



Policy paper
(supplement)

Physical and functional rehabilitation in long-standing (long-term) refugee camps

Technical Resources Division
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Foreword

In 1988, I went to spend two years in Thailand as an expatriate in the Cambodian refugee camps¹, which had already been open for several years. Handicap International was present in most of the camps scattered along the border, working in physical and functional rehabilitation:

- within various hospitals, with the objective of preventing secondary complications;
- in facilities (centres/workshops) where rehabilitation services were being developed, from postoperative care (Khao I Dang) to managing the most common impairments and disabilities, including the production of orthopaedic devices;
- within the community, with the objective of ensuring follow-up, advice and awareness-raising around the issue of disability.

At the time, Handicap International's whole large expatriate team was involved in an effort to standardise the practices developed in the different camps and to produce tools and protocols targeting a standard of quality appropriate to the reality of the context. Part of that effort was the development of a training curriculum (mid-level PT curriculum²) based on objectives-based teaching and aimed at rapidly training rehabilitation assistants, in order to make up for the very large turnover in refugee teams.

In 2009, as a technical advisor for the Rehabilitation Services Unit, I conducted an evaluation mission in the refugee camps in Thailand, along the Burmese border; there was one expatriate who - though he had a technical background - focused mostly on management, and a national team of rehabilitation therapists working in a number of camps (between 5 and 10). Fast-rewind. I felt like I had gone back twenty years; there were major quality issues, activities centred mainly on individual home-based care, and a team in search of a "mid-level PT curriculum" in order to set up trainings.

At each country and each camp, the operational strategies and modalities have to be adapted to the reality of the context. We have to fall back on past experience, and analyse it according to how Handicap International's models and positions have changed to produce recommendations that would make us more immediately and qualitatively relevant when setting up new projects. That is what this document will attempt to formalise.

Patrice Renard

¹ For more information on the notion of refugee and the various types of refugee status, see: Strategic Policy Unit. Internal guidance: People affected by forced displacement: Understanding their status and specific protection provisions. Handicap International, 2013

² Handicap International. Physical Therapy Assistant manual. 1990, 5 vol. / Manuel de formation du thérapeute. 1993, 3 vol. / Update in English: Training Manual for mid-level Therapists. 1996, 50 booklets: <http://www.hiproweb.org/fileadmin/cdroms/pta/PTA-English.htm>

A word of caution

- This document is a supplement to the “Physical and functional rehabilitation” policy paper; by itself it is not sufficient.
- It “is aimed primarily at an internal audience of strategy people - that is, Desk Officers, [Desk Project Officers], Field Programme Directors and Technical Advisers and [Technical and Operational] Coordinators”³.
- As its title indicates, it focuses solely on physical and functional rehabilitation services inside long-standing refugee camps:
 - although the situation studied was the result of an emergency situation, that situation is not discussed here, since different technical strategies are employed.
 - here we are concerned only with the services offered to the refugee population: if the host community also needs physical and functional rehabilitation services⁴, the technical strategies will be different.

A more comprehensive operational approach to refugees and IDPs, which takes into account changes in both the context and our interventions in emergencies, before situations become long-term, is thus not described here. The Operations Steering Committee will attempt to remedy that, in order to ensure the coherence and continuity of our operational policies.

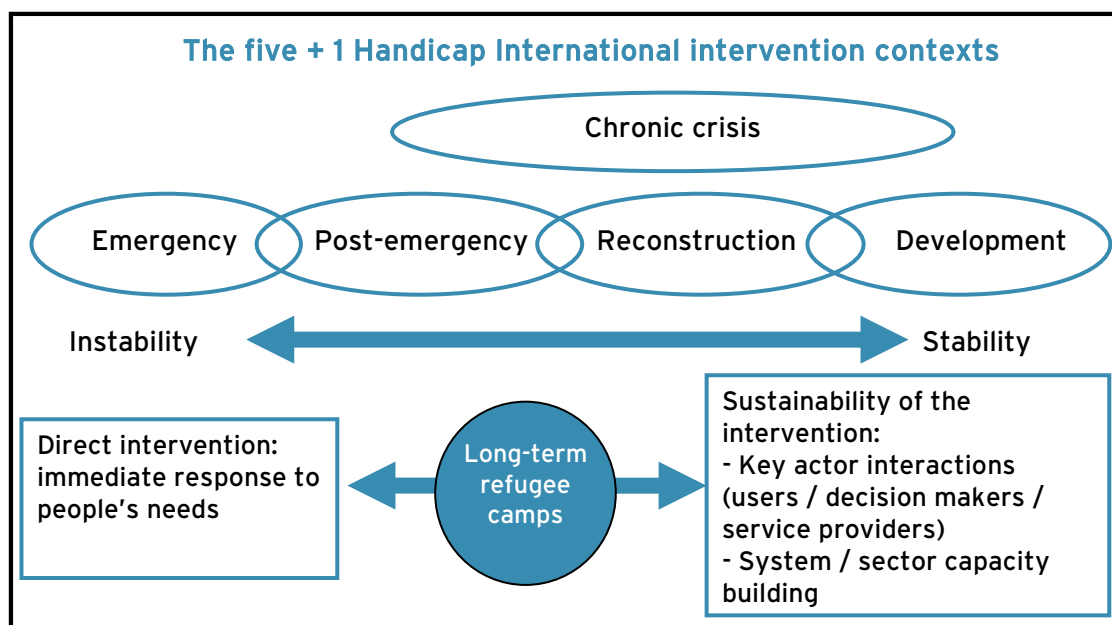
³ Handicap International. Physical and functional rehabilitation (Policy paper). 2013, p. 8 http://www.hiproweb.org/uploads/tx_hidrtdocs/PP10Rehabilitation.pdf

⁴ UNHCR. UNHCR Policy on alternatives to camps. 2014 <http://www.unhcr.org/5422b8f09.html>

Principles and benchmarks

A. A particular context

“In the context of a refugee camp, which is the epitome of an artificial structure, development projects are not possible. Swinging between emergency and post-emergency, the objective must be an appropriate response to basic and specific needs of vulnerable populations. Some camps last for years or even decades (e.g., Kenya and Thailand) however, making more advanced actions possible, including setting up rehabilitation and training activities”⁵. Representing Handicap International’s various intervention contexts schematically first requires including this particular situation, which itself requires adjusting several of our operating modalities.



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Because they are long-term - lasting beyond the initial crisis situation mobilising the international community - the activities to be developed are even more dependent on institutional donors. They cannot rely on either a full complement of actors (truncated triangle = Key actor interactions) or on a sectoral approach aimed at sustainability⁶. Given the unpredictability of resources and means (security/access, funding, actors present/services, and available human resources), project strategies must have modest goals, especially in terms of which impairments and disabilities to manage. The latter must therefore be carefully prioritised (via a situational analysis⁷) and discussed with partners and the population concerned.

⁵ Handicap International. Physical and functional rehabilitation (Policy paper). 2013, p. 28 http://www.hiproweb.org/uploads/tx_hidrtdocs/PP10Rehabilitation.pdf

⁶ Idem, p. 23

⁷ Idem, p. 29

B. Long-term camps

Definitions

Given that the same designation can refer a wide variety of situations, we need to evaluate each context via a situational analysis in order to develop appropriate operating modalities.

- “Currently [2012], two-thirds of the global refugee population, or 10.3 million people, are considered to be in protracted refugee situations”⁸.
- “It is estimated that the average duration of major refugee situations, protracted or not, has increased: from 9 years in 1993 to 17 years in 2003”⁹.
- “Camps are purpose-built sites, usually close to the border, and thus usually in rural areas (...). They are meant to be temporary, and thus refugees are not expected to be self-sufficient. They are geared toward repatriation, and most are closed, not allowing refugees to come and go freely (though it can vary)”¹⁰.
- “Some forty percent of all refugees live in camps, most often because they have no alternatives”¹¹.
- “Despite being anything but temporary, long-term camps often fall under this label. Even though many camps take on the characteristics of small cities over the years, camps are meant to be emergency “holding places” or “temporary structures” that are “seldom planned for long duration or population growth”¹².
- “Long-Term Encampment is one type of protracted refugee situation, which denies refugees a range of rights”¹³.

⁸ Refugee Law Initiative. Rights Displaced: The Effects of Long-term Encampment on the Human Rights of Refugees. 2012, p. 8

http://www.sas.ac.uk/sites/default/files/files/RLI/RLI%20Working%20Paper%20No_4.pdf

⁹ UNHCR. Protracted refugee situations. 2004, p. 2

<http://www.unhcr.org/40c982172.html>

¹⁰ Refugee Studies Centre. How long is too long? Questioning the legality of long-term encampment through a human rights lens. 2009, p. 8

<http://www.rsc.ox.ac.uk/files/publications/working-paper-series/wp54-how-long-too-long-2009.pdf>

¹¹ UNHCR. UNHCR Policy on alternatives to camps. 2014, p. 4

<http://www.unhcr.org/5422b8f09.html>

¹² Refugee Studies Centre. How long is too long? Questioning the legality of long-term encampment through a human rights lens. 2009, p. 12

<http://www.rsc.ox.ac.uk/files/publications/working-paper-series/wp54-how-long-too-long-2009.pdf>

¹³ Idem, p. 33

- “While it may seem clear that rights denials are only acceptable during the emergency phase, a time-specific definition of when the emergency ends is lacking in international law. (...) No clear definition of when an emergency ends or phases into something else, and camps in particular make it difficult to know (...). Refugee camps are also more commonly in evolution, from emergency reception, shelter, and assistance locations, through to more settled communities of greater or less permanence. Even for the State, in situations which may reasonably be classified as ‘emergency’ at one or other stage, exactly what human rights are due is not always clear”.

Time frame

The Refugee Studies Centre (RSC) considers a refugee situation “protracted” when the displacement has lasted more than five years, with no prospects for a durable solution¹⁴. In collaboration with the Norwegian Refugee Council (NRC) and the Internal Displacement Monitoring Centre (IDMC), the RSC has set up a specific project and website on protracted refugee situations. The definition given refers to descriptions by the United Nations High Commissioner for Refugees (UNHCR) of what might be considered as such. In addition, the 5-year time frame is often associated with a specific number of displaced persons: at least 25,000 people from a single country¹⁵.

Indeed, the UNHCR’s initial definition is as follows: “(...) a protracted refugee situation is one in which refugees find themselves in a long-lasting and intractable state of limbo. Their lives may not be at risk, but their basic rights and essential economic, social and psychological needs remain unfulfilled after years in exile. A refugee in this situation is often unable to break free from enforced reliance on external assistance”¹⁶.

In its “Conclusion on Protracted Refugee Situations”¹⁷, the UNHCR’s Executive Committee again took “five or more years” as the starting point for a so-called “protracted” situation.

¹⁴ <http://www.prsproject.org/>

¹⁵ Definition used, in particular, by the United States Department of State

¹⁶ UNHCR. Protracted refugee situations. 2004, p. 1

<http://www.unhcr.org/40c982172.html>

¹⁷ UNHCR. Conclusion on Protracted Refugee Situations, n° 109 (LXI), 8 December 2009

<http://www.unhcr.org/4b332bca9.html>

A|z Definition used by Handicap International

A long-term camp corresponds to a protracted refugee situation. The notion of a “protracted” situation refers to both the duration and to the lack of any prospect of return for the refugees, which leads support actors and the populations in question to develop action strategies incorporating elements of durability that go beyond the strictly provisional.

While Handicap International has chosen to use the most commonly-accepted duration of five years, it stresses that it is difficult to define a time frame beyond which a camp is qualified as “long-term”, and how politically tricky that qualification can be. For example, in conflicts where the prospects for resolution are highly uncertain, a camp situation might be qualified as “protracted” after only two or three years. On the other hand, population displacements due to large-scale natural disasters can also last several years without sites being considered long-term camps. The determination will therefore depend on an analysis of the situation and on the behaviour of the different actors.

So Handicap International does use the 5-year time frame, except in circumstances where the determining factors lead to a different analysis.

C. Existing camps

Listed below are only those locations where Handicap International is currently developing physical and functional rehabilitation services in physically-identified long-term refugee camps.

Host country	Date of camp creation	Country of origin	Start of Handicap International activities
Thailand	Late-1970s, early 1980s	Burma	1984
Bangladesh	1982	Burma	2007
Kenya	1991	Somalia	2007
Ethiopia	2009	Somalia	2011
Jordan	2011	Syria	2012

	Thailand	Bangladesh	Kenya	Ethiopia	Jordan
Number of camps considered	9 (Handicap International = 5)	2 (Handicap International = 2)	5 (Handicap International = 3)	5 (Handicap International = 5)	2 (Handicap International = 2)
Refugee population concerned	120,000	70,000	> 400,000	200,000	> 100,000
Refugee freedom of movement	Difficult	None	Difficult	Yes	Yes for one, none for the other
Location of rehabilitation services inside the camp	Hospitals		Hospitals		Hospitals
	Rehabilitation centres	Rehabilitation centres	Rehabilitation centres	Rehabilitation centres	Rehabilitation centres
	Community	Community	Community	Community	Community
Impairments and disabilities managed	Paediatrics*	Paediatrics*	Paediatrics*	Paediatrics*	
	Trauma: Amputations		Trauma: Amputations/fractures	Trauma: Amputations/fractures	War trauma**
		Hemiplegia	Hemiplegia	Polio	
Access to specialised services outside the camps (surgery/ orthopaedic)	Yes	Yes	Yes	Yes	The services come into the camp

fitting)					
Rehabilitation services for the host communities	No (other types of services)	Yes	No services	No (rehabilitation services in other districts)	Yes
National degree standards for national staff (host country) recruited by Handicap International for rehabilitation	Bachelor's in Physical Therapy (3 years)	Bachelor's in Physical Therapy (4 years)	Physical therapy diploma Occupational therapy diploma (2 years)	Bachelor's in Physical Therapy (3 years)	Bachelor's in Physical Therapy (4 years)

*Paediatrics: Cerebral palsy/Birth defects

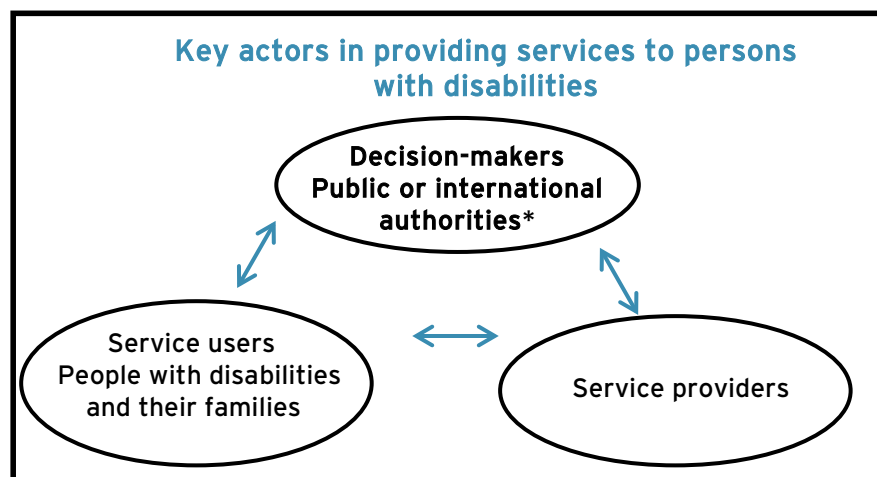
**War trauma: Fractures/Wounds, Amputations/Spinal cord injuries, etc.

D. Policy paper¹⁸ elements

The physical and functional rehabilitation-specific intervention principles and modalities presented in the policy paper must be considered when designing or monitoring a project in a long-running refugee camp - and in particular, the required situational analysis¹⁹, which should include the host community.

However, the particular context of long-term camps requires that some of the parameters discussed in the policy paper be studied and adapted specifically: "(...) quality must be considered at all levels of intervention; viability is intrinsic to the service level and sustainability to the sectoral level"²⁰.

- The decision-making level (system/sector) is not considered here, since the aim of sustainability - inherent to development strategies - is inconsistent with the artificial nature of the refugee camp context. It is, however, necessary to think about **durability**: this concerns the ability to maintain quality services over time via capacity-building (skills transfer and community mobilisation), but not the involvement of institutional decision-makers (save for the UNHCR) or financial viability.



* Development theme

© Handicap International, 2010

¹⁸ Another useful reference: UNHCR. Working with persons with disabilities in forced displacement. 2011

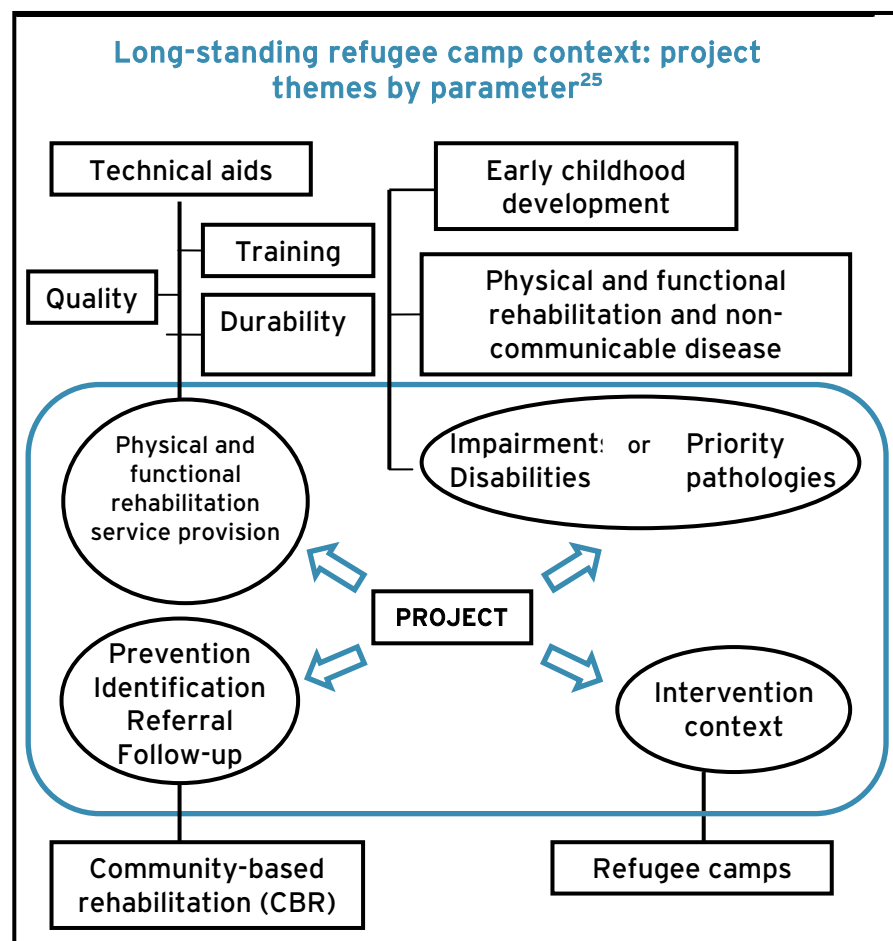
<http://www.unhcr.org/4ec3c81c9.html>

¹⁹ Handicap International. Physical and functional rehabilitation (Policy paper). 2013, p. 29

http://www.hiproweb.org/uploads/tx_hidrtdocs/PP10Rehabilitation.pdf

²⁰ Idem, p. 35

- “The viability of the service is ensured by the service provision meeting user needs and wants, the users’ ability to access the service, and good financial management”²¹. Inside a camp, the services are run by NGOs. The pursuit of viability is truncated, and usually dependent on secured funding from international institutional donors - funding not intended to support implementation of a long-term strategy. Hence there is one potential problem that should be anticipated.
- “The training of service practitioners yields a collection of skills appropriate to the [organization and the] expected level and quality of service provision (expertise and technical). That level is determined based on (...) the initial educational level of the professionals to be trained (...) and the anticipated scope of the service”²².
- “Setting up a community-based physical and functional rehabilitation project (...) to develop local human resources capable of identifying, referring and, if need be, following the users of a physical and functional rehabilitation service. (...) Local basic provision and user follow-up are monitored by service professionals”²³.



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²¹ Idem, p. 38

²² Idem, p. 38

²³ Idem, p. 36

²⁴ Idem, p. 64 (diagram adapted)

Type, nature and level of physical and functional rehabilitation service provision: specific elements to consider as part of the situational analysis	
Prioritisation of impairments and disabilities	<ul style="list-style-type: none"> • Preventing secondary complications • Restoring mobility to optimise functioning • Addressing other situations, if there is residual capacity for action
Service	<ul style="list-style-type: none"> • Actors in charge • Awareness-raising activities (<i>cf.</i> Intervention modalities A. Adapting the intervention strategy) • Ordinary, specific, support • Referral to secondary and tertiary levels • Centralised/dispersed • Best practice standards • Follow-up
Human resources	<ul style="list-style-type: none"> • Refugees: availability, stability, education/comprehension level • National/local (host country): availability, stability, skill level, teaching ability • Expatriate: expertise, number/stability-longevity (funding)

Intervention modalities

A. Adapting the intervention strategy

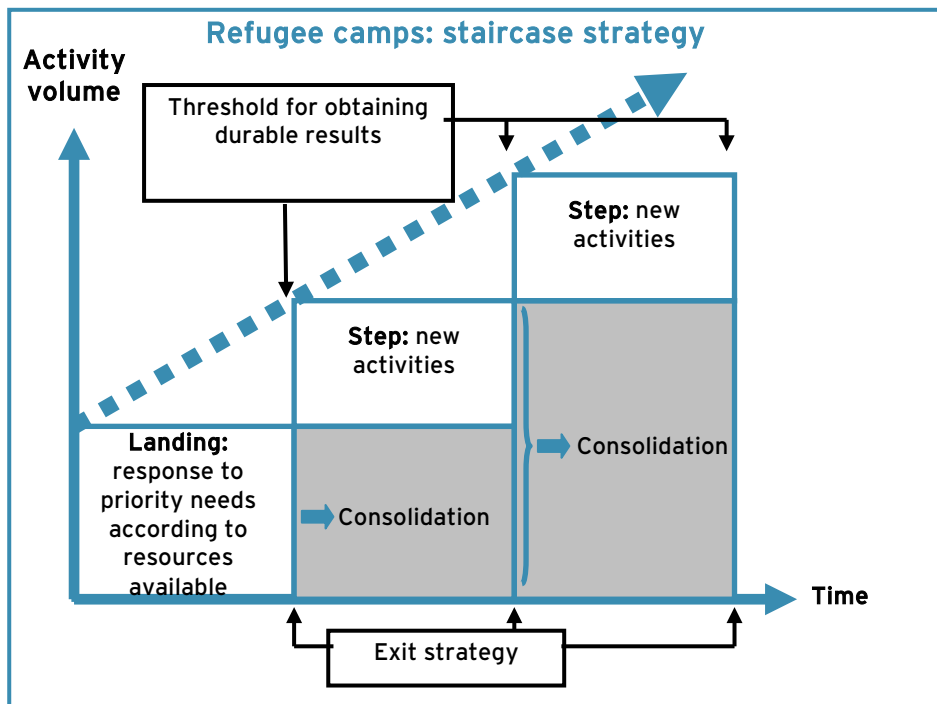
The issues

- Durability;
- Ability to address the needs (means, access/security, etc.);
- Stability of human resources (movement of refugee populations to the country of origin or a “third country”, competition among NGOs, UNHCR refugee indemnification policy, etc.) and technical skills (educational level, etc.).

When starting a project in a refugee camp, there is no way of knowing how long the camp is going to exist, or whether funding sources will be stable and uniform. A “staircase strategy” is therefore needed, which means:

- Taking an acceptable financial risk long enough to reach a landing deemed sufficient to ensure that activities addressing the priority needs, whatever their scope, produce tangible, measurable and durable results (exit strategy).
- Limiting the transfer of skills (including prerequisites) to those expected for that landing, so that the refugee teams achieve relative self-sufficiency as soon as possible (exit strategy):
 - to shorten the period of financial risk;
 - to reduce the risk of the project being interrupted, should the national and expatriate teams have to evacuate the sites for relatively long periods of time for security reasons.
- Designing a staircase approach, represented by a series of projects that, though time-limited, fit into a medium-/long-term plan, including a response to new needs. The steps are climbed progressively and in order, according to:
 - the recommendations from an evaluation or diagnosis produced at the end of each step;
 - the funding opportunities.

Each project must be self-contained (exit strategies), while preserving/reinforcing the gains from the preceding steps.



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- At the same time, advocacy should be aimed at institutional donors to ensure durable funding sources in keeping with the actions in progress.

In other words, we have to:

- Confine the scope of our action and expertise, and stick to it (not start doing everything at once);
- Communicate our limits;
- Develop a progressive strategy and stick to it, only fine-tuning it to funding opportunities if its sense can be preserved.

In addition, whatever the chosen theme for activities (health, physical and functional rehabilitation, etc.), there must be simultaneous promotion of **awareness-raising/education** about situations of vulnerability and discrimination (demystification, accessibility, education, protection, accountability of services, etc.) for the various actors operating in the camp and for the refugee community itself.

Simply disseminating messages is not, however, enough. The approach must be based on outcomes:

- Increased knowledge about disability;
- Changed practices with regard to disability.

B. Defining the types of service provision

Locations

In order to ensure continuity of service from prevention to follow-up:

- Physical and functional rehabilitation care must be offered in clearly-identified facilities: centralised (to bring people together and share expertise) and decentralised (using spaces available in blocks/neighbourhoods); as a rule, home-based services are not recommended (inconsistent with the aim of durability): it is better to decentralise services to be closer to users, and create groups in those locations to begin a process of peer self-help in the community. Care by loved ones should be increased to foster maximum self-reliance and reduce the number of trips to the service.
- Care should also be provided in camp hospitals (to prevent secondary complications and identify cases that require specialised care; early detection if referral is possible).
- In the community:
 - Resource people should be positioned for identification/referral/follow-up and advice (but not treatment);
 - A collective dynamic should be promoted, supported, and formalised via the creation of self-help groups/peer education, etc.
- Host community:
 - Whenever possible (situational analysis), the host community near the camp should be able to get the services offered to the refugee population. In this case, it should be trained in the identification and early referral of people with impairments and disabilities.
 - In all cases, existing host community services/processes should be analysed to consider possibilities for harmonisation or synergy between such services and those offered in the camp, and to avoid any potential negative impact from the project.

Pathologies

- In accordance with the staircase strategy approach, identify pathologies:
 - deemed high priority;
 - for which the necessary technical skills are available (or can realistically be taught);
 - for which care-related dangers/risk can be controlled.

Prioritisation criteria: quantitative or qualitative?	
Qualitative	Quantitative
Prevention of secondary complications according to risk and severity (respiratory, pressure sores, orthopaedic, etc.)	Depending on frequency
Tangible, measurable restoration of mobility (quality of life)	

Once the quality of care is ensured, other pathologies may be included, in order of priority (going up one step).

- Do not offer services that require overly-sophisticated technology or uncommon medications unavailable in the region of origin.
- Promote the distribution of mobility aids to improve accessibility and reduce vulnerability: respect the Handicap International recommendations²⁵, and ensure that the teams have acquired at least a basic level of skills via training²⁶.
- Surgical referrals: to be considered only if there are technical resources for intervening preoperatively (sometimes necessary) and postoperatively (always necessary): "(...) all actions aimed at developing rehabilitation activities must first analyse each aspect of the identification-to-follow-up cycle and determine the type and level of service provision, depending on whether there are physical and functional rehabilitation services and professionals"²⁷.

Actors

- "It is important to note that while impairments and disabilities of all sorts may be treated by physical and functional rehabilitation in a facility, (...) the "centre of gravity" of the intervention should ultimately be the user and his family, within his community"²⁸.
- Being a refugee can lead, over time, to a tendency to wait for humanitarian services (dependence), hindering the ownership needed for lasting change. In the medium term, the remuneration (incentive) policy established by the UNHCR²⁹ can be an obstacle to that ownership, if it demands a real work investment in return for such a low level of remuneration (motivation):

²⁵ Handicap International. The provision of wheeled mobility and positioning devices (Policy paper). 2013

http://www.hiproweb.org/uploads/tx_hidrtdocs/PP09WheeledMobility.pdf

²⁶ Idem, p. 33

²⁷ Handicap International. Physical and functional rehabilitation (Policy paper). 2013, p. 22

http://www.hiproweb.org/uploads/tx_hidrtdocs/PP10Rehabilitation.pdf

²⁸ Idem, p. 16

²⁹ UNHCR. Which side are you on? Discussion paper on UNHCR's policy and practice of incentive payments to refugees. 2014

<http://www.unhcr.org/5491577c9.html>

- In the community, full-time paid staff is not necessary; it is more important to mobilise community solidarity (depending on the culture) via the creation of *ad hoc* committees;
- In the services, building refugee team loyalty is more complicated, given the qualitative expectations and limited capacity for remuneration: it requires playing on people's motivations by stressing the value of the skills acquired through training (respectability, gratitude of users, skills that will be useful after returning, etc.).
- Recruiting a national physical and functional rehabilitation team is a must, to act as a bridge between the refugee and expatriate teams. It is important to invest in these professionals who, in some contexts, may be the only long-term human resources available. It is therefore essential to build the loyalty of these teams, considering the competition among the NGOs (attractiveness of the working conditions, salaries, etc.). Their technical abilities will depend on the level of training, given the national standards and their ability to adapt:
 - If necessary, offer additional training on the specific care modalities for the pathologies encountered in the camp;
 - Help them develop critical thinking based on **clinical reasoning** (using case studies), a rarely-developed skill in the countries where Handicap International works;
 - Develop/strengthen their **teaching skills**, insofar these professionals are often used as trainers.
- The expatriate team should be chosen according to its field experience and technical skills, and should be used to supervise and train the national team on an ongoing basis when activities start (quality and continuity of service). That support can gradually be scaled back, depending on the abilities of the national staff and the increasing skills of the refugee teams. Considering the staircase strategy and depending on the skill/autonomy level of the national team, deciding to "go up a step" requires the expatriate team's presence (expertise) or, if need be, external technical validation (Technical Resources Division).

C. Fitting the training to the context

The aim:

- To make continuity of action possible without Handicap International's presence (security/cost): to develop the skills of refugee teams, with a concern for adhering to quality standards.
- Cascade approach to training: Handicap International's technical and teaching expertise are passed on to the national staff, which passes it on to the refugee staff, which passes it on to users/user groups and their families ("the centre of gravity of the intervention should ultimately be the user and his family, within his community³⁰).

Creating a curriculum:

- It will depend on the level of knowledge of both the refugee teams AND the national staff. The lower the basic training level of the refugees, the more national staff involvement is needed. The lower the level of the national staff, the more expatriate team involvement is needed.
- It must target technical skills and teaching skills (cascading training).
- The curriculum should aim for a range of skills clearly presented to the learners.
- Modular training: it should start with a core curriculum (including awareness-raising activities), constructed as a base onto which topics are added according to the needs (staircase strategy). Note: the first landing of the staircase strategy might correspond to training objectives addressing emergency situations.
- One module should be designed for hospital personnel (prevention/identification/referral).
- There should be a sandwich course³¹ as soon as possible, aimed at clinical reasoning (+++) and stressing practice and the measurement of intervention outcomes.
- Functional approach to training: whenever possible, avoid teaching techniques that are too specific, as these foster dependence on the rehabilitation team and hinder self-care.
- Depending on the theme, it might be useful to develop collective care skills that can be passed on to groups of users (self-help groups), fostering a process of peer-to-peer mutual aid.

³⁰ Handicap International. Physical and functional rehabilitation (Policy paper). 2013, p. 16
http://www.hiproweb.org/uploads/tx_hidrtdocs/PP10Rehabilitation.pdf

³¹ Programme based on a combination of periods of theoretical instruction and in-service practical stages.



The training curriculum in Dadaab (Kenya): Rehabilitation worker training

- Ten-month (40-week) training course leading to a competency certificate.
- Two national trainers (one physical therapist and one occupational therapist) available full-time for training.
- Target skills centred on effective improvements in the participation of people with disabilities.
- Sandwich training: theory (320 hours in 25 modules) and practice (575 hours in a hospital, rehabilitation centre, etc.).
- Core skills are acquired in three weeks, after which the learners can begin a sandwich activity according to the modules being taught (prioritisation).
- Evaluations (35 hours), designed as pre- and post-tests.

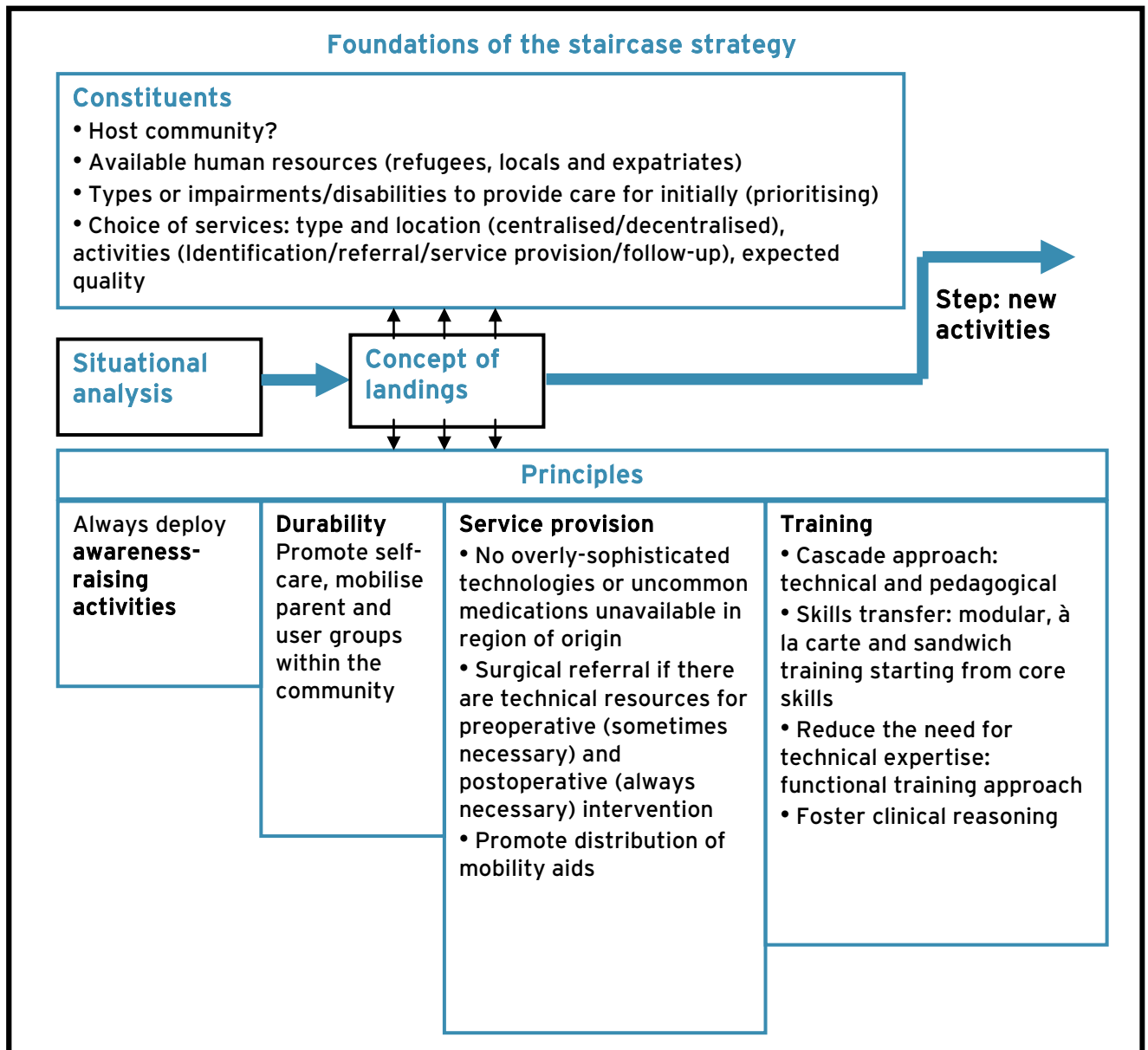
2015 objective: having the curriculum accessible on Skillweb.

Durability factors:

- In such an artificial context, considering the impermanence of the refugee and national teams, the only real stable/durable element is the user himself and his family, hence the importance of transferring self-care skills and mobilising parent and/or user groups within the refugee community.
- Depending on the instability of the refugee teams and national staff, the various modules that come after the core curriculum are designed in the form of “training kits”: rapid response to a need to train new refugee staff, targeting basic skills for quickly addressing the need for basic physical and functional rehabilitation care (basic training process that is standardised, reproducible and can be duplicated onsite or in other contexts: sustainability of the tool).
- The training curriculum should be designed based on:
 - professional standards and quality/accreditation criteria of qualification-level professional training courses;
 - if applicable, the existing situation in the country of origin and in the host country. Ideally, if the curriculum is well-designed, trainees can later better argue for recognition of some or all of the skills acquired through training and experience.
- It is important to be clear with trainees about the fact that the training course does not, at this stage, have any validity outside the camp. However, provide a training certificate detailing the skills acquired.
- Plan the curriculum in relation to subsequent opportunities for continuing education, or even offer qualifying training or accreditation for prior learning to people trained long ago with many years of experience in the camps. In that case, make sure they have the required entry-level training; if need be, find ways to offer them educational support.

D. In summary

Foundations of the staircase strategy



Project mode

The overall strategy can be developed as follows:

- **Reminder:**
 - We must confine the scope of our action and expertise, and stick to it (not start doing everything at once);
 - communicate our limits;
 - develop a progressive strategy and stick to it, only fine-tuning it to funding opportunities if its sense can be preserved.
- **Specific objective:** To strengthen access to appropriate physical and functional rehabilitation services for refugee populations in long-term camps (and for the host communities, if possible).
“Appropriate” here means technically appropriate and durable.
- **Expected outcome 1:** Increased awareness and education on the inclusion of people with disabilities and vulnerable people.
Audience: Organisations in charge of camp operations, existing services, the refugee community and - when possible - the host community.
Activities: Awareness-raising, training and follow-up.
- **Expected outcome 2:** Appropriate physical and functional rehabilitation care is fostered in the services.
Services: Hospitals, rehabilitation centres (including production and/or distribution of technical aids, according to the identified needs), and decentralised facilities.
Activities: Training for national and refugee staff (staircase strategy); provision of services.
- **Expected outcome 3:** Durability is fostered via community mobilisation (refugees and host community, if possible).
Activities: Train and support resource people for identification/referral/follow-up and advice, for training users and user groups/emulation by peers.
- **Expected outcome 4:** Quality physical and functional rehabilitation services can be duplicated in long-term refugee camps.
Activities: Collect best practices and lessons learned in order to capitalise on and disseminate them.

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Physical and functional rehabilitation in long-standing (long-term) refugee camps

This document is a supplement to the “Physical and functional rehabilitation” policy paper; by itself it is not sufficient.

it focuses solely on physical and functional rehabilitation services inside long-standing refugee camps (although the situation studied was the result of an emergency situation, that situation is not discussed here, since different technical strategies are employed).

It is aimed primarily at an internal audience of strategy people - that is, Desk Officers, Desk Project Officers, Field Programme Directors and Technical Advisers and Technical and Operational Coordinators.

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