and construction techniques employed.

Dwelling refers a self-contained unit of accommodation within a building where all the rooms are within entrances, that only those residents within the dwelling may use. For example, a single house in large grounds, or a single apartment in a building containing 20 apartments.

Institution refers to a building in which services are provided exclusively to a particular client group. Clients may be children alone, or children and adults. An institution may focus on a single client group, such as those who are difficulties with vision or with hearing and speech, or may cater for people with a wide range of difficulties. Clients may be resident in such

institutions permanently, with little contact with family members, or resident part of the time, spending some time with family members.

Segregated Special Education refers to the practice of placing children with impairments in separate schools or institutes that are often created specifically for children with the same category of impairment (physical, sensory, cognitive or behavioural).

Hawzin's Story (**Erbil)** Hawzin is 7 years old and has been diagnosed as having a ventrical septal defect (hole in the heart). Hawzin's father does not work as he suffers from diabetes and a blood disease. Her three older brothers support the family by working as construction labourers. The family was supposed to receive some statutory payment for Hawzin, but has received no money from either the government or any other organization.

Hawzin's mother was told to register Hawzin with the authorities and she has registered her daughter twice but this has not led to any offers of assistance or financial support. Other families in similar situations seem to have received pensions or land, including other families living on the same street as Hawzin. Hawzin's mother has given up trying to register her daughter now and has resigned herself to the reality of not receiving any state support.

3.   METHODOLOGY

3.1   Research Structure

UNICEF selected three survey governorates: Baghdad, Erbil and Basra where there were indications that disability was more prevalent. The choice between Wassit and Najaf as the fourth was left to the team leaders who selected Najaf to better reflect the diversity of Iraq.

Meeting the research objectives required a mixed methodology and six research phases:

Research Phases

Phase 1. Introduction of study, consultation with key stakeholders and secondary data collection.

Phase 2. Design of survey methodology and instruments.

Phase 3. Recruitment and training of the survey team.

Phase 4. 4 governorate household survey (Baghdad, Erbil, Basra, Najaf) and qualitative components – i.e. one-to-one interviews with institutional personnel, key stakeholders and selected households, coupled with key stakeholder focus groups: local government, community, religious leaders; health-workers; school principals, special-needs teachers, standard teachers, etc.   Data entry.

Phase 5. Initial data review; consultations with senior Ministry representatives and interim reporting.

Phase 6. Completion of analysis; delivery of study outputs and recommendations.

Phase 1 of the study commenced the consultations that feature throughout the research and involved the collection of contextual information to underpin the development of the research instruments (see Appendix 3). The Iraq Research Team Leader, Dr. Jawad Al Hashemy, held a series of meetings with senior representatives from relevant Ministries (e.g. the Ministry of Labour and Social Affairs [MoLSA], the Ministry of Education [MoE], and the Ministry of Health [MoH]); Parliamentary Committees (e.g. Education, Women & Children); representatives from the Education Directorates and COSIT, and a number of other key stakeholders at the national, regional and local governorate level.   Key characteristics such as statutory provision and supplementary support were identified. Extensive background information was obtained, including available MoLSA and COSIT data sets on schools and disability. Phase 1 tasks also included visits to schools and Institutes. Professor Slee and Dr Alborz were also able to meet with the KRG Minister for Education, Mr Safeen Dizayee, and with senior officers from the Ministry of Education Special Education Department.

The fieldwork in the four governorates comprised two main strands: a quantitative household survey using a fully structured interview with a key household informant, and individual semi-structured interviews with representative key stakeholders (including institutional personnel) and focus group discussions. A third strand on residential care institutions was incorporated into the qualitative component.

Strand 1: The Household Survey
This survey employed cluster sampling of households in localities and involved an interview with a lead informant for the household (normally a parent) using a fully structured questionnaire. The survey gathered data on development and 'status' of young children (0-8) and their families, and screened all children within households for disabilities. The survey identified vulnerable and disadvantaged children and the current sources of support used by households to promote child well-being and educational opportunity. Within the survey localities a team of two interviewers completed house-to-house surveys aiming to locate and complete interviews in households containing children aged up to 18 years. Fieldworkers identified and completed interviews at 20 households with children in each locality. Interviews were designed to take up to 1 hour and thirty minutes on average. See Appendix 3 for details of the household survey

Strand 2: Stakeholder Interviews and Focus Group Discussions
This research component involved semi-structured qualitative interviews with household members identified by interviewers in the household survey to represent a range of household and family situations identified by screening. These interviews provide further detail of the living situation, experiences and aspirations of families with vulnerable children. The interviews also reflect the challenges faced by a range of stakeholders in supporting households with children with disabilities. Guidance was provided to team leaders on the range of stakeholder groups to participate in the semi-structured interviews and focus group discussions. These included: community leaders; civil servants, school principals and classroom teachers; health and social care workers; representatives from disability organizations and activists; disabled people and caregivers; Institute personnel. (See Appendix 3 for rationale for stakeholder interviews and focus group discussions.)

3.2   Sampling Criteria and Selection

A number of areas were selected within each governorate to collectively reflect its key characteristics, on the basis of the geographic and economic demographics of the local populations (urban to rural divide and affluence to poverty spectrum, coupled with conflict and contamination dimensions, the latter spanning 'natural', 'industrial', 'warfare', 'other' or 'none'). (See Appendix 4 for details).

Dr. Al-Hashemy and his colleagues identified suitable areas drawing on Phase 1 secondary data and local knowledge, including advice from local government representatives. Within each area, survey 'localities' (Primary Sampling Units) comprising approximately 50 households were identified, with the spread of households reflecting population density within the area. 'Localities' ranged from a single street, to an apartment block, to an entire village or a cluster of isolated rural dwellings. A final random selection, through which up to

50% of proposed localities were eliminated, was undertaken by the UK research team to limit the possibility of selector bias.

3.3 Sample Size

The target number of respondents set for each of the governorates corresponded to their population sizes: Baghdad 2,000; Basra 1,500; Najaf 1,000; Erbil 1,500. These numbers were higher than required to ensure sound analysis of governorate level data. This allowed the data to be broken into sub-groups of interest such that groups remained large enough to allow robust analysis. The actual number of surveys administered overall slightly exceeded the target. In total, 6,032 valid questionnaires were completed, with a breakdown as follows: Erbil 1,507 (25%); Baghdad 2,022 (33%); Najaf 999 (17%) and Basra 1,504 (25%).

3.4 Fieldworker Training

Members of the UK Research Team travelled to Erbil to conduct a workshop to introduce the Iraqi survey teams to the issues being investigated in the household surveys, interviews and focus group discussions: early childhood development; disability; and inclusive education. The survey team members were familiarized with the survey instruments and it was trialled in Erbil. Survey Team Leaders were also introduced to the qualitative components of the research and interview techniques for one to one interviews and focus groups. Specific training was also provided for the team who would be entering the data from the completed survey questionnaires. The research training workshop provided an opportunity to test translations and to check on the cultural implications of specific questions for Iraq.

3.5 Fieldwork

The survey was implemented by 7 Iraqi survey teams over a period of 4 months. Two were Kurdish speaking and dedicated to Erbil. The other 5 teams collectively surveyed the remaining 3 governorates. Each team had a team leader and 10 fieldworkers, male and female. Within the localities, allocated by the team leader, a team of two interviewers completed house-to-house surveys aiming to locate and complete interviews in households containing children from birth up to 18 years of age.

3.6 Approaches to Analysis

Completed questionnaires were collected by team leaders and verified prior to delivery of batches to the data entry team. The data from questionnaires was entered into an SPSS database for analysis and checked for accuracy. Once complete, the database was compressed and sent to the UK team for further preparation for analysis. When the integrity of the database had been established, data analysis was undertaken using STATA and SPSS 16 statistical packages. Analyses were conducted for the sample overall and then separately for each governorate. Additional analyses reflected key variables that described, or were likely to impact on the status of the children. These included the age groups of children surveyed and aspects of the conditions in which they lived, including relative

household wealth, and educational attainment of parent and spouse. Initial descriptions of the data were shared with the research stakeholder consultation group in a meeting in Erbil in December 2010 (see Appendix for stakeholder consultation meeting delegates). Further analyses were undertaken in early 2011 responding to comments from the stakeholder delegates and examined situational factors relating to locality in which they lived.

The qualitative research comprised semi-structured one-to-one interviews and focus group discussions with a broadly representative cohort of stakeholders in each of the four governorates. The qualitative research was used to augment the findings from the household surveys. Transcripts were compiled from audio recordings, with interview note-takers notes as back up, and then translated from Arabic and Kurdish to English prior to coding. The transcripts are illuminating, providing insights into a range of community perceptions about support services and childhood disability; its causes and prevalence; the social reactions to disability; and the challenges that confront disabled people, their families, educators, service providers and government in Iraq.

Transcripts were analyzed according to sub-groups in each governorate:
- o Government officials;
- o Community leaders;
- o School principals / classroom teachers;
- o Parents or caregivers of a disabled child;
- o Disabled people;
- o Institution managers;
- o Non Government Organization (NGO) representatives; and
- o Academics.

The transcripts were coded, through a process of labelling, categorising and making inferential memos (Miles & Huberman, 1994; Punch, 2005), according to the repeated appearance of words, concepts and issues. These were then organised into themes and direct quotes were gathered to represent the views from the field. The "voices from the field" are integrated within the document and discussion of the research findings. The aim is to provide a sample of the perspectives offered by interviewees and focus group discussants.

3.7 Consultation
Consultations are an important part of the research strategy. Their main function was:
- o To gather information directly from key stakeholders on the ground in Iraq;
- o To gather initial responses to the proposed research;
- o To establish the status quo with respect to attitudes and opinions concerning early childhood development and the mainstream education opportunities for disabled children and young people;
- o To establish the range and availability of services and programme initiatives;
- o To seek reactions to our on-going analysis of the data;
- o To elicit responses to the findings and gather strategic and logistical advice for the research recommendations concerning early childhood development, the extension of inclusive education opportunities for disabled children and young people, and the model for teacher training in inclusive education from senior Ministry and

community representatives charged with responsibility for implementation of early childhood development services and inclusive education.

The first round of consultations was conducted as part of Phase 1 of the research (see research phases above). In addition, a consultation meeting was convened in Erbil to assemble senior Ministry representatives from national and regional governments (see Appendix 1: UNICEF/CARA Consultation Meeting 15-16 December 2010 Participants and discussion summary). This consultation involved the presentation and discussion of interim research findings, views on the purposes of education and disability awareness, a discussion of challenges and obstacles, together with a preliminary consideration of priorities for recommendations.

Key meeting outcomes included the clarification of stakeholders' perceptions about:
- o the purposes of education and early childhood development for children in Iraq
- o the role of inclusive education
- o the priorities for education reform
- o the priorities for early childhood development
- o the barriers, challenges and opportunities in reforming education and early childhood development in Iraq.

The views expressed by delegates at the meeting fell into four broad areas
- o *Improvement of the individual* Developing individual skills and knowledge.
- o *Development of Human Capital* Training individuals for the workforce is part of the goal of education.
- o *Civic membership and responsibility* The development of well-rounded individuals to contribute to the betterment of their community.
- o *Inclusion* Social integration to reduce difference, to normalise and accept disabled and disadvantaged children within existing school and community environments.

Specific priorities identified by the delegates for education
- o reform the education system
- o develop qualified trainers and teaching staff
- o develop new approaches to teaching and curriculum development
- o develop modern and well-equipped schools
- o expand education opportunities
- o maintain free and compulsory education
- o reengage 'drop-out' children
- o promote inclusive education
- o support gifted children

The views expressed by delegates concerning ECD encompassed three broad areas
- o *Review of existing provision* for children 0-4 and 4-6 including the split in Ministry responsibility for support to children of 4 and 5 years of age.
- o *Development of services* to ensure not only the availability of services nationally, but a range of support and services that meet global standards appropriate to the care and development of young children.
- o *Development of staff training* for staff supporting young children and parents, and monitoring the development of young children in nursery and kindergarten education.

The priorities identified by delegates for ECD
- o to establish ECD centres
- o to provide specialised training for staff
- o to promote full attendance
- o to clarify roles of different ministries
- o to develop modern programmes
- o to offer accurate and early diagnosis
- o to respond to all needs and requirements
- o to promote public awareness through media

The views expressed by delegates at the meeting fell into four broad categories
- o *Acceptance* to ensure child friendly schools for all children and to promote social integration and harmony
- o *Flexible curricula* to support a broad range of children and young people.
- o *Innovative teaching strategies* to reflect a range of well tested techniques to promote child friendly learning environments and differentiation of learning materials.
- o *Excellence in initial teacher training and continuing professional development of teachers* to reflect global standards of University level study for prospective teachers and ongoing training sessions delivered by accredited trainers and performance monitoring of existing teachers by school leadership.
- o *Family and community involvement* is a prerequisite for school reform that reflects the proposed disability legislation.

The views expressed by delegates in relation available resources

Legislation and policy
- o Existing regulation and legislation supporting inclusive education
- o New Disability Legislation, Inclusion strategies and policies in process

Finance
- o Administrative infrastructure from ministries to local government
- o Education Budget – rising to 5.5% of total annual budget in 2011
- o City Council budget allocations to education and health which have greater flexibility in allocation than the Ministry of Finance
- o Individual philanthropy

Expertise – human capital
- o Human resources and experienced staff – principals, teachers, specialist teachers, supervisors, administrative staff running institutions etc
- o Flexible thinking

Expertise – organisational
- o CBOs, NGOs, DPOs, INGOs and other international organisations
- o Specialist centres
- o Diagnostic centres
- o MoLSA and other training specialists

Wider support for change
- o Beneficiaries – the children themselves and their peers
- o Children's parliament
- o Families and family resources

- Media

Discussion relating to resources highlighted not just the extent of available resources, but how a collective, collaborative approach could increase the impact of those resources. The quality of teachers and teaching, and also the lack of special-needs teacher training were raised on numerous occasions as urgently requiring investment and intervention. However, it was recognised as important at the outset to embrace existing teaching staff as a resource in efforts to support inclusive education. Continuous professional development allows teachers to build on their existing skill sets and this was seen as one interim measure to support inclusion of disabled children in their local schools. A simple example might be to have MoLSA Specialists train local teachers about Braille so that they can support children with visual impairments in their local schools.

Discussion also pointed to the importance of casting a diagnostic eye on Iraq's schools where many of the problems with educational provision as a whole and inclusive education in particular, appeared to lie. Participants reflected on the potential for embracing a 'child friendly' and rights-based school philosophy in management and practice. In making recommendations and designing a teacher training model, the resources identified by the stakeholder group have been considered the foundation that will provide the impetus to take the first steps towards achievement of their vision for early child development and key educational achievements for all children.

A Teacher's Tale (Basra) Nassar is a history teacher at a Girls High School, the Head of the National Society for the Blind in Southern Iraq and a member of a Basra Advocacy Group founded 2 years ago to help raise awareness of the rights of people with disability.

He says it is common for disabled children to be bullied by peers in school. Even more distressing is that teachers don't always defend them. He had witnessed a teacher in his own school confront a blind girl "Why do you come to school?" and tell her to "Go help your mother to bake bread." Such comments could be catastrophic in undermining the pupil's confidence, as well as being cruel and unprofessional.

He knows of schools that have refused to admit disabled students, even when Disability Groups and NGOs have intervened, highlighting the school's legal responsibility to provide an education to all children. Recently, a blind boy had asked his Society for help in convincing the Headmaster of the local Islamic High School to admit him to the school. The Headmaster justified his refusal by saying that he was unaware of any blind person who had received an education and that he doubted the boy's ability to learn in the school. He did not want to "shoulder the responsibility" for the boy's education. Nassar convinced the Education Directorate's Director of Examinations to call the Headmaster, but the school Headmaster still refused.

4.   FINDINGS FROM THE HOUSEHOLD SURVEY

The findings from the Household Survey are first summarized to highlight key findings and needs assessment and then reported on in greater detail in the following three sections:

- o Demographic details of the households surveyed, including school attendance;
- o Early childhood development;
- o Childhood disability.

Household Survey Key Findings and Needs Assessment

Summary

Early Childhood Development
Overall, children in all age bands (from 0-8years) achieve age appropriate skills at satisfactory levels. In every 12 month band, especially in the pre-kindergarten years, a wide variation can be expected between the younger and older children, but most of the checklist items are achieved by around 50-90% of all children in the appropriate age band. The majority of children appear to be developing well physically, socially and cognitively, although there are significant concerns associated with the 'situation' and 'conditions' (see Key Terms) of some groups of children.

Within the overall developmental levels of the children, distinct variations were detected associated with their situation, that is, their geographical and socio economic location, including access to education and other resources. Differences have been identified between the four survey governorates.

This research also investigated the link between specific conditions of the household such as parents education level and skill achievements of children in different age groups. Counter-intuitively, age ranges 0-4years and 4-6years of male adults with the lowest education qualification were recording the highest skill levels. When children reached school, for the first time, (6 years of age) the educational qualifications of their male parents/family members begin to show advantages for the children's acquisition of 'school related' skills.

Fewer than 1% of children aged from birth to 4 years are reported to be attending nursery provision and only 3.3% of 4 to 6 year olds are reported to be attending kindergarten. Support outside the home for children under 4 is very limited – ie. health, care and education.

<u>Needs Assessment</u> Although new ECD education initiatives are being developed by both the Central and Kurdistan Ministries of Education (MoE), the survey recorded current access at 7.5%, considerably below the Central MoE's 40% target for access to free kindergarten provision. This is of course solely in relation to children aged 4 to 6 years, which most families in most governorates are unable to access

The developmental gap reported between the children from families with higher levels of qualification and income, which almost certainly widens as children go through school, is an indication of the need for the development of accessible and affordable ECD provision.

Birth Defects
Prevalence of birth defects overall (3.3%) was within the range identified internationally (3%-5%). However, the number of children identified as having a birth defect among households in Basra was well above this figure (8%). Presence of a birth defect was significantly associated with reports or perceptions of contamination from natural sources, warfare and contamination from 'other' sources as defined above. No relationship with consanguinity was evident. The prevalence of birth defects, therefore, is likely to reflect the complex interplay of a number of factors that are likely to have impacted on ante-natal development of children born in this country which has been subject to severe levels of upheaval as described above.

<u>Needs Assessment</u> As noted elsewhere, functional difficulties and presence of a birth defect are highly correlated. Hence the needs may be addressed together here. While it is acknowledged that the severe situation in Iraq over the recent past has hampered attempts to make progress in repairing and improving the infrastructure across the board, the findings of this study highlights that attention to the environmental situation of children and families is urgently required. Unsanitary conditions can impact on the ante or post natal development of children and such impacts lead to difficulties in accessing learning for many children. Civic programmes for the disposal of household waste therefore need to be implemented as a matter of urgency. Independent scientific assessment of air, earth and water purity is required to establish the veracity of local perceptions of the levels of pollution evident. This is important across Iraq, but our data suggests a particular urgency for this examination of the environment in Basra. Nevertheless, lack of independent verification does not mean that the high levels of need demonstrated in such areas should not be addressed. Indeed, it would be unethical to withhold additional resources from areas that have been demonstrated to have elevated levels of need.

Childhood Disability

Overall prevalence of child difficulties was found to be 14.2%, including confirmed risk of mental health issues among children aged 4-18 years. Sensory difficulties appeared under-represented and it was proposed that this was likely to be due to residential schools and homes that provide services to children with sensory impairments, reducing their numbers in households.

Needs Assessment There is a need to establish monitoring national monitoring system in order to be able to respond effectively in identified areas of need.

Functional Disability

Among children identified as having one or more functional difficulty (mobility, vision, hearing, cognition, self care, communication or health), proportionately more resided in rural communities. However those children with a greater range of difficulties tended to reside in Basra and Baghdad. Presence of a difficulty was frequently associated by respondents with perceived environmental contamination from natural and industrial sources, warfare, and other sources of contamination such as poor sanitation and accumulation of rubbish dumps in residential areas.

Needs Assessment There is a need to mobilize support to rural communities to reflect the incidence of functional disability. The reported link between functional disability and environmental factors warrants further scientific investigation. Where the environmental factors relate to sanitation, sewage and water cleanliness, remedial action should be urgently taken.

Mental Health Difficulties

Children at confirmed risk of mental health difficulties were identified in greater numbers in Najaf. Confirmed risk of mental health difficulties was more prevalent among children resident in the poorest households in urban localities in particular, but also in those areas that had experienced conflict in the recent past.

Needs Assessment While programmes of support are important for all children who may have suffered trauma as a result of the ongoing difficulties related to conflict and sanctions in Iraq, the data suggests that poor urban localities should be a major focus for screening for, and appropriate psychological support to, children. In particular, difficulties were highlighted in Najaf and further investigation is required to establish why, apart from pockets of urban poverty, the level of need appears to be elevated in this governorate.

Although UNICEF has been and still is supporting a number of initiatives responding to the lack of schools based psychosocial care in Iraq, with a major teacher training programme introduced in 2009, the lack of access to

psychosocial care is especially evident among pre-school age children – due in great part to a social bias that has historically failed to embrace early childhood development programmes.

Effects of Disability
The effects of disability were seen substantially in relation to distress for the child and burden on the family. The children's home and school life was affected for a significant number of disabled children, along with friendships and leisure opportunities.

Access to School
Questions relating to access to school suggested some difficulties with physical access to buildings, and physical positioning within the classroom to allow disabled children to see and hear their teacher's instructions. There were also reported difficulties for some children with concentration and understanding.

Needs Assessment The data on access to learning suggested that existing and new school buildings needed to be adapted to allow children with disabilities ease of access. They suggested that training for teachers is indicated on awareness of sensory difficulties and differentiation of learning materials, and that additional support for learning is required for some children to facilitate concentration and understanding of lessons.

Support
Respondents in Basra and Najaf suggested that more help was provided in these governorates.   It is speculated that this is likely to reflect the higher numbers of children identified with difficulties in these governorates. Among those who provided a response, the primary source of help was described as the family itself. It is also important to restate the observation in the Phase One Report that while 200 social workers are available, their lack of experience makes them largely ineffective

Needs Assessment This data suggests a need for development of a range of educational, social and rehabilitative support for disabled children in all governorates. There is particular urgency in Basra and Najaf where the numbers of affected children are greater. Arguably, suitably resourced schools could act as a community 'hub' for provision of a range of services to children and families outside normal school hours. This development would facilitate provision of services to children and families in rural, as well as urban localities. The Phase One Report notes that support service ranges from being severely limited to non-existent. There is a lack of trained personnel, such as primary health care workers and social workers. There is also the problem caused by the division of training and service responsibilities between the Ministry of Education and the Ministry of Labour and Social Affairs such as is the case with social workers.

4.1   Demographic Details of Survey Households

This section contains an overview of the demographic characteristics of households surveyed. Tables displaying details of findings are provided in Appendix 5 Section 5.1.

4.1.1 Household survey description

The units of analysis within this survey are the 'household' and 'child'. It is important to remind readers that the term 'household' is <u>not</u> equivalent to the term 'family' (see Key Terms section 2.3 above). The survey focused on children up to the age of 18. The only exception to this were a very few young people (N=26) aged between 14 and 18 who were living in the household, and parents themselves.

Fieldworkers described dwellings as being either of a 'permanent'[6] or 'temporary'[7] structure (see Appendix 5 Section 5.1 Table 2). Most households surveyed were in dwellings of a 'permanent' structure (96%), with more of the remaining households in dwellings that were unsuitable for long-term occupation in Baghdad (5.5%) and Basra (4.9%) than in Najaf (3.5%) or Erbil (0.9%). Speculation over this data may suggest that it reflects displacement and resettlement as a result of war and conflict.

Household sizes varied from 2 to 11 individuals and included between 1 and 7 children (see Appendix 5 Section 5.1 Table 3). The households surveyed in Erbil and Najaf tended to have fewer children than those in Baghdad and Basra.

A measure of 'wealth' was calculated for each household by combining indicators including 'owning home', 'crowding' (number of people in household/number of rooms in dwelling), and 'owning transport'. All were equally weighted. Scores from this measure were divided into quartiles (groupings each representing approximately 25% of all the households). The richest households among those surveyed were more likely to be situated in Erbil and Baghdad, while the poorest were identified in greater numbers in Najaf and Basra (see Appendix 5 Section 5.1 Table 4). Respondents (usually a parent of children in the household) were specifically asked whether they felt that their income was adequate to meet the needs of their family (see Appendix 5 Section 5.1 Table 5). Respondents in Erbil and Baghdad were more likely to feel their income level was satisfactory. This reflects the findings described by the wealth index and lends strength to this measure. Respondents were also asked whether they felt that their dwelling was adequate for their needs (see Appendix 5 Section 5.1 Table 6). More than half of respondents surveyed in Erbil and Baghdad were satisfied with their housing situation. However, there were substantial minorities who felt that their homes were severely inadequate for their needs in both Baghdad and Basra.

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[6] A dwelling in a building where materials used for construction were of a permanent nature

[7] Building materials such as plastic sheeting or corrugated metal used, suggesting the dwelling was not suitable for long term occupation

Other household characteristics that were considered likely to influence the 'situation' and 'condition' of children in the households surveyed included the educational level of respondents and their spouse (see Appendix 5 Section 5.1 Table 7 & Table 8).[8] Higher numbers of households surveyed in Baghdad contained adults with university degrees. The numbers with teaching or nursing qualifications were somewhat higher in Baghdad and Basra. In Basra and Najaf greater numbers of respondents or their spouse were qualified to high school diploma level. The largest group with no qualifications comprised women in Erbil. As one may expect, those with higher qualifications tended to be among the wealthier households.

Male respondents and male spouses were likely to be in employment (81.5%), while just over half of female respondents and female spouses were occupied by home duties within the dwelling itself (56.1%). A substantial minority of female respondents and female spouses were seeking paid employment (23.2%). (See Appendix 5.1 Table 9)

4.1.2 Children's characteristics (whole sample)
The data were further analysed to establish the characteristics of children identified within the households surveyed. The sample comprised 55.6% male children. This figure was consistent across age groups (range 54.6%-56.5%). Almost all children were resident in the households with just 0.4% living elsewhere. Of these 43 children, we were informed that 23 lived with grandparents and 9 with an aunt and uncle. The remaining 11 appeared to be resident (wholly or partly) in institutions. The ages of these children spanned the full range surveyed.

Children were parented by their natural father in 97.85% of cases. The father, or a father figure, was said to be absent in 1.8% of cases. The remaining children were parented by:
- an adoptive father 0.2% of children in the household survey;
- stepfather 0.01% of children in the household survey;
- grandfather 0.1% of children in the household survey;
- other relative 0.03% of children in the household survey.

Children were parented by their natural mother in 99% of cases. A mother, or mother figure, was absent in only 0.1% of cases. For the remainder, mothering was provided by:
- An adoptive mother 0.3% of children in the household survey;
- A stepmother 0.3% of children in the household survey; and
- A grandmother 0.2% of children in the household survey.

4.1.3 Children's characteristics (Early Childhood Development)
The number of children identified in each age group varies widely, as does the ratio of male and female children. No explanation has been found for this uneven distribution (see Appendix 5 Section 5.2 Table 1). The response rates for children in each age group and age band are entered in Tables 2, 3 and 4 in Appendix 5 Section 5.2. Checklist items were

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[8] These were usually parents, but also 'parent figures' where a natural parent was absent.

completed in reliable numbers for children aged 1, 2, 3, 4, 5, 6 and 7 years old, but for fewer than half of children aged under one year. It is not possible to determine whether respondents who identified children under one in their household were unable to report on the skill items presented to them because they were unsure of the answers, or whether the items seemed to them to be inappropriate for such young children.

4.1.4 School attendance (See Appendix 5 Section 5.1 Tables 10 – 14)
Respondents were asked whether each child surveyed attended school. For those that attended school, they were then described in terms of the organisation that ran the school; whether the school educated boys or girls alone, or catered for both genders; whether the child attended an ordinary class, a special class or other provision; distance travelled to school and how the child travelled to school.

4.1.5 Early years (0-4 years) and kindergarten (4-6 years)
Eighteen children aged 0 - 4 years were said to be attending 'school'.[9] Among children in nursery provision, eight attended a nursery for both genders, and three girls and six boys attended nurseries catering for girls or boys alone. Ten of the nurseries attended were located within 1km of the household (99.6%) and the remaining six were between 2 and 3 km away. Ten children were able to walk (or were carried) to their nursery and of the remainder, three travelled by car and three by bus.

Twenty-seven (3.1%) 4-6 year old children attended kindergarten. All but one attended an 'ordinary' class. Among kindergarten children, 8 attended a school for boys, 6 a school for girls and 13 attended a school for children of both genders. Most children were able to walk to their school (70.4%), while 6 (22.2%) were taken by car. Only one used public transport.

Overall, young children aged 0-6 years in Baghdad were more likely to access nursery care or kindergarten education. However, the numbers were extremely low. In households where female respondents or female spouses held a University degree, greater numbers of children attended nursery or kindergarten provision compared to households where female respondents and female spouses held other, or no qualifications. Relative household affluence did not appear to impact on attendance at 'school' in the early years.

4.1.6 Compulsory schooling (6 -12 years)
The majority of children and young people aged 6 to 12 years surveyed attended school (89.8%), with no difference in attendance between genders (male 90.2%, female 90.0%). However it is clear that attendance is lower in Basra (82.7%) and Najaf (87.3%) than in the other governorates (Erbil 91.6%; Baghdad 94.7%).

Children attended single gender schools, boys only (26.9%) and girls only (20.0%), and mixed gender (42.9%) schools. Among children in school, 89.1% attended an ordinary classroom.

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[9] Here it is understood that reference is being made to nurseries run by the MoLSA.

Most of the remaining children attended a special class in an ordinary school (0.6%) and three attended a class in an institute (0.1%).

The majority of children lived within a kilometre of school (77.5%) and 20.9% lived between 2 and 3 kilometres from school. A further 35 (1.0%) lived between 3km and 10km away from school. The remaining children travelled a substantial distance to school (0.5%, 50km or more). Most children walked to their school (75.9%), but significant minorities were taken by car (14.3%) or travelled by public transport (8.4%). A few children cycled to school (n=37, 1.7%)

4.1.7 Secondary schooling (12-18) After compulsory schooling, attendance dropped to 88.6% for 12-18 year old children overall and to 83% for those in Basra and Najaf. There was no difference in school attendance between genders (girls 88.5%; boys 88.6%). It appears reasonable to suggest that non-attendance for the older group may be associated with taking up employment or other work within the household.

Further investigation suggested a link between child's school attendance and respondents and their spouses' higher educational level and higher 'wealth'. This finding adds weight to the deduction above that older children may be missing from education due to the need for additional contributions to the household income. The data suggests that this is likely to be a particular issue in Basra and Najaf due to their relative poverty. (See Appendix 5 Section 5.1 Tables 15 & 16)

More children aged 12-18 years attended single gender schools, boys only (46.1%) and girls only (33.3%) than in younger groups. Only 9.0% attended a mixed gender school. Among children in school, 87.4% attended an ordinary classroom. Most of the remaining children attended a special class in an ordinary school (0.7%) and a few attended a class in an institute (n=4, 0.1%).

The majority of children lived within a kilometre of school (72.0%) and 24.5% lived between 2 and 3 kilometres from school. 5.4% of children travelled between 3km and 10km to school. The remaining 28 children lived 50km or more from school. Most children walked to their school (67.2%) but significant minorities were taken by car (16.4%) or travelled by public transport (14.5%).

Overall the majority of children attended schools run by a public authority (99.2%) with most of the remaining children attending a school run by a voluntary organisation (0.7%) and a very small number attended a privately run school (0.1%).

Where children attended school, respondents stated that very few did not attend for the full amount of schooling available to them. However, a number of schools operated a shift system to help meet to local needs, with only 2-3 hours of schooling available on any one day. Overall, respondents stated that 2% of children did not attend for the full time available each day, and 1% did not attend every day that school was open.

Previous reports from the Iraqi Ministry of Education, UNICEF and Save the Children on school attendance reported only 30% of Iraq's 3.5 million school-aged children were attending classes (Baker, Ismael & Ismael, 2010:130). Our qualitative research in Baghdad, Najaf and Basra repeatedly identified the fragility of security and safety as a factor that compromised school attendance. Security factors have also impacted on teacher attendance. However, a Headmistress of a school in Baghdad suggests that:

> *"The improvement in security over the last two years has regularised attendance. Families are now sending their children to school. We previously had a high percentage of truancy."*

Interviewees from poorer communities reported very low school attendance. A school principal from Basra is indicative:

> *"The rate of registering children in the first class is very high but the problem is continuing education as (the child) reaches the third or fourth grade and then goes to work in a shop or something else. They are forced to do that because of financial needs due to the fact that the father might be dead or does not have a pension and so the child has no choice but to take to the street and work and quit the school. Registration is good but continuation is very low."*

Another school principal spoke of there being, "*One school for four districts. This affects pupils' attendance*".

Unsurprisingly, Al-Obaidi & Budosan (2011:38) report the greater likelihood of non-attendance amongst disabled children. The decision to send a disabled child to school is not straightforward. The distance to the school coupled with the cost or limited availability of suitable transport present barriers to school attendance. Some respondents in the interviews referred to families keeping disabled children at home through shame or because they wanted to protect them from the taunts of other children. Anecdotal evidence suggests that disabled girls are even more unlikely to attend school.

4.2   Early Childhood Development (ECD) Findings

This section of the report presents general findings from the household survey on early childhood development, summarising those features that are significant to the development of an early childhood education and care programme in Iraq.

The assessment of specific levels of disability is covered in the findings on childhood disability (see 4.3 Childhood disability). Details of the developmental checklist used and associated cautions on the use of checklists to screen young children are included in Appendix 3. The developmental checklist itself is attached as Appendix 6.

The importance of **early childhood development programmes** including health care, nursery provision and early childhood education (pre-school) has been recognised internationally. The *Education For All – Dakar Framework for Action* (UNESCO, 2000) has as its first EFA goal:

'Expanding and improving early childcare and education especially for the most vulnerable and disadvantaged children.'

The *Multiple Indicator Cluster Survey 2000* indicates the very low provision for early childhood education in Iraq:

'The percentage of children aged 36-59 months attending these programmes amounts to 3.7 per cent with 3.8 per cent males and 3.6 per cent females (Table 7). The percentage in urban areas is 5.2 per cent, against 0.9 per cent in rural areas. The table also indicates that 5 per cent of the children aged (48-59 months) have enrolled in nurseries and kindergartens compared to 2.6 per cent for younger children.' (UNICEF, 2001, page 19)

Findings from this research highlighted this as a continuing problem:

'Fewer than 1% of children aged from 0-4 years are reported to be attending 'school' or preschool, and only 3.3% of 4-6 year olds are reported to be attending kindergarten.'

The analysis of findings seeks to answer four research questions
- o What is known about the development of young children aged from birth to 8?
- o What aspects of children's situation are associated with their differential levels of development?
- o What aspects of children's conditions are associated with their differential levels of development?
- o What access do children aged 0-8, and their families, have to support for development, and appropriate services?

Each question was addressed in relation to three age groups: children below kindergarten age (Group A / 0-4 years of age), those of kindergarten age (Group B / 4-6 years of age) and those in the first two years of school (Group C /6-12 years of age).

4.2.1 What is known about the development of young children aged from birth to 8?
Overall, children in all age bands achieve age-appropriate skills at fairly satisfactory levels. In every 12-month age-band, especially in the pre-kindergarten years, a wide variation can be expected between the younger and older children, but most checklist items are achieved by around 50-90% of all the children in the appropriate age-band. The majority of children appear to be developing well physically, socially and cognitively, although there are significant concerns associated with the situation and conditions of some groups of children.

Group A (pre-kindergarten age): For one-year-olds an achievement rate of 52-72% on the skill items is reported, and for two-year-olds, a rate of 60-76%, while a greater spread of scores was reported at age 3. In every age-band, older children scored at significantly higher levels than did younger children on the age-specific items. Many of the first 18 items, such as 'Picks up objects between finger and thumb' or 'Walks confidently', tap into physical development and motor skills, rather than cognitive, linguistic or social skills. As a result there are lower levels of contextual variation than in older age groups, where children's skills may be 'learned', culturally, rather than 'developed', physiologically. (For details, see Appendix 5 Section 5.2, Tables 5, 6 and 7).

Group B (kindergarten age): Unlike the skill sets for younger children, which refer to gross and small motor skills and have a partly physical basis, these items reflect the social development that results from interactions within families and peer groups. They include for instance items that refer to 'Understanding adult questions and instructions' and 'Using words to describe things, such as colours, big/small, soft/hard, wet/dry'. The children in this age group show good levels of social competence and understanding. In the year before they start school in particular, the nine skill items can be seen as indicators of children's preparedness to move outside the family and immediate community and enter formal education. Children in this age band appear to have well-developed skills for this new phase in their lives. Most interact well with children and adults and are able to communicate their needs verbally. The range of percentage responses suggests that the majority of children are socially well equipped for school. (For details, see Appendix 5 Section 5.2, Tables 8 and 9). The survey confirms the Phase One Report's observation that there is 'little or no ECD provision… and little pre-school provision', so that most of the children in the age-band we have described as 'kindergarten age' are not experiencing any kind of school-based or centre-based education and care. The lack of such experience begins to be evident as children enter the third phase (school-age children), when differentials related to children's situation and condition begin to appear.

(Basra) Khan has worked in Basra since the 1930s … and believes that disabilities are increasing and health in the region is deteriorating. Polio and Diabetes are particular concerns.

For Khan, hope lies in following the lead of other countries: "In Algeria it was different. I attended a conference for the disabled. I asked a participant about the situation of the disabled in his country and he cut me short saying "I'm not disabled and you are no better than I am." Khan was pleased to see the man's dignity and strong sense of identity.

He believes school attendance is poor and provision of services appalling. He remembers previous ECD policies and comments "I really wish to return to the 1970s when schools provided every child with a daily apple and a cup of milk. They cared for children a lot back then. Now no care is provided."

Group C (school age children): In this age group, more than 50% and up to 90% of the children achieve at least six of the nine skill items. The nine items allocated to school-age children reflect school-related accomplishments, without which children will experience increasing difficulty as they progress through the education system: cognitive skills, academic skills and dispositions such as accepting the need for routines, and problem-solving. Some of them, such as counting objects, naming letters, or telling the time from a clock, are acquired as the result of explicit teaching; children who have not experienced such teaching are unlikely to have acquired the skill. Others, such as offering explanations, or concentrating, may be viewed as the outcome of children's innate dispositions, combined with the modelling of attitudes and behaviours by adults. (See Appendix 5 Section 5.2, Tables 10 and 11)

4.2.2 What aspects of children's 'situation' are associated with their differential levels of development? Within the overall developmental levels summarised above (and in Tables 1-11, Appendix 5 Section 5.2) are distinct variations associated with aspects of children's situation (their geographical and socio-economic location, including access to educational and other resources). One measure of the impact of 'situation' is an analysis of children's achievements, in all three age groups, by governorate.

Group A (pre-kindergarten): Roughly similar numbers of children aged 1 to 3 were identified in each of the governorates (see Appendix 5 Section 5.2, Tables 12, 13 and 14). Although the proportions of reported outcomes differ slightly by item, overall the results clearly favour children living in Najaf over those living in the other three governorates. For the majority of skill items, children living in Baghdad and Erbil appear to be at a disadvantage. There is no evident reason for these disparities, since the items to a large extent reflect physical maturation rather than social experience or instruction, but analysis of environmental features such as pollution, or the relative affluence of the region, may offer explanations.

The development of children in Erbil follows a particular route. Although children's skills are rather low in general, 2-year-old children score particularly highly on 'pretend play', a learned cultural behaviour. At age 3 however, children living in Erbil score unusually poorly on the self-care items of washing and dressing, in comparison with children living in the other three governorates. This may reflect the fact that cultural expectations for children of this age in this region differ slightly from those in other parts of Iraq.

Group B (kindergarten age): much greater variation is seen between the numbers of children in each governorate in this age group – among 4-year-olds for instance only 54 children were identified in Najaf, compared with 102 in Baghdad. Children's scores on skill items are generally satisfactory, ranging from around 60-90% on average, although children living in Erbil demonstrate lower levels of achievement, with 4-year-olds achieving 24% lower on some items than the higher-achieving groups in Najaf and Basra. For 5-year-olds however – many of whom may be attending kindergarten - the differential between children's scores in the four governorates is less than 10%. (See Appendix 5 Section 5.2, Tables 24 and 25)

These nine items tap into children's social development and their communication skills, and the scores may reflect a different life-style, and different cultural environment and expectations, experienced by children in Erbil.

Group C: When children begin school, their achievement continues to show distinct differences by governorate: the performance of children in Najaf continues to outstrip that of children in the other governorates, with children in Baghdad and Basra showing considerable disadvantage. Children living in Erbil, whose rating was only moderate in earlier age groups, have unusually high levels of success in literacy skills at this age, which may reflect their greater chance of accessing a preschool programme through the KIEP (Kurdistan Inclusive Education Programme) described in the Phase One Report. (See Appendix 5 Section 5.2, Tables 32 and 33)

4.2.3 What aspects of children's and 'conditions' are associated with their differential levels of development? Children's 'conditions' are aspects of their immediate environment, including the qualifications and wealth of household members. Also included here is one 'child factor' – sex, or gender – which is found to have some associations with the development of skills. While girl-children are widely reported to be disadvantaged in relation to boys, the findings from this study offer a more complex interaction between gender and achievement, which changes as children develop from 0 to 8.

The impact of adult qualifications on development *Group A (pre-kindergarten):* Group sizes for each level of 'adult qualification' are very different in this age group, and the majority of households include adults with skills-based (manual) qualifications. Somewhat counter-intuitively, the highest levels of skills reported for children in this age-band are found in households with the least-qualified adult males, those with no reported qualifications or with skills-based qualifications, while lower levels of skills are reported for children living in households where adult males hold a professional qualification or a university degree. These findings may be explained by the fact that children from unskilled/poorer households are required to become self-reliant at an earlier age than those living in more comfortable circumstances. Only as children approach the age of three are skills more widely distributed across qualification-groups. (See Appendix 5 Section 5.2, Tables 15, 16 and 17)

Group B (kindergarten age): In this age-group too, the majority of children live in households where adult qualifications are low, but these children are reported to have acquired higher skill levels than children from more highly-educated households. All children however appear to develop age-appropriate skills that will equip them for the move into formal schooling at 6 years. In the final year before school, children's achievement of checklist items showed some advantage to those from the most highly educated families (university graduates) although this group is relatively small. Differentials between groups on most items were also small. (See Appendix 5 Section 5.2, Tables 26 and 27)

Group C (school age children): When children are in school, for the first time, the educational qualifications of their male parents / family members begin to show advantages for the children's acquisition of 'school-related' skills. Children in households where someone has been to university, or has a professional qualification, achieve in larger proportions than children from families where no qualifications, or skills-based qualifications, are reported. Most between-group differences are relatively small (around 10%) but children from university-qualified households generally out-perform those from poorer educational environments. On the other hand, children from households with 'no skills' continue to do

well on items based on counting, concentrating and problem-solving, which are useful skills outside the school environment. (See Appendix 5 Section 5.2, Tables 34 and 35)

The impact of household affluence on development *Group A (pre-kindergarten):* Household affluence (a composite score made up of a number of discrete items) proves to be strongly associated with adult qualification levels. Children from 'poor' backgrounds, who are also those with poorly-qualified adults in the household, appear to have good levels of reported skills in their first four years of life. They develop self-help and self-care skills more quickly than children in more affluent circumstances. This association grows weaker as children approach the age of four. (See Appendix 5 Section 5.2, Tables 18, 19 and 20)

Group B (kindergarten age): Children from all households achieve well on the developmental checklist and only small differentials are found between children from more and less affluent households. The 'advantage' shown by children from poorer and less-educated households fades as children approach school age. (See Appendix 5 Section 5.2, Tables 28 and 29).

Group C (school age): When children enter school, the advantages of living in a more affluent (and more educated) household begin to become apparent. Although the differentials between groups are quite small at age 6 and 7, children from richer households begin to show an advantage. Certain school-related skills, such as literacy, are better developed in children from more affluent backgrounds. (See Appendix 5 Section 5.2, Tables 36 and 37).

The impact of gender on developmental outcomes Gender is analysed here as an aspect of children's 'conditions' rather than as an innate aspect of the 'child'. Whereas a child's sexual characteristics are biological, his or her gender characteristics are to a large extent socially and culturally constructed by the environment he or she grows up in. There is little evidence that boys' and girls' cognitive, linguistic or social development is associated with intrinsic differences in their brains or bodies. Developmental differences reported on the checklist are therefore viewed as outcomes of the developmental environment – of how boys and girls are predicted, and conditioned, to behave and learn in their home community.

Group A (Pre-kindergarten): Small and insignificant differences are reported between boys and girls in this age group although from the age of three, girls appear to achieve at slightly higher levels on communication and self-care items (Appendix 5 Section 5.2, Tables 21, 22 and 23). This is likely to be explained by their spending more time with adult females in the household.

Group B (kindergarten age): At 4, girls continue to achieve the checklist items at rather high levels, and probably reach the ceiling on the items by the age of 5. Boys, who lag behind slightly at 4, catch up at 5, before the start of school (Appendix 5 Section 5.2, Tables 30 and 31). It is not known whether the small minority of children who have kindergarten

experience includes equal number of boys and girls, or whether this has an impact on the achievements reported.

Group C (school age): Very small differences are found between the achievements of boys and girls in the first two years of school although girls maintain a slight advantage on some items. (See Appendix 5 Section 5.2, Tables 38 and 39).

4.2.4 What access do children aged 0-8, and their families, have to support for development, and appropriate services? Fewer than 1% of children aged from birth to 3 are reported to be attending 'school' or preschool, and only 3.3% of 4-6 year olds are reported to be attending kindergarten. This average figure appears to be swelled by the 6.6% figure for Baghdad, although it was reported that pre-school provision was being established more widely in Erbil (Kurdistan) through the KIEP. From responses given by informants on the main household survey, it is evident that almost all children are cared for in the home, by family members, until they are at least four years of age. A very small number then attend some type of 'kindergarten' provision which may be focused on preparation for school rather than on more holistic child development. Once children are of school age, it appears that more than 90% attend school in Baghdad and Erbil, while Najaf (87.3%) and Basra (82.7%) have lower rates of attendance. (See Appendix 5, Section5.1, Tables 11, 12 and 13).

These data indicate that support outside the home for children under four is very limited indeed, and that few children benefit from kindergarten attendance. There is additional information in the survey concerning the percentages of working mothers, indicating that 11.7% are in full-time employment, and 6.4% in part-time employment. No information is available on how the children of working mothers are cared for in the home. Most households are small and most families include only one or two children, which limits opportunities for traditional extended-family care giving.

4.2.5 Discussion and Implications The household survey has documented the general skills levels of young children 0-4, 4-6, and 6-8, and the specific disabilities amongst children under eight, in the four governorates surveyed: Erbil, Baghdad, Basra and Najaf. It also documented the services available to parents for these age groups. For children of pre-school age there is relatively little centre-based pre-school provision, of whatever kind. The consultation in Erbil in December 2010 raised some of the discrepancies in the figures concerning the attendance of young children at preschool establishments, which have now been addressed. The consultation meeting also highlighted the role of the various ministries involved, and their perceptions of shortcomings in the resources currently available for ECD, for instance training for those working in the field of ECD. The qualitative interviews detail some of the very specific referral services that are offered to young children with disabilities, and offer some general comments about ECD in Iraq.

This discussion builds on the data emerging from the Iraq household survey by locating it in current regional findings and discussion on the topic of ECD. These are set out for the Arab region in the recent UNESCO early childhood education and care report, which offers the

most comprehensive review to date in the region.[10] The UNESCO report is based on a survey of data from fifteen (15) Arab countries including Iraq, and makes general recommendations and puts forward guidelines for comprehensive national strategies.

The UNESCO report provides an overview of the current status of early childhood development in the Arab countries. It acknowledges the social and political factors that impact on the delivery of ECD in the region, notably civil strife and military confrontations especially in Iraq. It notes the considerable problems of displacement and resettlement and the burdens thus placed on families. Other factors such as income disparities, declining fertility and child mortality, changes in family structure, and health conditions have also resulted in new demands for ECD programmes.

Demography The traditional demographic balance in Arab countries has changed in recent decades. The total population of the Arab countries rose to 352.2 million in 2009. Population size varies considerably between the countries of the region from Egypt that accounts for 23.6 percent of the total Arab population to Qatar and Bahrain that account for less than 0.5% per cent. In the Arab countries, the declining fertility rates have caused important changes in the age structure of the population. The fertility rates in the Arab countries dropped from 4.7 (1990-1995) to 3.3 (2005-2010). The household survey in Iraq confirmed that fertility rates are around the current norm for the Arab region.

Urbanisation There has been increasing urbanization in the Arab region as a whole that is expected to exceed 50% by mid century although with substantial variations among countries. The extended family that used to provide emotional support, encouragement, and wisdom is more dispersed, making it difficult for working mothers to rely on their help in child care and therefore, the role of the extended family is being replaced by institutions in much of the Arab world.

In the last decade Arab women have made considerable gains, particularly in the areas of health and education. However, Arab women remain less economically and politically empowered than women in other regions of the world. Women's access to higher education soared from 9 % in 1990 to 19% in 2002. This access allowed women to delay marriage due to the longer duration of education and to desire greater economic independence. Therefore, female labour participation is expected to increase. Although their labour participation is still low (about 29% of the Arab region's labour force in 2000, and about 17.4% in Iraq), economically active women need day centres for their children given the decline in the extended family support and the relatively short duration of maternity leave in Arab countries.

Definitions of early childhood development The interpretation of early childhood development differs from one Arab country to another and within countries. The UNESCO report comments that:

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[10] UNESCO (2010) *Early Childhood Care and Education Regional Report: Arab states.* Paris. UNESCO. http://unesdoc.unesco.org/images/0018/001892/189209e.pdf

'… undoubtedly, there is no agreed upon common term and this will continue to spark debate among stakeholders about related childhood concepts such as care, development, and education. Health, nutrition and protection come first in the developmental support for those who focus on development and care. This diversity in term use has also led to various views about priorities and types of programmes.'

(UNESCO, 2010:20).

Programmes that serve these age groups range from infancy, preschool, kindergarten to early primary grades. These programmes vary not only by characteristics of the child in each stage, but also by purpose, pedagogical practices, and institutional sponsorship. Furthermore, programmes comprise a wide range of part-day, full-school-day, and full-work-day programmes under education, health, and social welfare auspices, funded and delivered in a variety of ways in both formal and non-formal settings in both the public and private sectors. These differences are reinforced by policy, funding and administrative divisions within and between the sectors at the state and local levels. [11]

Many programmes are distributed among public and private, for-profit and non-profit sectors, and non-governmental organizations. In terms of governance, it requires integration of several services of ministries (education, health, social welfare) that also intersect with various layers of government (national, municipal, and local community providers), and a range of interest groups. Data collection from all these ministries is a difficult task because of lack of coordination and cooperation among them. Countries are moving towards having a single body or a lead ministry in charge of coordination or administering early childhood programmes. At present such a leading body is present only in four Arab countries. In Jordan, Syrian Arab Republic, and Sudan there is a national council that acts as a coordinating body, although there are still difficulties in liaising across ministries and across layers of government.

The Iraq household survey, the consultation meeting and the qualitative interviews have confirmed that these definitional debates and overlap of functions also pertain in Iraq. Obtaining reliable data on which to base projections of need and uptake, has also proved problematic.

Levels of provision Across the Arab region fewer services are provided to children 3 and under than over 3. Data on this age group is especially poor. Official early childhood programmes targeting this age group are usually of a custodial nature. The low levels of access to early childhood services for this age can be attributed to a number of factors. First, societal and cultural views that both child rearing and child care are a mother's responsibility rather than a community responsibility. Second, costs per child for services to the very young are often higher than those for preschool-age children given the need for more staff per child and for specialised equipment and training. In most Arab countries, almost all of childcare centres, often referred to as day-care centres, crèches or nurseries, are privately

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[11] Faour, B. (2010). *Mapping Early Childhood Services and Programmes in Seven Arab Countries. Paper presented at the Regional Workshop on Advancing the ECCD Agenda in the Arab countries*. March 22- 25, 2010. Amman, Jordan.

operated either by not-for-profit community groups or by for-profit commercial businesses. Low-income groups are often excluded from access to centre-based services, unless government finance is made available. Low-income parents tend to rely on informal arrangements with relatives, neighbours, or babysitters.

In Iraq, very few children under three were recorded in the household survey as having access to official provision. MoLSA nursery provision prioritises working mothers, mostly those employed in the ministries.

Baghdad	Basra	Najaf
• 142 kindergartens • 151 nurseries • 1,905 primary schools • 933 secondary schools	• 60 kindergartens • 11 nurseries • 886 primary schools • 387 secondary schools	• 34 kindergartens • 7 nurseries • 498 primary schools • 196 secondary schools

Education and nursery provision (COSIT data 2007-8, CARA Phase One Report, 2010. Note: corresponding data was not available for Erbil).

The shortfall of provision means that there is little or no diagnostic or remedial help for young children with specific disabilities and little or no respite care. There was also concern expressed in the December 2010 Erbil consultation meeting about official relationships with and regulation of the private sector. Any comprehensive ECD policy within Iraq would need to address these points.

With regard to enrolment of children aged 3-6 (for age 3 up to when the child turns 6 years) in preschool, the figures from Arab countries remain much lower than the world average although there is slight improvement from 15% in 1999 to 19% in 2007. There is however wide regional variation; oil rich countries having levels of provision for children aged 3-6 above 75%. Enrolment at this age is beneficial for diagnosis and respite care, as above, but there is now a worldwide consensus that preschool education for this age group leads to smoother transition to primary school, and enhanced subsequent school performance. Iraq has one of the lowest regional enrolment figures, currently 7.5% of the age group, partly because of the disruption of the war. There are of course cultural factors that contribute to the low enrolment combined with the absence of provision.

Marginalised children The UNICEF report on *invisible and excluded children* [12] affirms that the exclusion of these children has multiple dimensions, including the deprivation of economic, social, cultural and political rights, making the marginalisation and exclusion a much broader concept than one grounded solely in material poverty or disability. Gender remains a contributing factor to the marginalisation of children. The unequal education chances for the girl child are a cause for concern.

Marginalised and excluded children in early childhood are commonly defined as:
- o Children with special needs,
- o Excluded and invisible children who are deprived of adequate food and appropriate health care and education,
- o Children who live in violent, abusive, and exploitive environments,
- o Children who live outside the family environment,
- o Orphans deprived of parental care,
- o Displaced children who live in emergency situations.

Generally it is very difficult to obtain adequate data on such children if they are below school age. However, there is a growing interest and sincere efforts in most Arab countries to provide programmes to serve children with special needs and their families. Many have begun implementing programmes that integrate children with special needs into public schools, including Iraq, but the information on the quality of services, performance indicators and the proportion of children who are beneficiaries is not generally available.

In Iraq, the survey suggested a level of special need of around 15%. However the survey also suggested there were children who may also be categorized as marginalized because of other circumstances such as refugee and displaced children. At present young children experiencing acute need, if they receive provision at all, tend to receive it within specialized MoLSA institutions, although MoLSA nursery provision does not cater for disabled children.

Licensing and Regulation The generally accepted criteria for quality provision in education are summed up in the *Education for All* goal six as:
- i. Healthy, well-nourished and motivated students;
- ii. Well-trained teachers and active learning techniques;
- iii. Adequate facilities and learning materials;
- iv. A relevant curriculum that can be taught and learned in a local language and builds upon the knowledge and experience of the teachers and learners;
- v. An environment that not only encourages learning but is welcoming, gender-sensitive, healthy and safe;
- vi. A clear definition and accurate assessment of learning outcomes, including knowledge, skills, attitudes and values;
- vii. Participatory governance and management; and
- viii. Respect for and engagement with local communities and cultures

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[12] UNICEF (2006) *State of the World's Children: Invisible and Excluded.* New York, UNICEF.

These criteria also have to be operationalised for pre-school children. A majority of Arab countries have established regulations and laws and licensing regulations for nurseries and preschools for the private sector and community associations. Special departments at the Ministry of Education monitor and evaluate the extent of the compliance to the regulations of setting up preschools for the age group three years and above. For day-care, the follow-up and evaluation are mostly under the supervision of ministries of social affairs. Seven Arab countries: Jordan, UAE, Bahrain, Tunisia and Saudi Arabia, Iraq and Egypt reported using assessment tools approved by their ministry of education during field visits by their experts. Most of the countries reported that their relevant ministries conducted periodic site visits to assess the quality of the preschools and nurseries and take punitive measures in cases of violations.

The Erbil December 2010 consultation meeting briefly mentioned that such licensing and regulation existed in Iraq, but concern was raised by some participants about the impoverished resources left after the United Nations sanctions and wars, the dated nature of ECD training and the ability of staff to deliver high quality care.

Funding of Early Childhood Programmes Financing is considered a critical factor in either improving the level of service, or causing it to deteriorate. Without relevant detailed data, arriving at a reasonable understanding of the sources of funding for early childhood programmes, planning and budgeting are extremely difficult.[13]

Reports indicate that the sources of funding for early childhood care and education programmes in the Arab countries rely on government support, regional and international donors, civil society and parents. Usually, parents are responsible for the costs of enrolment of their children in nurseries and private preschools. The findings also showed that many of the projects and programmes were funded by several regional organisations such as international organisations that collaborate with the Ministries of Health and Social Affairs and the Ministries of Education. However, no information on the duration or intensity of funding was available.

Challenges The UNESCO review of 15 Arab countries suggested that there were many obstacles to and challenges for developing comprehensive early childhood development policies. These were listed as:

- Lack of awareness at the community level and amongst decision-makers of the importance of this stage of childhood, and of its future impact on the growth of the child's mental physical, emotional and social development.
- No single entity responsible for the planning, implementation and documentation of ECD, leading to poor cooperation and coordination. It is often the case that some programmes advantaging the well to do are prioritized at the expense of other, possibly more necessary, programmes for marginalised children.
- Poor governance, coordination and integration; weaknesses in the provision of holistic services.

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[13] The goal suggested by OECD and currently being considered within the EU is 1% of GDP

- Limited services provided by the government which are few in number, and which come with high operating costs for both nurseries and preschools.
- Difficulty of providing early childhood services to rural and remote areas.
- Failure to provide poor and marginalised children with appropriate early childhood services despite the fact that they stand to gain the most.
- Shortage of specialised academic programmes for children (age 0-8 years) as well as a limited number of in-service training opportunities for staff.
- The apparent shortage of early intervention programmes for children with special needs that results in late developmental screening and follow-up.
- Concentration of early childhood services in the private sector. This implies programmes are limited to people living in major cities and to those who can afford the cost.
- There is inadequate compliance legislation for the private sector, therefore staff qualifications and ratios may be poor.
- Low salaries and lack of job security since the majority of early childhood programmes belong to the private sector.
- The academic nature of the curriculum in a majority of early childhood programmes especially those in the private sector where the focus is on the child's ability to read and write at the expense of other important skills.
- Deficiency in the measurement tools for the comprehensiveness of child development instruments. Furthermore, those who conduct these evaluations need extensive training.
- Weakness of follow-up and quality control measures in early childhood programmes.
- Dearth of accurate statistics and longitudinal studies of early childhood programmes.
- Fewest services for the youngest children

Many of these factors identified by the UNESCO study were also mentioned in the Iraq consultation discussions and qualitative interviews on ECD.

4.3 Childhood Disability Findings

The following section provides an overview and analyses of data relating to childhood disability. Unless otherwise stated, percentages take account of missing data. That is, the percentage of the whole sample is given and not the percentage of that portion of the sample for whom we have valid data. Hence percentages given in the text will not always sum 100%. Tables displaying details of findings are provided in Appendix 5 Section 5.3.

To establish prevalence of 'disability' it was necessary to establish whether each child had any 'difficulties' (or 'impairments') and then to explore the extent to which these 'difficulties' lead to problems with access to activities or environments within the home, community or in school. In terms of general health, respondents perceived that most children surveyed were in excellent or good health (89.2%), with a further 5.6% described as in 'fair' health. The remaining 4.6% of children (n=486) were seen as in poor or very poor health (n=10695) (see Appendix 5 Section 5.3 Table 1).

4.3.1 Presence of 'difficulties' Respondents were asked a series of questions about birth defects and difficulties with mobility, vision, hearing, cognition, self care, communication and health for all children (0-18 years). In addition, for each child aged 4 to 18 years, respondents completed a mental health screen (Strengths and Difficulties Questionnaire (Goodman, 1997)) from which scores (range 0-2) were computed that suggested the child had 'no risk', 'borderline risk' or 'confirmed risk'[14] for mental health difficulties. These data are reported below.

4.3.2 Birth defects (see Appendix 5 Section 5.3 Table 2) When asked whether their child had been born with a 'birth defect'[15], respondents confirmed that this was the case for 3.3% of children overall (n=354). There was no substantial gender difference in the presence of a birth defect (males = 3.4%, females = 3.2%). However, the overall prevalence of birth defects varied by governorate showing that Basra had a proportionately higher number of children born with defects (8.0%) compared to other governorates in Iraq (range 1.4 – 3.3%). Internationally, rates of congenital birth defects among live births range from 3-5%. A recent prospective study of birth defects in Lahore Pakistan (Gustavson, 2005), suggests a prevalence of 5.6% for live births in this area and an increased incidence (7%) for children born in 'periurban slums'. The figure for Basra is higher still than the latter finding suggesting that this is a significant issue for children in this governorate. This was confirmed by an Institute Director who when interviewed declared Basra to be "a factory for disabilities".

4.3.3 Mental health 'difficulties' (see Appendix 5 Section 5.3 Tables 3 to 13)
The analyses here included only children aged 4 to 18 years because the mental health-screening instrument (Strengths and Difficulties Questionnaire, Goodman, 1997 was not appropriate to use with younger children. Overall, Turning from birth defects to mental health, the presence of a confirmed risk of mental health difficulties was demonstrated for 10.7% of children surveyed. Gender did not appear to have a significant relationship to risk of mental health difficulty (males = 7.9%, females = 8.2% confirmed risk). However there was some variation between governorates.

There were greater numbers of children with a confirmed risk of mental health difficulties in Najaf (17.0%) and to some extent Basra (12.2%), compared to the other governorates (Erbil 6.4%; Baghdad 10.4%). There was no apparent relationship between educational levels of respondents, or their spouse, and confirmed risk of metal health difficulties. There did appear to be a relationship with 'wealth'. Larger numbers of children in the poorest households at confirmed risk for mental health difficulties.

The data above included only children aged 4 to 18 years because the instrument (Strengths and Difficulties Questionnaire) was not appropriate to use with younger children. When asked whether they thought that their child had difficulties with emotions, concentration or behaviour, 3.6% (n=282) of respondents said they thought their child had 'severe' difficulties. However, only 48.2% of these children were found to have 'confirmed risk' of mental health difficulties as established by this instrument. Indeed for 72.4% (n=614) of

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[14] 'Confirmed risk of mental health' difficulties does not equate with presence of mental health difficulties (see glossary page 11).

[15] Physical abnormalities that are present at birth. They are also called 'congenital abnormalities'.

those with 'confirmed risk' of mental health difficulties, respondents reported that they had no such difficulties.

The general health of this group of children was also perceived by respondents to be poorer than for all children surveyed. Overall 4.5% of children were perceived as being in poor or very poor health, while for the sub-group of children who were found at confirmed risk of mental health difficulties the proportion was 18.5%. This comparison masks some differences at governorate level. While in each governorate, the general health of those identified was more likely to be poor or very poor (Erbil all 1.8%, subgroup 10.2%; Baghdad all 2.3%, subgroup 10.0%; Najaf all 5.2%, subgroup 9.1%), there was a marked difference in perceived general health among those identified at confirmed risk of mental health difficulties and all those surveyed in Basra governorate (40.9% compared to 9.7%). So while proportionately those identified as having confirmed risk of mental health difficulties were more likely to be found in Najaf, it appears that the complexity of the difficulties evident for children so identified in Najaf and Basra are different. Those in Najaf are more likely to be perceived as otherwise in comparatively better health, suggesting a very specific population of children with difficulties in this governorate potentially in need of mental health services. The group in Basra appear to reflect a group with much wider and more complex disabilities requiring some mental health service input, in addition to other services.

Further analyses of the SDQ data were conducted to examine the types of mental health issues represented. Analyses were conducted separately for those children who had a confirmed risk of mental health difficulties, but no reported functional difficulties; with 1 or 2 functional difficulties; with 3 or 4 functional difficulties; or with 5, 6 or 7 functional difficulties. This was considered necessary to take into account the difficulty each group experienced when considering potential mental health difficulties

It is possible to generate sub-scores from the SDQ (Goodman, 1997) that reflect different aspects of mental health. These include Pro-social behaviour (e.g. kindness to others, readiness to share belongings or consideration of others' feelings); Hyperactivity (e.g. easily distracted, cannot stay still for long); Emotional symptoms (e.g. many worries, many fears, often unhappy); Conduct problems (e.g. temper tantrums, often fights with other children, steals from home and elsewhere); Peer problems (e.g. solitary, plays alone, picked on or bullied by other children, gets on better with adults than other children) (See Appendix 3 for Tables). Norms are given for data collected through parental report, by the author of the measure, which indicate ranges of scores for typical or normal mental health status, borderline risk of mental health issues, and 'abnormal' scores, indicative of a potential mental health difficulty. The analyses here focus on children who scores were within the 'abnormal' range.

Children with no functional difficulties (n=665) were primarily reported to show behaviour indicative of peer problems (83.3%). However substantial numbers were also said to show emotional symptoms (73.6%) and conduct problems (62.4%). Comparatively few were perceived to be hyperactive (28.8%) or have difficulties with pro-social behaviour (16.6%).

Children with one or two functional difficulties (n=90) displayed a similar pattern of potential mental health difficulties to those with no difficulties. 74.5% were reported to show behaviour indicating, or experience peer problems and 62.3% showed emotional symptoms. A smaller percentage, comparative with those who were not reported to have functional difficulties, were said to display conduct problems (43.4%). However, they were comparatively more likely to be reported as hyperactive (35.6%) or to have problems with pro-social behaviour (33.4%)

Among children with the greatest range of difficulties, those who were reported to have 4 or 5 difficulties (n=66) were primarily said to show emotional symptoms (84.9%), but a substantial proportion also experienced peer problems or have difficulty with pro-social behaviour (65.2%). For children with a greater range of difficulties, it is arguable that the difficulties identified through the mental health screen (SDQ) reflect their physical and intellectual issues and not necessarily additional mental health difficulties per se. Indeed for those with the most functional difficulties (5, 6 or 7 n=27) all are reported to have peer problems and difficulties with pro-social behaviour. For this group it is even more likely that this does not reflect mental health issues but the limitations on social interaction imposed by their functional difficulties. In addition, to difficulties with peers however, 81.5% of this group were reported to show emotional symptoms. They were less likely to be hyperactive (40.8%) than those with 3 or 4 difficulties but more likely to be so than those with few (1 or 2) or no functional difficulties. 48% of this group were said to have conduct problems. Conduct problems among people with profound and complex disabilities often reflect difficulties with communicating needs and wants and understanding the demands of others, as well as occurring in response to an impoverished living environment.

School attendance The majority of children with confirmed risk of mental health difficulties attended school (70.3%). This is a lower attendance rate than for children aged 4 to 18 years overall (79.8%). However, this figure masks some clear differences in attendance at school for this group between governorates. Fewer children with confirmed risk of mental health difficulties, compared to all children of a similar age surveyed attended school in Basra and Erbil (Basra all 73.7%, subgroup 53.2%; Erbil all 79.9% subgroup 69.5%). While in Najaf and Baghdad comparisons showed no, or little difference in attendance (Najaf all 72.6%, subgroup 73.4%; Baghdad all 85.5%, subgroup 81.1%).

Most children attended regular classes in their local school (range 95.2% to 100% across governorates), with most of the remainder attending a special class in a local school. Only three children (0.4%) attended classes at an institution. Two of these were in Baghdad and one in Basra. Five children attended schools run by private organisations, one each in Erbil and Baghdad, and three in Basra. Ninety two percent of these children attended school whenever classes were open.

Fewer children in this group (64.3%) walked to school compared to those surveyed overall (All walking 4-6 years 70.4%; 6-12 years 75.9%; 12 -18 years 67.2%), or used public transport (6.7%) compared to older members of the whole group (All public transport 4-6 years 3.7%; 6-12 years 8.4%; 12 -18 years 14.5%). However 27.0% of children with confirmed risk of mental health difficulties were taken to school by car. The latter represents a higher

proportion for this group of 4 to 18 year olds than the respective overall groups spanning this age range (Car 4-6 years 22.2%; 6-12 years 14.3%; 12 -18 years 16.4%). This suggests transport to school was an additional expense for these households.

Household 'conditions' and presence of confirmed risk of mental health difficulty There was no apparent relationship between educational levels of respondents, or their spouse, and confirmed risk of metal health difficulties. There did appear to be a relationship with 'wealth'. Larger numbers of children in the poorest households at confirmed risk for mental health difficulties.   Male respondents and spouses were less likely to be in full time employment and more likely to be in part time employment than the male respondents or spouses overall (All full time 46.5%, subgroup 42.1%; All part time 35.0%, subgroup 41.4%). They were also marginally more likely to be unemployed and less likely to have retired from work (All unemployed 1.9%, subgroup 2.6%; All retired 3.4%, subgroup 2.8%). Among female respondents and spouses, they were also less likely to be in full time employment, but also less likely to be in part time employment (All full time 11.7%, subgroup 6.8%, All part time 6.4%, subgroup 5.0%). These women were also more likely to be unemployed and seeking work or retired from work (All unemployed 23.2%, subgroup 29.1%; All retired 1.2%, subgroup 2.1%).

Only 1.7% of households with a child at confirmed risk of mental health difficulty were in receipt of financial support from outside household members themselves. Indeed in Najaf, not one of these households reported receiving any financial assistance. Many respondents in households with a child with confirmed risk of mental health difficulties in Basra and Najaf perceived their household income to be severely inadequate (48.1 and 51.9% respectively). This proportion of households was considerably higher than overall respondent ratings of household income adequacy (Basra overall 34.8% and Najaf overall 21.6%). A similar trend was evident in Erbil and Baghdad (Erbil all 14.7% subgroup 22.9%; Baghdad all 23.9%, subgroup 26.0%). This finding reflects and supports the analysis reported above on the link between households in poverty and increased prevalence of risk of mental health difficulties among children in those households.

4.3.4 Functional 'difficulties' (see Appendix 5.3 Tables 14 to 27) The remaining questions about difficulties were asked of all children (0-18 years). Respondents were asked to consider whether their child had any difficulty when compared to other children of the same

age in seven different areas of functioning. This was an important instruction because otherwise very young babies may be identified as having 'difficulties' because they cannot walk or feed, wash and dress themselves, and so on. Instead, because respondents compared their baby to other babies of the same age who were developing normally, babies whose development was unproblematic were rated as having 'no difficulties' in mobility, feeding and so on.

Evidence from this part of the household survey indicated that 8.3% of all children surveyed experienced difficulties in one or more of these areas.   More specifically, 2.9% of all children experienced mobility difficulties; 1.1% experienced a visual impairment; 0.4% experienced difficulties with

hearing; 1.6% of all children had difficulties in cognition; 4.3% had difficulties with self care; 2.1% experienced communication difficulties and 5.1% had difficulties associated with a health problem. The figures on visual and hearing difficulties are lower than expected. It is likely that this is due to the existence of institutions that focus on the residential care and education of children with these difficulties. They therefore may not be fully represented within households. The majority of children identified had a single difficulty (46%) with 36.7% having 2-3 difficulties and the remaining children having between 4 and 7 difficulties (16.2%). These types of disability, described above, are referred to as 'functional' difficulties or disabilities below.

The presence of a birth defect was highly associated with difficulties in one or more areas of functioning. Indeed, only two children identified as having a birth defect, were not described as having a difficulty in any of the areas listed. In calculation of prevalence of difficulties (impairment) and disability, therefore, birth defect was not included as a contributory factor in the calculation of prevalence of disability. We would argue that a child with a birth defect whose functioning is not impaired, nor their mental health negatively affected, is not a 'disabled' child. For example, a child born with a sixth finger on her left hand who is able to use her hands without any difficulty, is culturally accepted and experiences no embarrassment or distress at the physical appearance of her hand, such that it affects her mental health, is not a disabled child.

The general health of children with perceived functional difficulties was also perceived by respondents to be poorer than for all children surveyed. Overall 4.5% of children were perceived as being in poor or very poor health, while for the subgroup of children who were perceived to have functional difficulties the proportion was 48.8%. This is higher still than the figure for children with confirmed risk of mental health difficulties which was 18.5%. As indicated in the analysis above, there was a degree of overlap between children with confirmed risk of mental health difficulty and those with reported functional difficulties. The higher proportion of children with poor or very poor health among those with confirmed risk of mental health difficulties compared to children overall therefore may partly reflect the presence of those with functional difficulties within that subgroup.

The proportion of children with poor or very poor health in Erbil and Basra was considerably greater among the group identified has having functional difficulties compared to all children surveyed in these governorates (Erbil all 1.8%, subgroup 65.4%; Basra all 9.7%, subgroup 60.5%). However there were also considerable differences between the entire and subgroup with identified functional difficulties in Baghdad (all 2.3%, subgroup 31.8%) and in Najaf (all 5.2%, subgroup 40.4%). It is likely that there is some overlap here with those children identified as having health difficulties that affect functioning. However, a number of these children may function well for periods of time when their health issues are well controlled and so this overlap may not be entirely responsible for the marked difference in perceived health status between this group and all children surveyed in each governorate. The figures suggest between a third and two-thirds of children with functional difficulties have general health issues that are likely to affect their ability to participate regularly in educational settings.

Respondents were asked to provide descriptions of the impact of the difficulties they identified in their children. However, the numbers of respondents who provided this additional information varied and in some cases the amount of missing data in the comparatively small subgroups of children with specific difficulties makes it inappropriate to report on these aspects of the data within this report. Tables of data on descriptions of functional disabilities are provided however in Appendix 5 Section 5.3 (Tables 1 to 7) for information.

Children identified as having functional disabilities were much less likely to attend school than children aged 0 to 18 years surveyed overall (all 59.4%, subgroup 26.3%). In each governorate surveyed approximately 30% fewer children with functional difficulties attended school apart from Erbil where only 12.6% fewer children with functional difficulties attended school. This finding appears to reflect the policy on inclusive education adopted within the Kurdish Region (KIEP) and suggests that attempts at inclusion within schools in Erbil have resulted in improving attendance for children with identified functional difficulties in this governorate.

Household 'conditions' for children with perceived functional difficulties As with male respondents and male spouses in households where there was a child with confirmed risk of mental health difficulties, those in households where a child was identified as having functional difficulties were also less likely to be in full time employment than the male respondents or spouses overall (All full time 46.5%, subgroup 34.4%). However they were no more likely to be in part time employment (All part time 35.0%, subgroup 35.7%). Male respondents and male spouses in these households were also more likely to be unemployed and less likely to have retired from work (All unemployed 1.9%, subgroup 3.2%; All retired 3.4%, subgroup 1.7%). Among female respondents and female spouses, they were also less likely to be in full time or part time employment than female respondents and spouses overall (All full time 11.7%, subgroup 8.5%, All part time 6.4%, subgroup 5.3%). As with the women in households where children were identified as at confirmed risk of mental health difficulties, women in these household were also likely to be unemployed and seeking work but no more likely to have retired from work (All unemployed 23.2%, subgroup 35.9%; All retired 1.2%, subgroup 1.2%).

Zahra's Story (Baghdad) Zahra is 9 years old and was born paralyzed from the waist down. She had an unsuccessful operation an hour after her birth. Doctors say the only appropriate specialist treatment is available abroad, but the family can't afford it. Zahra's father has a small stationary shop and can only afford to pay for some of her medication and urine collection tubes and bags.

Zahra's mother takes her to school everyday in a wheel chair. The family flat is on the second floor and because of this it is difficult for her parents to take her to school. Before a school day Zahra's mother ties her to her chair with ropes to prevent her from falling out of her wheelchair. Her parents say that Zahra's self confidence is poor and that she is often very unhappy. At school she feels isolated and excluded and has no friends.

Zahra's parents do not get any support from the state and although they have asked many organizations, no help has been forthcoming.

In terms of additional income from agencies outside the household itself, only 2.6% reported that they were in receipt of such assistance. The majority of these households were located in Basra where 4.7% of households received assistance. However none of the households in Erbil, where a child with functional difficulties was identified, received any financial assistance. In remaining governorates the proportions receiving support was also very small (Baghdad 1.2%; Najaf 0.5%). Overall, more households among those where a child with functional difficulties had been identified reported that their income was severely inadequate compared to all households surveyed (All 23.9%, subgroup 33.4%). There was some variability among governorates with fewer households in Basra where a child with functional difficulties was identified, reporting that their income was severely inadequate compared to households surveyed overall (All 34.8%, subgroup 32.6%). This may reflect a small amount of financial assistance available to affected households as indicated above. However, the general trend across all governorates was for respondents to describe household income as less adequate and more inadequate than was reflected in data gathered from households overall.

Overall prevalence (see Appendix 5.3 Tables 28 to 30) Incidence of one or more difficulties among children aged 0 <u>up to</u> 18 (N=10695 ages 0-18 years) based on the data relating to seven areas of functioning (mobility, vision, hearing, cognition, self care, communication, and health), was calculated at 8.3% (N=885). In addition, 7.7% (N=609) of children aged 4-18 years (n=7936), who had no functional difficulties, had confirmed risk of mental health difficulties. This yields an overall prevalence figure for any type of difficulty (impairment) of 14.2% (n=1494/N=10553) of children surveyed for whom data was complete.[16]

4.4 Difficulties and Disability Findings (see Appendix 5 Section 5.3 Tables 31 to 32) For the purposes of investigating the nature and impact of difficulty (impairment) and disability, functional difficulties and ill health were explored independently from data on mental health. This is because the mental health data applies to a sub-group (4-18 year old children only) and because the instrument, while efficient in identifying those who are likely to receive a clinical diagnosis of mental illness, is not a substitute for professional investigation. It is therefore likely that the group thus identified will include a small proportion of 'false positives' (children scoring as at 'confirmed risk' who <u>do not</u> have a mental illness) and a smaller proportion of 'false negatives' (children scoring as having 'no risk' or 'borderline risk' who <u>do</u> have a mental illness). The questions on functioning, however, record information on observable evidence of difficulties so that respondents' reports are likely to be reliable.

4.4.1 Functional difficulties (see Appendix 5 Section 5.3 Tables 33 to 39) Of all children identified as experiencing functional difficulties (n=885), 59.8% were male. That is, 8.9% of all boys (n=5951) and 7.5% of all girls (n=4741) surveyed experienced functional difficulties.

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[16] As noted above, a substantial proportion of respondents whose child fell into the latter group, did not perceive their child to have severe difficulty with emotions, behaviour, concentration or getting on with other people. Hence the sections of the interview on effects on daily living, and help provided, or needed to support the child was not completed for these children.

Examination of the incidence of children with a greater range of difficulties (that is between 4-7 difficulties) among those screened indicates higher numbers identified in Baghdad and Basra compared to the other governorates. However, children with the most difficulties were identified in Basra (2.9% of all children screened compared to 1.2% in Baghdad).

The presence of 'difficulty', however, is not the same as 'disability', which is determined by the impact of the difficulty on an individual's life. Respondents were asked about the impact of the difficulty on the child's life and whether support was given for the child to be able to take part in activities within their home, community or school environment. The investigation of number of difficulties and the impact of these difficulties on ability to participate in daily activities is referred to as 'severity of disability' and is defined below.

Severity of disability Summing the number of difficulties for each child and weighting each of these scores by an increment reflecting the impact of this difficulty on the child calculated an indicator of 'severity of disability'. For example, on the screening question on mobility two children may be described as having 'a lot of difficulty' walking and so are given an equal score. However on the sub-question (completed only for those children said to have difficulties) one child is described as able to move about independently with the use of mechanical aids, but the other child is described as unable to move without human assistance. The initial score attributed to each child is then incremented by different amounts, with a higher increment added to the score of the child who is not independently mobile. This process is repeated for each of the areas of functioning and an overall score representing the child's overall severity of disability was allocated. The theoretical range of scores was from 0 to 28.88.

The severity index provides a more sensitive measure of the complexity of disability experienced by the child than a count of difficulties; in particular it allows a finer grading of the extent of the impact of difficulty on a child with a single or two areas of difficulty.

4.4.2 'Situation' of households and presence of functional disabilities (see Appendix 5 Section 5.3 Tables 40 to 51) An analysis of presence of disabilities[17], including children using mechanical aids, by governorate suggested that more children in Basra (15.6%) and Najaf (12.4%) experienced disabilities, than those in Baghdad (6.7%) or Erbil (2.4%). This distribution was reflected in average severity scores for those identified with disability in each governorate, though the difference was small (Erbil 4.05; Baghdad 4.56; Najaf 4.56; Basra 4.93). This suggests that children who experience the full range of disabilities, mild to very severe, reside in all four governorates surveyed. However the children with the most severe difficulties were more likely to live in Basra.

Environmental characteristics An exploration of the relationship of presence and severity of disability, or birth defects, with features of the environments in which households were situated was undertaken. In seeking to ensure that the survey was representative of characteristics of each governorate as a whole, team leaders, in consultation with local representatives, described each locality surveyed in terms of whether it was geographically urban or rural (observed by a team leader); had been subject to conflict of any type

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[17] That is difficulties that impact on everyday life for any reason.

(including sectarian) in the recent past (public record, that is reported by local representatives); and whether it was perceived to be subject to contamination from one or more sources (local informant perceptions/report or observation). Sources of contamination were described as 'natural', such as ingress of salt water into the rivers in Basra (reported); 'industrial', such as may arise from petrochemical or other industries (perception); 'war' related contamination, such as that remaining after the 'Iran Iraq' and 'Gulf' wars (perception); and 'other', which was a category used to described pollution due to lack of proper sanitation systems to take waste away from residential areas, or to dumping of household and other rubbish close to, or among dwellings and likely to cause a health hazard (observation).

'Contamination' data therefore is largely drawn from perceptions of local officials regarding environmental status, and/or observable evidence of 'other' pollution during fieldwork. They **do not** represent independent scientific analyses of earth, air or water at these locations.

The number of children with functional disabilities varied with geographic location, with those in rural locations more likely to be so identified (Urban 8.8%; Rural 10.3%). Households in rural areas were therefore more likely to contain children with disabilities.

Counter-intuitively, greater numbers of children living in areas that had <u>not</u> been reported as having experienced conflict in the recent past (<10 years) were identified as having functional disabilities (Conflict area 8.0%; Non-conflict area 10.3%). However, this weaker tendency for children in households that were situated in areas that had not experienced recent conflict to be identified as having disabilities did not quite reach statistical significance. On the contrary, the analyses suggest that it may not be conflict per se that impacts on childhood disability, but the environmental contamination it leaves behind. Greater numbers of children were identified as having functional disabilities in areas that were perceived to be subject to contamination from warfare (warfare 10.9%; no warfare 8.9%). This relationship (and those that follow) was analysed statistically using the Chi Squared test[18]. Households located in areas that were perceived to be contaminated by warfare were found significantly more likely to contain a child with functional disabilities. (X^2(1) = 45.3, p=0.000).

> *Needs assessment:* The numbers of children in rural areas described as having functional difficulties suggests urgent action should be taken to ensure that appropriate support and services reach those outside large urban conurbations.

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[18] The Chi Squared test is a simple statistical test that allows comparison of data between two or more groups. It generates a statistical value X^2 and provides an indication of whether any difference between the groups compared was likely to be due to chance factors (factors not measured by the characteristics compared but merely coincidence). A probability value (p) of less than 0.05 is said to indicate a 'significant' finding. That is, a p value of less than 0.05 indicates that there is less than 5% probability of obtaining the difference between scores shown here if chance factors were operating (i.e. that the finding was coincidental).

The association of residence in areas subject to contamination from different sources and functional difficulties was evident to greater and lesser extents. Children living in areas reported as subject to natural contamination (such as the contamination of rivers in Basra with salt water from the sea) were more likely to be identified as having a functional disability (natural contamination 15.0%; no natural contamination 8.1%). Households in such areas were significantly more likely to contain a child with functional disabilities ($X^2(1)$ = 158.7, p=0.000).

Areas perceived to be subject to contamination from industrial operations were also found to be associated with identification of higher numbers of children with disabilities (industrial contamination 10.2%; no industrial contamination 8.9%). The relationship between households containing a disabled child and situation in an area subject to industrial contamination was statistically confirmed ($X^2(1)$ = 29.9, p=0.000).

Finally, other sources of contamination, such as poor sanitation or rubbish dumping within residential areas were also related to identification of greater numbers of children with functional disabilities ('other' contamination 15.9%; no 'other' contamination 7.1%). Households in such areas were therefore found to be significantly more likely to contain children with disabilities ($X^2(1)$ = 271.0, p=0.000).

Overall therefore, in terms of functional difficulties, there was a significant association between difficulties and reported, perceived or observed presence of contamination from a range of sources. Poor sanitation and rubbish dumping likely to cause a health hazard, along with reported 'natural' sources of contamination were most strongly related with households containing a child with functional difficulties. However perceived contamination from warfare and industrial operations were also found related to presence of a child with functional difficulties in households.

The qualitative interviews build a general consensus that environmental factors have had a direct link with increased prevalence of disability. The following extracts are representative:

"After the 2003 war, the situation in the country deteriorated in general. We can also say that the percentage of disabilities has increased due to the effect of weapons on the soil, water, air and agricultural products. This led to the emergence of new types of handicaps that were not known to us before, particularly physical disabilities."

"We really have many of cases of disabilities in Najaf, especially after the war. The number of disabled children has considerably increased." (Institution worker)

"… Basra was subjected to various weapons and we were part of experimentation to field test a large number of weapons, including chemical weapons. We suffer from a

bitter reality in Iraq in general and Basra in particular. We have widespread mental illness because of the radiation emitted by the remnants of wars, such as tanks and other vehicles. Radiation has had a major affect on pregnant women with the birth of disabled and unhealthy infants … you could say that Basra is a disability factory."

4.2.3 Situation of households and presence of birth defects Reports in the media have linked the occurrence of birth defects with environmental contamination or 'pollution' (China Daily, 2009; Guardian, 2010). It was therefore considered appropriate to investigate the numbers of children identified as having a birth defect in relation to reported characteristics of the localities in which they lived. It must be borne in mind that there is a significant overlap between having a birth defect and consequent functional disabilities. This analysis therefore does not add a layer of disability on top of the prevalence figures provided above. It only provides richness to the data in terms of explaining why particular localities may require additional resources to support children with disabilities compared to others within a single governorate, or within Iraq as a whole.

There was no substantial relationship between living in urban and rural areas in and the number of children with birth defects (urban 3.5%; rural 3.0%), or living in an area that had experienced conflict in the recent past (conflict 3.4%, no conflict 3.4%). However, as noted above in relation to functional disabilities, it does not appear to be conflict per se that increases incidence of birth defect, but the debris of warfare. A larger proportion of children living in areas said to be subject to warfare contamination by survey team leaders in consultation with local officials, were identified as having birth defects than those not living in such areas (warfare contamination 6.3%; no warfare contamination 2.9%).

There were also differences between households in areas reported or observed to be subject to different sources of contamination and those that were reported as not being contaminated. A greater proportion of children living in areas reported as subject to natural contamination had birth defects compared to those who did not live in such areas (natural contamination 7.3%; no natural contamination 2.7%). Similarly, those children living in areas observed to be affected by 'other' sources of contamination arising from poor sanitation or accumulation of refuse among residential areas, were also more likely to be identified as having birth defects ('other' contamination 6.6%; no 'other' contamination 2.5%). However, the proportion of birth defects identified in areas said to be subject to industrial contamination was not appreciably larger than those area not identified as contaminated in

this way (industrial contamination 3.8%; no industrial contamination 3.3%).

Findings from this research suggest that contamination may be related to incidence of birth defect, but that the source is likely to be 'natural', 'warfare' or lack of sanitary conditions resulting in, for example, open sewers and rubbish accumulation in residential areas. The relationship between industrial pollution and incidence of birth defects deserves further investigation, but is beyond this study's remit.

There were many responses in the qualitative components of the research, interviews and focus groups that reflected a general consensus, with some exceptions, that the prevalence of disability was greater and that it was causally linked to warfare, poverty, lack of maternal education in pre-natal care, and to various sources of pollution or contamination.

Direct reference was made to sources of contamination throughout the qualitative data, with specific mention of the pollution of water supplies in Basra.

> *"… there is no electricity; water oozes inside classrooms; there is no follow-up by child-health committees … Disability is widespread. There are many cases such as: osteomalicia, blindness, blood disease, due to the drinking of contaminated water."*

Interview responses also referred to problems of sanitation such as general refuse, in addition to chemical pollution and industrial pollution.

> *"… environmental pollution in Akyo district, for example, is caused by the cement factory. It has a negative impact on people's health. The poisonous gases it emits have even affected the soil. Many people suffer from pulmonary problems and shortness of breath. Even cancer is very common in inhabitants due to pollution."*

While comments related to sanitation were an apparent endorsement of the findings from the survey, the survey did not find evidence of increased numbers of children with birth defects in areas perceived to be affected by industrial pollution.

The household survey on prevalence of disability was not designed to determine whether there had been an increase in the rate of disability in the recent history of Iraq. However, there was a widespread perception amongst those interviewed that there has been an increase in the numbers of disabled children and young people. One respondent in Najaf observes that:

> *"It has become rare to cross the road without seeing a disabled person."*

There was consensus that the incidence of childhood disability had increased, but this was not a unanimous view. A civil servant in Baghdad refuted the claims of a dramatic increase in the numbers of disabled children.

> *"It is wrong to use the term 'spread' of disability, as it implies there is an epidemic."*

The interviews and the focus group discussions converged on a strong perception of the correspondence of conflict and disability. Causes were perceived as directly sourced to conflict such as through explosions and terrorist activity, or through the residual environmental impact of contamination. The following comments are indicative.

> *"After the 2003 war, the situation in the country deteriorated. We can also say that the percentage of disabilities increased due to the effect of weapons on the soil, water, air and agricultural products. This led to the emergence of new types of handicaps that were unknown to us before, particularly physical disabilities."*

The recent EFA Global Monitoring Report, *The Hidden Crisis: Armed Conflict and Education* (UNESCO, 2011) describes both the immediate and the residual impacts of war on education. Not only is there the immediate impact of death, injuries, destruction of homes and industry, forced migration, grief, and fear, there is the extreme poverty that accompanies the collapse of industrial and agricultural infrastructure. Services such as sewage, waste disposal, the supply of clean water, fuel and electricity shut down and contribute to the spread of disease.

The link between poverty and disability is manifest in the both the quantitative and qualitative data. This link operates on a number of levels. First is the lack of health education for women and families with respect to pregnancy and childbirth. Second is the high cost of basic items such as prosthetic aids, medicines, suitable accommodation, transport, generators, air-conditioning and other necessities for healthy daily living that are unaffordable for many Iraqi families. The impact of "sanctions, international isolation, three wars and ongoing violence" (Al-Obaidi & Budosan, 2011:36) precipitated the flight of Iraqi professionals and the deterioration of infrastructure. The chronic undersupply of nurses, teachers and physicians is reflected in the commentaries of the stakeholders. Third is the fact that disabled children are given low priority in education when education funding is itself low and the state of education infrastructure and trained personnel severely restricted. Family carers are often unable to afford to pay for care to pursue work themselves and therefore are out of work and diminish the family resources.

> *Needs Assessment:*
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> There is significant overlap between birth defect and functional difficulties. Since the main focus of this study is on those children with birth defects who have difficulties and disabilities, the needs assessment is appropriate to both aspects of the analysis.
>
> As stated elsewhere, investigation of perceived and reported sources of contamination should be subject to independent scientific investigation of air, water and earth, to determine the type and extent of contamination found present. However, the messages from this data should not be ignored, in terms of the risk for children in households where local knowledge and existing evidence provides consensus that particular areas are likely to be contaminated. On the contrary, such areas should be prioritised in the allocation of resources to support children with disabilities. While Basra appears most significantly affected by perceived and reported sources of contamination, and therefore needs urgent assistance, smaller geographic areas of other governorates within the survey and outside of it, that experience similar conditions are likely to need a similar level of assistance.

4.4.4 'Situation' of households and presence of 'confirmed risk' of mental health 'difficulties' The remit for this survey of prevalence of childhood disability included an estimation of prevalence of mental health[19] difficulties. Child and adolescent mental health services are scant within Iraq because until recently child mental health services were provided by adult mental health providers (Al Obaidi, 2010), and hence likely that awareness of child mental health difficulties, or mental illness among respondents would be poor or unrecognised. The survey team adopted a general mental health-screening instrument to assist in the identification of children with mental health difficulties. The Strengths and Difficulties Questionnaire (SDQ, Goodman, 1997) is a well-validated instrument that has been found to be reliable across a number of Western, Australasian and Asian countries (see www.sdqinfo.org). Studies have confirmed that the SDQ is sufficiently sensitive to identify many children who have a confirmed diagnosis of mental illness, in that their overall score lies in the 'abnormal' or 'probable diagnosis' range (Goodman, 1997; Goodman et al, 2000). For the purposes of this study, the 'abnormal/probable' score is labelled 'confirmed risk' of mental health difficulty. We have done this because, although the instrument is likely to identify children who have mental health difficulties, its reliability is enhanced by obtaining information from more than one source. Furthermore, it is not a substitute for proper health investigation. A number who have been identified at 'confirmed risk' may not, therefore, have such difficulties. Nevertheless, there is a _real risk_ that identified children are experiencing mental illness, despite the lack of confirmation of such a diagnosis.

The SDQ can be used to screen for mental health issues for children aged from 4 to 18 years. It may be completed by older children by themselves, but has acceptable reliability when completed by a 'proxy' who knows the child well. In this case, our respondents were, in the main, a parent of the child and in the few cases where this is not the case, the respondent was another relative living in the household.

As noted above, analysis of responses to the questionnaire suggests that overall 10.7% (n=848) children were at 'confirmed risk' of a mental health difficulty. A greater proportion of children in Najaf (17.0%) and Basra (12.2%) were at confirmed risk compared to Baghdad (10.4%) and Erbil (6.4%). These data were further explored in relation to the characteristics of the localities in which the identified children resided.

Greater numbers of children were identified with 'confirmed risk' of mental health difficulties in urban localities (82.1%) compared to rural localities (12.4%). There were also larger numbers of children with confirmed risk for these difficulties identified in areas that were reported to have experienced conflict (conflict 49.4%; no conflict 45.8%). Combined with earlier analyses identifying wealth of households to be related to identification of 'confirmed risk' of mental health difficulties, this suggests a particular risk for children living in the poorest urban environments.

Analyses of data relating to reported contamination of localities by natural, industrial or other sources, or from warfare, were not associated with identification with higher numbers of children with confirmed risk of mental health difficulties.

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[19] See definition of 'mental health' in the glossary section on page 9

Needs Assessment:

Mental health difficulties are likely to impact on a child's school attendance, participation and achievement. Hence, it is important to address these often 'hidden' difficulties. Additional programmes of support to children who may have suffered trauma as a result of conflict and sanctions in Iraq are therefore urgently required. Investment is required to establish a countrywide Child and Adolescent Mental Health Service (CAMHS). The level of need suggested by the data here is such that an interim arrangement should be put in place pending the establishing of the countrywide programme. Poor urban localities have been demonstrated to contain proportionately more household with children with confirmed risk of mental health difficulties and so these areas should be a primary focus for screening for, and appropriate psychological support to children. While it is clear that some support has been provided in some areas of the country, for example the Heartland Alliance project supporting children with psychosocial needs within schools and the 'Iraq School-based Psychosocial Assistance Programme' providing support in Baghdad, Wasit, Missan, Thi-Qar, Basra, Erbil and Sulaymaniya, particular difficulties were highlighted in Najaf and therefore this governorate requires particular attention in relation both to interim support programmes and further investigation to establish why, apart from pockets of urban poverty, the level of need is elevated in this governorate.

4.5 Effect of Disabilities on Daily Living (See Appendix 5 Section 5.3 Tables 52 to 53)
The survey questions relating to the effects of difficulties (impairment) on daily living were answered by respondents for children for whom a difficulty was identified. As noted above, this excludes a subgroup of children who are at 'confirmed risk' of mental health difficulty where the respondent did not perceive a mental health difficulty nor any other functional disability affected their child.

Substantial numbers of children with functional disabilities were said to be negatively affected in a range of areas of their life. 38.9% of respondents (n=344) stated that their child was upset or distressed <u>constantly</u> as a consequence of their disability and a similar number confirmed that the disability constantly interfered with their child's home life (n=322, 37.6%). Significant minorities of children were also constantly affected in classroom learning (23.1%), developing friendships (28.6%) and in joining in outside of class activities (27.9%). Respondents reported that they felt that supporting their child's disability put a constant burden on the family (43.2%). Although not all respondents provided answers to these questions the majority of those who did, presented a picture of children who were put at serious disadvantage by their impairments.

Additional information was gained from a number of respondents about difficulties at school. 338 disabled children (38.2%) were identified as having some level of difficulty at school. In terms of facilitation of learning by schools, responses indicated that the greatest

difficulty arose with physical access to school premises and seeing the teacher or board and/or hearing their teacher's instructions. In addition, household survey respondents commented that concentration and understanding lessons presented difficulties for some children.

4.6 Medical Diagnoses of Disabilities (See Appendix 5 Section 5.3 Tables 54 to 55)

Respondents provided information on one or more medical diagnoses received by 654 of the children identified with impairments. These diagnoses are listed in Table 54). Among those children for whom data was provided (n=319), 8.5% of children received their first diagnosis in the first year of their life and a further 61.7% were diagnosed between the ages of 1 and 3 years (nursery school aged). Between the ages of 4 and 5 years inclusive 10.0% of children were given a diagnosis. Of the remaining children 19.4% were first diagnosed between 6 and 11 years of age. Only one child was diagnosed after the age of eleven (0.3%). Most children, (67.0%) received their diagnosis from a hospital doctor and a further 20.7% from a doctor practicing in the community. Only 5 children (0.8%) received their first diagnosis from a school health committee with three others (0.5%) receiving a diagnosis from another source. In Najaf, the diagnosis was more likely to be given by a doctor practicing in the community rather than a hospital doctor (community 60.3%; hospital 34.5%) compared to remaining governorates (community range 4.4-15.7%; hospital range 67.2-87.2%).

> *Needs Assessment:*
>
> 'Diagnosis' can be seen as potentially damaging to individuals because it may apply a diagnostic label to which stigma is attached causing distress to the child and family. However, such a label often also provides a key to a wide range of resources and support. Children require identification of their needs (diagnosis) to enable them to gain access to resources and services that will facilitate their participation at home, in school and in community life. The data provided suggested that many children receive diagnoses between the ages of 1 and 3 years. These are the years in which they are eligible for nursery provision in Iraq. Identification of difficulties through co-operation between nursery and health provision could provide the key to allow young children to gain access to resources that will help them to overcome some of their difficulties. This aspect of the research therefore, emphasises the need for widely available, affordable nursery provision that may act as a conduit to early intervention for young children with developmental delay that may otherwise become significant functional difficulties over time. As a result it is clear that communication between government ministries, and perhaps the aggregation of responsibilities, is required.

4.7 Supporting Children with Disabilities (see Appendix 5 Section 5.3 Tables 56 to 63)

4.7.1 Support received A series of questions were asked about support children with disabilities received currently. Of the 324 children aged 0 to 4 years identified with

disabilities, 173 (46.3%) received support. In addition 64 (53.3%) of 4-6 year olds; 165 (80.8%) of 6-11 year olds; and 120 (66.3%) of 12-18 year olds were receiving support of some type. Analysis suggests that more support was received in Basra (69.5%) and Najaf (55.1%) than in the other governorates (Erbil 40%; Baghdad 57%). While a substantial number of respondents did not state where support came from, it is clear from those who did that most was provided in the dwelling by family members in the form of human assistance and not provision of disability aids or human support from statutory services.

> *Marwan's Story (Baghdad)* Marwan is 18 years old and has been diagnosed with epilepsy. His condition started when he was about six. His mother blames it on an accident that occurred in kindergarten. According to her, his health was good until she went to collect him from kindergarten one day and found him huddled in a corner, squinting. She immediately took him to see a doctor who explained that he had had a stroke. His mother is convinced that the stroke was the result of an accident at kindergarten and that the teachers concealed the truth.
>
> Marwan is unable to walk and spends his days in bed completely unaware of his surroundings. His sister was prevented by her parents from getting a job so that she could care for him at home on a full time basis.
>
> His medication costs around 100,000 Iraqi dinars (approximately US$75). The Red Crescent provided it for only 2 months. His mother sent Marwan's medical records to a German doctor who said there might be some hope of improving his condition if he were treated in Germany, but the family can't afford it. Marwan's father, a disabled war veteran, is currently working in a grocery.

For children with confirmed risk of mental health difficulties, respondents described help with childcare as being provided in the main from their spouse (47.7%) or a grandparent (17.3%). However 14.4% of households reported that they received no help with childcare at all. A similar picture was presented in households where a child was identified with functional difficulties. In these households in 37.8% of cases help with childcare was received from spouses and in 24.7% of cases a grandparent provided assistance. 12.0% of respondents reported that they received no help with childcare from anyone.

Analysis suggests that more support was received in Basra (69.5%) and Najaf (55.1%) than in the other governorates (Erbil 40%; Baghdad 57%). While substantial numbers of respondents did not state where support came from, it is clear from those who did, that most support was provided in the dwelling by family members. This implies that 'support' involved and that this involved human assistance from members of the household and not rather than provision of disability aids or human support provided by statutory support.

4.7.2 Support needed Respondents perceived that 149 (39.8%) of the children with disabilities aged 0-3 years and 44 (36.7%) of children aged 4-5 years needed support. While 117 (50.2%) of children aged 6-11 years and 94 (51.9%) of children aged 12-17 years were perceived as needing additional support. Where respondents expressed an opinion about the locations in which the help was required, they suggested in the dwelling itself in the majority of cases. This reflects the finding above that the household itself is the major source of support to the disabled child, and respondents' perception of the burden carried by families.

It is clear that respondents did not perceive a specific need for aids to learning and this is partly related to age, in that the need was likely to be seen as marginal for younger children who have not yet started school. For children of school age, it is likely that respondents' knowledge of the type and uses of learning aids is severely limited and hence it is unsurprising that this sort of help is not heavily indicated. In relation to other support with access to learning, respondents perceived a need for help from a teacher with specialist knowledge was required. However, above all else respondent perceived that their child needed human assistance with 'healthcare' within the household.

Data from respondents suggests that more support is both received and perceived as needed in Najaf (received 55.1%; needed 49.2%) and Basra (received 69.5%; needed 47.2%) than in Baghdad (received 43.0%; needed 35.7%). While respondents perceived and reported both comparatively lower levels of receipt of support in Erbil (received 40%), and higher need for such support (needed 47.3%). The higher levels of support received in Basra and Najaf may reflect the comparatively higher levels of difficulties and disability identified in these areas. That is, comparatively greater household poverty and high numbers of children with disabilities was likely to have already occasioned some response from governmental and non-governmental organisations, as well as requiring support from members of the household.

> *Needs Assessment:*
>
> The data above suggest a slight increase in need for support as children age. This is likely to reflect both the increasing size and maturity of the children, but also the fatigue of household members who may have been coping without external support over many years. It is therefore important to conduct a series of local needs analyses with the households containing a child with difficulties and disability to establish definitive levels of current and required support. This is likely to include establishing services that will allow families to 'take a break' from caring for a few days or a week on a number of occasions over the year, by providing short-term residential facilities, or local fostering arrangements. Breaks from caring allow families time to rest and give attention to wider family concerns which helps them to continue to provide support to their son or daughter throughout childhood and into adulthood. International examples of best practice in this service to families may assist in the establishment of facilities or fostering services.

4.8 Institutions[20] (See Appendix 5 Section 5.4 Tables 1 to 4)

The aim was to explore this type of provision by gaining an overview sample of institutions catering for disabled children through qualitative one-to-one interviews and focus groups. Descriptions of institutions provided by the quantitative data are given below with associated Tables presented in Appendix 5.

Interviews were conducted in 29 institutions across the 4 governorates surveyed. These included 5 in Erbil, 9 in Baghdad, 6 in Najaf and 9 in Basra. Interviews were undertaken with the Director in 22 cases, a Deputy Director in 3 cases, a Section Manager in 3 cases and one with another person in authority. Twelve institutions (41.4%) were run by the Ministry of Labour and Social Affairs (MoLSA), 11 (37.9%) by NGOs, 5 (17.2%) by Charitable organisations and 1 (3.4%) by the Ministry of Health. Sixteen organisations (55.2%) catered for children and young people up to the age of 18, while the remaining 13 (44.8%) provided services to disabled people of all ages.

Interviewees described the primary functions of their institution as serving a number of purposes including residential care (17.2%); education (89.7%) work or work training (82.8%); to provide nursing care (58.6%) or another activity (31.0%).

These institutions provided services to people with a range of disabilities. Only two institutions provided services to people with visual impairment alone (one MoLSA and one Charitable), three provided services to those with hearing impairment alone (all Charitable), two provided services to those with cognitive impairment alone (both MoLSA) and one institution provided services to those with physical impairments alone (Charitable). All remaining institutions provided their services to populations who experienced two or more types of difficulty.

Staffing varied with the size of the institution. As the number of staff employed to support children with disabilities increased, the percentage of staff with a relevant qualification declined. This confirms Phase One Report findings, although a single professional may provide their services to a larger number of service users, than a single care worker who works directly with specific groups of disabled children throughout the day. The largest institution was a hospital. The higher percentages of qualified staff in medium and smaller organisations disguise a small number of services having few qualified staff. For example an organisation employing 15 staff to care for the children included only 3 people with a relevant qualification, and another with 24 staff included only 4 with a relevant qualification.

Residential institutions Of particular focus were those institutions that provided residential services to children and young people with disabilities. Five residential institutions took part in the survey. These included two in Baghdad run by charitable organisations, one of which provided a service to children up to 18 years with any type of disability, while the other catered for people of any age with cognitive difficulties. A MoLSA run residential school in Basra educated children aged 7 to 14 years who had visual impairments. The third, another

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[20] Up to date information on the number and disabilities of children attending institutions can be obtained through Central Organisation for Statistics and Information Technology (COSIT), Kurdistan Regional Statistics Office (KRSO) and Ministry of Labour and Social Affairs (MoLSA).

MoLSA residential institution in Najaf provided services to children aged 3 to 16 years with sensory and/or cognitive impairments, as well as catering for children with mental illnesses. The last was run by an NGO in Baghdad for those with cognitive impairments.

All five residential institutions stated that they provided 'nursing' care to their residents, and all, apart from the charitable home in Baghdad for people with cognitive impairment of any age, provided education, or training and/or employment for residents. High support staff to residents ratio was reported by institutions - 1:1 (2 institutions, including the residential school), 1:2 (2 institutions) and 1:3 (1 institution).

Sajjad's Story (Baghdad) Sajjad suffers from congenital pemphigus (blistering of the skin, usually the result of an infection). Doctors explained to the family that no treatment was available in Iraq and that Sajjad needed to go abroad. Sajjad's family is poor and cannot afford to travel abroad for treatment. His father is a taxi driver.

Sajjad goes to school regularly. At first the school refused to accept him because they thought that his disease was infectious, but after checking Sajjad's medical report the school relented.

Doctors believe that Sajjad's condition is caused by the fact that Sajjad's parents are related (cousins). Sajjad's parents did health checks and blood tests before their marriage and the results did not indicate any potential problems. Sajjad's father cannot meet all his son's needs. He has requested assistance from several organizations, but no support has been offered.

Inaam's Story (Najaf) Inaam graduated from the 8th grade of his school before joining the 'Productive Cooperative Society of the Deaf'. The Society's members are seamstresses and carpenters who create goods to sell in a cooperative model. Women join the sewing department and men work in the carpentry department. The profits from this enterprise are then distributed to the disabled members. Inaam earns 151,000 dinars a month (approximately US$100).

Inaam had a positive educational experience at the institute and maintains friendships with the people he met whilst there. It was at the Institute that Inaam learnt to write. The institute used to provide an education up to 8th grade, but the 7th and 8th grades have now been discontinued due to lack of classroom space in the building.

5. TOWARDS INCLUSIVE EDUCATION

5.1 Changing Public Attitudes

Dr. Alison Alborz and Professor Roger Slee met with the Kurdistan Region Government Minister for Education, Mr. Safin Mushin Dizayee, in Erbil in January 2010. At that meeting the Minister was asked what he would like to see as an outcome of the research. He expressed the hope that it would contribute to an overdue change in attitudes towards disabled people in Iraq and that the research would provide guidance on practical steps to improve early childhood development and inclusive education.

The qualitative interviews and the focus group discussions suggest the Minister is right to seek a change in attitudes towards disabled people. The interviews reveal tensions in the social responses to disability. There were numerous assertions that Iraq is an Islamic society and people are compassionate and merciful. Two brief quotes illustrate this position:

> *"Islamic society is a merciful society, so that we care and make donations."*

> *"As Muslims, kindness is always in our hearts."*

This religious commitment, while evoking the unequal social relations of charity, certainly provides a strong platform for support. We also encountered some very different responses in the interview transcripts. The philosopher Martha Nussbaum has encouraged us to listen to disabled people, for then "… it is possible to take the measure of the isolation and marginalisation imposed upon them, and the extent of their routine humiliations" (Nussbaum, 2004:305). A disabled person from Baghdad described the treatment of disabled people in the following terms

> *"Unfortunately society here does not care about people with a disability like us. They just look at us as if we are animals or creatures of a lower rank. This impacts negatively on the confidence of those with disabilities, killing ambition, dreams, and even the will to get better."*

Another disabled person in Basra is concise and direct:

> *"Society looks down on disabled people and does not respect them."*

A disabled activist and worker from Erbil said:

> *"The problem lies in the attitudes of Kurdish society towards disabled people … they look at the disabled person with pity and not with respect."*

Non-disabled people shared these views. For instance, a teacher in Najaf describes the social attitude to disabled people as follows:

> *"I am sorry to say that society looks down upon these people. Society needs to be educated and directed to help these people. The disabled receive little attention."*

In Baghdad another teacher is revealing in his remarks:

> *"According to my information and observation, people here do not have positive attitudes towards disabled people. People mock them, and families often take little*

responsibility for their disabled children. They are either neglected or abandoned in the streets. There are insufficient institutions to care for these children and sometimes they are exploited by terrorists."

The consultation meeting in Erbil in December 2010 also demonstrated tensions in thinking about disability. Although a rights-based approach was discussed, discussion tended not to be framed in the language of rights and entitlement. Rather, it was more frequently laden with a language of defectiveness and benevolence. In this respect there is, as the KRG Education Minister suggests, a need for public education that reaches into all quarters of Iraqi society.

5.2 Supporting Reform to Optimize Educational Opportunities in Iraq

The Education For All (EFA) Global Monitoring Report, *The Hidden Crisis: Armed Conflict and Education* (UNESCO, March 2011) chronicles the global reach of devastation associated with armed conflict. Specifically, it identifies its effects on children and education. The effects of armed conflict and violence are both direct and pervasive.

> In Iraq, poverty and insecurity deny over half a million children the right to go to primary school; their daily lessons are in hunger and loss; graduating to fear and hate. If regional and global insecurity are international priorities, we must address the poverty, social exclusion, and lack of opportunity brought about by conflict. That means bringing education to conflict zones because it undermines extremists and strengthens fragile states. But, more than that, it brings hope to millions of children who have never known peace. It brings opportunity to countries that are desperate for growth and prosperity.
>
> (UNESCO, 2011, page 23)

The destruction of education infrastructure, together with fear and insecurity, lowers enrolment rates (one third lower in conflict-affected areas) and predictably educational outcomes. The youth literacy rate for conflict-affected countries is 79%, compared with 93% for other developing countries (UNESCO, 2011, page 1). Gender disparities are also exacerbated by armed conflict and endure following periods of armed conflict. Unsurprisingly, poverty is deepened and the research-established link between poverty and educational failure is repeated (Connell, 1994; Kozol, 2005). The Education For All (EFA), Dakar Framework for Action goal (UNESCO, 2000) on early childhood education is swept aside by conditions of armed conflict.

Although the scope of this component of the research did not extend to investigating literacy levels of children in Iraq, the Phase 1 research report confirms the findings of the Global Monitoring Report.

> Two decades of wars and economic hardship have seen Iraq's schools fall into disrepair, enrolment drop, and literacy levels stagnate. Iraq's adult literacy rate is now one of the lowest in Arab countries; in 2007 UNESCO estimated literacy rates to be less than 60%, or 6 million illiterate Iraqi adults (*cf.* USAID 2007a). Rural residents and women have been hit hardest; only 37% of rural women can read, and 30% of Iraqi high school-age girls are enrolled in school compared with 42% of boys (*ibid.*).
>
> (CARA, 2010, page 19.)

Interviews and focus group discussions held across the four governorates confirmed the general observations about the interruptions to children's education caused by warfare. Destruction of buildings and the absence of children and their teachers because of security risks were referred to repeatedly. The poverty that accompanies armed conflict has gripped Iraq. In such conditions frequent references were made to children being kept from school to find work. The effects on girls and disabled children and young people are compounded.

The EFA Global Monitoring Report (UNESCO, March 2011) presses for an increase in the proportion of international aid finance invested in education for countries affected by armed conflict. Presently education constitutes only 2% of humanitarian aid globally and the redirection of 10% of current military expenditure in the 21 countries experiencing armed conflict would be sufficient to boost school attendance in those countries by 9.5 million children, some 40% of their combined out-of-school children (UNESCO, 2011, page 147). The report calls for a realignment of national and international priorities to achieve the six EFA goals, affirming curriculum reform and inclusive education as a practical strategy in the diminution of armed conflict.

> 'The teaching of subjects such as history and religion has a bearing on susceptibility to violence. In multi-ethnic or multi-faith societies, the curriculum helps shape how pupils view themselves in relation to the 'other'. Dealing with issues of identity confronts education reformers with tough choices and takes time.'
>
> (UNESCO, 2011, page 35)

The EFA Global Monitoring Report does not detail data on childhood disability associated with war. However, in a discussion of the concept of 'excess death' where attempts are made to measure death from conditions of malnutrition and disease that would not apply in the absence of armed conflict, the point is made that war creates conditions that impact on levels of impairment. The effects of war are both pervasive and enduring (Ghobarah et. al., 2003). Access to education is diminished under such conditions.

The findings of the research in this UNICEF commissioned report instance these impacts of armed struggle described by the UNESCO EFA monitoring team in the particular context of Iraq. This report adds to that work through recognition of the lower priority of disabled children and young people as prevailing negative social attitudes fuse with the pressure of scarce education resources, corruption and a lack of trained personnel to further marginalise

disabled children and youth. Social policy and practices in general and education practices in particular must change if we are to improve the conditions for early childhood development and the education of all children and young people, including those with disabilities.

5.3 Policy-making for Change.

In *Disabling Policies* (1989) Gillian Fulcher observes that education policy is contested and that it is made at all levels. It is important to consider both aspects of this proposition separately. Firstly is the proposition that education is contested. In other words, there are contradictory views about how to educate our children. There are different views about curriculum content, about how it should be taught and assessed, and about how the school system, the local school and the classroom should be organized and operated.
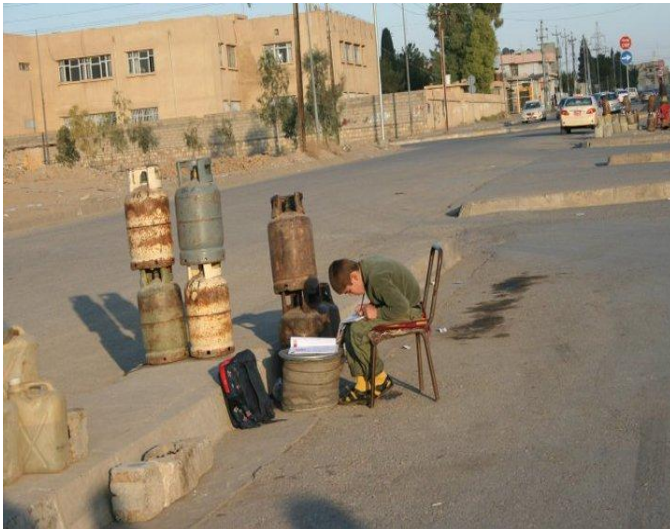
One such source of contest or difference of opinion involves the education of disabled children and young people. What Ellen Brantlinger (1997) refers to as the traditional special education view, advocates the separation of disabled children from their siblings and neighbourhood peers by placing them in specialized centres, institutes and schools. According to this view, the unique or special education needs of disabled children and young people can then be attended to by trained specialist teachers, therapists and psychologists (Kauffman and Hallahan, 2005; Farrell, 2006). Moreover, the able-bodied child will not be distracted by or bully these special children. Over time this form of organising and educating disabled children and young people has been challenged by research (Dunn, 1968; Tomlinson, 1982) and has been tested at law (Norwich, 2008). Including disabled children in their neighbourhood schools has improved the quality of social interactions, as well as their educational and vocational outcomes (Crawford, 2003). Human rights legislation for disabled people and international conventions reject the separation of disabled children through segregated education (Rieser, 2008). Achieving an understanding of disability and disablement and the promotion of social cohesion can only be achieved by ensuring the presence and participation of disabled people in all aspects of civil society.

The second proposition is that policy is made at all levels. This is wise counsel for those engaged in early childhood development and education reform. Formerly, it was suggested that changing education policy was a matter of altering the directions, expressed textually in legislation, regulations and instructions at the senior levels of the bureaucracy for implementation throughout the organisation (Dye, 1988). Colloquially, this is called a top-down model of policy analysis. Education policy analysts such as Fulcher (1989) Ball (1994 & 2009) Rizvi & Lingard (2009) and Slee (2010) disagree. They describe more complex relationships where policy is interpreted and reinterpreted in the field and then applied

according to a range of preconceptions. Accordingly, enacted policy may have little resemblance to the original reform intentions.

Changing education thinking and practice, therefore, means that the architecture for change must address all points of education activity. It must incorporate an agenda for the senior levels of decision-making that engages with questions of setting the vision, legislation, financial arrangements, professional recruitment and training, and so the list goes on. Policy reform must also address local thinking and practice in classrooms at a distance from central administrators. The move from special education to inclusive education requires a change in culture as well as structures, pedagogy, curriculum, assessment and school organisation and ethos. This is a tall policy order. It is all the more complicated in Iraq because of:

- o The impact of international isolation and war;
- o Competing views about disability and what is best for disabled children;
- o Contest between Ministries about jurisdiction responsibilities;
- o The destruction and unsafe condition of many schools;
- o Insufficient schools that must operate shifts to cater for large populations;
- o The lack of transportation to school for students in remote areas;
- o Depleted numbers of teachers and teacher educators;
- o The lack of investment in professional development for existing teachers;
- o Isolation from international developments in inclusive education.

Given the scope of the change agenda extending across early childhood development and school education, and the reduced conditions and capacity of Iraq, the task of increasing the opportunities for disabled children and young people through inclusive education should be mapped out over time through connected and achievable projects. There are large-scale agenda items:

- o Directing pressure on national government and international aid agencies to establish and maintain education as a key reconstruction strategy with greater priority;
- o Establishing the legislative and regulatory framework to promote disability rights and disability awareness;
- o Facilitating the aggregation of responsibility for early childhood development and the education of disabled children and young people to overcome the duplication and omission of service;
- o Developing a national framework for early childhood development that articulates with local community initiatives and modes of organisation;
- o Assuring that all children are engaged in early childhood development provisions through greater financial commitment and consolidation of jurisdictional responsibility;
- o Establishing priority according to levels of need;
- o Reforming the teacher education programme curriculum based on principles and practices of inclusive education;
- o Exploring options for the recruitment and supply of teachers and the establishment of a pool of inclusive education cadres linked with a network of international and local experts to support reform across Iraq;

- o Communicating a new language of inclusion and disability awareness as a basis for a national public education campaign.

There are also immediate steps that are required to support and sustain the reforms:

- o Conducting local professional learning opportunities for teachers, community and primary health care workers, doctors, nurses, civil servants, and community leaders in early childhood development, disability awareness and inclusive education;
- o Publicising successful local initiatives as a basis for scaling up projects that can be seen as having local credibility;
- o Moving children and resources into local schools or building bridging programmes between neighbourhood schools and institutions for disabled children and young people;
- o Training and appointing inclusive education consultants who are linked with wider networks to share initiatives and resources across Iraq;
- o Affirming the capability of disabled people through affirmative employment policies to guide aspirations for disabled children and young people, as well as their families and communities.

The reform agenda needs to set a strategic balance between the challenge of large scale social change that demands legislative reforms, fiscal reprioritising and institutional change in education on the one hand, and reaching out to local people to influence small-scale, but profoundly influential changes in Iraqi schools, classrooms and institutes for disabled children and young people on the other hand. In other words complementary agendas are mounted at different levels of Iraqi society that address short and long term objectives as well as national and local interventions. While pursued in different domains, the activity is interconnected. Therefore it is important to recognise the link between support for early childhood development and extending opportunities for disabled children and young people.

National Priorities & Reforms

Resourcing Local Needs & Initiatives

Achieving this agenda demands collaboration and cooperation across government and community agencies. Maintaining goodwill in a period of careful transition is important. A new approach to communications is needed to overcome present policy and administrative roadblocks.

Consultations in the course of our research underline the need for immediate interventions to assist those people working on the ground to work progressively to increase the inclusive education opportunities of disabled children and young people. To this end we suggest:

1. A plan of action – first steps towards making the education system more inclusive of children with disabilities and special educational needs; and

2. A model for training primary teachers in Iraq in inclusive education and building knowledge and skills of support workers and within agencies, including government departments, that are supporting early childhood development and disabled children and young people. (See Volume 3)

Other reforms that relate to the national government and KRG agendas, including restructuring civil service responsibility, establishing a legislative framework and securing fiscal capacity for prioritising and rebuilding education, will be pursued in the recommendations.

5.4 A Plan of Action: First Steps Towards Making the Education System more Inclusive of Children with Disabilities and Special Educational Needs

Step 1: Self-review process initiated by the National Inclusive Education Steering Committee
Interviews with government officials during the preparation of the Phase One Report (CARA, 2010) identified the formation in 2009 of a national inclusive education steering committee. The discussions in Erbil with the senior stakeholders group in December 2010 suggested that the Steering Committee was not effective. Moreover, the articulation between this group and The Disabled and Special-need People Care Association foreshadowed in the draft Disability and Special Needs Act was not specified. The national steering committee be reconstituted as part of the National Iraqi government's announcement of its commitment to expanding the education opportunities for disabled children and young people. Incorporating regional initiatives such as the Kurdistan Inclusive Education Programme established by the Kurdistan Regional Government Ministry of Education's Special Education Department, the National Inclusive Education Steering Committee should be trained according to the central questions in the teacher-training model. This will help to ensure that any actions taken to establish more inclusive schools take into account both the national and the various regional contexts within Iraq.
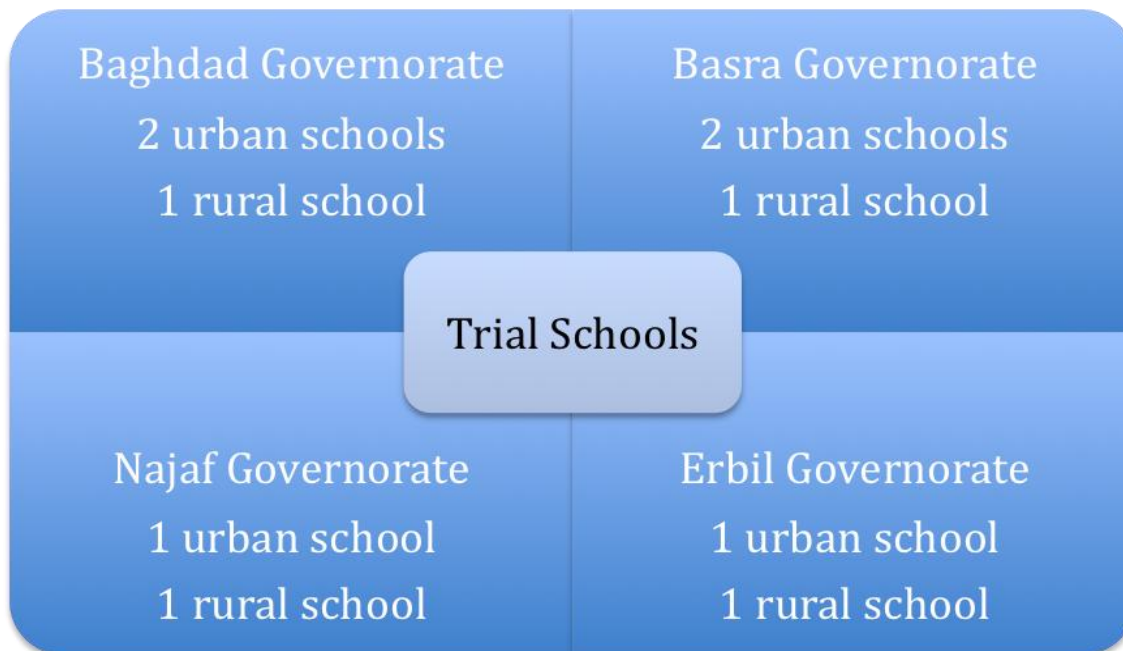
Step 2: Identify pilot schools
Identify ten (10) schools that will be supported to become the first pilot schools in the four (4) governorates in which the study took place:
Four (4) schools in urban areas – one (1) in each governorate;

Two (2) additional urban schools – one (1) in Baghdad and one (1) in Basra; and

Four (4) schools in rural areas – one (1) in each governorate.

Baghdad Governorate	Basra Governorate
2 urban schools	2 urban schools
1 rural school	1 rural school
Trial Schools	
Najaf Governorate	Erbil Governorate
1 urban school	1 urban school
1 rural school	1 rural school

Training Pilot Schools [21]

Urban schools Identify the six (6) urban schools according to their location, their infrastructure and their willingness to welcome children with disabilities into their classes. Ideally, they should be located close to an Institute for disabled children and young people. Where possible, they should also be within a reasonable distance of advisory staff from the Ministry of Education (MoE), the Ministry of Labour and Social Affairs (MoLSA), and the Ministry of Health (MoH) or front line primary health care workers. Opportunity should be made to ensure that early childhood development professionals are at hand.

This will enable specialist and advisory staff to make regular visits to support the pilot schools. It would also enable the pilot schools to specialize, if appropriate, in including children with particular impairments, in line with the expertise available in the nearby Institute. In this way there can be a transfer of knowledge and building of professional (and community) capacity.

Where possible, disabled people, advocacy organisations, and family and community members with relevant knowledge and experience, should be encouraged to participate in, and support, the pilot school.

The programme should recruit international inclusive education trainers to become critical friends to the project and a school. Sources for funding outside of the project should be targeted to achieve this so as to add to the overall project resources. This would also expose schools, government workers and communities to international networks and to current thinking about disability and inclusive education. At the outset it is important to link the training and professional development activity to supportive universities to open the

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[21] There may be an option to include early learning centres or kindergartens within this pilot programme.

potential for training modules to be award-bearing for the participants (See Attached training Module – *Inclusive Schools for Iraq*).
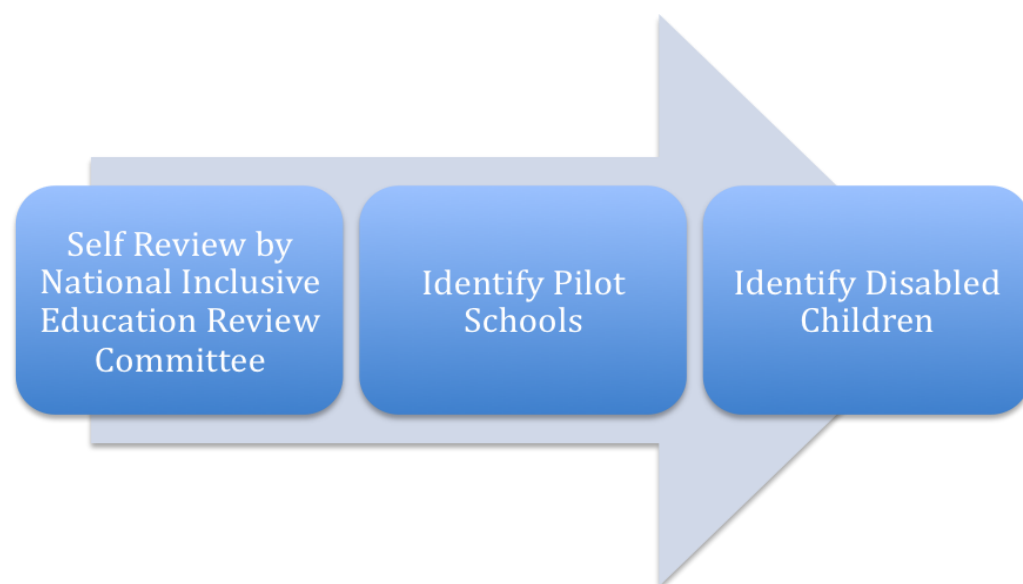
Rural schools Four (4) pilot schools should be identified according to their openness, their infrastructure and their willingness to welcome learners with disabilities. Selecting schools that already have disabled children attending would be strategic.

Step 3: Identify children with disabilities

Firstly, identify those children with disabilities who are already in the ten (10) pilot schools. It is likely that some children who are experiencing difficulties in learning have not yet been identified. It may be sufficient to focus on the children already attending the pilot schools before encouraging other children with disabilities to come to the schools.

Secondly, identify those children with disabilities who live in the surrounding area who do not attend their local school, and encourage them to attend. In some countries, school children have played a role in identifying their peers with disabilities and in accompanying them to school. With the support of Save the Children India, children living in a remote rural area that is a two-hour drive from Hyderabad in Ander Pradesh visited the families of children who were engaged in labour and whose families could not afford for them not to work to persuade them to let the children come to school while receiving support from Save the Children India. While visiting this school the children identified a young girl child who was to be married. Urged by the children from the village and supported to be able to feed and clothe their daughter, she was allowed to return to school.

Making a stand against child labour and child marriage in poor communities is meaningless unless the support is mobilised to ensure that people do not suffer greater hardship by allowing their children to attend school. The commitment must move beyond rhetoric. Herein are lessons for providing the material as well as the moral support for including disabled children and young people in their neighbourhood schools.[22]

Self Review by National Inclusive Education Review Committee	Identify Pilot Schools	Identify Disabled Children

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[22] This visit in 2010 was a field trip for a European Commission funded Save the Children India project being undertaken with the Institute of Education, University of London.

Step 4: Create an inclusive learning environment
Transport Ensure that children with physical disabilities are able to travel safely to and from school. Enrol school children and community members in helping their peers travel to and from school. Access awareness should be both a strategy and an objective of the project.

School grounds Ensure that the ground is flat and paths are wide enough for children who use wheelchairs. Remove any obstacles that may obstruct a blind child from moving safely around the grounds. Is the play equipment, if it exists, accessible for all children? At all times, ensure that the children are safe and enlist other children as well as teachers in checking this and progressively making the school more accessible and safer. Institutes for disabled children staff, parents and other disabled people will be able to assist with this important task.

Classrooms Ensure that the classrooms are physically accessible for children who use wheelchairs, or who use white canes to orientate themselves. Build ramps where necessary to enable wheelchair users to access the classrooms. Blackboards can be lowered to enable all children to write on them when invited by the teacher. Paint walls white to ensure maximum light – so that all children can see the teacher's face clearly. Think about seating – would it be helpful for some children to sit nearer to the teacher? Can children sit in groups so that they can learn from one another? Once more Iraqi Institute teachers could be enlisted in removing barriers from the project schools. Similarly, a range of people - including parents – could be enlisted into the task of planning for the transition of children with more complex impairments and support needs.

Furniture It may be necessary to adapt chairs, tables, even pens for children who have physical impairments. There are many materials available that provide practical advice on making the physical environment of the project schools progressively more accessible.

Step 5: Teacher learning, sharing and capacity building
All teachers in the pilot schools, including school principals, need to be involved in an initial training event. This is to ensure that children with disabilities are seen as everyone's responsibility. Ideally, teachers from all the pilot schools would meet whenever possible to share their experience. Learning to teach inclusively is more about familiarity, confidence, commitment and common sense than about specialist expertise. However, teachers could be encouraged to enrol in relevant courses in higher education to further their understanding and to learn new skills relevant to teaching children with a wide range of disabilities.

Targeting a cohort of teachers from the project schools to enter the teacher-training programme based on the inclusive education professional development model for primary school teachers, Inclusive Schools for Iraq (see Attachment 1), would also enhance the credibility of the teachers, the project and the training programme.

Teachers with direct responsibility for children with disabilities will need to meet on a weekly basis within or across pilot schools, if possible, to share ideas, problem solve, and

engage in any specialist training available from the Institute staff. The presence of an experienced 'critical friend' would assist. Once again, there are many materials available that provide practical advice on making teaching and learning more accessible for all children. There are also materials that provide advice on teaching children with particular impairments.

Step 6: Document the process and transfer knowledge and skills.
In his pioneering work with teachers to engage disadvantaged urban youth in education in America and forge 'new careers' Art Pearl declared: "If it ain't written, it didn't happen".[23] His message is simple and powerful: transferring knowledge requires us to capture it. This can be done in many different ways, for example, using photography, video, diaries, blogs and newspaper articles. It is important to record progress towards inclusion so that teachers can reflect on their learning, feel good about their hard work and strive to improve their practice. Such records can inspire other teachers in schools that have not yet embarked upon this process. The sophistication and reach of this work will be shaped by local conditions.

The records of learning should capture the perceptions of students and parents as well as the teachers. This will help teachers to see progress that they may not notice but is significant to parents and, of course, the disabled student.[24] It will be particularly important to make links between the children with disabilities identified in the survey and monitor their attendance and progress in pilot schools.

International organisations, such as the Inter-agency Network for Education in Emergencies[25], will be interested to hear about Iraq's experience in promoting more inclusive practices in education in the context of damaged infrastructure, teacher shortages and ongoing conflict. By documenting this experience, teachers in Iraq will be able to share their experience with audiences across the world. There exists the potential to become leaders to other countries mired in armed conflict where disabled children and young people are excluded from school and community participation.

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[23] For an example of this work see Pearl, A., Grant, D. & Wenk, E. (Eds.) (1979) *The Value of Youth* and Pearl, A. & Knight, T. (1998) The Democratic Classroom, Hampton Press.

[24] This lesson was learnt from interviews elsewhere where the teacher felt as if she was failing the disabled child whom she thought was making little progress. The parents of the child enthusiastically reported that the teacher was making outstanding as they observed the gains their child was making in the inclusive classroom.

[25] See Inter-agency Network on Education in Emergencies, 'Pocket Guides' entitled 'Education in Emergencies: Including everyone. A pocket guide to inclusive education'
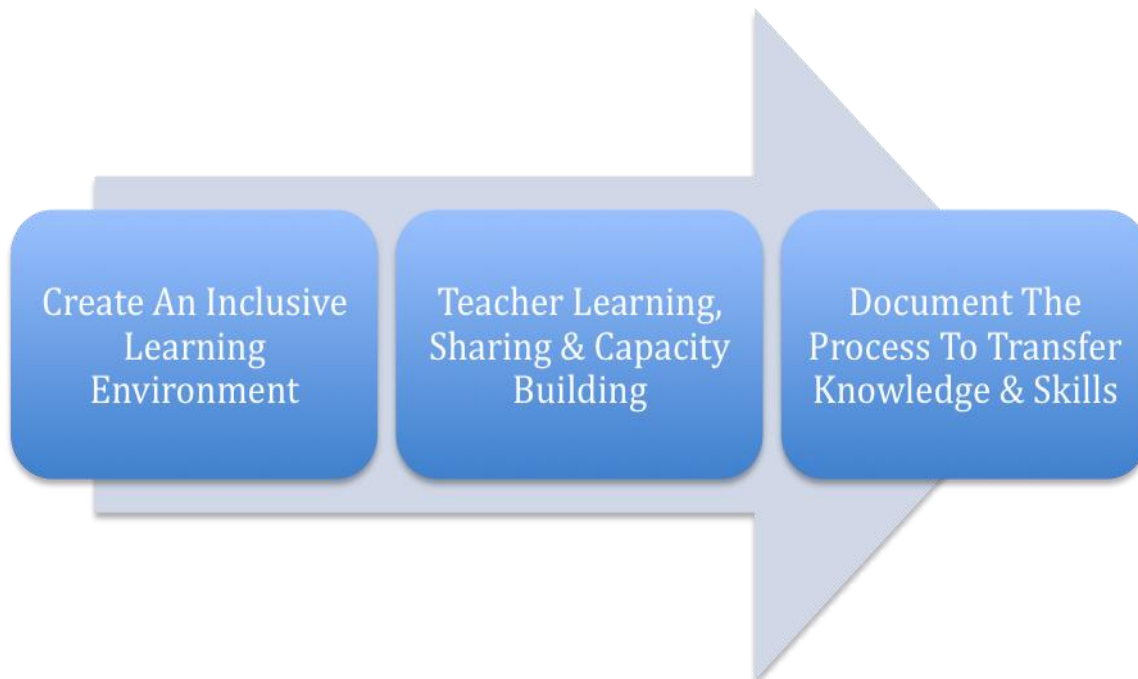http://www.eenet.org.uk/resources/docs/Teachers_can_help_everyone_learn_poster.pdf
and 'Supporting Learners with Disabilities'
http://www.eenet.org.uk/resources/docs/INEE_Supporting_Learners_with_Disabilities.pdf
INEE has also just produced a poster on this topic entitled 'Teachers can help everyone learn',
http://www.eenet.org.uk/resources/docs/Teachers_can_help_everyone_learn_poster.pdf

| Create An Inclusive Learning Environment | Teacher Learning, Sharing & Capacity Building | Document The Process To Transfer Knowledge & Skills |

Step 7: Expanding the school repertoire.

It is fine to start small with the move towards more inclusive education. Building confidence and making sure everyone in the school is supportive of this change in policy is more important than rushing to include everyone. Teachers need to develop their expertise and cultures need to change, and this takes time. There are too many examples of students being moved from special institutions for disabled children and young people to their neighbourhood school and experiencing segregation, albeit in a crowd. Inclusive education is more ambitious and therefore takes time, planning and ongoing resolution of challenges that may arise. Here are some examples of schools that have expanded their repertoire:

5.5 Building Teachers' Capacity to Increase Education Opportunities for Disabled Children and Young People.

The enormity of the school education reconstruction task that faces Iraq deflects attention from the plight of disabled children and young people in Iraq. Interviews conducted by Dr Al Hashemy in the first phase of this research revealed that special needs teachers had little, in some cases two weeks, or no training at all. Recent initiatives such as the Kurdistan Inclusive Education Programme (KIEP) have also met some level of resistance. In some quarters inclusive education has been described as a Western construct. Kurdistan has engaged partners to assist in short course and professional development events. A differential payment for special needs teachers, who may teach in classes with only two disabled children, fostered resentment amongst regular classroom teachers (CARA, 2010, page 25).

As reported, the conditions in which disabled children who do attend classes are taught are often extremely poor. In 2009, a strategic plan was developed to support a national inclusive education programme (see Annex 3). The strategy included special-education teacher recruitment and training targets (260 by the end off 2009), the expansion of current provision to primary school years 5 and 6, the establishing of a dedicated special needs body, development of special-needs curriculum, and a media awareness-raising campaign

amongst other initiatives. This research failed to yield evidence of systematic progress of the strategy.

Notwithstanding the repeated calls for separate schools and institutions for disabled children during the consultations and interviews in this research, this report recommends the priority must be the building of inclusive schools and communities. Parallel classes and schools are extremely costly and more so when resources are scarce or difficult to procure. The preparation of trainee teachers and professional learning for teachers working in schools across Iraq is a high priority in this context.

Attachment 1 sets out a training model for primary teachers for extending the mainstream education opportunities of disabled children and young people. The model is not a special education training programme. Traditional special education training is likely to compound the separation and stigmatization of disabled children in Iraq. Rather, it draws on disability equality training and principles and practices of inclusive education to improve the quality of the education experience for all children in primary schools and build the confidence and competence of teachers as they work with and draw benefit from the diversity of their students. It is also important to acknowledge the potential of the model for generating change beyond the classroom. It is expected that government officers, health care workers, parents and community leaders would engage with this programme of professional learning.

The model comprises three distinct modules (See Attachment 1). Each module introduces key topics in inclusive education and is designed to build on the local context and challenges that confront Iraqi teachers in their schools.
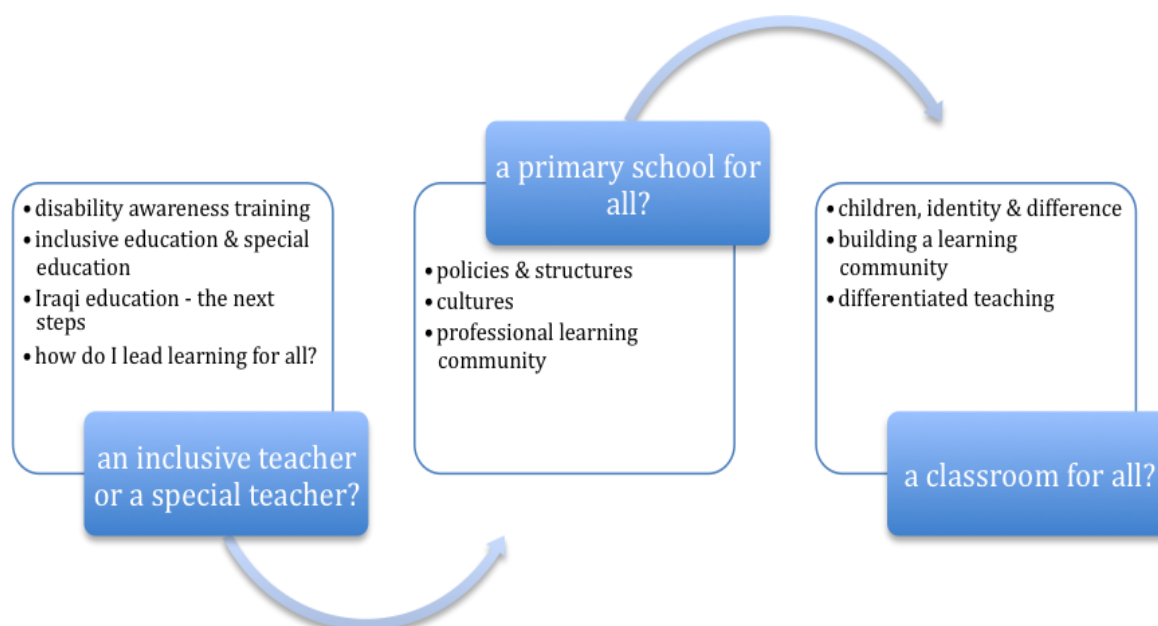
Although sequenced, the modules can be taken out of sequence to meet the needs of students and the availability of instructors. These modules should be submitted for institutional accreditation so that they become award bearing and contribute to both the

teacher's professional knowledge and build their teaching skills as well as providing them with a qualification.   Modules 1 and 2 are also intended for participants who are teachers. They would be of benefit for government and community workers, health care workers, parents and teaching assistants. The rationale and extended description of the programme and the individual modules are attached.

Zaynab's Story (Baghdad) Zaynab is four and suffers from a variety of disabling conditions. She had an operation immediately post birth to correct what her mother described as "an opening". Whilst it led to some improvement, she also suffers from a spine defect, leaving her with poor mobility. She can only walk a few steps.

Her father is a guard, but his salary isn't sufficient to meet the family's needs, including Zaynab's medications. The doctor suggested they take her abroad to have an operation to strengthen her legs, but her father can't afford to do so.

A rope around her legs acts as a brace to keep her legs in the correct position. She has physiotherapy to help strengthen her leg muscles. Zaynab's father is proud and has never asked for financial support, but his low wage means he can't afford to send her to school.

A Care Worker's Story (Najaf) A manager in the care department for special needs at a private institute for the deaf and hearing impaired. She explains that families have expectations about care and state support, that is informed by the support provided by other countries: "They want their children's disability to become a condition that is provided for, as in neighbouring countries."

Families play a key role in advocating for disabled rights: "The issue of provision for deaf people needs to reach ministerial level, because families constantly demand it." Need far exceeds provision, for example "30 disabled children want to enter school or the institute, but the administration is not listening."

She is also concerned about how society reacts to the disabled, "society views disability in an unusual way. Its view is negative. Society should be merciful to the disabled, as neighbouring countries are."

Education for the disabled creates further challenges. Even where schools are available, reaching these schools can prove very difficult: "Most disabled people have a problem with transport which is very expensive." An integral approach to education in which the disabled child's education is supported by their family and teachers is essential to realizing a good quality education. She believes this layer of communication is currently lacking in Iraq: "There must be a close link between the family and the teachers that does not exist at present."

6.   RECOMMENDATIONS

The following recommendations respond to the findings from this research, as well as to the advice drawn from extensive consultations begun in Phase 1 of the study and concluded at a meeting with senior cross-government stakeholders convened by UNICEF in Erbil in December 2010.   These recommendations also benefit from a meeting with the KRG Minister for Education ahead of survey team training in Erbil.   We were also able to draw advice from Mr. Edress Laua, Head of the Special Education Department in the KRG Ministry of Education and Ms. Karen Chesterton, Independent Consultant, ECD and Inclusive Education in Erbil and from Mrs Assima Majeed Hasany, Head of the Special Education Department, Baghdad General Education Directorate.

The recommendations embrace the urgent need to provide appropriate and immediate support to children with disabilities and their families for whom the difficulties of daily living in Iraq are exacerbated by the additional needs associated with the care and education of a disabled child.   It is also clear that intervention is required to establish early childhood development services as an area of serious priority in order to support the efforts of those already engaged in this work across the Ministry of Labour and Social Affairs and the Ministry of Education.   The recommendations also support the work currently being done by the national government of Iraq and the Kurdistan regional government (KRG).   We support the observation made by senior government officers at the consultation meeting in Erbil in December 2010 that progress must be supported by greater communication between the national and Kurdistan regional governments.

Diagram 6.1 Policy co-dependence

Following the lessons drawn from policy researchers such as Gillian Fulcher and Stephen Ball contained in Section 5 of this report, *Towards Inclusive Education*, the recommendations reflect a strategic agenda for change.   Moreover, the recommendations address the need to engage with the meta-tasks at the national, and international level, that address legislative

reform, establishing political and fiscal priorities, reorganising and coordinating jurisdictional responsibilities, and developing a national public education programme for early childhood development and inclusive education, accompanied by a coherent and effective communication strategy. Simultaneously, there is just as great a need to develop recommendations that support those engaged in operations at a regional level such as the Kurdistan Inclusive Education Plan (KIEP). The sheer urgency of the issues means that the recommendations must address immediate needs of children and families, classroom teachers, health workers, social workers and others on the ground. This is not intended as a descending order of priority, for all are equally as important and interdependent (See Diagram 6.1 Policy co-dependence).

As stated at the very beginning of this report the recommendations acknowledge the extreme difficulty of rebuilding a mass compulsory education system for all children amidst the destruction of the existing school provision, poverty and chronic lack of resources. As stated by interview respondents the paucity of resources to support improving education in general and improving education opportunities for disabled children and young people in particular is also a reflection of existing priorities and corruption. The recommendations attempt to find a balance of addressing local needs and building a national inclusive education system that reflects global standards. The recommendations respond directly to messages from the survey data and to issues raised in interviews, focus group discussions and consultations.

The recommendations urge that the Council of Ministers intervene to resolve jurisdictional rivalries and impasses between and within the Ministries of Education and Labour and Social Affairs that obstruct the realisation of a national plan of action for inclusive education and early childhood development. The current legislative allocation of responsibilities and authority is a roadblock to the establishment of responsive systems of support for disabled children and young people and also for planning for early childhood development provision.

Legislation must be enacted to assure the entitlements and rights of disabled people across Iraq and aggregate responsibilities to systematically safeguard rights, improve access and participation in education and civic life and establish coherent and consolidated administration. The enactment of the draft Disability and Special Needs legislation is a matter of urgency and should be expedited to affirm a commitment to increasing education opportunities for disabled children and young people.

National legislation would be reinforced by also signing the United Nations Convention on the Rights of Persons with Disabilities and Optional Protocol (United Nations, 2006). By signing the United Nations Convention, Iraq will become more connected to the international disability rights community. This will raise awareness within government and the civil service and will also reach more broadly across Iraqi civil society.

Communication and cooperation across government are minimum requirements for increasing the education opportunities of disabled children and young people and building services to support early childhood development in Iraq. In other words, there is an urgent need to revisit and prepare a feasible, yet more ambitious, cross-government strategic plan

that positions education and care as a priority and ensures greater attention to increasing the opportunities of disabled children and young people. Evidence gathered and set out in the Phase One Report (CARA, 2010), together with the consultations underline the absence of adequate early childhood development provisions extending to early childhood health education and care, nursery and preschool provision across Iraq. At this point in time disabled children from age 0 to 4 have minimal provision.

The plan needs to account for areas of priority. It must detail policies and programmes of action that demonstrate national leadership and respond to local and regional contingencies with clear objectives and timelines. The plan should incorporate and aggregate existing national and local, as well as international, resources in the implementation schedule. There is great scope for coordination of existing initiatives such as the National Inclusive Education Plan (NIEP) and the Kurdistan Inclusive Education Plan (KIEP).

The recommendations also aim at providing a framework for school reform to build an education system that is inclusive of all children and specifically establishes its mandate for disabled children as an educational objective and not just an addition to systems of care. The recommendations therefore also draw from evolving international legislative frameworks that advance the rights of disabled people to civic membership and participation in all social institutions including education. In this respect the recommendations are aimed not just at disabled people themselves, but also at the broader community to foster a fundamental understanding of inclusive education and a deconstruction of the barriers to access, participation and success. The education plan and professional and community education plans and programmes are elaborated in Section 5: *Towards Inclusive Education*, and in the teacher training model: *Inclusive Schools for Iraq*, which is attached as Volume 3 to this report.

The recommendations are presented within a framework that attributes level of action:
  o   National (N)
  o   Regional (R)
  o   Governorate (G)
  o   Local (L)

As will become clear there are many overlaps. The point is not to make the rubric work. The point is to demonstrate that the recommendations are intended to address all spheres of Iraqi society. In this respect the report underlines the importance of local action to build community level support for families and children.

6.1 Legislation and Framing a National and Regional Strategy that Reaches Local Communities and Families

Although Iraq has drafted disability legislation this has not yet passed into Law via the Council of Ministers. Legislation will not of itself deliver the change required to change the circumstances for disabled children and young people in Iraq.   It is however an essential first step. The force of civil rights legislation is derived from people understanding what it is and what it means. This is especially important for government officials and civic and religious leaders. It is also essential that everyone engaged in education understand the thinking that

informs this legislation and what that means for their day-to-day work in schools. For that reason a prominent national public education campaign supported by early childhood development and disability-equality training across the civil service (including teachers and health workers) is urgently required.   This campaign must be endorsed by and communicated from the most senior levels of Iraqi national and regional governments and reach across all governorates into isolated geographic areas as well as urban centres. Disabled people need to be enlisted into the publicity campaign so that the presence of disabled people is common and accepted. Exercising affirmative action policies, disabled people with appropriate experience and qualifications must also be enlisted into positions of authority and responsibility. Key local leaders and respected identities should be included in the education programme.

Iraqi leaders must strive to bring the country and region into alignment with international thinking and practice with regard to disability issues. This will be demonstrated by ratifying the proposed disability legislation. However, this aim would be facilitated further by signing, and ratifying, the Convention on the Rights of Persons with Disabilities and Optional Protocol (United Nations, 2006), which is an important step in joining the international community.

Legislation is no guarantee of the extension of opportunities in the education mainstream for disabled children and young people. The will to enforce legislation and promote an understanding of disablement as a social construction is required. We saw evidence of this commitment across the senior stakeholder group. *A co-ordinated plan of action* that is well conceived, practical, deliverable, implemented and evaluated, and overseen by appointees determined to make it work should supersede the current state of affairs where a national plan is thwarted by bureaucratic blockages. A coordinated plan of action requires constant surveillance, the allocation of responsibilities and resources, and open monitoring and reporting on progress. As we have observed, senior cross-ministry stakeholders at the Erbil 2010 consultation meeting agreed to the need for constant and open communication to build alignment and effectiveness.

This research found no evidence of consistent, comprehensive practices of identifying children with difficulties or referral for diagnosis of medical conditions. Opportunities for and referral of children suspected of having developmental difficulties appeared severely lacking. This is especially the case in the early years where formal health screening appears minimal and nursery provision limited to isolated pockets within larger urban areas. However, there are also concerns over identifying the needs of children not attending, or absent from school. A system of developmental checks that is resourced and administered through a single agency would change this circumstance. National data keeping needs to continue to be improved. The correlation of poverty and disability in this research should be reflected in priority setting for the allocation of resources.

High correlation between disability and birth defects and environmental factors requires a determination to implement a coordinated plan of action to improve the environmental conditions across Iraq. Resources are available in the community to enlist local people to improve sanitation and water quality.   There is scope for supporting local action that mobilises and builds communities in self-help programmes. Issues appertaining to perceived

contamination from warfare require independent scientific analysis to confirm the source and extent of the problem. Action to neutralise such contaminants would require strategic, and most likely costly, government intervention.

Recommendation 1:
The government (Council of Ministers) pass into law the draft Disability legislation, and endorse and ratify the Convention on the Rights of Persons with Disabilities and Optional Protocol (United Nations, 2006). (N)

Recommendation 2:
The government's signing of the Convention on the Rights of Persons with Disabilities and Optional Protocol (United Nations, 2006) is supported by a national disability-equality training programme (based on the social model of disability) that reaches across all national and regional government departments and into community life across Iraq. (N/R/G/L)

Recommendation 3:
The Council of Ministers should investigate the work of the present bodies responsible for the National Inclusive Education Plan and design a new structure (e.g. steering committee) and strategy that is afforded the expertise, (external advice may be required), the resources, and the authority to guarantee implementation. This work should also involve those working on The Kurdistan Inclusive Education Plan (KIEP) to ensure the alignment of objectives and to draw benefit from what has been effective on the ground in Kurdish Region. (N/R)

Recommendation 4:
Disabled people with appropriate experience and qualifications should be appointed to high profile positions to lead disability policy and programme development and implementation. (N/R/G)

Recommendation 5:
The National Inclusive Education Plan should be revised to ensure realistic targets, a feasible operational protocol that coordinates implementation activity, a communications strategy, and a reassessment of jurisdictional responsibility to enhance efficiency. This work should be pursued in dialogue with officers from the KRG who are overseeing the implementation of the Kurdistan Inclusive Education Plan (see recommendation 3). (N/R/G)

Recommendation 6:
The Council of Ministers should ensure that the 'steering committee' is given clear terms of reference with a remit to investigate the structure of responsibility and delivery of education for disabled children and young people, and early childhood development. They should be charged with developing a plan that aggregates resources, unifies responsibilities, sets priorities, opens communication and ensures efficient delivery of services to those in need, a recommendation to be mirrored by the KRG. (N/R)

6.2   Early Childhood Development Policy and Programmes

The importance of focusing on the development of very young children has been increasingly highlighted in the recent past as it has become clear that children of this age learn at a great rate and that this learning sets the scene for later performance in formal educational contexts. In response, government departments in many countries have put in place strategies to monitor the development of young children and ensure they receive high quality, play-based, education from a young age (typically intense developmental checks 0-5 years/education from 2-3 years). This type of initiative is increasingly evident in Gulf States.

The survey found little evidence of nursery or kindergarten attendance, hence there appears to be a real need for urgent action in this regard. In this respect the agendas for early child development and identification of difficulties merge. While at one level, engagement in early child development activities promotes skills vital to later optimal levels of performance in school; they also provide an opportunity to support those experiencing difficulties. Early intervention can minimise the impact of difficulties for the child, and their family. To push this concept further, and ensure that developmental delay or impairment is minimised, screening should begin at the antenatal stage with the care and education of mothers-to-be.

Stakeholders however reported that a major barrier to expanding kindergarten provision was the lack of suitable buildings, some existing ones having been co-opted for use as schools, and a lack of suitable equipment and qualified teachers, despite the development of a good kindergarten curriculum and teacher guide.

Recommendation 7:
The national and regional government develop a strategy for early childhood care and education and an action plan with a clear and specific budget; implement comprehensive programmes for all areas of children's development, to include health, nutrition, educational and psychosocial aspects. (N/R)

Recommendation 8:
Establish an Early Childhood Development Board, positioned in a leading ministry, which is in charge of the planning, implementation, follow-up and evaluation. The function of this body is also to cooperate and coordinate between ministries and various sectors concerned with early childhood programmes. Delegates from KRG should be engaged in this work to ensure coordination between the National government and KRG. (N/R)

Recommendation 9:
Give priority to the development of education and care programmes for children (0-4 years). A public awareness raising / parent education programme that educates the wider community about the importance of these programmes for 0-4 year olds in providing a future that benefits children in their health, social, and academic development. Importance must be attached to directing resources to programmes for disadvantaged children, children living in remote areas and displaced children. (N/R/G/L)

Recommendation 10:
Attention needs to be directed to a clearer articulation between early childhood programmes and the primary school. This may result in reforms to the formal curriculum primary school curriculum and traditional teaching methods which may be at odds with the essential developmental needs of children in this particular age group, who require informal and play-based learning programmes. (N/R/G/L)

Recommendation 11:
Extensive dissemination of health education and healthcare support is required for mothers and young children. The use of a developmental checklist is advised to promote and support parenting skills and health education. Communities, especially poor and isolated communities, need to be systematically targeted to raise awareness of pre-natal and antenatal health care. This includes consideration of issues such as consanguinity. A useful outcome may be that the Ministry of Health takes on this responsibility, but uses local school infrastructure, as well as primary health care centres, as a resource in healthcare delivery. (N/R/G/L)

Recommendation 12:
Family health care workers and social workers need to be trained in greater numbers and deployed to agreed areas of need. (N/R/G)

Recommendation 13:
The Iraq government encourages the development of schools as community hubs for the education of parents and for enlisting their support in the school programme (see recommendation 22). (N/R/G/L)

Recommendation 14:
The first Education for All goal focuses on: '*Expanding and improving early childcare and education especially for the most vulnerable and disadvantaged children*'. Pursuant to this goal, the development of integrated model nurseries and kindergartens for children aged 0-6, which could also address the needs of those young children suffering from developmental delay and trauma is required. The extension of portage models of early childhood education[26] where parents are invited to learn skills to promote child development alongside professionals as they interact with the child, is recommended. (N/R/G)

Recommendation 15:
Improve training and curriculum development alongside the development of integrated model kindergartens. (N/R/G)

Recommendation 16:
Develop short-term intensive programmes to support children in their transition to school, especially those who have had no previous experience of schooling. (N/R/G/L)

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[26] This model has been successfully introduced as part of the KIEP.

6.3 Medical & Professional Services, Health Care Support and Diagnosis

The current approach to identification of developmental and health difficulties and referral has been identified as problematic. There are conflicting views on the efficacy of the medical examination carried out by the Ministry of Health Medical Committees when children enrol in primary school. This school-based approach does not reach out-of-school children. Early diagnosis is not achieved, as there is a chronic lack of specialists.

This research identifies the pervasive risk of mental health difficulties associated with the 'conditions' and 'situation' of living in Iraq. There should be greater access to psychological counselling and psychiatric services. Mental health education should reach across communities and into schools.

Recommendation 17:
To facilitate early identification of developmental and health difficulties, the Ministry of Health recruitment and training plans should be reviewed and plans made for enlisting international support in building local capacity able to reach all communities across Primary Health Care. Investigation should include review of whether schools (or a lead school) suitably staffed and supported, should be developed as a community resource for delivery of developmental and health monitoring along with health promotion for children and mothers, and provide a contact point for access to rehabilitative resources. (N/R/G/L)

Recommendation 18:
The government establishes an on-going capacity to monitor disability prevalence and co-ordinate services to meet the requirements of changing patterns of prevalence and need. (N/R/G)

Recommendation 19:
Greater support is given to enable access to health care requirements for disabled children and their families. This includes subsidies for medicines, aids, transport and personal assistants. (N/R/G/L)

Recommendation 20:
Child mental health services need to be established as a budget priority. Professional diagnostic and treatment capacity should be increased over time with clear targets that reflect priority. (N/R/G)

Recommendation 21:
A child mental health education strategy should be developed through collaboration between the Ministries of Health and Education. (N/R)

Recommendation 22:
Child mental health support must be deployed across schools to support families, children and young people. Schools should be supported to take up a mental health education and advocacy role as a part of the development of schools as community services hubs. (G/L)

6.4 Childhood Disability, Early Childhood Development and the Environment.
This research identifies an apparent link between birth defects and the pollution or contamination of the environment. The scientific community is divided over the question of soil contamination from warfare and war debris. Claims about links between birth defects and industrial pollution are also contested. What seems more straightforward from this research is the necessity to address compromises to sanitation, sewage and the cleanliness of the water supply.

There is an opportunity to mount local action by educating, leading and mobilising local communities. Coordinated campaigns across identified risk areas and a more pervasive campaign are warranted. Regional and Governorate authorities could work with community groups to build environmental learning and action projects.

Recommendation 23:
Given the association between perceived and observed sources of contamination, and disability and birth defects, the 'Steering Committee' needs to work with government, community and international organisations to establish an environmental sustainability strategy that urgently investigates reports of contamination and tackles areas of greatest need to avoid ongoing impact on children and families. (N/R/G)

Recommendation 24:
Areas of greater poverty, areas with confirmed higher levels of contamination (natural and non-natural) and rural areas will need to be identified and resources directed to support the likely higher numbers of children with functional difficulties. (N/R/G/L)

Recommendation 25:
Resources need to be identified and deployed to the regional, governorate and local levels to support localised projects to improve waste disposal, sewage and water cleanliness. (G/L)

6.5   Inclusive Education Policy and Programmes
It is important that government provides a clearly communicated framework for inclusive education that promotes not only the rhetoric, but also the practice of increasing education opportunities for disabled children and young people (following the Salamanca Statement and Framework for Action on Special Needs Education UNESCO, 1994). The current urgent need to rebuild and improve school stock and teaching capacity in Iraq provides an opportunity to build a unified inclusive education system for all children. The administration of two parallel systems of schooling (regular and special) is costly and educationally unsound. Flexible approaches are required that enable all children to participate and succeed in their neighbourhood schools using resources deployed on a single site. This is likely to involve the redeployment of resources from special institutes and centres into a service delivery model to support regular teaching staff and particular children. Children may need to receive education at different times in different places to facilitate their health needs and accessibility of learning materials. However, this should be the exception and not the norm for educational provision.

Greater attention is required to meet the mental health needs of children in education in a society that has endured protracted war. International support must be enlisted in supporting the training requirements for teachers and health professionals. The school curriculum is an important resource for diminishing violence and promoting the wellbeing of children in contexts of war and armed-conflict. (see 6.2, Recommendations 11, 12 & 13)

The teacher is the most important element in the improvement of educational experiences and results for all children. Stakeholders reported practices as variable in quality and largely outdated, that are common among teachers in primary and secondary education in Iraq. Resources need to be focussed on the training and continuing professional development of an educational workforce that is familiarised with international theory and practice, disability issues and legislation, and trained in inclusive education practices. This suggests an overhaul of pre-service teacher training and continuing professional development to achieve this goal.

It is essential that the government recognise the need to support families who experience additional financial hardships ensuring that their disabled children's health and education requirements are met.

The government needs to investigate the current division of responsibilities for the education of disabled children and put in place an administrative system that is able to:
- o Facilitate identification of childhood disability at an early stage and the scope of needs of each cohort, through each educational stage;
- o Investigate age-based transition through school rather than criteria-based progress that may unhelpfully hold up a child's progress because they are deficient in one particular aspect. Children with moderate cognitive impairments would be unlikely to progress far in such a system and therefore be unable to maintain peer relationships on a year-to-year basis, as their classmates progress on up the school without them.
- o Track the progress of disabled children through education as a basis for inquiry into curriculum, pedagogy, assessment and school improvement;
- o Aggregate services (that is, make one department responsible for all educational provision) so that overlap and omission in provision is avoided;
- o Establish accountability procedures that eradicate corruption and the misdirection and wastage of scarce resources;
- o Put in place communication systems that ensure that people are aware of available support and that provide channels for the flow of information back from service consumers and local support workers to aid the improvement of service delivery.

This research was informed by our consultative groups and by the qualitative research respondents of the widespread need for more extensive community health education. This is especially the case for isolated and poor areas where health care and education resources are absent.

Recommendation 26:
The Iraq government continues to affirm the expectation that all children, including disabled children, enjoy the right of access to, participation in and successful completion of school education in their neighbourhood. (N/R)

Recommendation 27:
The division of responsibility for education between MoE and MoLSA causes anomalies. This directly affects children aged 0-4 years and all children with disabilities. Currently the MoE has no responsibility for children less than 4 years of age. Supporting the educational requirements for early childhood development suggest the need to evaluate this division of responsibilities. The 'steering committee' should investigate and produce recommendations on an acceptable form of integration of activity. A useful outcome might be the location of responsibility for all education (including nursery provision) to lie with MoE, with specialist training in disability related strategies from experienced staff from MoLSA. (N/R/G)

Recommendation 28:
Resources are directed to the development and implementation of inclusive education programmes for trainee teachers and for the continuing professional development of qualified teachers. (N/R/G)

Recommendation 29:
The Iraq Government and Kurdistan Regional Government Ministries of Education resist the pressure to develop further separate institutes for the care and education of disabled children. Instead resources should be redirected to neighbourhood schools to facilitate the improvement of support infrastructure and inclusive teaching and learning. The existing expertise in MoLSA will be critical in providing support for children with the most severe disabilities. (N/R)

Recommendation 30:
Resources should be dedicated to enlisting international support for building greater capacity to respond to and educate learners with diverse educational needs. This includes the improvement of buildings, equipment, curriculum development, pedagogical knowledge and family and community engagement. (N/G)

Recommendation 31:
A pilot professional development programme is implemented across the four governorates as a model for the wider adoption of *Inclusive Schools for Iraq* (see Attached Teacher Training model for primary teachers). (UNICEF/N/R)

7. REFERENCES

Ainscow, M. (1999) *Understanding the development of inclusive schools.* London, Falmer Press.

Ainscow, M. and Miles, S. (2008) *Inclusive education: A Reference Document.* Paper prepared in advance of the 48th International Conference on Education, 'Inclusive education: the Way of the Future'. Geneva, 25-28 November 2008.

Ainscow, M., Booth, T., Dyson, A., with Farrell, P., Frankham, J., Gallannaugh, F., Howes, A. and Smith, R. (2006) *Improving schools, developing inclusion*. London: Routledge.

Al-Obaidi AK (2010) Iraqi psychiatrist in exile helping distressed Iraqi refugee children in Egypt in non-clinical settings. *Journal of the Canadian Academy of Child and Adolescent Psychiatry* 19 (2) 72–3.

Baker, R.W., Ismael, S.T. and Ismael, T.Y. (Eds.)(2010) *Cultural Cleansing in Iraq.* London, Pluto Press.

Booth, T. & Ainscow, M. (2002). *The Index for Inclusion (2nd Ed.).* Bristol: Centre for Studies on Inclusive Education.

Brantlinger, E. (1997) Using ideology: Cases of non-recognition of the politics of research and practice in special education. *Review of Educational Research,* 67(4)**,** 425 - 459.

Brantlinger, E. A. (2006) *Who benefits from special education? Remediating (fixing) other people's children.* New Jersey, Lawrence Erlbaum Associates.

China Daily (2009) Birth Defects Soar Due to Pollution. Chen Jia 31.01.2009 Available from [http://www.chinadaily.com.cn/china/2009-01/31/content_7433211.htm] Accessed 25.02.2011

Connell, R. (1994) Education and poverty. *Harvard Educational Review,* 64(2)**,** 125 - 149.

Davis, P. and Florian, L., with Ainscow, M., Dyson, A., Farrell, P., Hick. P., Humphrey, N., Jenkins, P., Kaplan, I., Palmer, S., Parkinson, G., Polat, F., Reason, R., Byers, R., Dee, L., Kershner, R., and Rouse, M. (2004) *Teaching strategies and approaches for pupils with special educational needs: a scoping study*. London: DfES. Research Report 516.

Dye, T. R. (1972) *Understanding public policy.* Englewood Cliffs, Prentice-Hall.

Dyson, A., Howes, A., & Roberts, B. (2002). A systematic review of the effectiveness of school-level actions for promoting participation by all students (Inclusive Education Review Group for the EPPI Centre, Institute of Education, London. http://eppi.ioe.ac.uk/EPPIWeb/home.aspx?page=/reel/review_groups/inclusion/review_one.htm). Last accessed 30 January 2008.

Farrell, M. (2006) *Celebrating the special school.* London, Routledge.

Florian, L. (Ed.) (2007) *The Sage Handbook of Special Education.* London: Sage.

Ghobarah, H. A., Huth, P. and Russett, B. (2003) Civil wars kill and maim people long after the shooting stops. *American Political Science Review*, Vol. 97, No. 2, pp. 189–202.

Goodman, R. (1997) The Strengths and Difficulties Questionnaire: A Research Note. *Journal of Child Psychology and Psychiatry* 38(5) 581-586

Goodman, R. Ford, T. Simmons, H. Gatward, R. and Meltzer, H. (2000) Using the Strengths and Difficulties Questionnaire (SDQ) to screen for child psychiatric disorders in a community sample. *British Journal of Psychiatry*, 177, 534-539.

Guardian, The (2010) Research links rise in Fallujah birth defects and cancers to US assault. Martin Chulov 30.12.2010. Available from

[http://www.guardian.co.uk/world/2010/dec/30/faulluja-birth-defects-iraq] Accessed 25/03/2011

Gustavson, H-K (2005) Prevalence and aetiology of congenital birth defects, infant mortality and mental retardation in Lahore, Pakistan: A prospective cohort study. *Acta Pædiatrica*, 94, 769–774.

Jeffree, D.M. and McConkey, R. (1998) *P.I.P. Developmental Charts. Second Edition*. London, Hodder Education

Kauffman, J. M. & Hallahan, D. P. (2005) *The illusion of full inclusion: A comprehensive critique of a current special education bandwagon.* (2nd edition). Austin, Pro-Ed.

Kozol, J. (2005) *The shame of the nation: The restoration of apartheid schooling in America.* New York, Crown Publishers.

Lewis, A. and Norwich, B. (2005) (Eds.) *Special teaching for special children: a pedagogy for inclusion?.* Maidenhead: Open University Press.

Miles, M.B. and Huberman, A.M. (1994) *Qualitative data analysis.* (Second Edition), Thousand Oaks, Sage.

Mitchell, D. R. (2005) *Contextualizing inclusive education: Evaluating old and new international perspectives.* London, Routledge.

Norwich, B. (2008) *Dilemmas of difference, inclusion and disability: International perspectives and future directions,* (London, Routledge).

Oliver, M. (2009) *Understanding disability: From theory to practice.* (Second Edition), Basingstoke, Palgrave Macmillan.

Punch, K. (2005). Introduction to social research: quantitative and qualitative approaches. London, Sage.

Riehl, C. J. (2000) The principal's role in creating inclusive schools for diverse students: A review of normative, empirical and critical literature on the practices of educational administration. *Review of Educational Research,* 70(1), 55-81.

Rieser, R. (2008) *Implementing inclusive education: Commonwealth guide to implementing article 24 of the United Nations convention on the rights of persons with disabilities,* (London, Commonwealth Secretariat).

Skrtic, T. (1991) *Behind special education: a critical analysis of professional culture and school organization*, Denver: Love.

Slee, R. (2010) *The irregular school: Exclusion, schooling and inclusive education.* London, Routledge.

UNESCO (1994) *Final report: World conference on special needs education: Access and quality.* Report for UNESCO (Paris).

United Nations (2006) *Convention on the Rights of Persons with Disabilities* New York, United Nations.

UNESCO (1994) *The Salamanca Statement and Framework for Action on Special Needs Education.* Paris: UNESCO.

UNESCO (2000) Education For All. Dakar Framework for Action Goals. http://portal.unesco.org/education/en/ev.php-URL_ID=42579&URL_DO=DO_TOPIC&URL_SECTION=201.html . UNESCO, Paris (retrieved Tuesday 23rd March 2010, 5.20 am).

UNESCO (2001) *The Open File on Inclusive Education*. Paris: UNESCO