



Rapid Needs Assessment

Situation of people with disabilities in 4 camps in Erbil
– Kawergosk, Darashakran, Qushtapa and Basirma



August 2014



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Cover photo: Handicap International assessor with a Syrian child in Basirma camp

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Table of Contents

Table of Contents.....	3
Acronyms	4
Acknowledgements.....	5
Executive Summary.....	6
Key Findings	6
Introduction	12
Objectives.....	13
Specific objectives.....	13
Methodology.....	13
Guiding Approach	13
Data Collection Methods	14
Data Analysis.....	16
Rapid Needs Assessment Team	16
Limitations of the Assessment.....	16
Findings and Recommendations.....	18
1. Indicative profile of Refugees with Disabilities.....	18
2. Health.....	23
3. Rehabilitation.....	28
4. Livelihood.....	32
5. Education	35
6. Protection and Sexual and Gender-Based Violence	37
7. Shelter and Surrounding Areas.....	40
8. Water, Sanitation and Hygiene (WASH)	44
9. Food and Non-food item distribution.....	47
10. Access to information and community life.....	48
11. Transport.....	53
12. Differences between the 4 camps.....	55
13. Differences between men and women with disabilities	59
14. Differences between various age groups	59
15. Cross-cutting	60
Summary of Priorities	64
References	65



Acronyms

ACF	Action Contre la Faim
CWDs	Children with Disabilities
DoH	Department of Health
DPO	Disabled Peoples' Organisation
DVFP	Disability and Vulnerability Focal Point
HI	Handicap International
ICRC	International Committee of the Red Cross
IGA	Income Generating Activities
IMC	International Medical Corps
IRC	International Rescue Committee
KRI	Kurdistan Region of Iraq
MWD	Men with Disabilities
NCCI	NGO Coordination Committee of Iraq
NFI	Non Food Items
NRC	Norwegian Refugee Council
PRC	Physical Rehabilitation Centre
PWDs	Persons/people with Disabilities
RNA	Rapid Needs Assessment
SHG	Self Help Groups
SGBV	Sexual and Gender-Based Violence
UNHCR	United Nations High Commissioner for Refugees
UPP	Un Ponte Per
WASH	Water, Sanitation, and Hygiene
WFP	World Food Programme
WHO	World Health Organization
WWD	Women with Disabilities

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Executive Summary

Under stable conditions, most People with Disabilities (PWDs) face both attitudinal and physical barriers in gaining equal opportunities and participating as equal citizens. After displacement and in the midst of conflict, their precarious situation is considerably worsened; meeting basic needs becomes a challenge. PWDs face additional hurdles in accessing assistance and protection. The humanitarian community generally intends to reach the most vulnerable. However, the lack of disability data collected and lack of active inclusion of disability in their programming leads to neglect of PWDs in humanitarian response. The objective of this Rapid Needs Assessment (RNA) was to understand the situation of children, youths and adults with disabilities within and around four camps near Erbil, in the Kurdistan Region of Iraq (KRI). The RNA findings intend to contribute to evidence based inclusive programming in KRI and the region in general.

The RNA methodology consisted of 57 interviews with service providers and Syrian refugees as well as 1055 surveys conducted with local and international service providers, children with disabilities and their parents, adults with and without disabilities, elderly persons, and local authorities. The RNA explored the needs of refugees living in four Syrian refugee camps around Erbil: Kawergosk, Darashakran, Basirma and Qushtapa.

With this report and its dissemination, Handicap International (HI) aims to highlight the situation of refugees with disabilities and provide actors working for the Syrian crisis with the means to make programmatic considerations that support the rights of PWDs and ensure inclusive and non-charity oriented actions. It is worth mentioning that this objective is in line with the Convention on the Rights of Persons with Disabilities (CRPD), ratified by Iraq in March 2013, and the UNHCR governing Executive Committee conclusions on refugees with disabilities on non-discrimination and equal protection in emergencies (UNHCR, 2010).

Key Findings

Profile of Refugees with Disabilities

- 56% of the respondents were men and 44% women
- 53% had no education, 36% primary education, 9% secondary education; 56% are illiterate
- 50% of households have more than 5 people
- 42% of the respondents have another family member with a disability → increasing vulnerability, health care costs and likelihood of poverty.
- 68% of people require assistance with their self-care tasks
- 80% arrived in Iraq 6 months to a 1 year ago, 14% have been here longer than a year.
- Difficulties sorted by highest prevalence:
 1. 64% have a **mobility problem**
 2. 58% of people have some **psychological difficulty**
 3. 47% have **difficulty with self-care** (i.e. including disabling chronic disease)



4. 47% have some **visual difficulty**
5. 39% having **difficulty using their hands or fingers.**
6. 36% having **intellectual and learning difficulties.**
7. 30% have **difficulty with behaving** age-appropriately.
8. 29% have **difficulties with communication.**
9. 28% have some **hearing difficulty.**

Health

- 60% of PWDs had sought medical care since their arrival, with top services received being health consultation visits (61%) and access to necessary medication (29%).
- 73% of people state having no access to the medication they need
- PWDs experience less mental health than other refugees due to confining conditions of camp. They spend most of their days in tents bored, isolated, and unhappy; this is due to the inaccessibility of camp roads and infrastructures, as well as lack of their active inclusion.
- 65% who sought medical care faced difficulties due to the following barriers: travel costs (38%), payment for health services (35%), and lack of specialist care (30%).

Rehabilitation

- Majority of refugees with disabilities have long-standing disabilities and received little to no previous rehabilitation; as such, they have not learned to maximize their abilities.
- Children/adults with multiple disabilities spend most of their days lying down on their backs due to the lack of supportive seating.
- 18% of people lost their assistive devices when they fled from Syria; the main devices that were lost are glasses (31%), wheelchairs (24%) and hearing aids (15%).
- 45% reported having specific rehabilitation needs, the main ones being (1) physiotherapy (53%), (2) cognitive rehabilitation (29%), (3) counseling for psychological difficulties (24%).
- 65% of persons face difficulties accessing rehabilitation due to the lack of knowledge of where to go (41%), the unavailability of rehabilitation services in camps or in the area (32%), travel costs for rehabilitation (20%), and physical difficulties to get to and back from services (13%).
- 89% have not received rehabilitation services since their arrival in Iraq.

Livelihood

- Families with a member with a disability are amongst the poorest due to disability-related costs (e.g. diapers, tests, physiotherapy/health services outside camp, transportation).
- 94% of PWDs do not participate in livelihoods and have no source of revenue, compared to 39% of refugees with disabilities who were working prior to displacement.
- 70% of them face barriers in accessing livelihoods.
- Families need emergency cash assistance to cover unmet priority needs, such as: medication costs (80%), transportation costs to specialized services outside the camps (35%), food items purchase (25% - the food provided is not adequate to some people and/or do not meet nutrition needs), and assistive devices purchase (17%).

**Education**

- Currently, 70% of PWD do not receive any education, 21% attend primary school, 4% secondary school, and 3% try to home school their children.
- In some cases, families have lowered expectations of children for education, impacting the child's future.
- Mothers of infants with disabilities are not aware of typical child development to notice delay and ways to foster the early development of their child.
- 44% face difficulties accessing education, mainly due to physical accessibility of school (30%), difficulties to reach school due to terrain (15%), and negative attitudes (13%).

Protection and Sexual and Gender Based Violence: 14% have concerns regarding their safety at the camp, for the following reasons:

- 1) Verbal harassment by others (27%)
- 2) Fire within the camp due to various issues i.e. power cuts, highly inflammable waterproof tents (12%)
- 3) Extortion, such as food items being stolen (7%)
- 4) Armed violence (6%)

Shelter and Surrounding Areas

- Many interviewees do not like to be around others and feel camps are crowded, particularly Kawergosk.
- PWDs feel agitated living in camps compared to homes in Syria. Parents sometimes get short-tempered with their children, and children with disabilities often develop new behavioral issues.
- The majority of refugees with disabilities live in tents (85%), in containers made of tin (9%), in brick homes (3%), or improvised shelters made of tarps/salvaged materials (2%).
- Most PWDs live in difficult conditions (i.e. power cuts induce unbearable heat in summer and cold during winter), thus aggravating skin conditions/pain/stiffness/disability.

Water, Sanitation, and Hygiene

- 40% of persons have difficulty to access drinking water.
- 85% of PWDs rely on their family to bring them water, 4% get support from neighbors, while others struggle to get it by themselves despite major difficulties.
- Barriers to access drinking water are (1) difficulty carrying water from water points (48%), (2) Water point inaccessibility (38%), (3) difficulty getting to/back from water point (37%).
- 54% of people use latrines, 38% use a western toilet, and 4% defecate in tents, another 6% use a mix of toilet/latrines/diapers depending on ability that day and accessibility.
- 42% of people have difficulty accessing toilets/latrines.

Food and Non-food Items Distribution

- 53% of people have difficulty accessing food distribution.
- 67% of persons who need a specific diet (e.g. diabetes, celiac disease) do not have access to it.

Access to information and community life

- In KRI, the family networks are much smaller than in Syria.
- 85% of people do not participate in community activities and have no access to community spaces.
- PWDs are eager to participate in activities and report being very bored and under-stimulated. However, they cannot participate due to physical and attitudinal barriers.
- The main community activities persons are interested in (or would like their children with disabilities to have access to) but cannot currently participate in are: child-friendly spaces (19%), camp/community consultation (19%), sports activities (14%), and internet/computer training (14%).

Transport

- To access different services, distance and transportation were reported as a key facilitators (i.e., close distance) or key barriers (i.e., far distances).
- Camp roads are totally inaccessible for PWDs, especially since they are often placed in parts of camps that have unpaved rocky roads where they have no autonomous mobility. As a result, PWDs are mostly prisoners of their own tents and cannot go out at all, or only with much difficulty for their families.

Differences between the 4 camps

- Kawergosk has the highest percentage of persons with mobility disabilities (70%)
- Qushtapa has the highest percentage of persons with mental health difficulties (36%)
- Darashakran has the highest percentage of PWDs who are independent in self-care (41%)
- Qushtapa has the highest percentage of PWDs in need of assistive devices
- Darashakran/Kawergosk have almost a double proportion of families with two or more members with a disability.
- Kawergosk PWDs have the lowest level of education.
- Kawergosk has the highest percentage of PWDs facing barriers in accessing services.
- The proportion of PWDs having access to specific nutrition is two times higher in the larger camps (Kawergosk/Darashakran) than in the smaller camps (Basirma/Qushtapa).
- The shelter situation is the best in Basirma where 56% live in caravans, whereas the most difficult one is in Qushtapa/Kawergosk where respectively 100% and 96% live in tents.
- The travel distance to latrines is the biggest barrier in Basirma with 29% having distance difficulties compared to 3-14% in the 3 other camps.
- Concerns of personal safety seem to be the highest in Qushtapa with 28% in comparison with the other camps ranging between 9% and 15%.

Differences between men and women with disabilities

- The proportion of men with disabilities (MWDs) who reached secondary education is almost double (65% compared to 35%) compared to women with disabilities (WWDs). This trend is also noticed for literacy: 50% of MWDs are literate, while only 35% of WWDs are literate.



- Proportion of people living with diabetes is double among women (9.5%) compared to men (4%). Road traffic accidents were three times more the cause of disability of men (9%) compared to women (3%).
- MWDs are more interested to be included in sporting activities than women (19% vs. 8%). Whereas 20% of women with disabilities are eager to participate in social groups (e.g. women's groups).

Differences between various age groups

- The main financial need for the elderly (over 60) is transportation costs to health services, whereas for children and young adults with disabilities it is diapers purchase.
- Assistive devices are necessary and helpful to all age groups.
- Children with disabilities (5 to 11 years old) are most likely to participate in community activities at 29% participating compared to 0% of people over 80.

Cross-cutting

- Several service providers have said they have 'not seen a person with a disability in the camp', which shows how tent-bound some PWDs are: they become invisible to service providers who do not realize the extent to which they are being excluded.
- Sensorial disabilities seem the most overlooked by service providers: little to no adaptations were made for people with visual and hearing impairments.
- Most service providers have not given basic disability training to their staff, hence why staff do not feel confident to welcome PWDs in their services.
- 7 out of 13 actors surveyed do not have monitoring and evaluation tools that disaggregate disability, and consequently are not able to adapt service provision to meet their users' needs.

Key recommendations

1. Support health services providers in **advocating for accessible and affordable transportation** so PWD can access necessary health/rehabilitation services outside camps.
2. **Organize appropriate assessment and distribution** of assistive devices, instead of blanket distribution (e.g. one size fits all wheelchairs)→ Please refer to HI when a PWD in the camp needs equipment, so the right assessment and equipment can be provided.
3. **Request mainstream livelihood actors to collaborate with HI for 'inclusive livelihood'** to include PWDs in vocational training and other livelihood services.
4. For children with disabilities who need additional support in school – make an **adapted learning plan and mobilize 'supportive teacher' as well as peer to peer support**.
5. Encourage **basic early childhood education for infants/toddlers (under 5) with disabilities**.
6. Work with SGBV sub-group and key partners to **establish a system to integrate PWDs in SGBV prevention and response mechanisms**.
7. **Develop checklists of possible protection risks faced by PWDs** and corresponding warning signs (e.g., withdrawal, behavior change, markings on body).
8. **Adapt latrines** for people who cannot access them. Do a focus group to see if families would be interested in using reusable diapers in camp environment.



9. **Solutions for water access** and working with people with disabilities:
 - Minimize distance to clean water point
 - Include PWD in water committees to test accessibility and advising
 - NGOs to use universal design in all toilets/water points
 - Diversify the size and shape of jerry cans for different hand function/strength
10. Ensure **separate queues** during food and NFI/CRI distribution, **smaller food parcels**, or **shelter-to-shelter distribution** for PWDs and other vulnerable sub-groups as needed.
11. **Social activities designed for PWDs should be goal-focused, helping PWDs to develop specific abilities rather than being** merely a distraction. Activities for inclusion and development targeting adults/elderly should be initiated; to date, there is a disproportionate focus on children/youth.
12. **Support to primary caregivers.** Families with more than one member with a disability are the most impacted, the poorest and their caregivers are exhausted – they need respite support systems
13. **Improve camp accessibility and transportation solutions**
 - Remove barriers (posts/ rocks) around the camps- where PWDs may fall or cannot push wheelchair around. Create small bridges over potholes and waterways.
 - Ensure PWDs are located close to services and in the heart of camp life.
 - Train a small group of volunteers that can guide/accompany people with visual disability or people with intellectual disability to and back from the services.
 - Develop diverse transport solutions: increase in bus services frequency to camp to shorten waiting times, taxi government coupons for PWDs who cannot afford them.
14. **Provide** information and accompaniment to PWDs. A major facilitator to access services is to **know where to go and get help to explain your case once you get there.** To help coordination of PWD services in and around camps, HI will **set-up DVFPs** (disability and vulnerability focal points) **with a mobile component to support case management and social inclusion of people with disabilities.**
15. For service providers and the humanitarian community:
 - Include basic disability training in new staff orientation package (HI can support organizations with this).
 - Hire and include people with disabilities: **Livelihood access** is the main priority mentioned by PWDs and their families. Work opportunities can help improving their overall quality of life by enabling them to afford their health and social needs.
 - Include targeted actions to address the specific needs of people with disabilities (WRC, 2013). **Set indicators that identify 10-15% of the target group as people with disabilities and elderly.** Disaggregate data to monitor how effectively programming is reaching this group.
16. For donors and funding agencies:
 - A higher proportion of refugees with disabilities live in urban areas compared to being inside camps, there **needs further funding and support to study the situation of PWDs in urban areas.**

Introduction

Syrian refugee camps around Erbil vary in size, age and status, however, people with disabilities living there share common problems of reduced access to services and opportunities as well as feeling isolated and hopeless. The four camps included in this study had the following populations: Kawergosk (13,343), Darashakran (7,503), Basirma (3,184) and Qushtapa (4,545), for a total of 28,575 (Camp Health Profile - April 2014, DoH Erbil and UNHCR). These numbers likely underestimate the total camp population, as unregistered and visiting families are not captured in these statistics.

An estimated 38.9% of Syrian Refugees in Erbil live in camps, while 61.1% live in urban areas (UNHCR Registration trends, June 2014). People with disabilities (PWDs) in camps arguably face more difficult living situation due to long distances between the camps and the city of Erbil where (1) specialized services are available to help increasing their functional abilities and (2) work opportunities are easier to access. In spite of food and water provision, basic shelter provision, community activities and basic health services being available in camps, access for PWDs is more difficult. This RNA took a snapshot of the experiences of refugees with disabilities in these 4 camps, capturing barriers and facilitators they face accessing key services.

In mid-2012, during the first arrivals of Syrian Kurds in Kurdistan, Kurdish authorities ensured that refugees had freedom of movement, the right to work legally, and access to health care and primary education. In late 2012 and early 2013, the authorities began expressing frustration towards the lack of international support when they started facing huge daily increases in refugee numbers without prior experience or technical capacity to handle such a situation (NRC, 2013). As such, authorities shifted towards a more restrictive refugee policy, delaying provision of residency cards to refugees, thereby restricting their ability to work and to receive food rations provided to residents.

People with disabilities (PWDs) are over-represented amongst the poor – global estimates are that PWDs make up 20% of the poor (Elwan, 1999). For the purposes of this RNA, to avoid under-capturing the number of PWDs, disability was measured using the *United Nations' Washington City Group on Disability Statistics* set of questions (Madans, date unknown). These set of questions capture the number of PWDs by identifying '**persons with difficulties**' (in seeing, hearing, thinking, moving, communicating, self-care and managing feelings/emotions) rather than persons labeled by the community as 'disabled' which typically focuses on persons with severe visible physical impairments rather than honoring the wider spectrum of impairments that exists in reality. Limited disability awareness became evident during interviews with camp management and NGOs alike, some reporting they 'had not met anyone with a disability in their work so far'. The latter has various contributing factors explained later in this report.

Objectives

The **overall objective** of the RNA was to understand the situation of children, youth and adults with disabilities in 4 camps near Erbil, in the Kurdistan Region of Iraq: Kawergosk, Darashakran, Basirma and Qushtapa.

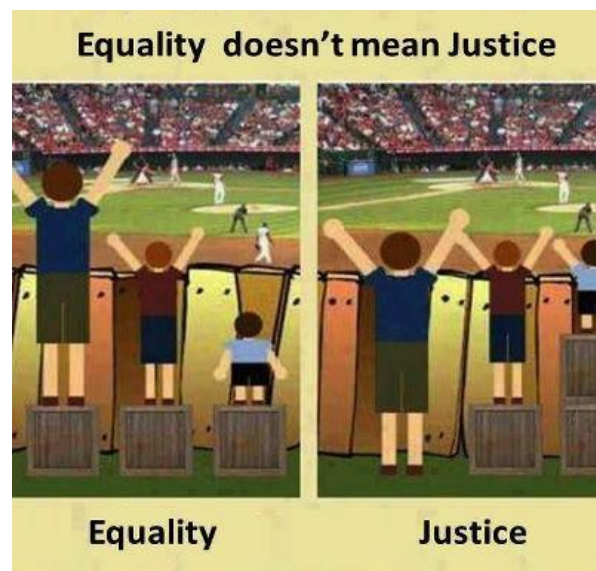
Specific objectives

1. To identify the **needs and barriers of refugees with disabilities to access humanitarian services**.
2. To examine existing resources and **capacities of service providers in regards to disability inclusiveness** in their service provision.
3. To understand any **age and sex-disaggregated findings** affecting refugees with disabilities

Methodology

Guiding Approach

In light of Iraq's CRPD ratification and UNHCR's governing Executive Committee conclusions on refugees with disabilities adopted in 2011, a **rights-based approach** guided the assessment. The overall role of a rights-based approach is to strengthen the opportunities for rights-holders (i.e. people with disabilities) to claim their rights and the capacity of duty-bearers (i.e. NGOs, UN, local authorities) to respond. Therefore the study highlights gaps in the obligations of duty bearers (i.e. NGOs, UN, local authorities). In the context of disability, adopting this perspective not only has the benefit to improve access to quality health and social services, but also to increase PWDs' participation in decision-making and creating public awareness and demand for services. The picture below illustrates the Rights-Based Approach: it describes how everyone's situation is different (e.g. PWD's starting at a disadvantage), and identifies solutions to bring up everyone to a level where their rights are realized.



Data Collection Methods

The qualitative and quantitative data collection methods included:

- document review
- interviews
- surveys
- observation

The different tools were intentionally designed to explore similar topics so that the information collected could be triangulated and confirmed from different perspectives.

Document Review

A review of rapid needs assessments in other contexts, field reports in KRI and other relevant documents was conducted to help the methodology development and develop the assessment tools. Two other disability assessments have been conducted in Erbil camps (REACH 2014, WHO 2014) and reviewed. While they provided some overviews on the disability situation, the identification of specific barriers/facilitators and the lived experiences of people with disabilities were not captured by those reports. The current RNA was carried out to provide programmatic nuances needed to successfully include PWDs in the humanitarian response.

Interviews

Interview guides included questions about how PWDs have experienced camp services and how far service providers have come towards disability inclusiveness and the challenges they have encountered in doing so.

Key informants were purposively identified. The sample included representatives from:

- Local and international service providers
- Children/youth with disabilities and their parents
- Adults with disabilities
- Elderly (i.e., above 60 years old)
- Local authorities

Surveys

Two separate surveys were used to gather information: (1) a survey used with PWDs and a small sample of people without disabilities on the situation of children, youth and adults with disabilities in the four refugee camps and (2) a survey with service providers to determine their current status of provision, understanding and planned action towards inclusiveness.

Survey on the situation of PWDs

The survey identified people with disabilities as those who were experiencing difficulties in basic domains (seeing, hearing, moving, etc.) according to the recommended cut off points as developed by the UN Washington City Group on Disability Statistics. The Washington Group method is a conceptual approach grounded in the WHO ICF, using self-reporting of difficulty and has been tested across cultures. The survey included the Washington Group recommended short list of six questions on limitations in seeing, hearing, walking or climbing



steps, concentrating, communicating and in self-care (shower or dress) and two additional questions on behaviour and mental health. The cut off points for identifying people with disabilities were those who responded “some difficulty”, “a lot of difficulty” or “cannot do at all” to the questions such as: “Do you have difficulty hearing, even if using a hearing aid?”

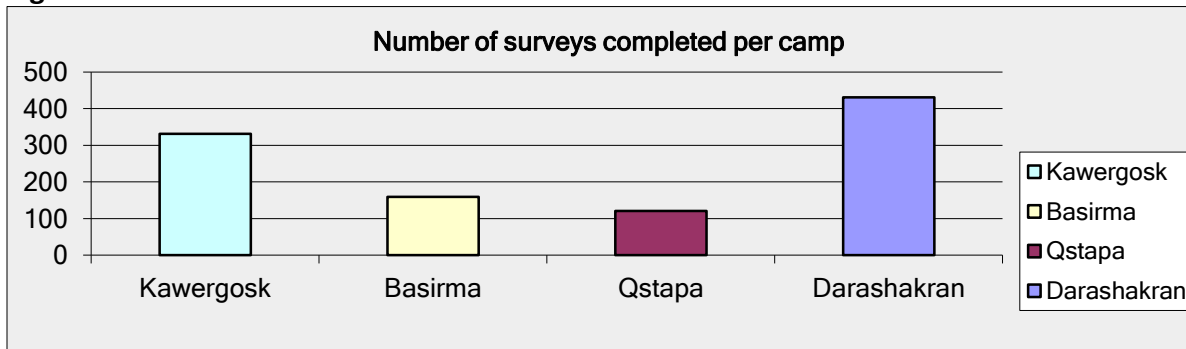
Participants were identified via multiple methods to ensure persons with different difficulties (e.g., persons with speech, intellectual and mental health problems) who are often under represented and difficult to identify were surveyed. Referral sources included list of all known PWDs in each area provided by other NGOs. These lists did present difficulties as many residents had moved shelters or moved to Turkey and were not easy to locate. As a result surveyors eventually opted to do a tent-to-tent assessment, as this was deemed more efficient and accurate than trying to locate people from lists that contained many inaccuracies.

Surveyors were asked to focus on persons living with an impairment (physical, sensory, cognitive, mental health) and experiencing barriers in daily life. The team purposively selected people to survey to ensure an equal numbers of female and male respondents and a range of ages and impairments. Persons with ‘disabling chronic diseases’ were also included in this RNA, meaning those experiencing barriers in self-care and independence.

The survey was carried out in individuals’ homes. Given the total population of the 4 camps as 28, 575 (UNHCR and DoH, April 2014) and the WHO/WB estimates that 15% of a population is living with a disability, with 2-3% facing moderate to severe disabilities, the survey team collected quantitative data from a total of 1,042 respondents inside of the camp (3.7% of total camp population, as stated above).

Number of surveys completed per Camp			
Kawergosk	Basirma	Qushtapa	Darashakran
331	159	121	431

Figure 1.



Survey with Service Providers

For service providers, an electronic questionnaire, using the Survey Monkey program, was sent via email to actors identified from the list of service providers provided by the NGO Coordination Committee for Iraq (NCCI) and camp management distribution lists.

Observation

We conducted observations of camp areas including WASH points, shelter points, and look for crowding of camps, and spaces for accessibility, etc. Interactions between the general population and people with disabilities was observed to identify attitudinal and social barriers. These observations enabled us to gain a better understanding of how accessible and inclusive the camp is for people with disabilities.

Data Analysis

Three types of analysis were carried out:

Needs analysis

Needs analysis answered the following questions:

- How has the crisis impacted PWDs and their access to services within and outside the camps?
- What are the differences in experience between men and women with disabilities, differences between experiences of PWDs in the 4 camps, and inter-generational differences between different age groups of PWDs?

Service provision gap analysis

An assessment was done to determine the existing resources and enabling facilitators of service providers in regards to disability inclusiveness in their service provision.

Rapid Needs Assessment Team

The rapid assessment team consisted of: HI Technical Advisor, HI Project manager, 4 data entry officers, 2 translators/field officers, and approximately 66 surveyors distributed across the 4 camps (with approximately 20-22 surveyors for each of the larger camps of Darashakran and Kawergosk). In each camp, the team of assessors were provided with half a day of training to discuss the following: survey form; expectations and processes for implementing the work; and conducting quality and ethical assessments.

Limitations of the Assessment

The assessment was carried out under challenging circumstances, which placed constraints on the collection and analysis of RNA findings. These include:

- *Assessment fatigue of PWDs:* Some degree of assessment fatigue was seen in most camps, where PWD had already been interviewed by up to 20 organizations (i.e. Kawergosk) and had seen little change in their lives and were reluctant to participate in yet another NGO assessment; despite our specific focus on their experiences as people with disabilities. This seemed to impact the depth with which some families were willing to get into explaining

their difficulties and experiences, with a small percentage of surveys being partially completed only.

- *Lost in translation:* Information was collected in Arabic and translated into English and some inconsistencies or discrepancies may have occurred during the translation process.
- *Sensitive topics:* Due to the sensitive nature of discussing SGBV topics, the RNA may not be the best tool to capture SGBV issues with problems not being verbalized adequately and explored minimally by assessors. This limitation was mitigated through ensuring the RNA team had gender representation and to recognize that deeper exploration of SGBV issues will be done subsequently during fieldwork.
- *High prevalence of chronic diseases:* Despite the fact that assessors were trained to include persons with ‘disabling chronic diseases’ in this assessment, there remained some difficulties with being able to draw the line at what is ‘disabling’ and there is likely a higher percentage of persons with medical issues (rather than disability issues) captured in this assessment.
- *Limited capacity of the assessment team:* Some of the assessors had limited assessment experience or exposure to disability issues in a post-crisis situation, and there was insufficient time to provide extensive training. This limitation was mitigated through providing ongoing support and supervision to local research team (e.g., daily debriefing team meetings and providing individual feedback on data collection upon review of completed surveys), who quickly incorporated all recommended strategies.
- *Low response rate of service providers’ surveys:* For the on-line survey sent to service providers, a low response rate (n=13) was achieved: 2 UN agencies and 11 NGOs. This low response rate results in our survey not being representative of service provision for PWDs in refugee camp. This limitation was mitigated through using key informant interviews to triangulate the findings.
- *‘Available services’ we listed in this report are not exhaustive.* We recognize that we will not have captured all available services in this report, only the ones that were known to assessors at the time of the RNA. Camp managers are the best source of information on the services in camps, and service directories for urban areas will emerge in the coming months to more fully capture available services outside camp zones.



Findings and Recommendations

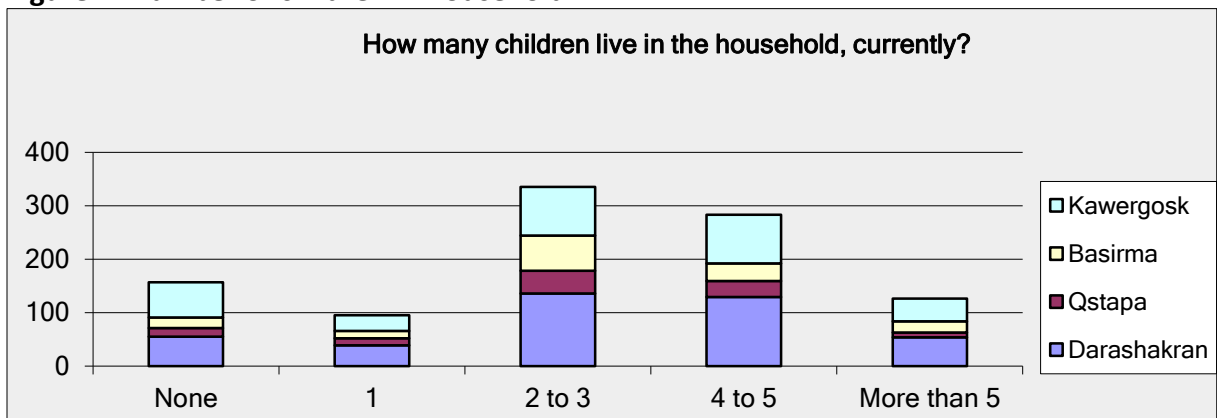
1. Indicative profile of Refugees with Disabilities

- 56% of respondents were men and 44% women
- 99.4% are Kurdish and 0.6% Arabic; 99.5% are Muslim, with 0.3% being a minority religion
- 53% had no education, 36% reached primary education, 9% reached secondary education
- 50% of households have more than 5 people
- 33% of households have 2-3 children, 28% have 4-5 children and 13% have more than 5 children
- Age distribution of respondents can be seen in Table 1.

Table 1: Age distribution of respondents

Age: what is your (or your child's) age group?		
Answer Options	Response Percent	Response Count
0-4 years old	9.9%	97
5-11 years old	15.7%	154
12- 17 years old	9.7%	95
18- 29 years old	16.1%	158
30-59 years old	36.8%	362
60-69 years old	7.1%	70
70- 79 years old	3.3%	32
>80 years old	1.5%	15
Answered question		983

Figure 2. Number of children in household



- 42% of respondents have another family member with a disability, thus increasing vulnerability, health care costs and likelihood of poverty.
- Other family members with disabilities were: the father (26%), the mother (22%) and 28% of cases were sibling (brother/sister) of person with disability; remaining (other) were spouses.



Figure 3. Other family members with a disability

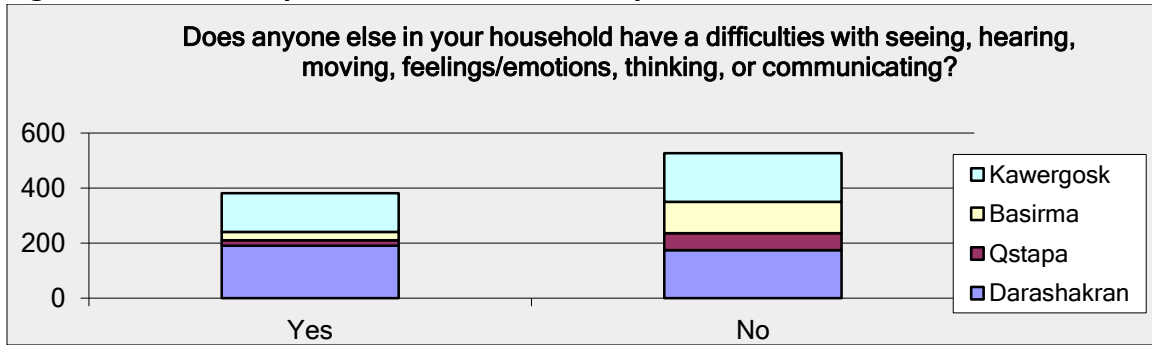
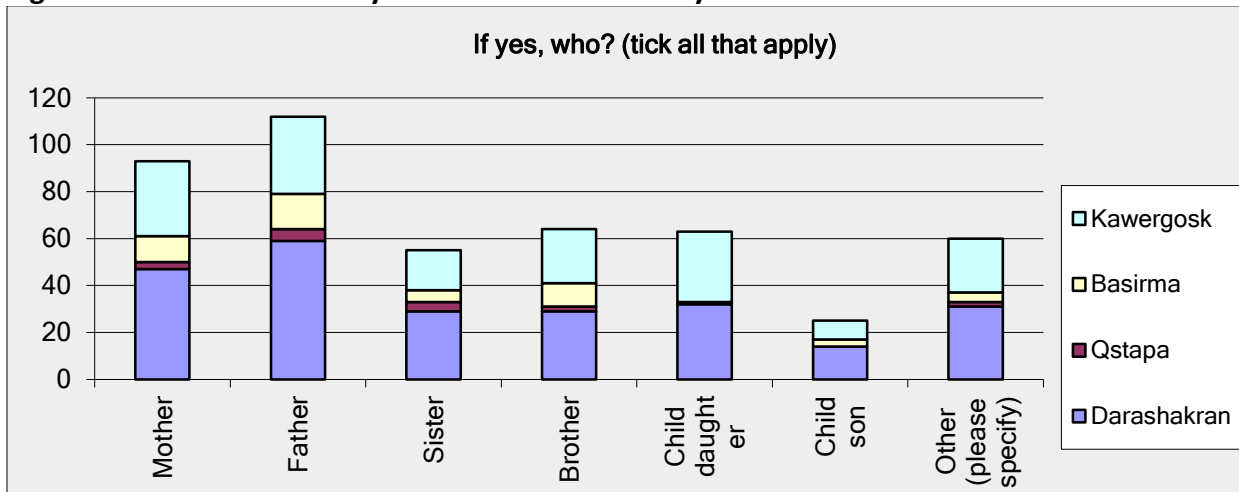
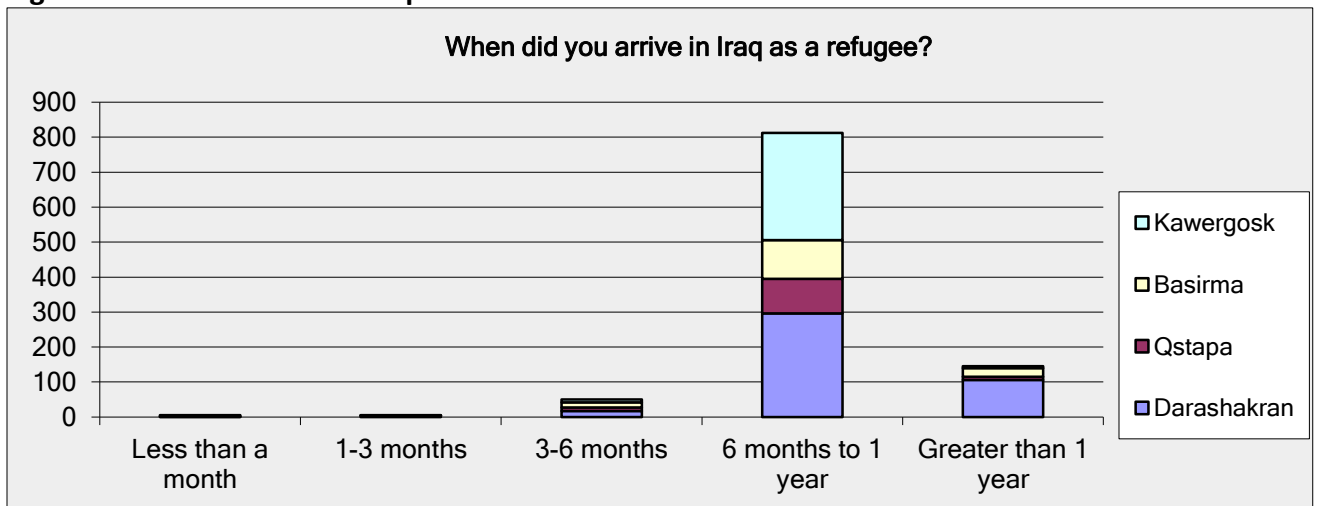


Figure 4. Which other family member has a disability



- 80% arrived in Iraq 6 months to a 1 year ago, 14% have been here for more than a year.

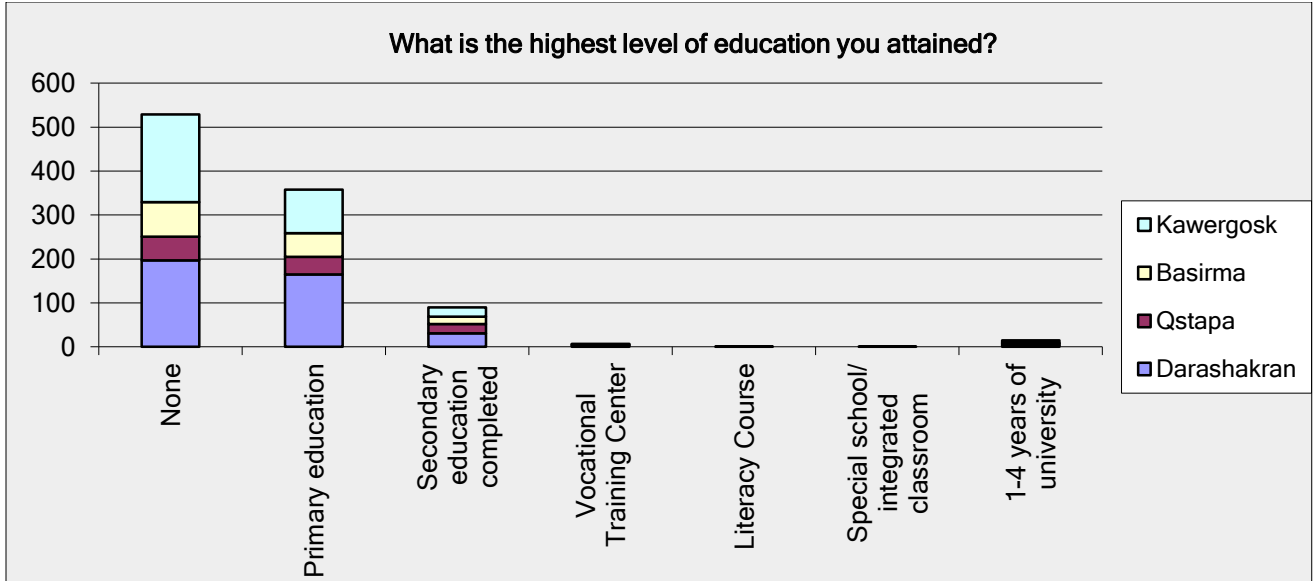
Figure 5. Time of arrival in Iraq





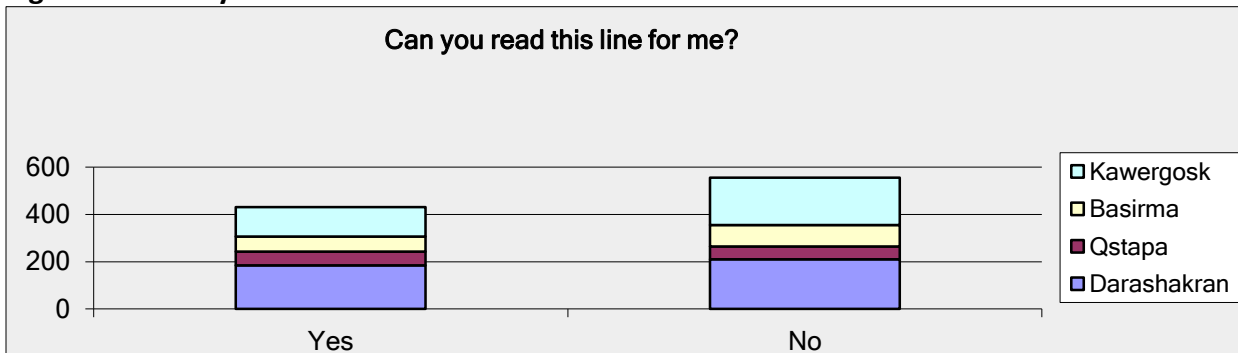
- 53% of people with disabilities have not received any formal education: 36% completed primary education, 9% completed secondary education, and 1.5% some university education.

Figure 6: Highest level of education attained



- 56% are illiterate, meaning writing communication mechanisms will not reach them. The 44% who are literate likely have only basic literacy level.

Figure 7. Literacy levels



Disability types and causes of disability

People often had more than one difficulty; overall findings can be seen in Table 2. Difficulties in order of highest prevalence:

1. 64% having a **mobility problem** with 9% not being able to walk at all
2. 58% of people have some **psychological difficulty** with 6% have severe mental illness.
3. 47% have **difficulty with self-care** (i.e. those with disabling chronic disease), including 12% being totally dependent for self-care



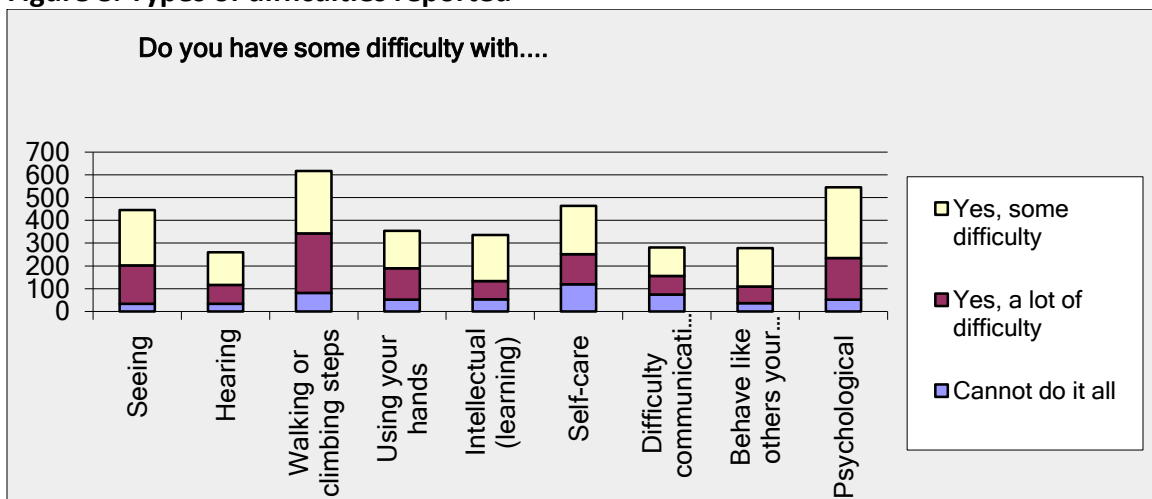
4. 47% had some **visual difficulty** with 4% not being able to see at all.
5. 39% having **difficulty using their hands or fingers**, with 6% not able to use them at all.
6. 36% having **intellectual and learning difficulties**, with 6% not able to think independently.
7. 30% have **difficulty with behaving** age-appropriately, 4% totally developmentally delayed.
8. 29% have **difficulties with communication**; including 8% have no communication method.
9. 28% had some **hearing difficulty** and 4% not being able to hear at all.

* 1,029 answered this question; with 3,579 different 'difficulty' response counts, meaning that many people have multiple difficulties/disabilities.

Table 2. Distribution of difficulties/disabilities

Do you have difficulty with...						
Answer Options	No difficulty	Some difficulty	A lot of difficulty	Cannot do it all	Response Count	% Having difficulty
1. Seeing	508	243	168	34	953	47%
2. Hearing	658	144	82	34	918	28%
3. Walking or climbing steps	347	273	261	82	963	64%
4. Using your hands	554	165	137	52	908	39%
5. Intellectual (learning/concentrating)	610	203	80	53	946	36%
6. Self-care	517	212	133	119	981	47%
7. Difficulty communicating	685	125	82	74	966	29%
8. Behave like others your age (intellectual)	639	169	72	37	917	30%
9. Managing negative feelings (psychological)	394	310	183	52	939	58%
<i>Number of people who answered this question</i>					1029	
<i>Total 'difficulty' response count</i>					3579	

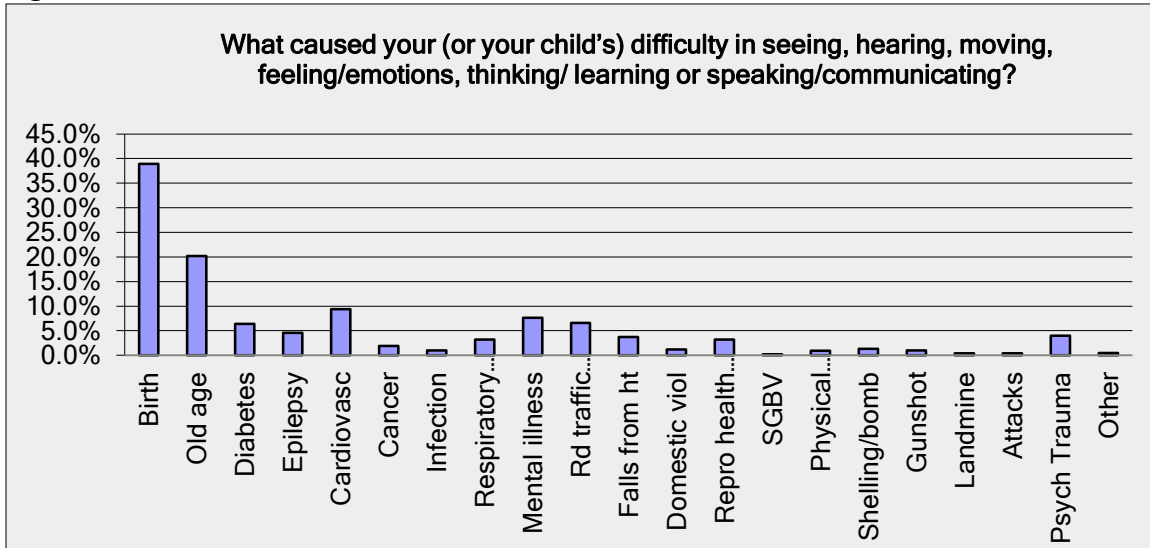
Figure 8. Types of difficulties reported





- 39% of disabilities were congenital (from birth), 20% due to aging, followed by 9% due to cardiovascular limitations, 8% due to mental illness, 7% due to road traffic accidents, and 6% due to diabetes.
- Unlike the Syrians arriving in Jordan/Lebanon, the Syrians with disabilities in KRI do not seem to be suffering from a high number of war injuries though psychological trauma resulting from displacement is evident with 58% of PWDs reporting having difficulty managing negative feelings.

Figure 9. Causes of difficulties/disabilities



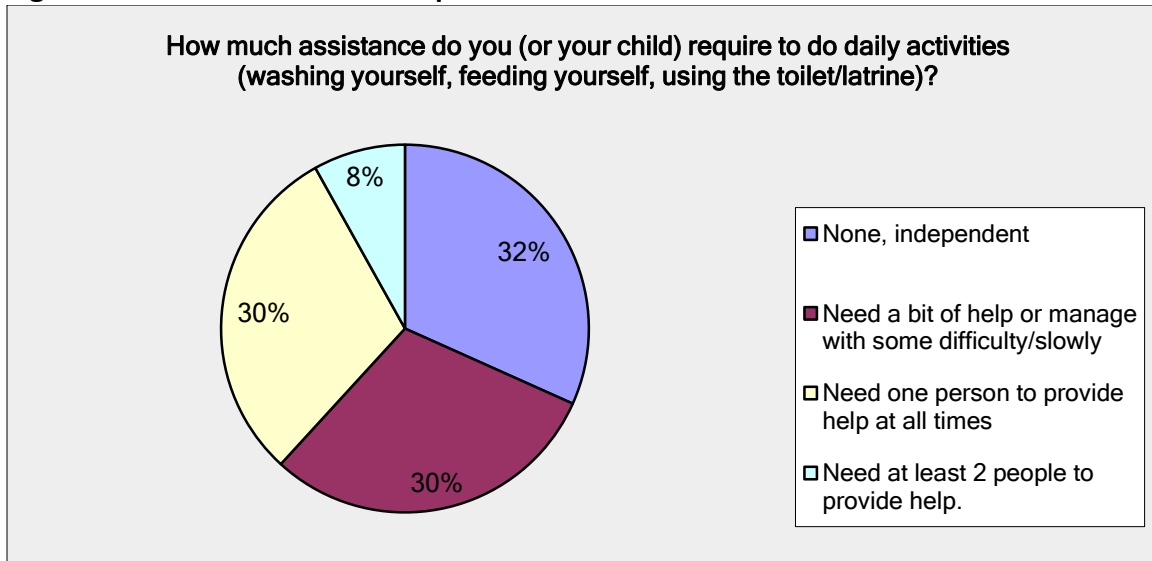
- Prior to arrival in Iraq, the livelihood situation for PWD was as follows: 20% did not work, 46% did housework or were housewives, 6% had their own businesses, 8% worked as farmers, 15% as laborers, 7% as craftsmen, 3% as professional employees (teacher, engineer, nurse, etc.).
- Only 7% of families have more than one household living in their shelter.

Assistance needs and Caregivers

68% of PWDs surveyed require assistance with their self-care tasks (i.e., feeding, grooming, toileting, etc.). It was reported during interviews that mothers and wives are most often the caretakers of PWDs, with many mothers seldom leaving their shelter because of the need to stay and care for the PWDs. Women looking after multiple persons with disabilities (husband and child, or multiple children) report that there is little community support, they rarely leave their tent to go to women’s centre, they desperately need a change of atmosphere from the tent space; furthermore, such women caregivers are experiencing extreme fatigue and more mental health difficulties - which can leave the family in a precarious situation if the main caregiver cannot one day look after others.



Figure 10. Level of assistance required for self-care



Access to general services

The main barriers in accessing services in order of prevalence are:

- 1) Not knowing what services are available and where to access them (38%)
- 2) Services are difficult to reach due poor roads/terrain in the camp (19%)
- 3) Staff of services are not able to address specific needs of PWDs (15%)

For barriers in accessing services outside the camp, top reasons were:

- 1) Difficulty paying for transportation (68%)
- 2) Not knowing what services are available and where to access them (22%)
- 3) No one available to accompany the PWDs to access service (10%)
- 4) Difficulties with getting permission to leave the camp (9%)

Those who are able to access services, said it was due to the 'close distances' (45%), or because family members accompanied them to such services (39%).

2. Health

"Our programs have been designed to meet the needs of a broad population. They are not specifically designed for individuals with disabilities." (Health Service provider, male)

"We were told in Syria that if we come to Iraq, we get access to free health services, this is not the case and this is not what we expected." (mother of a child with a disability, Basirma camp)

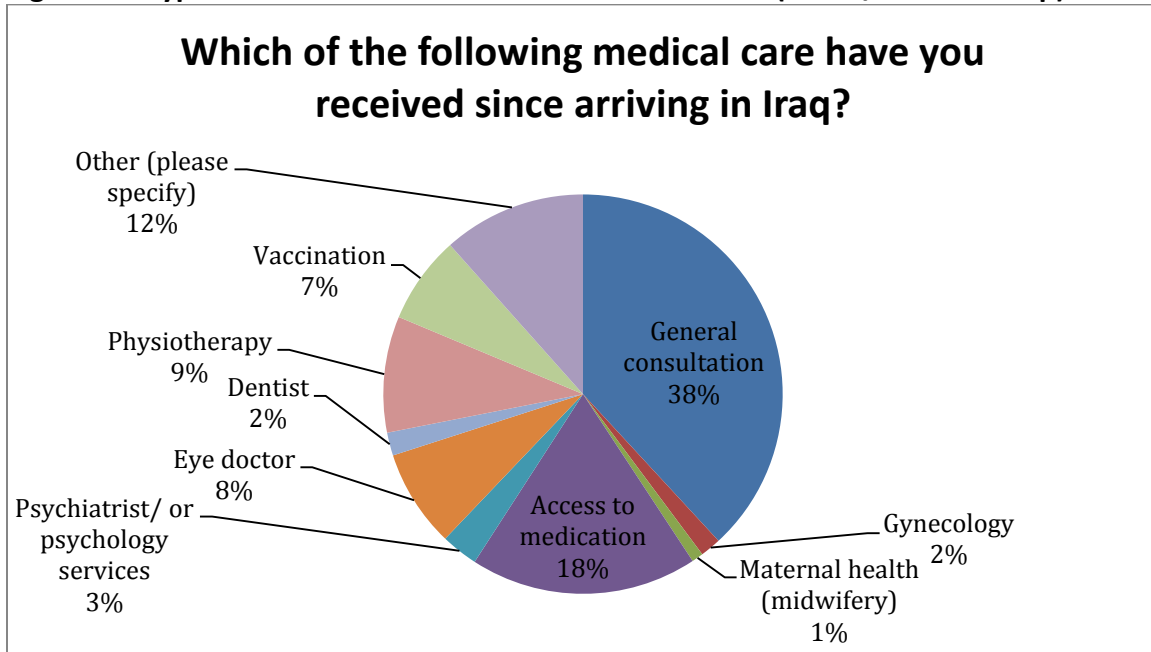
"There are a lack of specialists, many Syrian doctors have gone abroad, there are fewer specialists here in Kurdistan than back home." (male with a disability, Kawergosk camp)

"Many of the refugees don't trust the doctors here. So when we try to make a referral, they give us reasons to not go and we realize they don't want to go." (Health service provider)

Key Findings

1. 60% of PWDs had sought medical care since their arrival, with the main services received as seen below in the pie chart, with the higher reasons being (1) health consultation visits (61%) and (2) access to necessary medication (29%).

Figure 11. Types of medical services received since arrival (inside/outside camp)?



Medication access limited

- 73% of people state not having access to the medication they need – conversely, medical service providers report that the medication may be available but under a different ‘brand name’ and sometimes not acceptable by local populations.
- Many specialized prescriptions (e.g. chemotherapy) could not be obtained due to lack of availability in camp (mainly medications for chronic conditions were available) and because they are not stocked at local pharmacies/hospitals.
- Many have inconclusive medical situations. They are not sure if their (or their children’s) disability will improve and are not 'moving on' and adjusting to life with disability. They are seeking more closure on their medical situation (i.e. more eye tests/surgeries) and spending their savings to do so.
- Some NGOs (Intersos) reported that some PWDs reject getting treatment in KRI as they think they may be resettled and wait to get treated abroad (i.e. we did not find this in our interviews); many were hoping and asking for referral to get international surgeries for rare/specialized cases.
- Families have sent elderly family members or those needing medical care over the border. Many are choosing to get their surgeries done in Kurdistan as seeking medical care in Syria is unsafe and possibly life threatening (i.e. requires travelling to big cities through conflict zones), and this could quite possibly be a key reason they came to Kurdistan.

Reduced mental health resulting from displacement

- Most surveyors reported that PWD experience less mental health than other refugees and that they are often isolated in their tents, compared to reports of a good family and community life they had in Syria. Surveyors reported that PWDs had a low mood and seemed resigned to a life of boredom and inactivity in the camps – being mostly restricted to their tents.
- Many persons are extremely homesick for Syria. Another source of stress is the high level of uncertainty coming from being a refugee. Many do not know what their future will be, if they will stay in the camp or ‘get kicked out’. They feel they have little control over the future; they also have fewer options to flee to Turkey or ‘western’ countries to start a better life due to their disability situation reducing their socio-economic status and also with difficulties they may have accessing suitable transportation to take them cross-border and discrimination they will face to be accepted by countries abroad due to disability.
- The teams also heard reports of increased bedwetting compared to Syria (i.e. for kids with disabilities and for those without, which is likely to be linked to psychosocial stress).

Available Services

Health services available within the 4 camps are:

- Vaccinations (UNICEF- DoH)
- Primary health care (MSF, IMC and DoH)
- Mental health care (Un Ponte Per, MSF)
- Gynecological consultations (UNFPA, DoH, IMC)
- Reproductive health consultations (UNFPA)
- Psychiatric consultations (MSF, UNHCR-UPP)
- Dental clinic, pharmacy, laboratory (WHO-DoH)

Access to Services

Inside camps

- Health centres are generally not very accessible, there is a small step up to the consultation room (i.e. as per caravan/container structure), and so persons in wheelchairs are carried up by the health centre staff.
- Mobile ambulances that can bring people from homes to health centres are available, however, we have had various reports from people that these ambulance services are not always reliable or that when they are called, families are sometimes asked to bring the patient themselves despite explaining there are accessibility barriers to do so.
- No special techniques are used by health centres to communicate with persons with intellectual or communication difficulties (e.g. draw pictures of situation, write in Arabic), mainly health workers converse directly with family, and thereby excluding PWDs. This is also due to the fact that health workers have many consultations to do on some days and less time to spend with families/patients to explain things. Thus, support from HI to follow-up on some cases and work with PWDs will be needed.



Outside camps

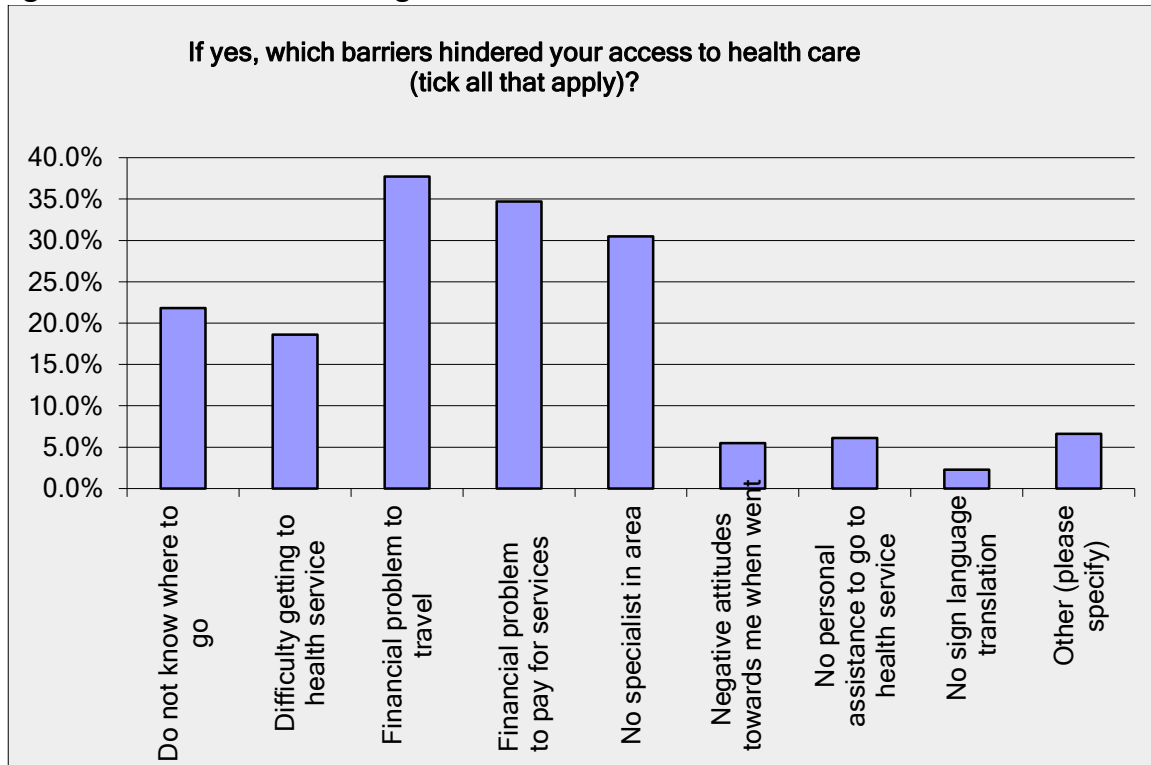
- Health and rehabilitation services provided by the government should be available to all at no-cost in KRI, however, this is not always the case and refugees often have to pay additional costs for certain tests/procedures (e.g. cancer, specialist tests/diagnosis/consultation).
 - Some families have sought out private medical consultations where it costs for example 25,000 dinars. Multiple consultations like this start to weigh financially on family. Families pay privately to get medical clarity or medical closure (e.g. a second opinion at times), to know if the person's impairment will improve or not.
 - Some of the required surgery interventions are expensive in Erbil (i.e. reports of 3000\$, families do not have money for such private surgeries). Many are asking for support to go abroad for specialized care and surgeries that will increase their function (e.g. reduce tremor/shaking, reduce debilitating headaches from brain disease, prevent spinal cord injury for cases where spinal cord is deformed), otherwise people are afraid to stay dependent on their families and burden them.
 - A family who helps their elderly mother go to a hospital for cancer treatment report it costs them about 300,000 dinar/month and that this is impacting their financial situation – also her son who is the head of household has health issues and cannot work. Prior to this treatment, the elderly mother was fully dependent on the family, now she is able to mobilize herself independently and meet some of her basic daily needs.
- Oftentimes families need to get specialist care but do not even dare to look into such care as they assume costs are above what they can afford.

Barriers

- 19% of people sought support to access services not provided in the camp (e.g. surgeries, specialist consultation – orthopedic/pediatric/audiology/cardiology, medication not available at camp pharmacy, batteries for hearing aid) and reports little results/changes in their situation.
- Reasons for reduced access to specialized medication is:
 - 1) Too expensive (57%)
 - 2) Not available locally (32%)
 - 3) Families do not know where to get it (25%)
- 65% of those who sought medical care faced difficulties in access due to the barriers listed in Figure 12, with travel costs being the top reason (38%), followed by payment for health services (35%), and lastly lack of specialist care in camps (or difficult to find) (30%).



Figure 12. Barriers to accessing health services



Facilitators

For those who managed to access health services, facilitators were:

- 1) Family assisting them with physical/financial access (40%)
 - 2) Service was closely available (e.g. in camp) (40%)
 - 3) Service was free (35%)
- Referrals are consistently made by MSF to specialist health services outside the camp and have also tried to accompany a few of the complex cases.
 - Free transportation is offered to access health services outside the camp- but this has reportedly been inconsistent and not always adequate. The inability to pay transport fees was identified as the most significant barrier to accessing health services and is a priority point to address.
 - Directory of specialized services existing in KRI for PWDs has been previously published by Nujeen and Handicap International and can be used to guide referrals.

Recommendations

17. **Any health information** disseminated needs to be translated into clear and informative messages that are widely disseminated amongst people with hearing and visual impairments (large print, pictorial), as they reported the most problems in receiving information and accessing health services. Also as 56% are illiterate, written information will not be accessible to all and using other audio-visual methods is recommended.
18. Support health services providers in **advocating for accessible and affordable transportation** to access necessary health services outside of camp.



19. **Ensure tailored accompaniment** of few cases that are not able to access services in Erbil independently and need **support with getting medical closure**.
20. Support health service providers to make sites accessible and learn best methods to interact/treat patients with disabilities.
21. Staff of health centre have basic awareness of rehabilitation needs of persons, and much more can be done to work with them to **identify cases where disability can be reduced via rehabilitation and to refer to HI** (e.g. burns cases, persons with stroke, persons with sensorial impairments, etc.), and HI can subsequently handle the case or refer externally.
22. **Advocacy for resettlement** due to medical reasons → We discovered families of children with severe disabilities (severe autism, kids needing multiple surgeries over their lifetime due to their spine being outside their spinal cord, etc.) and where a good solution locally is not possible- these kids are really at risk in the camps and their families would benefit from resettlement to places where the children can access a supportive health system.

3. Rehabilitation

“We had a couple of disability cases. We referred them to Erbil, but they came back with no treatment.” (child protection actor, Qushtapa camp).

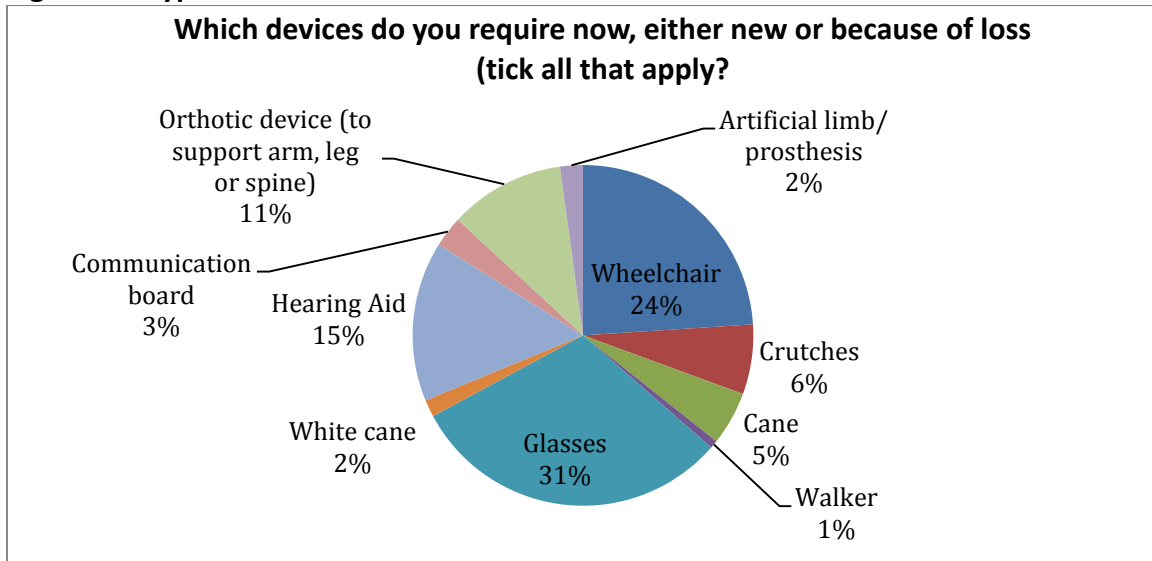
“Our child has autism and he has much difficulty as the tent is small here, before, he would play in our garden in Syria. Now, he breaks things and goes into other people’s tents. We found a day centre in Erbil for children with autism, but it costs 500,000 dinars (~415\$) a month. We did not even visit the centre, we cannot afford that.” (Father of child with autism, Basirma camp)

Key findings

- The majority of refugees with disabilities have long standing disabilities where they received little to no previous rehabilitation; there is minimal need for acute medical care but a strong need for medical closure and rehabilitation support to maximize their function (i.e. through assistive devices, teaching adaptive techniques and strengthening).
- Children/adults with multiple disabilities spend most of their days on their backs due to lack of supportive seating causing less social interaction/less stimulation, confining them to tents, and impacting their breathing and digestion.
- 18% of people lost an assistive device during their flee from Syria, with leading devices lost or needed being: glasses, wheelchairs and hearing aids (see Figure 12).

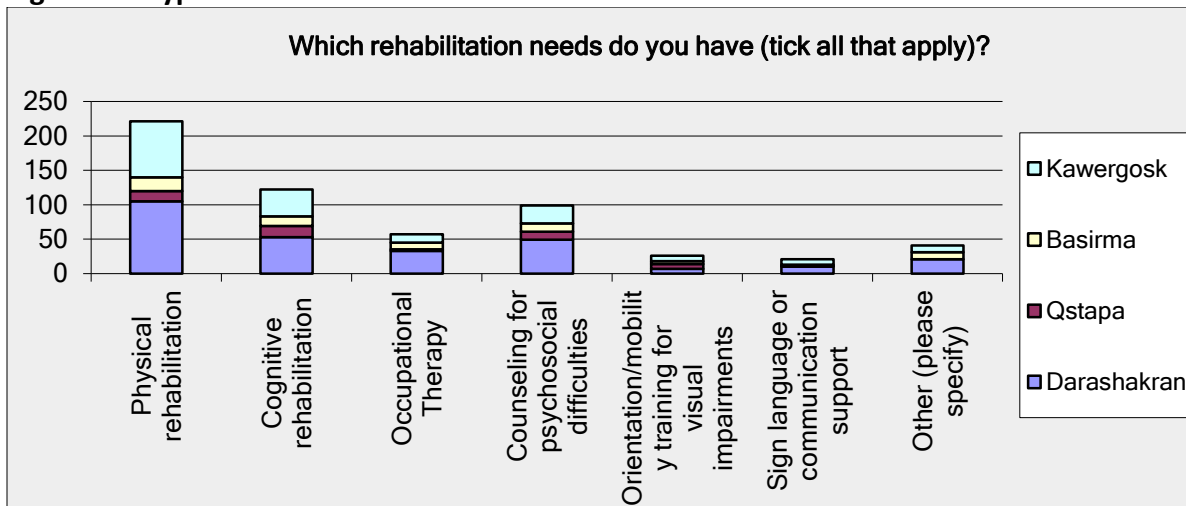


Figure 13: Types of assistive devices needed



- A number of people who answered ‘other’ to Figure 12, specified that they need some kind of surgery (not life-saving but ability-enhancing). Also medical shoes were mentioned as another aid.
- The main reason persons have not yet replaced or bought assistive devices is due to the cost (54%).
- In family interviews, many PWDs have never had access to speech/communication therapy but have potential to learn to speak basic words or communicate with family through pictures/signs.
- 45% reported having specific rehabilitation needs for their disability, with the main needs being (1) physiotherapy (53%), (2) cognitive rehabilitation for intellectual/learning disability or brain injury (29%), and (3) counseling for psychological difficulties (24%).

Figure 14. Types of rehabilitations needs





- These numbers may under-represent actual rehabilitation needs, as people know more about physical therapy, but other therapies (cognitive/occupational) are not readily available in Syria/Kurdistan and people may not be aware of their benefits/advantages to have requested them.
- 65% of persons faced difficulties accessing rehabilitation, this was due to:
 - 1) Lack of knowledge where to go (41%)
 - 2) No rehabilitation services available in the camp/area (32%)
 - 3) Cost to travel for rehabilitation (20%)
 - 4) Difficulty physically getting to/from service (13%)
- 89% of persons have not received rehabilitation since their arrival in Iraq.

Available Services

- There is no physiotherapy formally available in camps. It is likely that those who received physiotherapy travelled to urban areas where it was available. Otherwise, there is a handful of Syrian residents in camps with physiotherapy or massage therapy training, as well as local NGOs with untrained volunteers who have reportedly done some physiotherapy with camp residents; the quality and safety of such physiotherapy is questionable, considering many are untrained and those who are trained have a 1-2 year diploma, not a bachelors degree meeting international standards.
- Support programs for those who are blind, deaf or living with intellectual disabilities are located mostly in Erbil and few/no referrals have been made to these services.
- ICRC, based in Erbil, provides orthotics and prosthetics with corresponding physiotherapy services, as well as mobility equipment (e.g. wheelchairs, crutches, walking frames). Camp actors have been referring to them.

Access to services

- For ICRC, there has been delays in rate of provision of specialized wheelchairs due to out of country orders (e.g. at time of RNA shipment for pediatric wheelchairs would take 'a few more months' to arrive)
- ICRC reported that 3% of their clientele is refugees, transportation is provided for the 1st visit and all rehabilitation and equipment costs are free of charge. ICRC requests that family support with subsequent transportation costs if they can, otherwise in real poverty situations, ICRC will support additional transportation costs.

Barriers

- No actor seems to offer neuro-rehabilitation. The 'Emergency hospital' in Erbil has a spinal unit and also supports persons with burns/amputation; however a dedicated unit for neuro-rehabilitation seems unavailable at this time.
- There are other services that exist outside the camp, however, very little awareness on these services by camp actors and PWD alike.
- There is reduced trust towards unknown services. A family was encouraged to visit a rehabilitation service provider in Erbil, the head of household reported he does not trust the local 'society' and is afraid to send his wife with his son into the city to go seek services.



Facilitators

Those who managed to access rehabilitation services did so because:

- 1) Family assisted them to do so (financially/physically) (39%)
 - 2) Service was close in distance (34%)
 - 3) Service was free (31%)
 - 4) Service provided outreach services (6%)
- KRI disability legislation is based on a rights based approach; therefore, refugees with disabilities are mandated to be treated with fairness, dignity and sensitivity to their diverse needs as individuals.
 - Mainstream organizations like the Barzani Charity Foundation (BCF) have tried to support funding of hearing aid batteries for those who needed them.
 - BCF have distributed wheelchairs and crutches, but it seems this was not done with the help of a physiotherapist, so correct fitting and training on use wheelchair was limited.

Key recommendations

- **For persons with severe disabilities**, good positioning and seating are very important, currently they spent most of their times laying on their backs. We need to prioritize good seating for these persons in partnership with ICRC and other resources in Erbil; ICRC provides wheelchairs appropriate for camp terrain and pediatric wheelchairs. HI can also flag equipment/prosthetic-orthotic repairs needed and refer to ICRC and follow-up at the camp level on a day-to-day basis for new rehabilitation issues that arise.
- **Appropriate assessment and distribution** of assistive devices (e.g., hearing aids, glasses, specialized mobility aids) to people with disabilities, instead of blanket (widespread and unspecific) distribution (e.g., one size fits all wheelchairs). Please refer to HI when a PWDs needs equipment, so the right assessment and equipment can be provided.
- Many parents of children with intellectual disabilities would like help to teach their children basic self-care (dressing, washing face) and teach them toilet training. Arrange workshops and training for parents to teach kids with learning difficulties basic self-care.
- HI teams to make the essential link between PWDs living in camps and disability services in Erbil, as much as possible.
- In general, disability support centres (e.g. for blind/deaf/person with intellectual disabilities/childhood disabilities) in Erbil are open to refugees to access, but since refugees have not tried to access them, it is not clear what the refugee experience would be like with these centres. In the coming months, as HI refers and collaborates with these centres, accessibility and quality of services will be assessed. In particular, services that support parents on behavior modification are a great need. Many persons with physical and intellectual disabilities have aggravated behaviors since displacement to camp due to confining living conditions.
- Communication is a basic human need and there is a low percentage of communication by people with disabilities in the camp. See how basic speech therapy and 'communication boards' (board with pictures/words) can be provided to give PWDs solutions to communication. Consider offering standardized sign language training to persons who are

deaf and/or mute, most of them use a family sign language mainly understood by their parents but no one else.

4. Livelihood

*"I worry night and day about this situation, 2 young men sitting in the house and not working".
(mother with 3 children with disabilities- including two young men)*

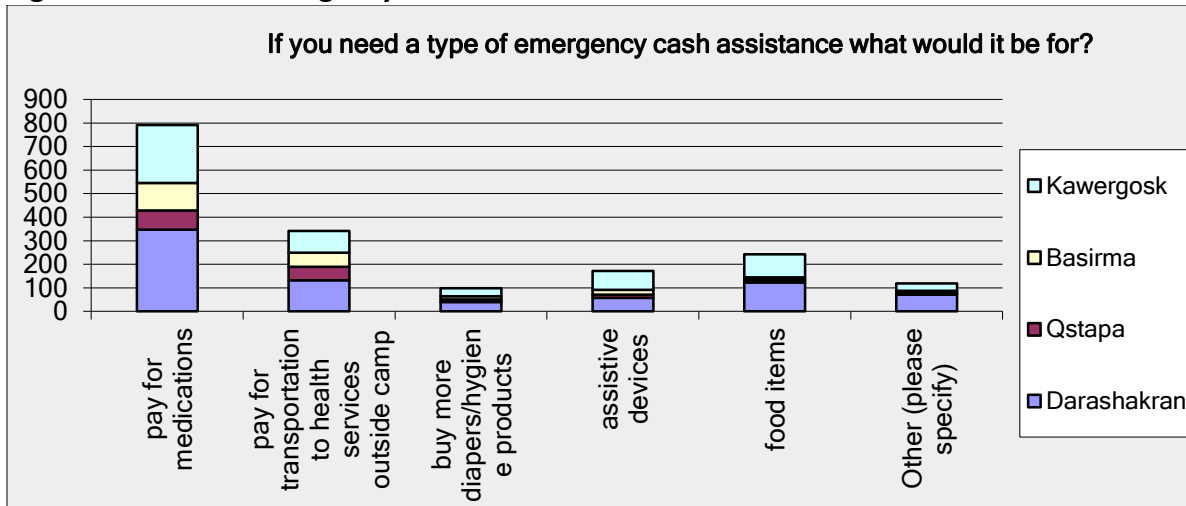
"PWD are poorer than others. They have less ability to work, their families look after them, so overall they and their families are poorer." (Representative of local disability NGO Dazheen, Darashakran camp)

Key Findings

- **Families with a member with a disability are poorer.** Due to ongoing costs related to disability (e.g. diapers, physiotherapy/health services outside camp, transportation), people with disabilities are poorer. This compounded with the fact that they are overlooked for participation in livelihood activities aggravates their economic situation, making them more vulnerable than other refugees. Some PWDs are in debt from borrowing from family members or are begging towards other refugees in the camps or camp management for financial support to cover their additional needs.
- 94% of PWDs do not participate in livelihood and have no means of revenue, compared to 39% of **refugees with disabilities who worked prior to displacement.**
- 70% of them face barriers in accessing livelihood.
- The main type of livelihood that PWDs do in camps is labour work - for those able to.
- 40 persons interviewed work in the formal sector (e.g. as guard for NGOs or cleaning camps for camp management); 30 persons work in the informal sector running small shops in the camp, cutting hair, sewing and so forth.
- Only 15% of persons have received cash support from NGOs or from UN agencies. This 15% had predominantly seemed to have larger families (50% had more than 5 people) but no other distinguishing factors in terms of sex, age or impairment type,
- Many families need emergency cash assistance (see figure 15), to cover needs not covered by free camp services. Priority needs are medication fees (80%), transportation for specialized services outside the camps (35%), food items (25%) [food given is not adequate or do not meet nutrition needs, or families are tired of the same type of food and sell food rations to buy different food], and assistive devices (17%).
- Other uses of emergency cash reported: surgery fees, treatment or physiotherapy fees, purchase of musical instrument or some sort of entertainment to relieve the extreme boredom PWDs experience in camps.



Figure 15. Uses of emergency cash assistance



- Refugees feel there is an attitude of favoritism in recruitment procedures in the camps. They are resigned to face difficulty finding work as many feel they do not have the social connections and ‘relatives in high places’ to get livelihood opportunities.
- In Syria, people lived with some financial difficulties, but they had the social fabric (e.g. families/neighbours) to borrow money from; this is more difficult in Kurdistan where extended relative/families did not all arrive here together.
- A large portion of salaries of families with a PWD is allocated to medication and costs of health care/rehabilitation needs.
- Families with PWD have irregular, unpredictable income from daily work that trickles in.
- It is 3000 dinar per bus ride to reach the city and scout for job opportunities, people have to “spend money to make money”, which is not possible for persons who are extremely poor.
- Persons with mild/moderate disabilities would like to be working in camp but are unable to tolerate the same workloads (intensity and speed of work) as before. They need employers to be understanding and open to modifying work style (longer hours with more breaks). DVFP team can work with such people to think of adapted positions/equipment and work pace to get a task done.

Available Services

- DRC (in partnership with HI) will be providing livelihood opportunities to a limited number of vulnerable persons, including people with disabilities.
- Kawergosk, Darashakran and Basirma have a job-centre where the CVs of refugee residents are available based on the profile sought by an employer/NGO. Many refugees question the neutrality of the job centre in selecting CVs. The job centre was designed to (1) ensure equitable distribution of employment, livelihood and cash for work opportunities across families living in camps and (2) ensure candidates are competent and in good standing with previous employers and the community.
- Zhin NGO (local NGO) provides vocational training in various areas.



Access to Services

- Few PWDs were involved in the camp vocational training programs.
- PWDs mainly going to camp management to get work as guards, but there is a limited amount of jobs and most are unsuccessful in such attempts.
- In Basirma, the wife of a man who is deaf was able to get him a job by advocating to the camp manager. This is successful in smaller camps it seems where residents can build stronger links with camp management.

Barriers

- 77% of persons report having a residency card, with 87% of them having a 6-month card, and 13% having a 3-month card given. Residency cards are essential to work in the formal sector, and hence create vulnerability in persons who may not be hired by organizations who are apprehensive about the lack of residency card or pending expiry date. Otherwise, persons with a lack of or expiring residency card may be hired informally by some companies and mistreated by not having a formal contract.
- Residency cards are issued by the Asayish in each camp, and wait times can vary.

The main barriers in participating in livelihood are:

- Start-up costs to run a business (36%)
- Physical inaccessibility of camp areas (33%)
- Lack of information about livelihood opportunities in camp (17%)
- Negative attitudes relating to disability and abilities (14%) from livelihood actors.

Facilitators

For those with a livelihood activity, top reasons:

- The main reason why PWDs were able to start livelihood was the help of a family member (41%). This echoes the interviews where people reported you need family support or strong connections within the camp community to be able to get a job locally.

Recommendations

1. Help reduce feeling of resignation that refugees have around the lack of fairness of recruitment processes. Try to ensure a climate of neutrality in recruitment for vocational training/jobs. Ensure a certain quota of PWDs is reserved in any large-scale recruitment, to give them an opportunity to take part.
2. Most people with disabilities looking for work in the camps as 'guards' and there are few other ideas proposed by families, so expanding their thinking around possible livelihoods would be a good exercise and see what kind of services/businesses are in need in the camp.
3. **Encourage mainstream actors to have 'inclusive livelihood services'** and develop accessible vocational training (e.g., IOM vocational project). Projects should consider how to incorporate work tasks that are competitive on the local market, culturally sensitive (e.g., location of trade may be more home oriented for women) and take a person centered approach.



5. Education

“He used to go to the kindergarten here and he suddenly stopped, we don't know why but he does not want to go anymore.” (parent of 4-year-old boy with arm paralysis)

Key Findings

- Currently, 70% of people do not receive any education, 21% attend primary school, 4% secondary school, and 3% try to home school their children.
- Several parents feel the kindergartens have reduced staff to student ratios and that children are often left to play alone, they feel nervous about having their children attend such spaces and possibly be ‘neglected’.
- In some cases, family have lowered expectations of children as they do not know, for example, that children who are blind can be taught to walk around safely within the home environment, or that they can learn to make tea, or learn to find a path to go to the toilet. As a result, parents do not give CWDs opportunities to try things and develop independence. This makes children a burden on their family and also makes children learn to be helpless and lowers their self-esteem.
- Mothers of infants with disabilities are not aware of typical child development and they do not notice when their children are behind in child development skills. They need training to work towards developmental milestones with children (e.g. a 10 month old with visual impairment could not sit by himself, something typically done at 6 months).
- A few families have been teaching children with disabilities to be self-sufficient and contribute to the household, but this is not common practice in all families especially for those with members with intellectual or visual difficulties.
- One mother advocated persistently for her daughter (who had mild cerebral palsy) to be included in the schools – and the school accepted this.
- Some teachers are worried about the safety of CWDs who may get trampled on by other kids during play time or as the kids run out of the class quickly and are not mindful of those who move more slowly.

Available Services

- Kindergarten (DoE- Rwanga, Save the children, ACTED)
- Elementary school (DoE-UNICEF)
- Secondary school (DoE- UNESCO)

Barriers

44% face difficulties accessing education, for the main following reasons:

- 1) Physical inaccessibility of the school (30%)
 - 2) Difficulty walking/ reaching school due to terrain (15%)
 - 3) Negative attitudes related to disability (13%) (from teacher or other students)
- Parents cannot leave their other children or family member with a disability alone at home to accompany CWDs to school.
 - Teachers are uncertain of how to teach CWDs; and there are no support staff on inclusive education working in camp schools.



- Overcrowding in camp schools; therefore, lack of enrollment of many children, including CWDs.
- Institutionalization/segregation of CWDs in the KRI has contributed to a culture of NOT enrolling children with disabilities in mainstream schools.
- Although children with disabilities are not actively excluded from camp schools, they are not actively encouraged to attend either.
- Class sizes are large at about 35 students, so tailored support is limited.
- With good intentions, partners of UNICEF tried to support the inclusion of a few students with disabilities, due to limitations in expertise and know how to make the necessary adaptive measure for quality inclusion –the students came to the school initially but had a negative experience (e.g. bullying, difficulty following teacher, feeling of isolation), were poorly integrated, and subsequently, dropped out of school. If CWDs are bullied and feel lonely, ‘inclusion’ is not true inclusion and can be a negative experience for the child.

Facilitators

- The mother of a girl with physical disability in Basirma had to advocate for school admission and she did so successfully.
- A 9-year old boy in Basirma who is blind and does not go to school, has his 7-year old sister tell him about school life and what she learned that day, as a means to keep him connected.
- A teacher who works at government school in the camp has tried to include children with mild visual impairments as he did in Syria. He typically put them at the front of class and tries to write in large print.
- **Youth with disabilities WANT to learn and can.** A youth with a hearing impairment has not been taught to read by anyone, but she managed to self-teach Arabic letters and numbers, basic drawing skills and basic sewing skills. Many children we met had great potential to learn, if only a supportive environment is made available.
- For the most part CWDs are not included in schools. However, in Darashakran, there is a refugee who was a sign language teacher in Syria and currently works for ACTED to teach 3 young pupils Arabic sign language and basic literacy skills.
- For those who did access school, facilitating reasons were:
 - 1) Close distance of school (55%)
 - 2) Family assisted with access (32%)
 - 3) Transportation to school was supported (11%)

Recommendations

1. For children who need additional support in school, make an adapted learning plan and see about using ‘support teacher’ or peer to peer support from other children/older children. **Human resources (youth and adults who are not working) in the camp are a tremendous resource to mobilize to support people with disabilities in school and community life in general.**
2. Early childhood education is super important for infants and toddlers with disabilities and has a very positive long-term impact for the rest of their lives. HI teams to ensure families

are aware of development milestones and how to help young children with disabilities reach milestones.

3. Collaborate with sign language teacher working for ACTED to work with other service providers and adults with hearing impairments to teach them basic sign language. HI will also see how this teacher's valuable skill set can be mobilized to benefit a maximum number of people (i.e. so far 3 children being taught only). Sign language training needs to also be given to parents/siblings and hearing people in general, so deaf children a wider circle to communicate with.
4. For children with intellectual disabilities, families need support to know how to teach child some basic life skills such as safety, behavior management (listens to basic request, maintaining attention, teach not to break things, find their way back to the tent, etc.). HI Mobile team can teach children such skills using landmarks/colors and other supportive mechanisms.
5. Pairing up adults with disabilities who are confident and living in the camps, with younger children with disabilities (e.g. blind adult who plays/teaches music near Domiz, with a young child with blindness) to show families the future potential of children and motivate them for school enrollment.
6. Actively **encourage parents to register CWDs** for school by increasing their awareness on the right of CWDs to education and availability of free access to education. Discussions could occur on individual basis with parents and also raising the general need for inclusive education with all children and community members.
7. Hire and train **support teachers on inclusive education** to travel to CWD in schools/home/child friendly spaces to provide support to meet the needs of the CWDs.
8. **Adapt the physical environment** in existing schools in camp so it is fully accessible to all.
9. Advocate for and support local authorities in mainstream/specialized schools to **accommodate the growing number of Syrian CWDs** by creating additional classroom or additional daily schooling sessions (i.e., in camp there is morning classes for one group and afternoon classes for another group).
10. Carry out an **in-depth assessment** of the readiness of schools and organizations to accept CWDs; this RNA explored this only minimally.

6. Protection and Sexual and Gender-Based Violence

"We live safely here, no violence like in Syria. No one make a problem with us" (55-year old man with a disability).

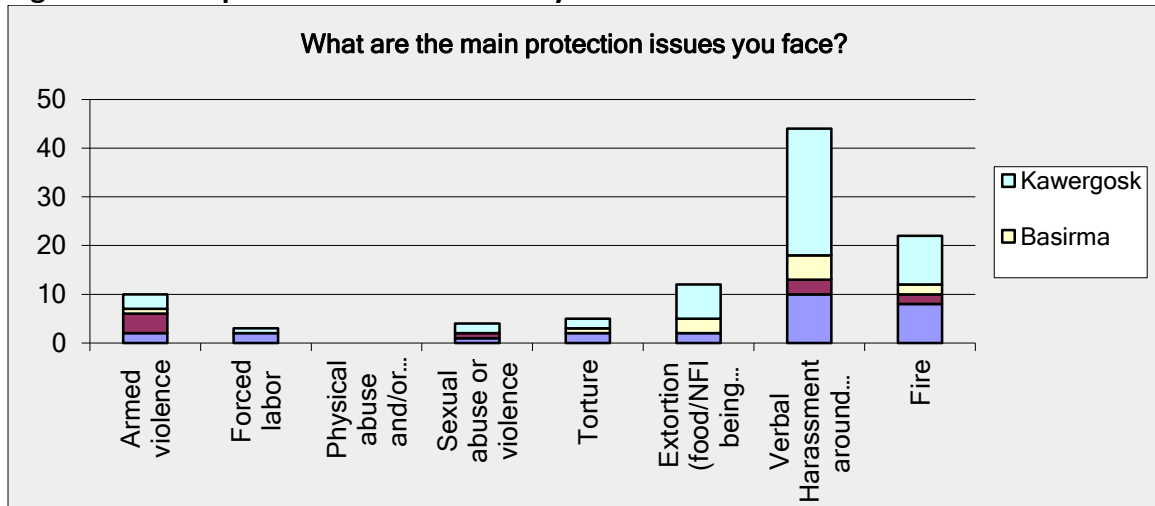
Key Findings

- 10% of people report being separated from family members with 19% being given support to reunite with families.
- 14% have concerns regarding their safety at the camp, the main reasons being:
 - 1) Verbal harassment by others (27%)
 - 2) Fire within the camp due to various issues (power cuts, waterproof tents that go up in flames in seconds) (12%)
 - 3) Extortion (food/items being stolen) (7%)



4) Armed violence (6%)

Figure 16. Main protection issues faced by PWD



- Other protection concerns were fear generally around being left alone in the tent and the 'behavior of neighbors'.
- Though efforts have clearly been made to have fire extinguishers be available close to each sector, PWDs were requesting their own fire extinguishers, as they fear being unable to access fire extinguishers in time to put out a fire.
- Most people report they will stay in camp as it is safer than in Syria, even if the economic situation is precarious right now; they feel they have no other options and at least a basic shelter and food is provided in the camp.
- Some youth with disabilities who get teased/bullied, get upset and at times and will try to hit others who are bullying them.
- Tents are very close to each other, some with single men in them. Families worry about being close to single men.
- The extent to which girls/young women with disabilities are verbally harassed compared to their peers without disabilities needs to be studied further.

Available Services

- Legal support (Qandil/UNHCR)
- There is inter-agency coordination around SGBV and child protection, disability issues are being raised by HI at these forums, as possible.
- UNFPA provides reproductive health support, runs a youth centre, runs a women's listening centre, works against early marriages of young girls, identifies SGBV cases to support, and provides general counseling and psychosocial support.
- NRC provides case management support to SGBV cases.

*** NGOs working in protection are too numerous to list, the service directory being produced in Erbil will more accurately outline the actors, we list only some of the actors here.**



Access to Services

- 47% of PWDs accessed protection services or legal assistance. Those that had difficulty accessing services reported that it was due to lack of knowledge on where to go (37%), followed by needing someone to come with them and explain their case (31%), and lastly difficulty getting to service (26%).

Barriers

- Surveyors told us there have been exaggerated reports produced in the past on SGBV issues in camps that have misrepresented the situation (over-reporting of prostitution). Such reports have brought shame to camp residents; as a result, surveyors feel they will not report SGBV issues readily to NGOs now.
- There are cases of violence that were observed during the RNA. One young boy with an intellectual disability is interested in marrying his cousin and often visits her tent, his uncle is frustrated by this and has admitted to hitting him and chasing him away. Supporting families to deal with such scenarios in a less violent way is needed.
- In another household with children with multiple disabilities and where the parents both have disabilities, the mother, at times, hits the children and her husband, due to stressors in her situation and camp life in general.
- One protection actor recognizes that SGBV case identification is challenging in general. However, for women with visual, intellectual and communication difficulties, there would likely be additional challenges in reporting any abuses, and that solutions to support these women should be thought of and put in place.

Facilitators

Those who successfully accessed protection services did so due to:

1. Family assistance to access service (54%)
 2. Close distance (51%)
- The sub-group on SGBV has worked to develop referral pathway/good coordination around cases that arise.
 - Majority of people surveyed are not separated from family (only 10% in both urban and camp areas), meaning arrival at camp with caregiver is likely.
 - No instances of CWDs or elderly with a disability living alone were identified and majority of CWDs live with at least one of their parents.

Recommendations

1. Several different actors have case management activities (Intersos, Qandil, NRC, etc.) while such organizations do not exclude PWDs, they also do not have specialized skill set to support PWDs, so it will be useful to work in conjunction with HI to help find the best method to identify barriers and ways to overcome these barriers. Referrals alone do very little for people if they have no means to mobilize transportation to access a service, or they do not fully realize the impact a service can have on increasing their abilities, etc.
2. HI to support SGBV sub-group in mechanisms to mainstream disability into their work (e.g. input on camp Safety audit questionnaire, August 2014)

3. For fire safety of people with disabilities, consider provision of shelters that are fire-proof and will not go up in flames; consider provision of fire extinguisher to families of people with disabilities (i.e. who cannot mobilize quickly in case of fire – visual/physical impairment). Must also work with families and neighbors on plan of evacuation for member with disability in even of an emergency.
4. **Community support for protection of unattended children** home alone (i.e., parents identify trusted individuals to leave children with for hours they will be unattended).
5. Targeted study on whether **young girls and boys with disabilities are prone to harassment/extortion** compared to their peers.
6. **Ensure protection messages** are available in **multiple and appropriate formats** such as: easy picture format for persons with intellectual disabilities and hearing impairments, sign language, braille, loudspeakers, and audio-video.
7. Work with SGBV committee and key partners to **establish a system to monitor** persons at heightened risk and integrate **PWD throughout SGBV prevention and response mechanisms**.
8. **Develop checklists of possible protection risks faced by PWDs** (e.g., sexual violence, domestic abuse and physical abuse; abduction/separation from family members; elderly abuse; manipulation of persons with intellectual disabilities; neglect, abandonment, concealment, intimidation; theft of medicines/food/belongings/identification documents) and corresponding warning signs (e.g., withdrawal, behavior change, markings on body).
9. **Inform and train PWDs**, as well as their families and caregivers, **on how to recognize, avoid, and report instances of violence, exploitation, and abuse** (UNHCR, 2011).
10. Arranging respite caregiver network in each camp, to support families with multiple members with disabilities where the main caregiver (usually the mother) is isolated, exhausted and where the situation is fragile and easily prone to family breakdown.
11. **Expansion of access to justice programs**, human rights/rule of law education, and training for government and non-state actors and for refugee with disabilities, especially for those in urban areas who have reduced access to protection/legal assistance.

7. Shelter and Surrounding Areas

“Tents do not keep scorpions and insects out, a caravan is better. We worry about our children (with disabilities) getting bitten”. (Mother of two girls with cerebral palsy, Basirma camp)

“I cannot move around easily in my tent, it is crowded with all these mattresses, it is not like my house in Syria where I had more space and grass and animals.” (Young man with a disability, Qushtapa camp)

Key Findings

- Many do not like to be around others and feel camps are crowded – particularly Kawergosk.
- PWDs feel more agitated living in camps. It may be parents who are short-tempered with their children, other times it is children who are having worsened behavioural issues and

acting out (hitting, yelling) with their parents or their siblings, out of frustration of the confining space. This makes for difficult social environment for all.

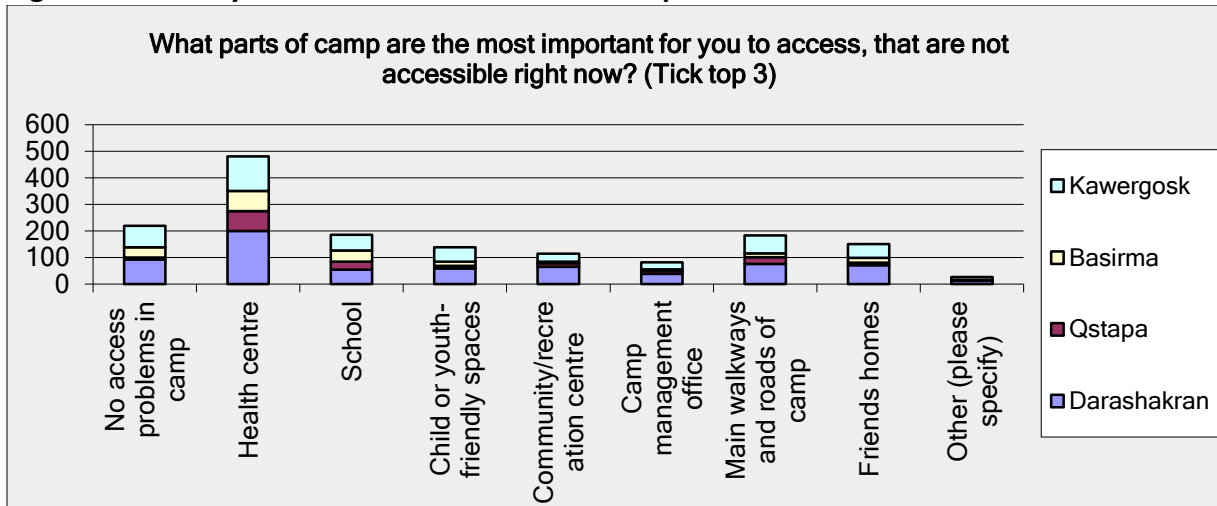
- Electricity cuts have a particularly negative impact on PWDs who sit in stuffy, hot tents because family cannot take them out to shadier areas. This is uncomfortable and a health hazard for dehydration of children and adults with severe mobility impairments, also heat and power cuts are creating and aggravating skin diseases, creating more coughing and respiratory problems as well.

Picture on right is of the caravan of a family with a member with disability in Basirma.



- Some PWDs have to wait a long time before they can get a tent and are not always able to self-advocate and explain their situation clearly to camp management/authorities: Support effective self-advocacy of PWD in difficult shelter situations.
- Shelter in some parts of Kawergosk camp are built high up with multiple steps leading to the entrance, being totally inaccessible for PWD.
- Bathing area in some shelters does not have a flat surface (i.e. covered with dirt/mud) and this makes it hard in winter where it gets extremely muddy.
- Some persons with psychological trauma/difficulties want to be left alone and have their own space within the shelter (e.g. separate tent/room). They cannot co-exist with other family members in such enclosed spaces, so families are trying to build/arrange for quiet, separate space where possible.
- The majority of refugees with disabilities live in tents (85%); then in containers/ 'caravans' - permanent shelters made of tin (9%) some live in homes made of bricks/cement (3%); and others improvised shelters made of tarps/salvaged materials (2%),
- Though some efforts have been made in some camps (e.g Basirma) to provide better shelters (e.g. caravans) to people with disabilities, the majority of people with disabilities live under the difficulty condition of a tent (unbearably hot in summer/chilling in the winter), aggravating skin conditions/pain/stiffness and disability situations.
- The top sites for persons to access are: health centres (53%), schools (20%), and main walkways of the camp (20%). See figure 17 for more details.

Figure 17. Priority sites to make accessible in camp



Available Services

- NRC supports PWDs with improving their existing shelters to make them more insulated and provide privacy.
- ACF is incorporating disability considerations into some of their construction work.

Access to Services

- The situation varies from camp to camp, with many people with disabilities in Basirma having a caravan/container to live in, while all people in Kawergosk live in a tent.
- Currently, a global assessment is underway by NRC to help make shelters accessible.

Picture below is of typical entrances to home of PWD in Qushtapa– stairs or slippery slopes:



Barriers

- 48% of people report having difficulty moving inside their shelters due to:
 - 1) Doorways/entrances being too narrow (60%)
 - 2) Steps leading to shelter being inaccessible and keeping them isolated at home (52%)
 - 3) Floor space being too small in shelters (16%) – thereby limiting use of wheelchairs to outdoors only, even if person needs it to move within shelter.
 - 4) Items in shelter are too high/low - no shelves/furniture at appropriate height for person (11%)
 - 5) Bed height is inappropriate (typically mattresses are on floors), making it difficult to get up and mobilize. (10%)
- Inside some shelters, when the floor is wet, it is extremely slippery (also maybe mold is growing) and there is a risk for people with slow and unsteady walking to fall. Rubber strips on the ground to increase safety would be a good idea.
- Very little ‘space’ in camp to live and walk around. The amount of space people had in Syria promoted mental health, while the lack of space is creating a feeling of imprisonment in camps. Also for children with autism and intellectual disabilities, the lack of space is particularly difficult, especially during extreme summer and winter months where they are confined to tents.
- Camp terrain is hilly, rocky, uneven, filled with potholes – making safe mobility challenging for persons with mobility difficulties who use aids. Families worry about people with mobility limitations that if they walk they may get hit by a vehicle, trip, or fall. As a result, many stay inside shelter.

Picture on right shows space of tents and barriers PWD have to cross (i.e. person using wheelchair or having visual impairment has no chance to navigate safely)

Facilitators

- Some families who have lived in camp longer and been able to gradually add a tent to their shelter to lengthen it, explain that this has had a very positive impact in having a sleeping space and where a living room and sleeping space have been separated.

Recommendations

1. **Winter-summerization and insulation of tents** is a top priority to prevent worsening of health concerns for persons who are immobile and may have breathing issues, suffer from debilitating chronic disease or who experience conditions worsened by the cold.
2. **Ensure PWDs are priority for relocation to more central areas of camps and more spacious shelters (containers/double tents).** Especially for families with children with intellectual disabilities and physical disabilities, the shelter is the main space they occupy



(i.e. at risk of falls if outside), so ensure the space is not too confining and does not feel 'like a prison'.

3. **During planning phase of camp or relocation of tents**, avoid placing PWDs in sections far from the center of camp where they cannot travel long distances in uneven, hilly and pot-holed camp area. Generally, house people with disabilities and their families close to essential services and facilities (e.g., water, latrines and bathing areas, health centers, schools, food and nonfood distribution points, fuel collection, community centers, camp offices). Otherwise, consider more decentralization of services within camp.
4. **Ensure construction of new shelters/structures (e.g. playgrounds) incorporate universal designs** and does not contribute to isolation/exclusion (e.g., difficulty getting out of shelter, lack of visibility of street, darkness inside shelter).
5. **Plant trees and provide small areas of green space** in every area of camp where people with and without disabilities can gather for respite from camp traffic/shelter.

8. Water, Sanitation and Hygiene (WASH)

“The toilet is outside the tent and it is so narrow. We carry our son there. We sometimes wait in a row for the toilet” (mother of child with a disability).

Picture on right is of path leading to water point in Kawergosk camp, near the home of one person with a disability.

Key Findings

- 40% of persons have difficulty accessing drinking water.
- 85% of PWDs rely on their family to bring them water, 4% get support from neighbors; others struggle to get it themselves despite difficulties.
- 54% of people use latrines, 38% use a western toilet where possible, and 4% of people defecate in tents. Others use diapers (older children and adults who are incontinent).
- Diapers cost about 80-100,000 (67-83\$) dinars a month. Many go without and this causes hygiene and dignity problems for family and PWDs. In one extreme case, the family lives isolated from others in the camp and has been rejected by the community due to the bad odor coming from the tent.
- Families find the latrines very dirty and don't want their children to use them. It is common for parents to get children to urinate in the drainage hole in the kitchen area, which does not drain into a sewage pipe but outside into the open dirt (i.e. hygiene concern).
- 42% of people have difficulty accessing toilets/latrines, this is due to:



- 1) Mobilizing to reach the toilet (56%) due to long distance/uneven terrain, especially those with balance problems.
 - 2) Latrine/toilet is physically inaccessible (41%) step to get into it, such as: no grab rails inside, squat toilet too low, latrine too small, etc.
 - 3) Latrine is unclean (17%) and slippery/dirty floor can be further cause of falls/disease.
 - 4) Toilets are often mixed and not sex-separated (15%)
 - 5) Lack of knowledge if there is accessible toilet elsewhere in camp (13%)
- Toilets also do not have lighting and people do not feel safe using them especially at night and with long distances.

Available Services

- DRC (in partnership with HI) will be supporting households with someone with disability to create an accessible WASH situation.
- More and more measures are being taken to design accessible latrines (e.g. ACF, NRC). Through a disability coordination sub-group, standard designs for universally designed toilet/shower units have been developed and adapted pit/squat latrine designs are also currently being developed for KRI refugee camps. However, WASH adaptations are still done as one off measures, not systematically built into construction activities of all actors.

Picture to right is of ACF staff assessing latrines of health centre in Darashakran to see about accessibility.

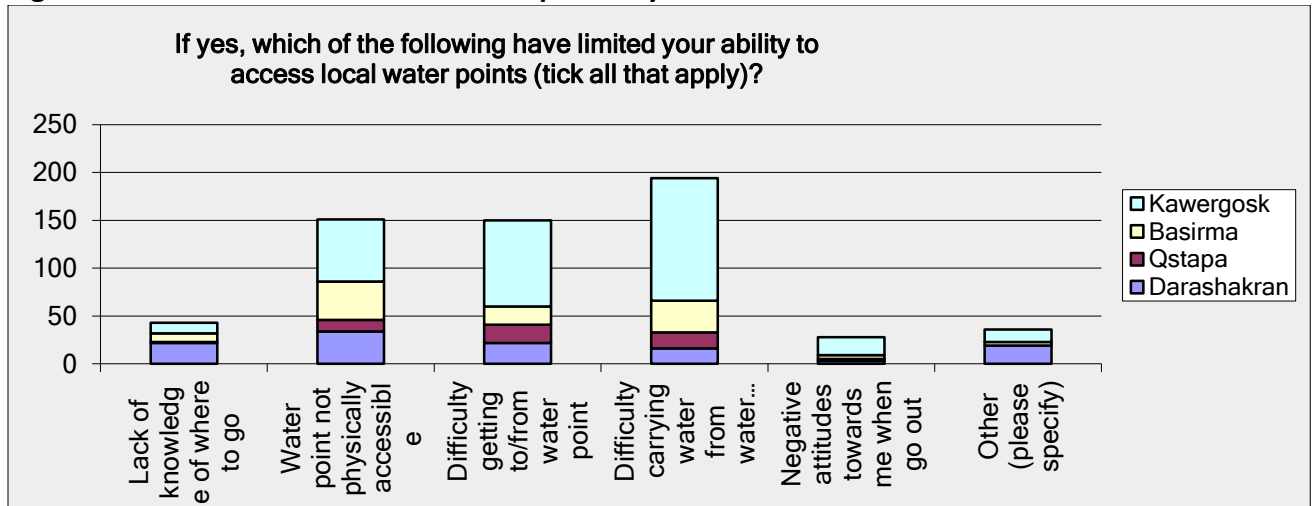


Barriers

- Barriers to access drinking water are:
 - 1) Difficulty carrying water front water points (48%)
 - 2) Water point is not physically accessible (38%) – too low; persons can reach/bend down to access.
 - 3) Difficulty getting to/from water point (37%)
- Latrines are not accessible to PWDs and older people. At the minimum need grab bars in every latrine to help people stand. For those with no ability to stand, toilet chairs can be used in tents or over private pit latrines.
- Terrain to reach latrines is very poor; many PWDs cannot get to latrines, let alone use them, so use the tents.
- A 9-year old boy who is blind lives far from the latrine (about 70m from his shelter) and it is down a steep incline that is unsafe, with wiry posts in the way and other hazards. He cannot access the latrine without his father as he risks serious falls and injuries.



Figure 18. Barriers to access local water points by PWD



Facilitators

- Barzani charity foundation reported to be the most supportive to families in distributing diapers, though this is mainly focused on children less than 1 year of age and older children or adults with disabilities are overlooked and do not access diapers.

Recommendations

1. **Adapt inaccessible latrines** for people who cannot access them.
2. Due to the unsustainable cost of diapers for families, do a focus group to see if families would be interested in using reusable diapers in camps (i.e. for children and adults). See if a prototype can be produced locally. ACTED has had some experience with running focus groups on this topic in Jordan, good to collaborate further on this topic.
3. For those at risk of falls/injury (persons with visual/mobility impairments), ensure path to toilet is flat and barrier free, to be accessed safely and independently.
4. In summer months or during high temperatures, ensure persons with severe mobility problems have adequate **access to cool spaces and clean drinking water**.
5. **Solutions for water access** and working with people with disabilities:
 - Minimize distance to clean water point
 - Include PWDs in WASH committees to test accessibility and provide advice
 - Support NGOs to use universal design in all toilets/water points
 - Diversify the size and shape of jerry cans for persons with different hand function/strength (e.g., some with wheels– this will benefit children, short people, the elderly and pregnant women)
 - Provide assistance for PWD to carry empty containers and full water containers to their homes if they cannot do so themselves
 - Refer to inclusive WASH resources to help with technical details of inclusive WASH. See p. 5 http://www.handicap-international.de/fileadmin/redaktion/pdf/disability_checklist_booklet_01.pdf And <http://www.inclusivewash.org.au/>



9. Food and Non-food item distribution

“Food services are good, but I need help from others to get the food. Sometimes they take some of the food” (male with a disability).

Key Findings

- 53% of people have difficulty accessing food distribution
- 67% of persons who need a specific diet (e.g. diabetes, celiac disease) do not have access to it.
- Intersos/WFP report that they do support families with mobility problems by bringing food to their shelters, as needed.
- Mothers with multiple children with disabilities have difficulty leaving tent to go get food during food distributions.

Available Services

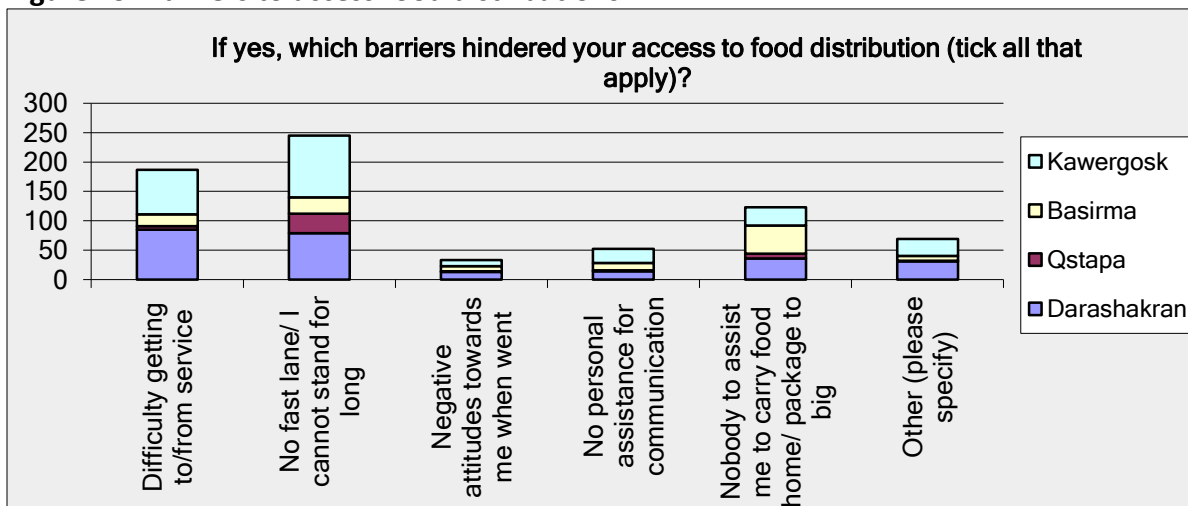
- In Basirma and Qushtapa, Intersos and WFP work jointly for food distribution.
- In Darashakran and Kawergosk, ACTED and WFP work jointly for food distribution.
- Barzani charity foundation - essential items (diapers, milk, kitchen tools, etc.)
- Clothes distribution was done during the winter by Save the children, INTERSOS, Qandil and maybe DRC/NRC.

Access to Services

- For PWDs who do have adequate access to food, access is facilitated due to close distance and the support of family/friends to transport food.

Barriers

Figure 19. Barriers to access food distributions



- No fast lane for receiving food and need to stand for long periods of time (49%)
- Difficulty getting to/from distribution points (38%)
- No assistance to carry food back (25%)



- Difficulties with accessing special diets are:
 - 1) Too expensive (49%)
 - 2) Not being available locally (in or near camp) (37%)
 - 3) Families do not know where to get it (30%)
- WFP does post-distribution monitoring of food to see how food was used, but no specific disability follow-up. Data from this has yet to be analyzed to see if there are any specific trends for vulnerable persons.
- In food provision, something often over-looked is how and if person can cook and prepare food, and how they can also be supported with those tasks. WFP has no systems to monitor this, but recognizes it needs to be taken into consideration.
- People with dietary problems (e.g. diabetics, celiac disease) are experiencing worsening in condition weight loss/gain due to lack of appropriate food available.

Facilitators

Persons accessing food distribution with the help of:

- 1) Relatives/family (74%)
- 2) Close distance of distribution points (24%)
- 3) Home delivery in some areas (7%)

Recommendations

1. Flag families who have difficulty leaving shelter (e.g. caregiver for many CWDs) and provide support.
2. Ensure **separate queues, smaller food parcels, or shelter-to-shelter distribution** for PWDs and other persons with mobility limitations (e.g. pregnant women, elderly), as needed.
3. For those with chewing problems, diet is limited to bread soaked in milk, and yogurt, since harder food cannot be blended easily. Thus, consider provision of small blenders to family with persons with chewing problem (e.g. children with cerebral palsy, adults with strokes).
4. Ensure shops built by WFP in camp for food distribution are **accessible** and trolleys/carts with wheels are available to **support PWD transporting the food** back when they cannot carry items independently.
5. Follow-up with WFP once **post-distribution monitoring data** has been analyzed to see if persons with mobility problems/disabilities are able to use and cook food.
6. For people who have dietary problems (e.g. diabetics, celiac disease) and whose condition may be worsening (e.g. weight loss/gain due to lack of appropriate food available):
 - **Food voucher system (like Domiz) is much better than packaged food system. So families can buy things that better meet their needs and customize to needs.** Flag persons that are particularly under-nourished and have difficulty consuming the current food provided.

10. Access to information and community life

“In Syria, my daughter had more friends and she could communicate with them because they knew her for a long time, here she doesn’t have many friends and she is unhappy.” (mother of 15 year old girl who with a hearing impairment Kawergosk camp)



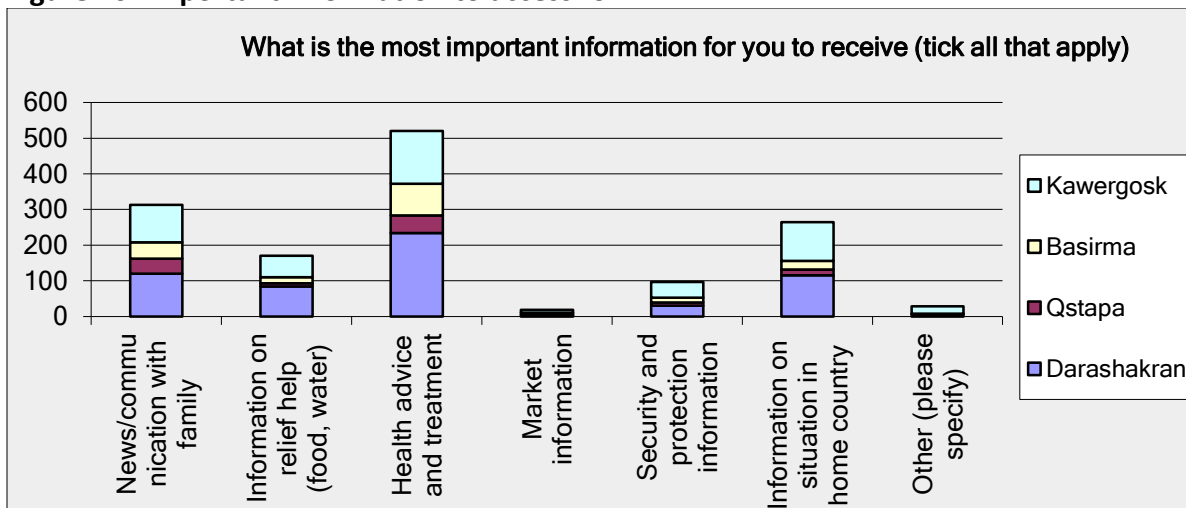
“In Syria, our son visited his grandparents and his aunts and uncles and he felt happier and more loved, but here there is only us and he misses his uncle a lot.” (mother of a boy with a disability, Qushtapa camp)

“I hope our child is allowed to use the playground once it’s built, like the other children” (Father of child with disability, Darashakran camp)

Key findings

- The main source of information for PWDs is through word of mouth from friends/family (64%)- with family adapting information using family sign language or simplifying for persons with intellectual disabilities- followed by television (59%), and then by visits to their tents by aid workers (12%).
- 95% of PWD do not belong to any camp committees or representative groups.
- 82% are not aware of any support groups for PWD that meet.
- 85% of people do not participate in community activities and community spaces.
- In camps, the family networks are much smaller compared to Syria, or families are distributed amongst different camps and urban areas – with transportation as a challenge.
- Dazheen NGO has provided computer training to some PWD and other social activities (e.g. painting, drawing, drama), there has yet to be follow-up of activities to see if those who received training are accessing computers and impact of this training.
- Many PWD are experiencing lowered mental health due to tent/camp environment and requesting to visit a garden locally or in in Erbil. A simple outing could be very therapeutic.
- The main type of information that people are interested in is:
 - 1) Health advice and treatment (58%)
 - 2) News from family and communication with family (35%)
 - 3) Information about the situation in their home country (30%)

Figure 20. Important information to access for PWD

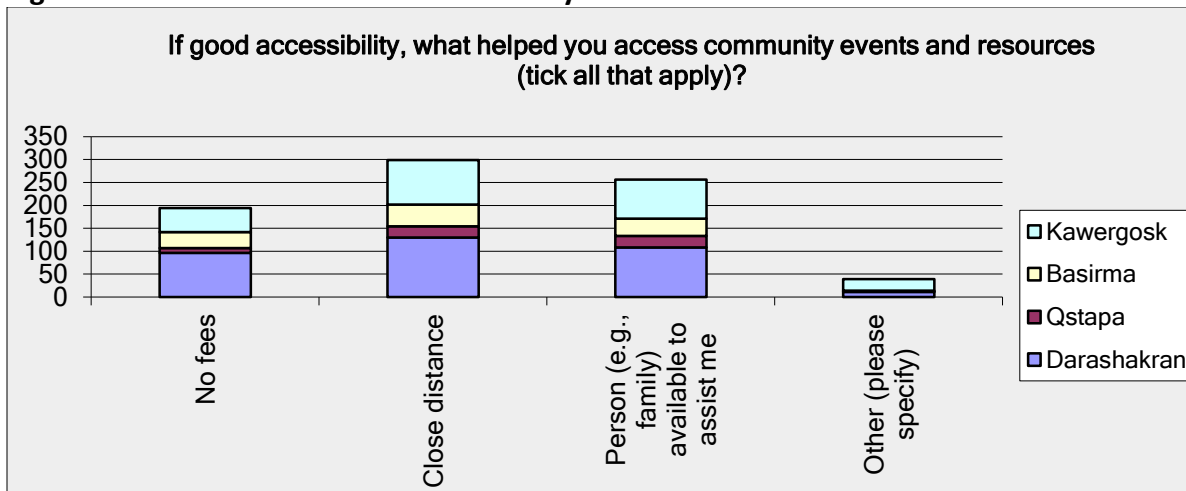




Child-friendly spaces (CFS)

- ACTED has a social worker dedicated to supporting CWDs in their CFS. Staff are dealing with a wide breadth of disability types and behavioral challenges. As these social workers seem to have generalized training (not disability specific), they requested a bit more training and are very open to learning how to support CWD better- particularly for children who may have aggressive behaviors (due to fear, difficulty communicating, etc.) or those who have challenges in sustaining attention and do not seem engaged. Thus, further coordination with ACTED and Save the Children on this will be valuable.
- A refugee in Basirma is conducting activities for children with various disabilities in the 'social centre' donated by an American philanthropist/missionary. Parents report enjoying going to this space and having a place to be with other parents and children with disabilities.
- Some parents are concerned staff of CFS may not know how to support their son with autism and they are not comfortable sending him there.
- Lots of parents at a loss for what to do for their children, they need support on how to develop their children, since it is hard for them to see what abilities are present and how to work within those reduced abilities.

Figure 22. Facilitators to access community events



- PWD are eager to participate in activities and report being very bored/under-stimulated, but cannot due to various physical and attitudinal barriers.
- The main community activities persons are interested in (or would like their children with disabilities to have access to), that they cannot currently participate in are:
 1. child-friendly spaces (19%)
 2. camp/community consultation (19%)
 3. sports activities (14%)
 4. internet/computer training (14%)

- Other activities mentioned are: visiting other families in the area, learning drawing, sewing, musical activities, religious activities, general entertainment, cultural activities (music, poetry).

Available services

- Child-friendly space (Terre des Hommes, Intersos, SCI, ACTED, UNCEF, PAO)
- Community cultural centre Basirma (Barzani Charity Foundation)
- Jaladat Baderkhan Social Centre Basirma
- Oasis social centre (for men and women's empowerment) (NRC)
- Nergiz women's space (Al-massalla-UNFPA)
- Social centre Basirma (Mr. Luqman runs centre)
- Nuraddine Zaza Community Centre Kawergosk (BCF)
- Community centre Kawergosk (ACTED-UNHCR)

Access to services

- ACTED has a disability social worker involved in the activities of the child/youth-friendly spaces and ensures active inclusion of children and youth with disabilities in Darashakran and Qushtapa camps; this has helped access greatly for some of the kids in the camps.
- Many of the CFS are far from homes of families, so they cannot bring them regularly, CFS staff (e.g. ACTED) sometimes support families to bring children to the spaces.
- Inside the ACTED CFS, there are some paved pathways for easier wheelchair access CFS, but this path doesn't reach all parts of space (e.g. performance stage has stairs and no connection with pathway). Other agencies' CFS have little to no access with rocky terrain. No accessible toilets were seen in any of the CFS, though some actors (e.g. ACTED) are ready to adapt spaces with support.

Picture on right is of performance stage in ACTED CFS (needs accessibility features added, ACTED open to this).

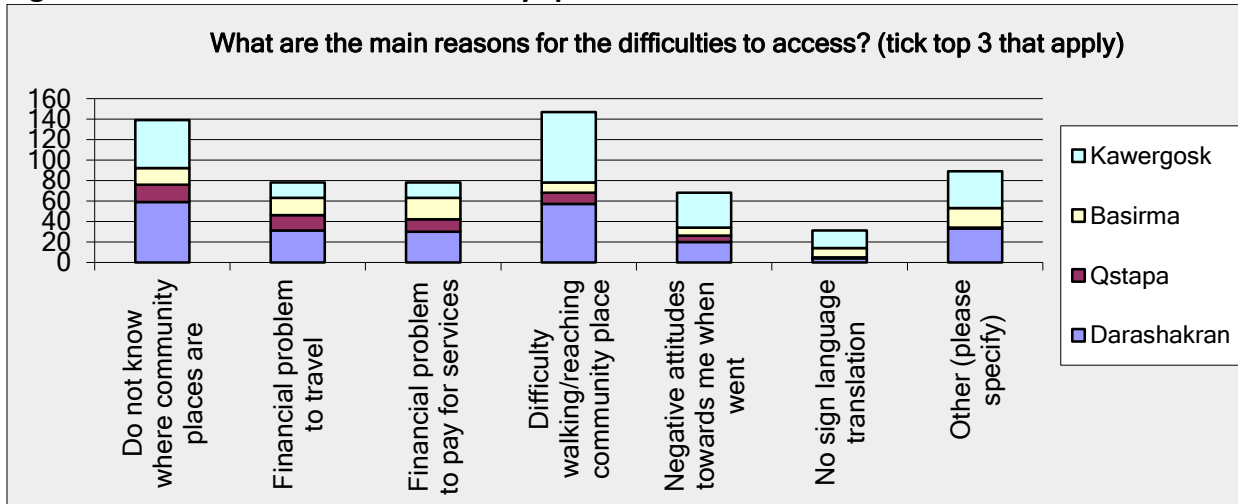
Barriers

- Challenges in participation of CFS are long distances to reach centre, and 1 on 1 support needed for some children (i.e. the CFS social workers need to dedicate entire time to one child- this is not always possible).
- 43% of persons have difficulty accessing community services. With the main difficulties being:
 - 1) Getting to and from community spaces (32%), they cannot walk/mobilize the distances required (~100-200 metres in rocky/uneven/sloppy terrain).



- 2) Lack of knowledge on where the community spaces are (30%), especially for caregivers who spend the majority of their time inside/nearby their tents.
- 3) Financial problem to travel to community sites (17%), if there is a need to hire a small car because the family member cannot be carried (if no suitable wheelchair).

Figure 21. Barriers to access community space



- Others reported that due to their disability or their family members mental illness, they would not feel able to partake in community activities or not be welcomed, or families are embarrassed/ worried to take PWD.

Picture on right is of inaccessible toilet at CFS in Darashakran) steps and narrow pit latrine.



Facilitators

- There is a social centre that was built in Basirma where fun group activities for children with various disabilities are run by Mr. Luqman (a teacher of special education).
- Most families would love their kids to participate in meaningful activities and be engaged in something; families will likely be supportive of inclusion activities if well run.

Recommendations

- Some NGOs (e.g. Dazheen) are focused on people with disabilities and ‘bring people out of the tents’, they do this by providing social activities for people with disabilities to participate in. To enhance impact of activities, help PWDs have goals and work on self-

development, so **activities are not just distraction/entertainment, but help develop communication skills, confidence and ability of PWDs/CWDs to live confidently alongside the community and contribute.** For example:

- Teaching a child with a visual impairment and instrument to develop listening/thinking skills;
- Doing physical exercise with persons with visual and intellectually impairments as their body awareness seems – which is reduced compared to peers;
- Supporting deaf youth to participate in sports/games where less communication may be needed and they can be alongside hearing children to play with a ball or some other prop.
- Though some actors are taking more leadership on making sites accessible, other actors should also try to make efforts to make their activities/spaces inclusive. For instance, for some families the CFS of one actor may be closer to them, and children with disabilities should have the right to access all child-friendly spaces in the camps. Children may get bored with going to the same space every day and should be able to access the same sites as other children. HI is happy to support any and all actors in these efforts towards accessibility.
- Due to the lack of human resources to bring CWDs to CFS in some camps, develop ‘leadership and citizenship activities’ with youth (19 years and over), to include CWDs in community affairs and CFS. Youth can help families bring their CWD out and support social workers that cannot spend entire time with one CWD (if they are helping 4-5 in one day).
- Support existing CFS actors to develop child to child activities that engage CWDs with their peers and not just adults, use activities in the CFS to develop communication, increased attention and healthy behaviors with other children.
- Though there are many activities for children in camps and inclusion of CWDs is encouraged (i.e. particularly by ACTED, Mr. Luqman in Basirma), there is a gap in supporting children and families in the home environment to manage self-care tasks, communication with family, basic toileting and hygiene. HI hopes to bridge this gap and to address issues at home before or in parallel to CWD attending child friendly space.
- Activities pairing children with the elderly were suggested; little funds/projects have been developed so far and could be of future considerations by service providers.

11. Transport

“This tent feels like a prison for us, you have seen the camp, it is very hard to move around outside our tents.” (Man with a disability, Kawergosk camp)

Key Findings

- As seen above, the main reason respondents do not access community spaces is that they have difficulty travelling to community space.
- PWDs need transportation support more than people without disabilities due to mobility problems and as they cannot access transportation consistently due to financial barriers.



- Across different services, distance was reported as a key facilitator (i.e., close distance) or key barrier (i.e., far distances) to accessing services, which is interlinked with transportation.
- Camp roads are totally inappropriate for PWDs. They are often placed in parts of camps that have unpaved roads that are rocky and where they absolutely cannot mobilize. As a result they are prisoners of tents and cannot go out at all, or with much difficulty for their families. All camps have terrain issues, though the main roads of Darashakran camp seem more user-friendly than other camps. But even in Darashakran, the small roads to reach the main roads are difficult and exhausting for PWDs to use or for many, impossible. The 3-wheel wheelchairs that ICRC is to provide will help this situation, but in many cases wheelchairs will need to be lifted over holes/cracks in roads and there is actually no feasible route for the person to take (e.g. Kawergosk camp)- it is a wonder how people have been getting around, with many having been carried by others.
- Many families having no transportation options and deciding whether it is worthwhile to pay 30,000 per trip to reach Erbil for medical visits is a real dilemma for families.

Available Services

- ICRC provides 'motivation' wheelchairs with 3 wheels that are more appropriate (i.e. stable and able to overcome rough terrain) for camp geography. During interviews, HI was unable to discuss with refugees who may be using these wheelchairs to see how they found them.
- Ambulance transportation for people needing medical services is provided- though not always reliable according to refugees.
- Taxis will pass by the camps, varying in price to and from Erbil (depending on the location of camp), costing less if it is shared and more if hired privately. Due to fuel increases with the new crisis (e.g. Mosul), cost for one way trips between Erbil and the following camps are as follows: Basirma 50 000- 60 000 IQD, Qushtapa 20 000 IQD, Kawergosk and Darashakran around 25000 IQD. Refugees reported that travel to Erbil is often less costly (i.e. as persons can share a taxi from the camp) and more costly upon return to camps from Erbil (i.e. as may be harder to find people to ride-share taxi and share costs).
- No availability of trained volunteers to accompany persons with visual impairments who may need guides.

Access to Services

- Financial access to transportation is the biggest barrier for most people, due to unemployment and lack of transportation subsidies.

Barriers

- PWDs are using poor quality mobility aids considering terrain of camp.
- Uncoordinated and unsystematic distribution of low quality mobility aids like wheelchairs, and lack of follow-up of wheelchairs usage/repairs.



Facilitators

- ACTED reported that they are planning to have vehicle pick-up children and bring to CFS at a future date.

Recommendations

1. Increase coordination of mobility aids between organization (i.e. please coordinate with HI before providing equipment) and increase access to quality mobility aids, as possible.
2. **Distribute all terrain wheelchairs** to manage muddy/bumpy/hilly camp for sustainable use and less need for repair.
3. **As much as possible, remove barriers (posts/big rocks) around camps- where PWDs may trip/fall or cannot push wheelchair around.** Create small bridges over potholes and sewage waterways.
4. **Even out camp terrain** - no rocky/pebbly areas – flat dirt or paved roads.
5. **Ensure PWDs are placed close to services and the heart of camp life.**
6. **Train a small group of volunteers that can guide/accompany** persons with visual impairments or with an intellectual disability to/from service (if family members unavailable). Also, services to post pictorial/large font signboards to help orientate PWDs.
7. **Develop diverse transport solutions** such as; increase frequency of bus services to camp to shorten waiting times, government coupons for taxi use for PWDs who cannot afford them.

12. Differences between the 4 camps

The four camps share some common elements, but also vary considerably in size, population, proximity to urban areas, shelter situation, availability of services and mood/social cohesion of the local population. As a result, this has created some differences to note below.

Most disabilities are similarly distributed amongst the camps, still some differences exist:

- Kawergosk has the leading proportion of persons with mobility disabilities (70% of interviewed). This is also reflected in 65% having difficulty carrying water back from water points compared to 18% of people in Darashakran. This is also shown by 8% of person in Kawergosk defecating in tents, compared to only 1.5% in Darashakran who likely can better access toilets/latrines, either due to less physical disability and/or better accessibility of latrines (often 1 per family).
- Qushtapa seems to have the highest proportion of mental health difficulties, with 36% requesting psychological counseling, compared to 20-23% in other camps.
- In Darashakran:
 - PWDs have the highest level of independence with self-care (41%) compare to the other 3 camps where PWD range in independence from 13-28%.
 - There is the lowest proportion of people with learning/intellectual disabilities (31%) compared to the other 3 camps that range from 35-40%.
 - There is the lowest proportion of persons with communication disabilities at 21%, compared to the other 3 camps that range (32-39%).

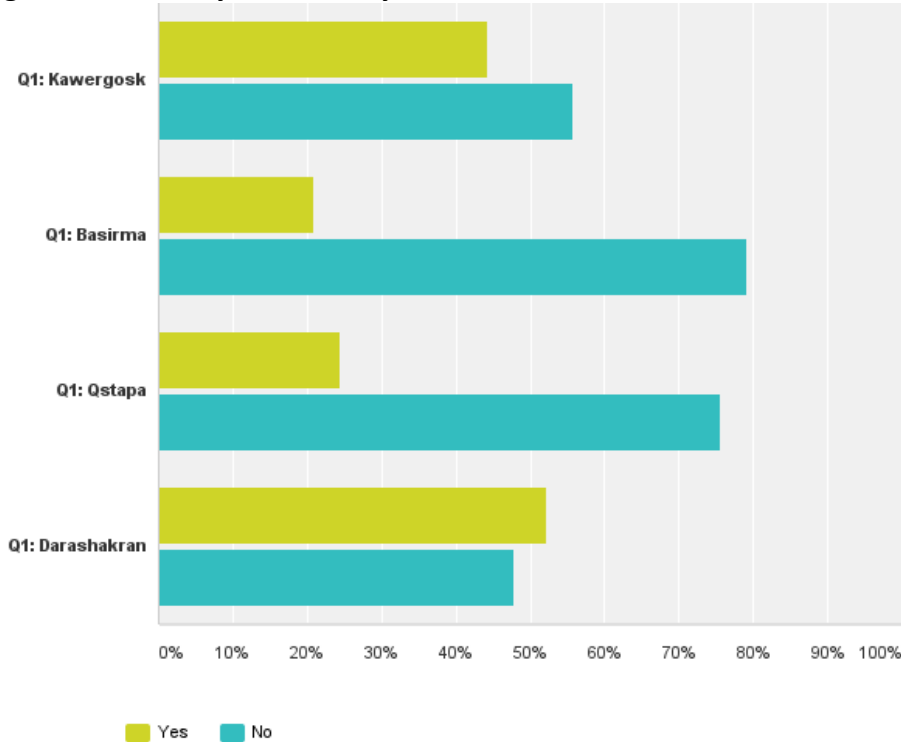


In terms of assistive devices, the following are most noticeable needs for devices by camps:

- Qushtapa, 38% require a wheelchair, meaning wheelchair distribution likely has been higher in the other camps and reaching those in need.
- Qushtapa refugees lead the other camps in needing glasses/eye care at 45% for PWDs.
- Qushtapa PWDs seemed to have the least awareness (42% unaware) of where to get assistive devices compared to other camps that range at 19-27% of unawareness.
- Basirma doubles the other camps in terms of needing access to prosthetics.
- Residents in Kawergosk double other camps in needing financial support to buy assistive devices at 25%, whereas the other camps range between 12-14%.

Figure 24 shows that Darashakran and Kawergosk have almost double the number of households with more than one person with a disability, compared to Basirma and Qushtapa.

Figure 24. Beside yourself, do you have other household members with a disability?



- There is a difference in the length of time refugees have left Syria- per camp. In Darashakran, 25% of PWDs left more than 1 year ago - compare to 1% of refugees in Kawergosk, who left Syria more than 1 year ago. See Figure 25.



Figure 25. Arrival time in Iraq as a refugee – per camp

	□Less than a month	□1-3 months	□3-6 months	□6 months to 1 year	□Greater than 1 year	Total
Q1: Kawergosk	0.93% 3	0.31% 1	2.48% 8	94.74% 306	1.55% 5	323
Q1: Basirma	0.00% 0	0.00% 0	9.93% 15	73.51% 111	16.56% 25	151
Q1: Qstapa	0.83% 1	0.83% 1	8.33% 10	82.50% 99	7.50% 9	120
Q1: Darashakran	0.24% 1	0.71% 3	4.02% 17	69.98% 296	25.06% 106	423
Total Respondents	5	5	50	812	145	1017

- PWDs living in Kawergosk have the lowest level of education, amongst all camps: at 60% having had no previous education, compared to 45%, 49% and 51% in other camps.

Figure 26. Highest level of education attained (per camp)

	□None	□Primary education	□Secondary education completed	□Vocational Training Center	□Literacy Course	□Special school/ integrated classroom	□1-4 years of university	Total
Q1: Kawergosk	60.79% 200	30.09% 99	6.38% 21	0.61% 2	0.00% 0	0.30% 1	1.82% 6	329
Q1: Basirma	50.98% 78	35.29% 54	11.11% 17	1.31% 2	0.00% 0	0.00% 0	1.31% 2	153
Q1: Qstapa	45.38% 54	33.61% 40	17.65% 21	0.00% 0	0.00% 0	0.00% 0	3.36% 4	119
Q1: Darashakran	49.25% 197	41.25% 165	7.75% 31	0.75% 3	0.25% 1	0.00% 0	0.75% 3	400
Total Respondents	529	358	90	7	1	1	15	1001

Highest percentage of barriers experience to access general services is seen in Kawergosk

- Difficulty with mobility around camp terrain to access services (42%), this is understandable considering Kawergosk has the worst accessibility of all camps in terms of congestion, uneven terrain, obstacles and so forth.
- Negative attitudes when accessing services at 20%. This was noticed in the needs assessment where PWDs seem more in despair and negative than persons in other camps, due to various reasons (e.g. camp congestion, being ‘overly-assessed’ and under-served, etc.)

Leading barriers on access to health by PWD were seen in Kawergosk and Basirma

- Kawergosk, 26% of PWD lack of information on where to go for health services



- Basirma had the highest proportion of difficulty in accessing medication (89%) compared to the other 3 camps (i.e. ranging at 54-79%).

Differences between smaller and larger camps

- There is a marked difference with access to specific nutrition between the larger camps and the smaller camps. In Basirma and Qushtapa, 19/21% had access to specific nutritional needs, compared to Kawergosk and Darashakran who had almost double the access at 49/56%. This may be due to more local shops being available within the larger camps.
- Another difference between the smaller and larger camps is access to rehabilitation. In Basirma/Qushtapa there is 26/15% access respectively, and Kawergosk and Darashakran accessing rehabilitation at 43/38% respectively.

Shelter and WASH differences

- The shelter situation amongst the camps varies greatly with things better in Basirma - only 39% of PWDs live in tents and 56% live in Caravans. In Qushtapa, all PWDs live in tents.
- Drinking water access is the most difficult in Kawergosk with 63% have difficulties, and the lowest in Darashakran with only 18% having access difficulties.
- The travel distance to latrines is the biggest barrier in Basirma with 29% having distance difficulties compared to 3-14% in the 3 other camps; this could be possibly due to fewer latrines or positions chosen for latrines in relation to PWDs.

Protection differences

- Support for reuniting with family members has been considerably better in the bigger camps of Kawergosk and Darashakran at 21/30% people supported, compared to 6/11% only in Basirma and Qushtapa.
- One of the main safety concerns of PWDs in Darashakran is fire, with 24% reporting worries about this. This may be due to several other family having experienced fires in their tents in this camp, and/or general threat of this happening, and PWDs feeling more vulnerable than other to be able to escape a fire in time.

Points unique to Qushtapa

- Concerns of personal safety seem to be the highest in Qushtapa at 28% compared to the other camps ranging at 9-15%.
- There is a higher report of armed violence in Qushtapa with 4 persons reporting this as concern, compared to 1 person in Basirma (a camp slightly bigger than Qushtapa) and 2-3 people reported in Kawergosk/Darashakran (camps that are 3-4 times Qushtapa's size). This could be due to influence by team surveyors and how they asked the questions, or an actual difference in concern by PWDs.
- Qushtapa also reports having the lowest access to protection/legal services at 2% compared to other camps at 41-50%.
- In Qushtapa, there seems to be the lowest participation of PWDs in camp representation and disability support groups. Only 2% of PWDs in Qushtapa are aware of any disability self-help groups, compare to 11-26% in the other camps.



- In Qushtapa, PWDs have the highest participation in livelihood at 17% compared to 2-7% in the other camps.

In access to health care, people with disabilities Qushtapa camps seems to have reduced access compared to other camps

- 87% of PWDs in Qushtapa had difficulty accessing health care compared to 53-64% in the other 3 camps.
- Qushtapa also lead other camps in difficulty with financing transportation to access health at 62%, compared to the other camps at 28-36%.

13. Differences between men and women with disabilities

- Some differences were seen in educational level reached by men and women with disabilities (WWDs). Men with disabilities (MWDs) double women with disabilities in terms of receiving secondary education at 65% compared to 35% for women. This trend was also noticeable in literacy, 50% of MWDs are literate, while only 35% of WWDs are literate.
- Women with disabilities may be more vulnerable due to lower percentage of marriage/higher percentage of widowhood, compared to men with disabilities (56% men with disabilities are married; 44% women with disabilities married).
- Proportion of people living with diabetes is double in women (9.5%) compared to men (4%). The same was seen with cardiovascular disease at 13% for women, compared to 6% for men. Road traffic accidents were three times more the cause of disability for men at 9% compared to women at 3%; similar trends with falls from heights causing disability (5% for men and 2% for women).
- MWDs are more than twice as eager to be included in sporting activities (19% vs. 8%) as women. Whereas 20% of women with disabilities are eager to participate in social groups (e.g. women's groups).
- Encouragingly, there are similar proportions of men and women with disabilities representing PWDs in camp committees (~5% for both).
- Men with disabilities are 3 times more likely to participate in livelihood compared to women with disabilities (9.5% vs. 2.8%)

14. Differences between various age groups

- There is almost triple the number of women with disabilities over the age of 80 compared to men (11 vs. 4).
- Visual and hearing disabilities were more prevalent in people over 60 years of age; elderly persons are more likely to have multiple disabilities and need multiple adaptations for inclusion.
- Mobility aids are required by elderly people in a greater proportion. While aids for communication are more needed for children with disabilities. Orthotic devices are also far more require for children with disabilities (under 5 years of age) compared to any other age group.



- The highest participation in camp committees is seen in 18-29 year old persons with disabilities.
- The main financial need of elderly persons over 60 is to help pay for transportation to health services, while for children and young adults with disabilities it is to buy diapers.
- Assistive devices are necessary and helpful for all age groups.
- Children from 5 to 11 years of age are most likely to participate in community activities at 29% compare to 0% of people over 80, and 7% of persons over 70 and 6% of persons over 60. It seems social participation and community participation is more difficult for elderly persons.

There are various types of community centres in the camps but low attendance by PWDs. There seem to be noticeable efforts made to engage children with disabilities in child-friendly spaces (i.e. visiting families and occasionally helping bring kids to spaces); less is formally done for adults with disabilities and elderly persons. Also, parents with more than 1 child with a disability cannot take 2-3 children to the CFS and need support from staff/volunteers- community support needs to be mobilized.

Picture on right is of an elderly man mobilizing out of his tent in Kawergosk, a rare occasion.

15. Cross-cutting

"I have not seen any people with disabilities in my work, I don't think there are many in the camp." (service provider, male)

"I have been interviewed by approximately 20 organizations and seen nothing. We don't believe anybody because nobody has helped us, we are tired of talking." (woman with a disability, Kawergosk).

"People with disabilities are not represented on any of the committees we work with" (service provider, male)

"Referral pathways are non-existent right now or informal and based on informal relationships." (service provider, female)

Key Findings

- Several service providers have said they have 'not seen a person with a disability in the camp', this shows how tent-bound some PWDs are that service providers don't even realize they are living in the camp. At the same time that service-providers are not aware of PWDs in the camps, PWDs are sitting in tents frustrated, bored, under-stimulated and consequently, a worsening mental health status.
- In interviews with service providers on barriers for PWDs, they reported general issues in the camps that were not specific to PWDs. It seems PWDs are quite invisible and the



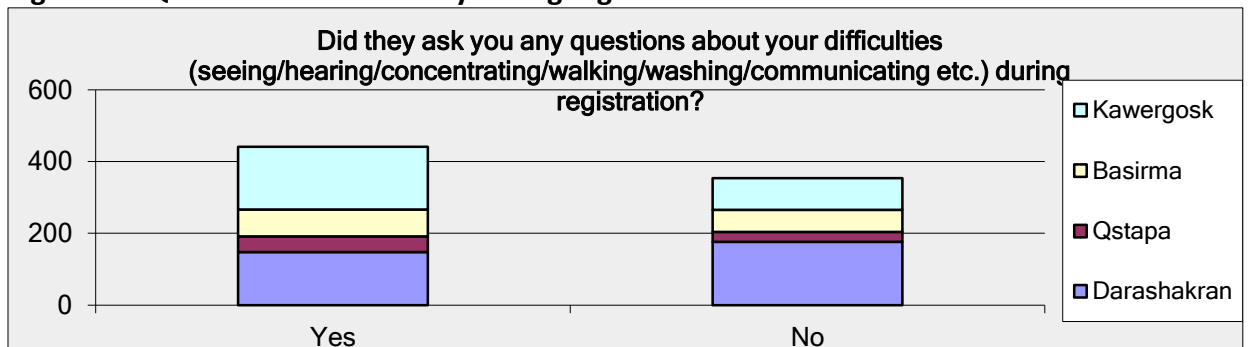
barriers facing them are not known to service providers who may not be aware of the extent of exclusion taking place in the camps.

- Sensorial disabilities seem the most overlooked by service providers- little to no adaptations were made for people with visual and hearing impairments. Some adaptations for these groups are easy and low cost, such as: written materials being provided in large print (font 16 minimum), contrasting colors (e.g. yellow print on black background), pictorial signs for persons with hearing problems.
- Most service providers have not given basic disability training (11/13) for staff, and hence why staff do not feel confident to welcome PWD into their services. Make basic disability training routine part of staff orientation, and then redirect towards HI.

Data collection gaps

- In interviews, most actors focus on training as the solution to creating disability-inclusivity within their organization; few mentioned changes in policy/targets and internal procedures to have more sustainable incorporation of disability into their work.
- 7 out of 13 actors surveyed do not have monitoring and evaluation tools that disaggregate disability, and so, they will not be able to pick up on difference in access to service.
- Families that were extremely poor in Syria are finding things better in camp as have shelter, food and water access. Families who were less poor in Syria and lower middle class are finding it harder in the camps and their quality of life has declined substantially from Syria.
- During registration 45% of people were not asked about their disability- meaning that a lot of disabilities may not be captured and registered – especially non-physical or invisible ones (e.g. intellectual, hearing, partial visual impairment). Furthermore, 80% of PWDs were not referred to any camp services or provided any information to help with their disability.

Figure 23. Questioned on disability during registration



Barriers

- PWDs have a generalized lack of awareness of services in the camp and in Erbil.
- To avoid interviewing fatigue, coordinate and share assessment results. Embed assessments in project activities and avoid doing assessments as stand-alone activities that are not be followed by any intervention; refugee population is now distrustful and frustrating with being assessed.



- The majority of service providers surveyed (8 out of 13), had not consulted PWDs in planning their services. Their main barrier was how to communicate with PWDs and adapt their premises.
- Children with disabilities are reported to be more visible than the frail elderly who are more secluded in tents, whereas CWDs are taken out from time to time.
- Few links with disability movement/services in Erbil.

Facilitators

- The main measure taken to support persons with physical disabilities was outreach to their home/shelter (7 out of 13 actors service providers), following by building flat structures.
- Main measure to support persons with intellectual disabilities was making communication adapted to their needs, using pictorial or verbal messaging where possible (5 out of 13 service providers)
- The UN is working on a referral system, and the SGBV working group has also been working on Standard Operating Procedures (SOPs) and referral mechanisms that may be adapted and adjusted to be used for general, non-SGBV cases.
- There is a widespread desire/demand by service providers to learn more about helping people with disabilities.

Recommendations

- Charity/assistance mindset is the prevalent approach towards PWDs, and may be linked with religious principles. Idea of inclusion and equal participation needs to be promoted. Some NGOs have focused primarily on social activities for PWDs that segregate them (specific activities rather than inclusion in mainstream ones). However, PWDs want to mix with people without disabilities and aiming for mixed spaces is the inclusive way forward. Handicap International recommends building an inclusive society where PWDs are seen as equals and attitude barriers are broken.
- A major facilitator to accessing service is **knowing where to go and getting help to explain your case once you get there**; therefore, information and accompaniment is needed. To help coordination of PWD services in and around camps, HI will **set-up DVFPs** (disability and vulnerability focal points) **with a mobile component to support case management and social inclusion of people with disabilities. DVFPs will help orientate and accompany refugees towards other service providers** or support them to achieving small goals and projects in the camp environment or outside.
- Many more refugees with disabilities live outside camps than inside, there also **needs further funding and support to study PWDs in urban areas.**
- There are widespread perceptions among PWDs of misuse of power by sector leaders. Therefore, it is important to encourage **PWDs and their families to take part in committees**, to see how decisions are made.

Actions for service providers and local authorities

- Include basic disability training in new staff orientation package- training does not automatically bring operational changes, but it can be the first step for staff awareness - HI can support organizations with this if specific requests are made.
- Consult refugees with disabilities on service provision - HI will create at least 8 peer groups that can be used for consultations and planning.
- Learn how to make offices and services accessible - HI and Erbil accessibility sub-group can support.
- Include targeted actions (e.g. Active inclusion) to address the specific needs of people with disabilities (WRC, 2013). **Set indicators that identify 10-15% of the target group as people with disabilities and older persons.** Disaggregate disability data (by sex and age) to monitor how effectively the program is reaching PWD. Examples of indicators are:
 1. Number of boys/girls and men/women with disabilities (and/or their family members) approached by mainstream service providers for information and assistance
 2. Number of barriers to access services assessed and removed
 3. Proportion of refugee outreach volunteers who are men/women with disabilities
 4. Number of staff (community center, outreach volunteers) that received training on disability inclusion from HI or other reliable service providers.
- **Long-term planning is necessary.** Refugees report that they intend to stay in KR-I for the next few years. Long-term projects to improve the socio-economic situation of PWDs would be the most fruitful compared to stand-alone, short-term quick fixes.
- **Hire people with disabilities**, and involve them as community volunteers. Collaborate with PWDs as much as possible.
- Local governorate, who is planning refugee policies for the long-term, **should consider some revision of social protection mechanisms** and how they could be applied to vulnerable PWD refugees who are in the lowest income groups and have difficulty working.
- Ensure that **questions on disability are included in all subsequent data collection of service providers**, population census or registration exercises.

Summary of Priorities

1. **Livelihood access** was the top priority for PWDs/families. Work opportunities can improve their overall quality of life by enabling them to pay for their health and social needs.
2. **Access to rehabilitation and specialized services** is necessary in order to maximize a person's abilities and increase their chances to lead an independent life: access school, access work, get water/food, raise a family and participate in community life.
3. **Support to primary caregivers.** Families with multiple PWDs seem to be the most impacted, the poorest and caregivers the least free to think of ways of improving their life situation because they are spending their days surviving. Mothers/caregivers are physically exhausted: they need respite support or they will lose their mental health. We need to prioritize support to these families and consider a 'respite' caregiver solution (e.g. 1 day a week of caregiver support to give caregivers a break)
4. Due to mobility problems and because of financial barriers to accessing transportation, **affordable and diverse transportation** was identified as a top priority for PWDs. PWDs need affordable transportation options to access rehabilitation and health services.
5. **Insulation of shelters** was identified as a key priority. Insulation was particularly important for refugees living in tents given the proximity to winter to prevent worsening of health concerns for persons who are immobile and may have breathing issues, suffer from debilitating chronic disease, or who experience conditions worsened by the cold.
6. **Physical accessibility to camp roads is desperately needed** – especially road access to shops/neighbors house – otherwise PWDs will continue to feel imprisoned in their tents. The disability sub-group is developing Universal Design drawings for KRI looking at squat latrine and toilet/bathing area standards. Beyond this all camp spaces/structures and **especially paths leading to them**, should have a basic level of accessibility. A universal design approach to construction in the camp benefits everyone.
7. **Coordination around disability issues is basic and needs to go further.** Coordination has mainly around accessibility of camps structures; the next step for the 'disability sub-group' is to tackle inclusivity of service provision (beyond physical access). For this to happen successfully more NGO/UN engagement is necessary and we look forward to a deeper dialogue on such issues, in the coming months.

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