



## Rapid Needs Assessment

**Situation of children, youth and adults with disabilities,  
within and around Domiz, Northern Iraq**



**December 2013**



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Cover photo: Two families from Syria are shown meeting outside of one of their homes in Domizrefugee camp.

All photos are courtesy of the authors with permission.

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## Acronyms

<b>CWDs</b>	Children with disabilities
<b>DPO</b>	Disabled People's Organisation
<b>DVFP</b>	Disability and vulnerability focal point
<b>HI</b>	Handicap International
<b>IGA</b>	Income generation activities
<b>IRC</b>	International rescue committee
<b>KRG</b>	Kurdistan Regional Government
<b>NCCI</b>	NGO Coordination committee of Iraq
<b>NFI</b>	Non food items
<b>NRC</b>	Norwegian refugee council
<b>PRC</b>	Physical rehabilitation centre
<b>PSS</b>	Personalized social support
<b>PWDs</b>	Persons with Disabilities
<b>RNA</b>	Rapid needs assessment
<b>SHG</b>	Self help groups
<b>SGBV</b>	Sexual and gender based violence
<b>UNHCR</b>	United Nations High Commission on Refugees
<b>UPP</b>	Un Ponte Per
<b>WASH</b>	Water, Sanitation, and Hygiene
<b>WFP</b>	World Food Programme
<b>WHO</b>	World Health Organization

## Acknowledgements

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## The Rapid Needs Assessment Team

This RNA was developed and led by ShirinKiani and Janet Njelesani, with input from Ulrike Last, HI and with support from Nujeen.

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**Nujeen** is an independent, humanitarian, non-profit, non-Governmental organization, working towards building a civil democratic society through community participatory approaches and Government coordination. Nujeen has implemented more than 25 projects since 2003 with various donors. Recent work has included carrying out assessments on Syrian refugees, developing a directory of services existing in Dohuk for persons with disabilities, and establishing Disability Information Points, contact: [info@nujeen.org](mailto:info@nujeen.org)



Assessment team, Domiz Camp, November 2013

## Executive Summary

Invisible at the best of times, persons with disabilities (PWD) are among the most neglected during displacement. Due to communication or physical barriers, negative attitudes or other obstacles, PWD face hurdles in accessing assistance and protection. It is therefore important to ensure that these barriers and obstacles are removed by all actors, so that people with disabilities can enjoy equal protection and rights during their displacement in and around Domiz.

The objective of the Rapid Needs Assessment (RNA) was to understand the situation of children, youth and adults with disabilities within and around Domiz camp, in Northern Iraq. The RNA findings will contribute to an evidence base for inclusive protection for actors involved in the humanitarian response to the Syrian crisis in Iraq and the region.

The RNA methodology consisted of 6 focus groups, 77 interviews, and 388 surveys conducted with local and international service providers, children with disabilities and parents, adults with disabilities, non-disabled adults, older adults, sector camp leaders, and local authorities. The RNA explored the needs of refugees living in Domiz camp as well as those living in an urban area in the host community.

## Key Findings

### Indicative Profile of Refugees with Disabilities

- 31% of PWD surveyed had more than one PWD living in their home.
- 59% of PWD had more than 5 people living in their household.
- 54% of PWD could not read or write.
- 89% of PWD had only primary school education.
- 47% of PWD were born with their impairments.
- <1% of PWD surveyed sustained a physical injury from the war.
- 67% of PWD reported that either they or someone in their household feels worried, nervous, sad and/or anxious on a daily basis.
- Mothers and wives were the care providers to the 63% of PWDs requiring assistance with self-care tasks (e.g., grooming, toileting).

### Health and Rehabilitation

- As majority of PWD had long standing disabilities they had minimal acute health and rehabilitation needs, the free access available to KRG services meet the majority of their needs.
- 44% of unregistered PWD reported they had accessed health care services in comparison to 69% of registered PWD.
- Persons with seeing and hearing difficulties reported the most problems in accessing health services.
- Persons with intellectual impairments did not have any access to rehabilitation, the only services that exist are open to persons who are citizens of KRG.

- Adults over the age of 60 (50%) had the greatest need for assistive devices, with glasses and wheelchairs being the most needed items.
- Less PWD living in the urban area (38%) had access to information than those (58%) living in camp. There were also differences in receiving information based on a person's sex (49% of males, 56% of females) and by impairment, as persons with visual impairments received less information than others.

### Livelihood

- 99% of refugees with disabilities were not working in comparison to 86% of the non-disabled control group.
- Of PWD who were working, a gender gap existed as the group primarily consisted of males working in the informal sector.
- Livelihood was identified as the number one priority for PWD as 30% worked prior to displacement.
- The greatest barriers to working were costs needed for starting a business and physical inaccessibility to work places.
- Families were under financial stress prior to crossing the border; therefore, their capacity to bring their work tools and money to KRG was very limited.

### Education

- Cost of school supplies and transport, and physical accessibility of schools were indicated as the greatest barriers to attending school.
- Teachers were uncertain of how to teach CWD.
- Institutionalization of CWD in the KRG has contributed to a culture of not enrolling children with disabilities in mainstream schools.

### Protection and Sexual and Gender Based Violence

- 93% of PWD in the camp and 99% of persons in urban areas felt a sense of security.
- Women with disabilities were seen as more vulnerable as they were unmarried compared to men with disabilities who tended to marry non-disabled women.
- 90% of PWD were NOT separated from family; 28% of those separated were between the ages of 30-59, with no difference by gender.
- More persons in the camp (n=14) belonged to Syrian DPOs back in Syria compared to 1 person in urban area, this shows more potential for strengthening the disability movement within the camp.
- The majority of PWD (77%, 80%) did not know about the UNCRPD, and only a small minority were interested on receiving training on the UNCRPD (19%, 22%). The lack of interest in learning about the UNCRPD could be because people may not understand what advantage may come from claiming their rights and/or how to use the framework to access their legal entitlements.

### Shelter and Surrounding Areas

- 69% of PWD in camp were living in tents, dissatisfied, and anxious about wintertime.

- PWD living in the urban area reported it is a better set-up than the camp but the cost of housing is a worry.
- A disability sector (i.e., concentration of PWD placed to live in specific area) had emerged in the camp that is located at the far end of Domiz, away from main road and services.

#### **Water, Sanitation, and Hygiene**

- 20% of PWD living in camp had difficulty using constructed latrines due to distance or inaccessible features.
- 24% of PWD living in camp had difficulty accessing water because water points were not physically accessible.

#### **Food and Non-food Items Distribution**

- 30% of PWD could not access food distribution points independently and needed support to get there and carry food back.
- 24% of people in the camp had difficulty accessing food, compared to 57% of persons in the urban area, with women (30%) having less difficulty accessing food than men (44%).

#### **Transport**

- PWD using poor quality mobility aids considering the terrain of the camp.
- Due to inaccessibility or unavailability of transport, insufficient mobility devices (such as tricycles or wheelchairs), and financial barriers, affordable and diverse transportation was identified as a key priority for PWD.

#### **Registration**

- 79% of PWD in camp were registered with UNHCR, while 70% of urban refugees were registered. For registration status no significant difference existed by sex or type of difficulty.
- Information about disability was not being systematically collected during registration.

#### **Children and Youth with Disabilities**

- 26 % of survey respondents were children (0-11 years old) with disabilities (CWD) and/or their parents and 9% were youth (11-17 years old) with disabilities.
- 55% of CWD were boys and 45% were girls.
- 77% of CWD and 63% of youth with disabilities were born with their impairment.
- 39% of CWD and 23% of youth with disabilities identified having a communication difficulty.
- 34% of CWD and 50% of youth with disabilities reported difficulty with mobility.
- 68% of CWD and 70% of youth with disabilities had accessed health care services, with medication being the most accessed type of care.
- 13% of children and 10% of youth with disabilities reported needing an assistive device, with glasses, hearing aids, and wheelchairs being the most needed items.
- 85% of children and youth with disabilities were not attending school or child friendly spaces.



- Of the 7 survey respondents in total that reported protection issues in camp, 3 of the respondents were children less than 12 years old; their cited protection issues included armed violence, physical abuse, sexual abuse, and verbal harassment.
- Children between the ages of 5-11 years old were the least likely to be registered (65%) in comparison to boys and girls 0-4 years old (88%) and youth 12-17 years old (83%).
- 16% of children and youth living in camp were separated from family, with children between the ages of 5-11 years old being the most likely to be separated (22%).
- No instances of CWD living alone were identified and majority of CWD live with at least one of their parents.
- Youth with disabilities were not participating in vocational training programmes.
- No children or youth with disabilities were reported to be working.
- No recreational, educational, or psychosocial activities have been initiated in camp that are inclusive for children or youth with disabilities.

#### Cross-cutting

- Across the different sectors, most service providers passively excluded PWD in their work and did not have specific mechanisms to target or reach PWD.
- PWD had a lack of awareness of services available and how to access these services.

### Summary of Priorities for PWD

1. **Livelihood access** was identified as the number one overall priority.
2. Due to inaccessibility or unavailability of transport, insufficient mobility devices, and financial barriers, **affordable and diverse transportation** was identified as a top priority.
3. **Child and youth with disabilities participation** in the community, particularly in school and child-friendly spaces as the majority of CWD and youth have not been seen to attend school or play in common areas.
4. **Insulation of shelters** was identified as a key priority for refugees living in tents given the proximity to winter.
5. **Physical accessibility** to camp spaces for PWD living inside of the camp.
6. **Coordination around disability issues.** Mechanisms to ensure disability issues are discussed will help create a change in service delivery for refugees with disabilities.

### Key Recommendations

- At registration provide service directory information.
- Establish coordinated disability and vulnerability focal points amongst service providers and community structures that can provide information, orientation and accompaniment, provide a space to strengthen the disability movement within and outside the camp and contribute to coordination on refugee disability issues.
- Develop accessible vocational training and referrals for PWD and provide information on business registration process.
- 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 CWD.
- Actively encourage parents to register CWD for school by increasing their awareness on the right of CWD to education and availability of free access to education.
- Develop checklists of possible protection risks faced by CWD (e.g., sexual violence, physical abuse, neglect, abandonment, concealment, intimidation) and corresponding warning signs (e.g., withdrawal, behavior change, markings on body).
- Insulate/winterize shelters as a priority for people who are bed ridden or with severe mobility restrictions to prevent worsening of health concerns.
- Actively include and target PWD (vs. passive exclusion) in services, moving from charity to rights based/inclusion action.
- Actively involve persons with disabilities as collaborators in programming.
- Use the principle of Universal Design to guide site planning and design.
- Study the needs of PWD where the situation is different from Domiz, including in other urban areas and in and around other camps in the KRG.

## Introduction

Domiz camp, just outside the city of Dohuk, in the Kurdistan region of Iraq, opened in April 2012 and currently houses approximately 45,000 Syrian refugees (UNHCR, 2013); surrounding areas are estimated to house almost triple that number, 130,000 (UNICEF, 2013). The rapid needs assessment in this report was primarily conducted in Domiz, with some data collected from surrounding areas to give a snapshot of the experience of refugees with disabilities in urban areas. In mid-2012, during the early days Syrian Kurds arrived in Dohuk, the Kurdish authorities ensured that refugees had freedom of movement, the right to work legally, and access to health care and primary education. However, in late 2012 and early 2013, the authorities began expressing frustration at the lack of international support when faced with huge daily increases in refugee numbers and without prior experience or technical capacity in handling such a situation (NRC, 2013). As such, there has been a shift towards a more restrictive refugee policy, delaying provision of residency cards to refugees, thereby restricting their ability to work and receive food rations provided to residents. Persons with disabilities (PWD) are over-represented amongst the poor – global estimates are that PWD make up 20% of the poor (Elwan, 1999) and consequently, are increasingly disadvantaged from reduced access to food rations and access to work.

Though many basic services are offered in the camp, it remains critically overcrowded (i.e., planned for 27,000 initially) and has suffered from a measles outbreak, which affected over 300 children who had arrived at the camp (PU-AMI, 2013). New shelters were erected in an arbitrary fashion, in walkways and other unplanned spaces. Overcrowding, lack of privacy, and a feeling of competition for services, has put psychological pressure on refugees and also exposed them to risk of fires, diseases such as diarrhea, cholera, and hepatitis (NRC, 2013), and an increasing feeling of mistrust and diminishing social cohesion.

Disability was measured using the United Nations' Washington City Group on Disability Statistics set of questions and with the following overall definition of disability (Madans, date unknown):

*“Defined as the ability or inability to carry out basic bodily operations at the level of the whole person (i.e., walking, climbing stairs, lifting packages, seeing a friend across the room).”*

With a generally accepted proportion of 10-15% of PWDs in a given population sample (WHO, 2011), the potential number of refugees with disabilities in Domiz Camp could reach between 4,500 and 6,750. This estimate, however, appears much higher than the reports made in compared to UNHCR registration records. Out of a total of 3% refugees with special needs reported (e.g., child at risk, women at risk, torture, disability) 0.7% of them were persons with disabilities in the overall refugee population (NRC, February 2013). This discordance between reports and estimates (0.7% in lieu of 10-15%) could be due to several factors. Refugees with disabilities are among the most neglected and invisible during flight and displacement. Due to communication barriers, negative attitudes and physical obstacles, they face many hurdles in

accessing or being identified during registration.

With this report and its dissemination, Handicap International(HI) aims to illuminate the situation of refugees with disabilities and provide actors working for the Syrian crisis ways to make programmatic considerations that support the rights of PWD and ensuring inclusive and non-charity oriented actions are developed and implemented. This is further supported by the Convention for the Rights of Persons with Disabilities (CRPD), ratified by Iraq in March 2013, and the UNHCR governing Executive Committee conclusion on refugees with disabilities on non-discrimination and equal protection in emergencies (UNHCR, 2010).

## Objectives

The **overall objective** of the RNA was to understand the situation of children, youth and adults with disabilities within and around Domiz camp, in Northern Iraq.

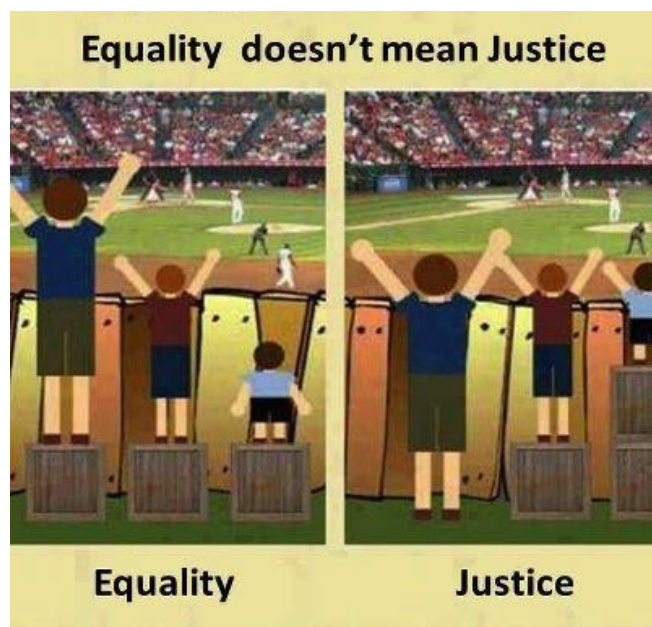
### Specific objectives

- To identify the needs and barriers of refugees with disabilities to accessing humanitarian services.
- To examine existing resources and capacities of service providers in regards to disability inclusiveness in their service provision

## Methodology

### Guiding Approach

In light of Iraq's CRPD ratification and UNHCR's governing Executive Committee conclusion on refugees with disabilities from 2011, **rights-based approach** guided the assessment. The overall role of a rights-based approach is to strengthen the opportunities for rights-holders to claim their rights and the capacity of duty-bearers to respond to such claims and fulfill rights, and therefore was chosen to guide the study as the approach can highlight gaps in the obligations of duty bearers. In the context of disability, adopting this perspective has the benefit of not only improving access to quality health and social services, but also increasing persons with disabilities participation in decision-making and creating public awareness and demand of services. The picture below on the right explains a rights based approach: it appreciates that not everyone's situation is the same (e.g., PWD), and to identify the solutions to bring everyone up to a level where their rights are realized.



## Data Collection Methods

The qualitative and quantitative data collection methods included:

- document review
- focus groups and interviews
- surveys

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

### Document Review

An extensive review of rapid needs assessments, field reports and other relevant documents was conducted to inform the methodology development and develop the assessment tools.

### Focus Groups and Interviews

The information collected in the surveys and the document review was validated and triangulated, and explored in more depth the views and practices of key stakeholders. Focus group discussions (FGDs) were used as a means of soliciting qualitative data on issues where group opinion and consensus was sought, such as understanding the priorities of the group. FGDs were organized in the camp and held in the community. Organization of FGD outside of the camp was more challenging than in the camp because of the difficulty of identifying high concentrations of refugees. Each FGD had between 4 and 12 participants. For older adults and adults, FGDs were conducted with questions while for the children, the FGDs were conducted through child-friendly methods including drawing activities.

Interview guides included questions about how persons with disabilities have experienced and viewed camp services and how far service providers have moved towards disability inclusiveness in their programming and what challenges they've encountered in doing so.

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

- Local and international service providers
- Children/youth with disabilities and parents
- Adults with disabilities
- Older adults (i.e., above 60 years old)
- Sector camp leaders
- Local authorities

### Surveys

Two separate surveys were used to gather information: (1) a survey with PWD and non-disabled people on the situation of children, youth and adults with disabilities in and around the Domiz Refugee Camp and (2) a survey with service providers to determine their current status of provision, understanding and any planned action towards inclusiveness.

### *Survey on the situation of PWD*

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, that uses 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 “a lot” or “can not do at all” to the questions such as, “Do you have difficulty hearing, even if using a hearing aid?”

Sample sites were purposively selected that represented a cross-section of typical areas and affected populations within and around Domiz camp. The site selection included 10 regions of Domiz camp as divided by UNCHR (i.e., Phases 1-5, 7-8, Transit 3, 4, 7) as well as in one urban area outside of Domiz (i.e., Var City).

Participants living inside of the camp 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 the list of persons with disabilities collected during the registration process provided from UNCHR and a list of all known PWD in each area provided by camp sector leaders. Using these two lists, the survey team visited each person on the list and selected persons to be surveyed who had either a physical impairment, sensory impairment, cognitive impairment, mental impairment, or complex/multi-impairments and who was experiencing participation barriers in any area of 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. For the control group, the referral source included lists provided from sector leaders. Non-disabled people were selected purposively to ensure a broad range of demographics (e.g., sex, age) were covered.

The survey was carried out in individuals’ homes. Given the total population of the camp is 45,000 (UNHCR, Nov 2013) and the WHO/WB estimates that 15% of a population is living with a disability, with 2-3% facing moderate to severe disabilities (at higher risk of protection issues and access barriers), the survey team collected quantitative data from a total of 307 respondents inside of the camp: 260 persons with disabilities and 47 non-disabled persons as our control group. The survey team collected data from 74 respondents outside the camp: 62 PWD and 12 non-disabled as control.

### Survey with Service Providers

For service providers, an electronic questionnaire, using the Bristol Online Survey program, was sent via email to each actor identified from the list of service providers provided by the NGO Coordination Committee for Iraq (NCCI). 29 surveys were sent out and a 28% response rate (n=8) was achieved. Responses were received from at least one agency per sector (i.e., health, WASH, Education, Shelter, Camp Management, Protection & SGBV).

**Table 1: Summary of RNA Participants**

Tool	CWDs and parents	Elderly refugees	PWD	Non-disabled person	Service provider	Local authority	Sector leader	Total
FGD	1	1	3	None	None	None	1	6 (60 persons)
Interview	14	None	31	None	16	5	11	77
Survey	Included in PWD total	Included in non-disabled total	322	59	7	None	None	388

### Data Analysis

Three types of analysis were carried out:

#### Needs analysis

Needs analysis answered the following questions:

- How has the crisis impacted PWDs differently from non-disabled persons?
- Which locations and disability sub-population groups have been most severely affected on protection issues, non-access to services, and family impact?

To determine this:

- The synthesized assessment findings were reviewed to determine which issues are the most urgent in nature and reviewed comparable data and broke down the impact of the crisis by the major population groups affected, including by sex, and type of and or severity of disability.

#### Serviceprovision 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.

#### Gap analysis

The gap analysis was used to answer the following questions:

- What are the priority disability concerns and gaps in accessing humanitarian assistance and satisfying basic needs as prioritized by various stakeholders, including PWD and their families?
- What barriers to humanitarian assistance exist, as prioritized by various stakeholders,



and how can these be solved?

- Is there a gap in protection between PWD and non-disabled peers?

### Rapid Needs Assessment Team

The rapid assessment team consisted of two international consultants, 8 assessors from Nujeen, including one national research assistant (Mr. Teli), and 2 data entry assistants. The team was provided with training (1 day) to review and discuss the assessment instruments; expectations and processes for implementing the work; pilot the survey; 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:

- *Translation:* Information was collected in Kurdish and translated into English and some inconsistencies or discrepancies may have occurred during the translation process.
- *Culturally sensitive topics:* Due to the sensitive nature of discussing SGBV in this context, time constraints, and the lack of confidentiality in focus groups, some SGBV experiences may not have been vocalized adequately and explored only minimally. This limitation was mitigated through ensuring the RNA team had gender representation.
- *Limited capacity of 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 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:* For the Internet survey sent to service providers, a 28% response rate (n=8) was achieved. This low response rate results in our survey not being representative of the inclusiveness of service provision for PWD in Domiz camp. This limitation was mitigated through using a mixture of methods (i.e., key informant interviews, focus groups, surveys) to triangulate the findings.
- *Information collected on PWD is biased against people without visible difficulties:* Sector leaders and UNHCR may have provided lists of PWD that under represented people without visible difficulties. To mitigate this limitation, the survey team targeted more difficult to reach PWDs (e.g., persons with severe disability/mobility restrictions) and people who are more difficult to identify (e.g., people with intellectual, mental, and hearing impairments) by specifically asking sector leaders about people living in their sector who may demonstrate behaviors (e.g., do not speak, do not leave tent) or other factors (e.g., family members collect all of their food) that may identify a person as having a non-visible impairment.
- *Identifying refugees with disabilities living in urban areas:* Except for Var City, finding refugees living in urban areas was complicated, as no recent mapping of urban refugees had been carried out. Var City was the only community that had a high concentration of refugees and in which service providers were established (e.g., UNICEF supported school).

## Findings and Recommendations

### 1. Indicative profile of Refugees with Disabilities

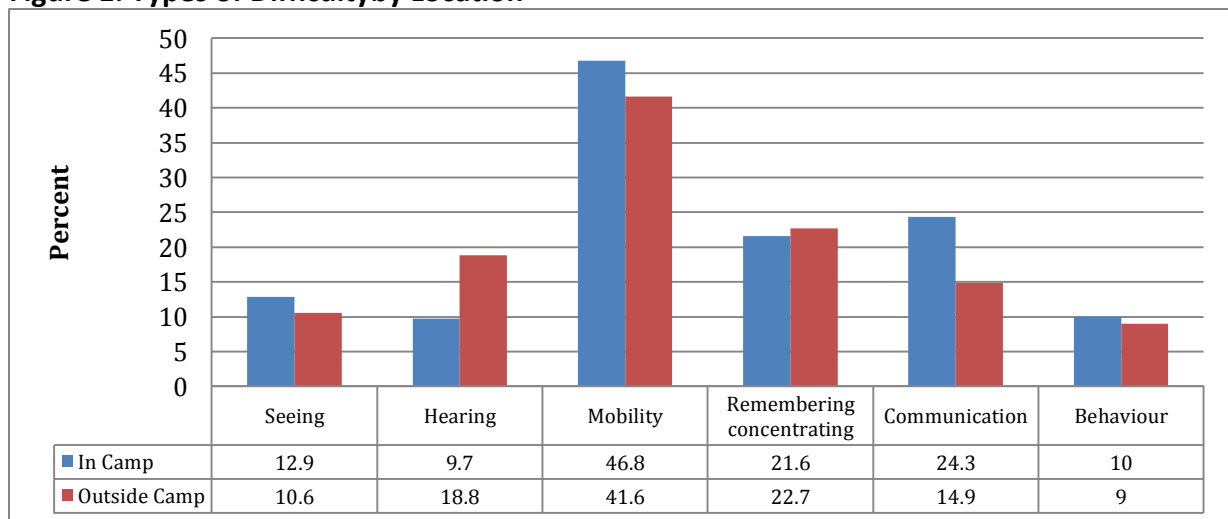
#### General Demographics of the Sample

- A similar number of adult males (52%) and females (48%) were surveyed
- 26% of PWD surveyed were children (0-11), 9% were youth (11-17 years old), 21% were between 18-29 years old, 37% were between 30-59 years old, 7% were over 60 years old, with no significant difference by sex
- 59% of PWD had more than 5 people living in their household (57% for PWD living in camp, 62% for PWD living in urban area)
- 54% of PWD surveyed were married (57% for male, 51% for female)
- 31% of PWD had more than one PWD living in their home (31% for PWD living in camp, 32% for PWD living in urban area)
- 45% of PWD have been living in Domiz camp for more than one year, with 88% settled over six months ago. Outside of the camp, people have resettled more recently (24% arriving under six months ago), which is congruent with Domiz camp being closed for receiving new settlers since August 2013
- 100% of PWD surveyed speak Kurdish and 75% also speak Arabic, with 100% identifying as being of Kurdish ethnicity
- 44% of PWD surveyed could not read or write (52% for male, 36% for female)
- 88% of PWD had only primary school education (84% for male, 92% for female)

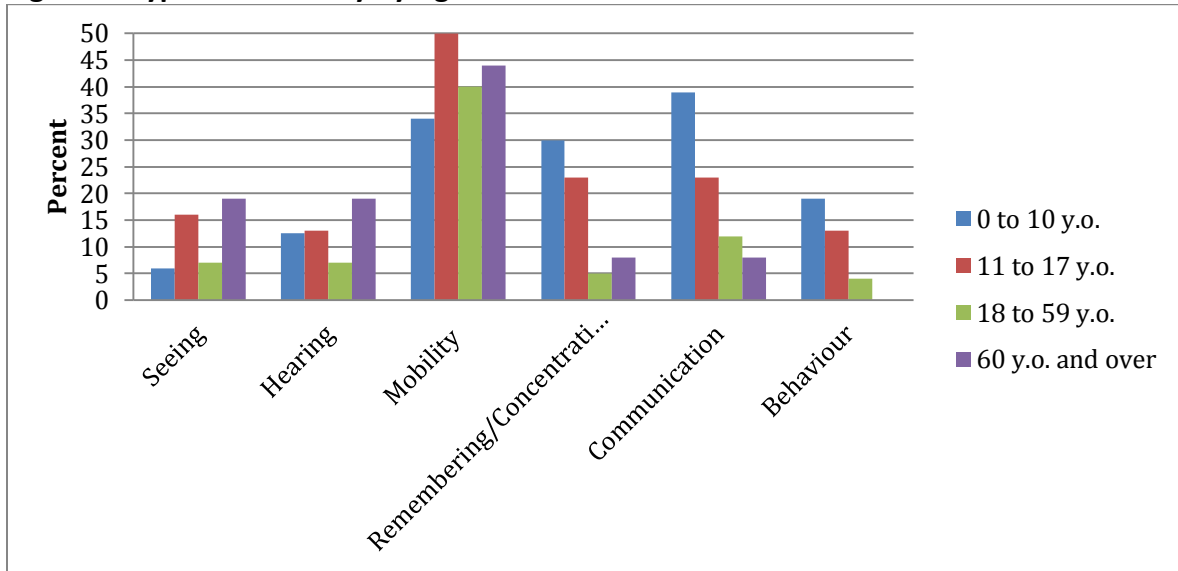
#### Self-reported Type of Difficulty

PWD were identified across the spectrum of difficulties, with more people reporting difficulty with mobility than other difficulties, as seen in Figure 1. There was no significant difference in type of difficulty by sex. However, a difference existed in living location as seen in Figure 1 and by age as seen in Figure 2.

**Figure 1: Types of Difficulty by Location**



**Figure 2: Types of Difficulty by Age**

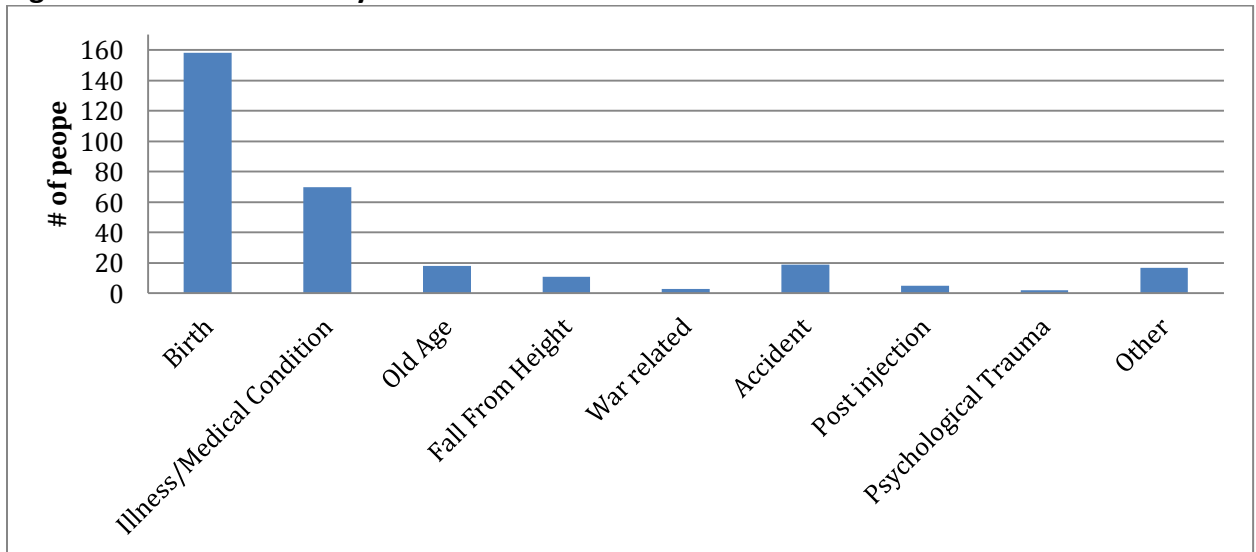


In addition to the difficulties reported, 67% of PWD reported that either they or someone in their household feels worried, nervous, sad and/or anxious on a daily basis.

**Self-reported Cause of Difficulty**

Most PWD reported that their difficulty was caused at birth and many people (<1%) did not report become physically injured as a result of the war, as seen in Figure 3. There was no significant difference in cause by sex, living location, or type difficulty. However, a difference existed in age, with 77% of CWD and 63% of youth with disabilities citing birth as the cause of their difficulty in comparison to 25% of adults and 11% of older adults.

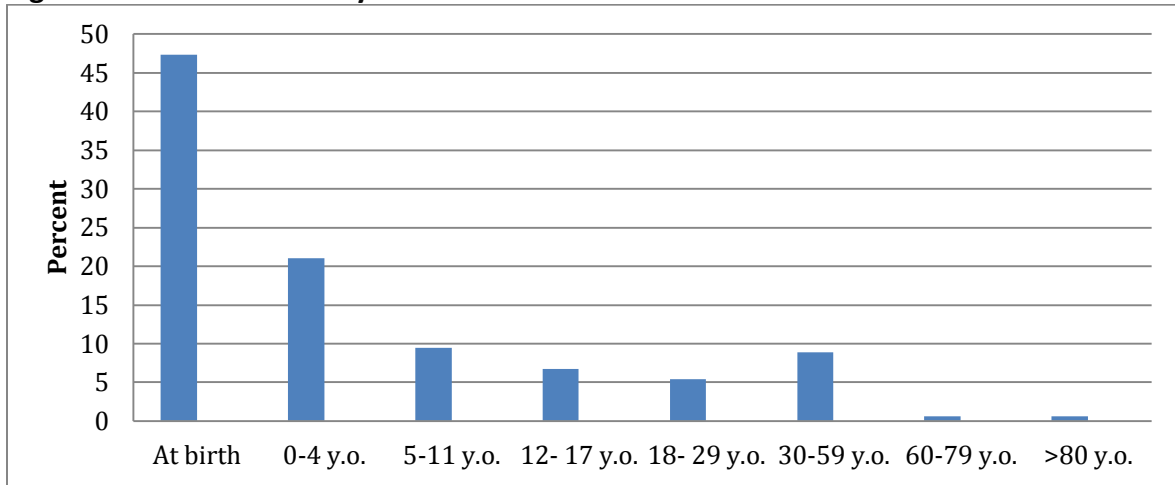
**Figure 3: Cause of Difficulty**



### Self-reported Onset of Difficulty

As seen in Figure 4, 47% of the people surveyed were born with their difficulty. There was no significant difference in onset by sex, living location, or difficulty. However, a difference existed in age, with 77% of CWD and 63% of youth with disabilities having been born with their difficulty in comparison to 25% of adults and 11% of older adults.

**Figure 4: Onset of Difficulty**



### Assistance needs and Caregivers

63% of PWD surveyed require assistance with their self-care tasks (i.e., feeding, grooming, toileting, etc.), with washing being the task requiring the most assistance, followed by toileting. It was reported during interviews that mothers and wives are most often the caretakers of PWD, with many mothers seldom leaving their shelter because of the need to stay and care for the PWD.

## 2. Health and Rehabilitation

*"I go to clinic by walking because transportation is too expensive"* (31y.o. man with a disability).

*"No service gaps for PWD, but would be good if more service providers gave assistive devices"* (male, local authority).

### Key Findings

- As the majority of refugees with disabilities in Domiz have long standing disabilities there is minimal need for acute rehabilitation and medical care.
- The health and rehabilitation services available to all for no-cost in KRG meet the majority of refugees with disabilities needs.
- 49% of the surveyed persons with disabilities needing rehabilitation reported not facing any barriers. The main barrier experienced was a lack of knowledge of where to go and the major facilitator was free services.
- 83% of the surveyed persons with disabilities reported not facing any barriers to accessing medical care. The main barrier experienced was the transportation costs and the major facilitator was free services.
- Unlike the Syrians arriving in Jordan/Lebanon, the Syrians with disabilities in KRG do not seem to be suffering from war injuries though psychological trauma of displacement is evident, as 67% of PWD reported that either they or someone in their household feels worried, nervous, sad and/or anxious on a daily basis.

### Available Services

Health and rehabilitation services available within Domiz Camp include:

- Chronic disease clinics (Kirkuk Centre, MSF)
- Emergency care (MSF)
- Mental health care (Un Ponte Per, Kirkuk Centre, MSF)
- Physiotherapy assessment (Kirkuk Centre)

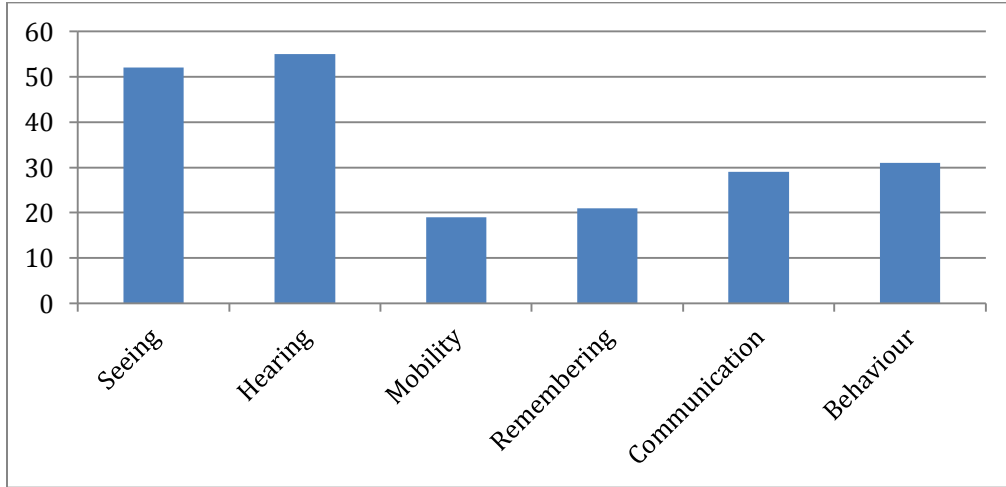
Outside of the camp, refugees have free access to all health and rehabilitation services that KRG offers, other than institutional based care (e.g., residential care center for persons with intellectual impairments). These KRG institutional care centers are not open to persons who are not citizens of KRG.

### Access to Services

65% of PWD reported they had accessed health care services at least once since arriving in the KRG, with no significant difference in living location (64% living in camp, 66% living in urban area) or sex (66% of males, 60% of females). Where a difference existed was in whether a person was registered or not, as 69% of registered PWD reported they had accessed health care services in comparison to 44% of unregistered PWD. A difference also existed with age, as 68% of CWD and 70% of youth with disabilities had accessed health care services in comparison to 60% of adults and 61% of older adults.

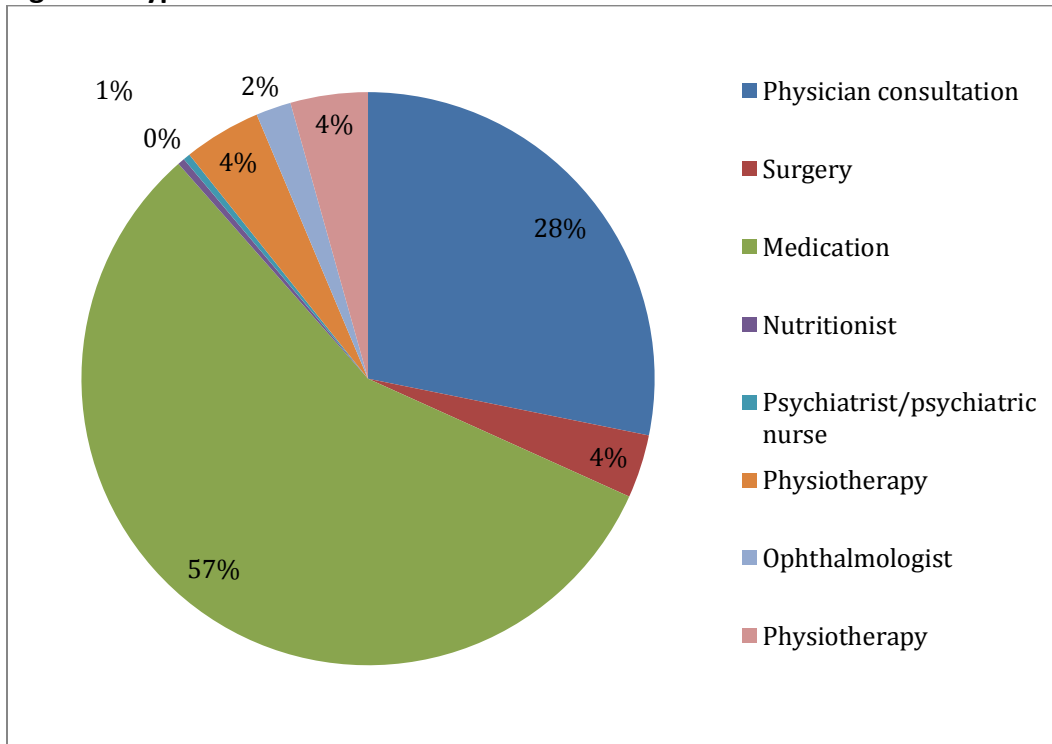
83% of PWD reported no problem in accessing health care, with no significant differences existing between sex, living location, or registration status. However, differences did exist by difficulty as indicated in Figure 5, as persons with seeing and hearing difficulties reported the most problem in accessing health services.

**Figure 5: Problems in accessing health care services by difficulty**



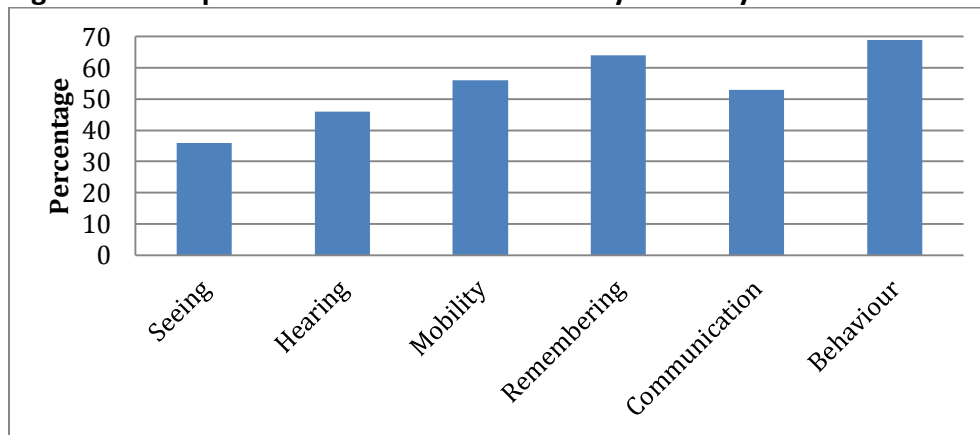
The type of health service most accessed by refugees with disabilities since arriving in KRG was medication, and physiotherapy was the rehabilitation service most accessed, as illustrated in Figure 6, with no significant differences existing between sex, age, or living location.

**Figure 6: Type of health and rehabilitation services accessed**



54% of PWD reported they had received information on how to access health care services. Less PWD living in the urban area (38%) had access to information in comparison to those (58%) living in camp. There were also differences reported in receiving information based on a person's sex (49% of males, 56% of females had received information). Furthermore, as seen in Figure 7, differences did exist by impairment, as persons with visual impairments received less information than other PWDs.

**Figure 7: Receipt of health care information by difficulty**



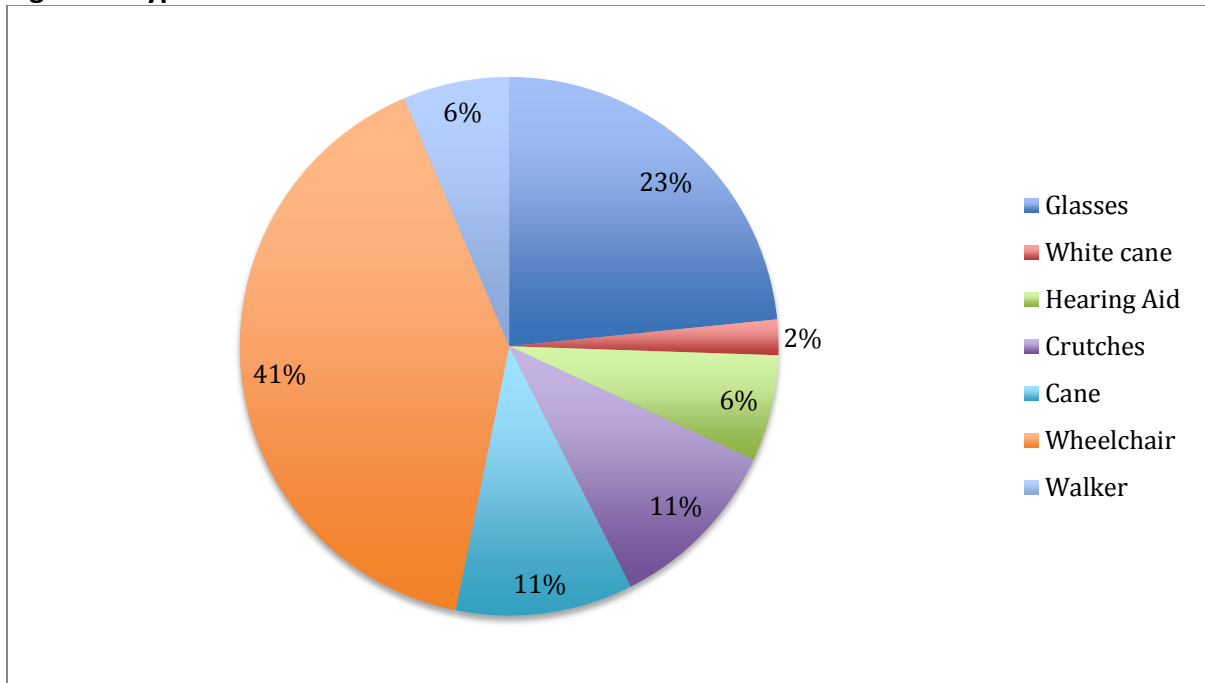
During key informant interviews, local authorities reported that health access awareness campaigns were not a priority as the majority of people had been living in the camp for a significant period of time and therefore knew of existing services.

#### **Needsof Refugees with Disabilities**

- 80% of refugees with disabilities reported having no current rehabilitation needs. Of those requiring rehabilitation, physical rehabilitation was identified as the top need followed by cognitive rehabilitation/occupational therapy.
- Persons with intellectual impairments did not have any access to rehabilitation as the only services that exist are open to persons who are citizens of KRG.
- 15% of PWD reported needing an assistive device, because it was either lost during flight from Syria, was never previously owned, or as a result of a worsening in their condition since arrival in KRG. Children (13%), youth (10%), and adults (10%) reported less needs of assistive devices than adults over the age of 60 (50%).

- As seen in Figure 8, the devices cited as most needed were: wheelchair (n=19), glasses (n=11), hearing aid (n=6), cane (n=5), crutches (n= 5), walker (n=3), and white cane (n=1).

**Figure 8: Types of assistive devices needed**



### Barriers

- Many specialized prescriptions (e.g., chemotherapy) could not be obtained due to lack of availability in camp (only emergency and medications for chronic conditions were available) and because they were not stocked at local pharmacies/hospitals.
- As reported by camp health and rehabilitation service providers, the technical capacity of the specialist disability services in Dohuk is limited to respond to the number of people and the types of disabilities.
- Lack of knowledge of how and where to go to access services; therefore, many PWD were not aware that services provided by Ministry of Health (MoH) hospitals and primary health care centers (PHCCs) are free-of-charge.
- Minimum standard is one health centre for 20,000 persons but only one currently exists in the camp that serves over 6,000 people per month; therefore, long line ups at health clinic and refugees with disabilities are not given priority treatment as clinic operates on triage<sup>1</sup> model of care.
- Lack of coordinated camp health system. In the camp, all service providers are not aware of all rehabilitation services available to refugees with disabilities; therefore, inter-agency referrals are not consistently being made (e.g., MSF to Kirkuk Center).

<sup>1</sup>Triage model of care includes determining the priority of patients' treatments based on the severity of their condition.



## Facilitators

- Referrals are consistently being made by MSF to specialist services outside the camp.
- Free transportation is offered to access health services outside the camp; however, many refugees with disabilities living in the camp were not aware of the service as the inability to pay transport fees was identified as a significant barrier to accessing health services.
- Many parents were sending children with disabilities to private doctors and physiotherapists in Syria; therefore, parents hold an understanding of the rehabilitation needs of their children.
- Collated directory of services existing in Dohuk for persons with disabilities has been previously published by Nujeen and Handicap International and disseminated to PWD.
- Having no fees to pay was the most cited factor that influenced people's access to health care. Family accompaniment and the availability of outreach services also enabled health care access.
- KRG disability legislation based on rights based approach; therefore, refugees with disabilities are mandated to be treated with fairness, dignity and sensitivity to their diverse needs as individuals.
- Basic mobility devices were distributed based on priority lists made by camp sector leaders.
- KRG health clinics do not ask for registration cards, although having a referral from a camp service provider (e.g., MSF clinic) expedited the service received.

## Recommendations

1. Development of **referral pathways** and coordination of health system to make services more accessible to all and to benefit from the array of services offered by the range of service providers.
2. **Health information** needs to be translated into clear and informative messages that are widely disseminated amongst people with hearing and visual impairments, as they reported the most problems in receiving information and accessing health services.
3. **Diagnosis and rehabilitation services for persons with intellectual impairments** as no services currently exist in or outside of the camp that refugees can access.
4. **Appropriate assessment and distribution of** assistive devices (e.g., hearing aids, glasses, specialized mobility aids) to persons with disabilities, instead of blanket distribution (e.g., one size fits all wheelchairs).
5. **Scale up resources of local rehabilitation** providers to provide sufficient services and in the long-term focus on quality.

### 3. Livelihood

*“Want to teach and play music, all I need is a space” (24 y.o. man with a disability).*

*“If we don't work, we cannot live because life is harder here”(32 y.o. man with a disability).*

#### Key Findings

- 99% of refugees with disabilities were not working in comparison to 86% of the non-disabled control group who identified as not working
- 30% of refugees with disabilities worked prior to displacement
- 24% of refugees with disabilities in camp and 11% in urban area have work permits
- Of PWD who were working, a gender gap existed as the group primarily consisted of males living inside of the camp working in the informal sector (e.g., selling cigarettes) as seen in Table 2

**Table 2: Total people working by survey category, living location, sector of work, and sex**

Location	PWD		Control		Total
Inside Camp	12		8		20
	Formal	Informal	Formal	Informal	
	3 (2 male, 1 female)	9 (9 male, 0 female)	2 (2 male, 0 female)	6 (6 male, 0 female)	
Urban Area	0		0		0

- The most common work occupation for males was operating their own businesses (e.g., selling goods) and for the one female was service provision (i.e., hairdressing).
- 11% of refugees with disabilities living in camp and 7% of refugees living in the urban area received cash support from humanitarian actors.
- Refugees are not eligible for KRG disability allowance, only citizens of KRG are eligible for the benefit.
- Most families are in debt and only have support from working extended family members or access to small loans from family living in the camp (for those living in urban settings). These supports and small loans are used to cover basic needs but are not enough to fund businesses.
- The cost of living in KRG is higher than in Syria.
- No respondents reported that CWD were engaged in income generation (as is occurring with non-disabled children refugees) or begging activities to support their family.

#### Available Services

- Organizations (i.e., IOM, IRC) have established coordinated in-camp business permit system, small business grant program, on the job training, and vocational programs to enable refugees to work.
- No inclusive vocational programs operated by any camp service providers.

### Access to Services

- No PWD were involved in the camp vocational programs.
- PWD were unfamiliar with camp business permit process; therefore, none have applied for a permit.
- No youth with disabilities were participating in the vocational training provided by IOM that non-disabled adolescents were accessing.

### Barriers

- Refugees living outside of the camp have experienced delays in the provision of residency cards and thereby receiving work permits.
- The greatest barriers to working were the start-up costs needed for a business followed by physical inaccessibility of the workplace. The lack of cash support coupled with the lack of work, has contributed to most PWD and their families experiencing severe financial difficulties.
- Families were under financial stress prior to their crossing the border; therefore, their capacity to bring their work tools (e.g., musical instruments, carpentry tools) and money to KRG was very limited.

### Facilitators

- Of the PWD that were working, having family assistance (e.g., accompany them to/from work) and being able to work close to home (e.g., setting up business in camp sector close to shelter) were the factors that most supported work opportunities.
- UNHCR set up a livelihood committee to see how most vulnerable can be targeted.
- Positive employment experiences of PWD in Syria; therefore, refugees with disabilities brought skills and work experiences.
- Culture of disability acceptance; therefore, PWD did not report discrimination as factor that impeded work opportunities. Furthermore, if tools and/or start-up funding is provided refugees will be empowered to resume their livelihood activities.

### Recommendations

1. Awareness raising, **information on business permit process** and start-up business grants are required to avoid PWD from being excluded from livelihood assistance. In addition to business start-up funds, grant program could include funding for reinvesting in missing work tools.
2. **Actively include PWD in 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.

#### 4. Education

*“My name is not registered in school because school has many pupils” (14 y.o. boy with disability).*

*“He is not allowed to attend school because of his disability. The teacher told me that we could wait until a school is opened for disabled people” (mother of 9 y.o. boy with disability).*

#### Key Findings

- 16% of CWD living in the camp and 10% of CWD living in the urban area are attending school, with no significant difference by sex (14% of boys, 12% of girls). Prior to displacement, 29% of CWD living in the camp and 27% of CWD living in the urban area were attending school.
- Similarly to Syrian refugee children without disabilities, Syrian children can register free of charge in public schools. The following barriers were identified to all children’s enrollment in school:
  - Lack of recognition of Kurdish education certificates in Syria
  - Language of instruction of schools outside of camp; therefore, Syrian children, although Kurdish, received schooling in Arabic and are unable to read and write in Kurdish but only a few Arabic schools exist (concentrated in specific areas like Ankawa) leading to high transportation costs for schooling.
  - Schools outside the camp do not have the capacities to accept greater numbers of children.

**Figure 9: Girl with disability playing with siblings**



### Available Services

- Construction of new physically accessible temporary schools (e.g., accessible toilet facilities for each sex) has been carried out by one organization (i.e., Save the Children), but is not systematically done by all actors.
- Actors (e.g., UNICEF) in Domiz Camp have set-up child and youth friendly spaces; however, CWD are not actively included in the programming.

### Barriers

- The cost (most families do not have the financial resources to spend on school bags, uniforms or transport costs) and physical accessibility of the schools were the greatest barriers to attending school as identified by parents of CWD; however, none of the families have resorted to sending CWD away to relatives or friends.
- No service providers (0%) surveyed thought that education services are fully accessible to CWD.
- Education service providers reported that questions on disability are not included on the school intake assessments.
- Parents cannot leave their other children or family member with a disability alone at home to accompany CWD to school.
- Teachers are uncertain of how to teach CWD; therefore, no support staff on inclusive education are working in camp schools.
- Overcrowding in camp schools; therefore, lack of enrollment of many children, including CWD.
- Institutionalization of CWD in the KRG has contributed to a culture of not enrolling children with disabilities in mainstream schools.
- Although children with disabilities are not being actively excluded from camp schools, they are not actively encouraged to attend.

### Facilitators

- Training for teachers in inclusive education is being carried out by one service provider (i.e., Save the Children).
- Of the CWD going to school, being able to go to school close to home and having family assistance (e.g., accompany to/from school) were the factors that most supported school attendance.
- For education service providers surveyed the most important factor for CWD being able to go to school is having teachers who are welcoming and have inclusive learning and teaching materials.

## Recommendations

1. As intake of children into new schools is commencing, **include questions on learning needs and disability on the intake assessment**. Early identification of learning needs and disabilities could help teachers develop a more comprehensive understanding of the needs of all of their students that is at the same time inclusive.
2. Actively **encourage parents to register CWD** for school by increasing their awareness on the right of CWD to education and availability of free access to education. Discussions could occur on individual basis with parents of CWD by camp sector leaders and also raising the general need for inclusive education with all children and community members.
3. Provide financial support to high-priority families (e.g., no person in household earning income) to enable them to **cover the costs of school items and transport**.
4. 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 CWD.
5. **Include children with disabilities in all child friendly spaces** activities.
6. **Adapt the physical environment** in existing schools in camp so that is fully accessible to all.
7. Advocate for and support local authorities in mainstream schools to **accommodate the growing number of Syrian CWD** 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).
8. Carry out an **in-depth assessment** of the readiness of schools and organizations to accept CWD.
9. **Inclusive education teacher training** to be expanded to all NGOs working in education sector.

## 5. Protection and Sexual and Gender-Based Violence

*“We live safely here, no violence like in Syria. No one make a problem with us”*(55 y.o. man with a disability).

*“I spend all the day inside the tent and sometimes I don't eat anything till my son comes home in the evening and prepares food for me”* (79 y.o. man with a disability).

### Key Findings

- 93% of PWD in camp and 99% of PWD in urban areas feel sense of security. Very few SGBV cases were reported (none of PWD); therefore, there is likely an under-reporting of cases.
- Of the 10% of persons living in camp separated from family, 28% were between the ages of 30-59, 16% each between ages of 0-4, 12-17, and 18-29, and 22% from 5-11 years old. Of the 10% of persons separated from family in urban areas, 38% were between the ages of 18-29, 25% each were between the ages of 5-11 and 60-69, and 13% were between the ages of 30-59. There are no differences in separation by gender.
- More persons in the camp (n=14) belonged to Syrian DPOs back in Syria compared to 1 person in urban area, this finding shows more potential for strengthening the disability movement within the camp. There is also more willingness to join a support group in camp (20% willing) compared to urban area (0% willing).
- In camp areas, the majority of PWD (74%) have not received any information on disability rights, and most do not belong to any committees (87%) or support groups (93%).
- In urban area, the large majority of PWD (94%) have not received any information on disability rights, and most do not belong to any support groups (98%).

### Available Services

- An inter-agency strategic plan (includes UNICEF, HI, IRC, Save the Children, UPP, Harikar, MSF, ACTED, MAG, UNCHR, DOLSA) has been developed for children considered to be the most vulnerable, of which CWD are included.
- UNICEF and the DOLSA have set up a child protection unit (CPU) with a mobile component to visit/counsel families of vulnerable children, to register child protection cases, and refer children and families to other actors who may support interventions.
- ACTED has a child protection officer involved in the activities of the child/youth-friendly spaces and ensures inclusion of children and youth with disabilities.
- Harikar is a local NGO that provides legal protection, offers literacy courses, encourages Roma parents to send their children to school, and has offered cash assistance to vulnerable families.
- 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.
- Un Ponte Per (UPP), the Kirkuk Centre and MSF all provide psychological counseling to persons who may have experienced protection issues.

### Access to Services

- In camp areas, 60% of PWD accessed protection services or legal assistance; in urban areas, 45% of people accessed these services. Those that had difficulty accessing services reported that it was due to lack of knowledge on where to go for services and the distance to these services.
- 60% of women with disabilities have accessed services, compared to 46% of men, showing potentially an increased need in such services or increased ease of access for women.

### Barriers

- 10% of people in the camp and 19% in urban area share shelters with more than one household → reported as a risk factor for protection/SGBV between members of different households.
- High percentage (54%) of people in camp and urban areas are illiterate which is risk factor for access to information on protection/SGBV.
- Many PWD in camp and in urban areas have difficulty with communication and remembering/ concentrating which is a risk factor for under-reporting of protection/SGBV.
- In camp areas, 7% of people worry about their safety/security, as opposed to 1% in the urban areas. 7 respondents reported protection issues in camp (e.g., armed violence, forced labor, physical abuse, verbal harassment, neglect by father) compared to none reported in urban areas. One key informant reported that theft occurred inside his tent. In urban areas, no protection issues were reported, this may be due to under-reporting or absence of cases. Almost double the number of single persons (8.4%) compared to married persons (4.3%) worried about their security.

### Children's issues

- There are various reports that sometimes both parents are away during day for work and other purposes leaving unattended children, which is a risk factor for protection issues.
- 16% of children and youth living in camp were separated from family, with children between the ages of 5-11 years old being the most likely to be separated (22%) in comparison to boys and girls 0-4 years old (16%) and youth 12-17 years old (16%). There were no differences in separation by gender.
- Of the 7 respondents that reported protection issues in camp, 3 of the respondents were children less than 12 years old and their cited protection issues included armed violence, physical abuse, sexual abuse, and verbal harassment.
- Extent to which girls with disabilities are verbally harassed or take part in contractual and/or child marriages is unclear, compared to their non-disabled peers where these reports are more common.

### SGBV issues

- Women with disabilities (WWD) seen as more vulnerable as they remain unmarried compared to men with disabilities who tend to marry non-disabled women.
- Service providers confirm that SGBV cases are sensitive and not shared openly, general claims are made yet inter-organizational sharing is uncommon; therefore, the scale of SGBV unclear.



- UNFPA reports that most SGBV cases are of domestic violence and of “uneducated” and agricultural families.

### *Rights and support groups*

- Only 3/5 of service providers surveyed had developed specific information and rights materials targeting and/or being inclusive for PWD.
- Syrians cannot register with KRG DPOs as members, and KRG DPOs report caution to open the gates to refugees with disabilities as they could not handle the large influx of persons that would want to access programming due to their limited funding.
- In both the camp and urban areas, the majority of people (77%, 80%) do not know about the UNCRPD, and only a small minority are interested on receiving training on the UNCRPD (19%, 22%). The lack of interest in learning about the UNCRPD could be because people may not understand what advantage may come from claiming their rights and/or how to use the framework to access their legal entitlements.

### *Facilitators*

- 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.
- 63% of PWD have family support with daily care, often by female relatives.
- Until now there has not been a clear referral pathway for SGBV cases, but the coordination committee on SGBV is working to develop one where there is consensus for strengthening coordination.
- In camp areas, for persons who accessed protection/legal assistance, 13% report it is due to the help of a family member, 4% due to proximity of service.
- In urban areas, persons who were able to access protection/legal assistance, 39% report it is due to the help of a family member.
- UNHCR reports that some young girls have been going around the camp to do awareness raising on early marriages for peers.
- No instances of CWD living alone were identified and majority of CWD live with at least one of their parents.

### *Recommendations*

1. At registration, **provide service directory information** (sample for Dohuk available HI/Nujeen Disability Information point, simpler version can be created for Domiz) and inform PWD of steps they can take in the event of a protection/SGBV violation.
2. **Community support for protection of unattended children** home alone (i.e., parents identify trusted individuals they can leave children with for hours they will be unattended).
3. Targeted study on whether **young girls and boys with disabilities are prone to sexual harassment** like their peers.
4. **Prepare key messages**, particularly those specifically targeting PWD (e.g., disability rights and how to access rights) **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.

5. 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**.
6. **Develop checklists of possible protection risks faced by PWD** (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).
7. **Inform and train PWD**, as well as their families and caregivers, **on how to recognize, avoid, and report instances of violence, exploitation, and abuse** (UNHCR, 2011).
8. For the 10% of PWD separated from family, **prioritize reunification efforts** as separation from caregivers will have important impact on protection and inclusion of persons.
9. **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.
10. Only small numbers of persons are keen on idea support group and/or advocacy group (e.g., DPO) for PWD. Best to **start any such groups in camp areas** where there was more interest, to explain clearly the impact such a group can have if it is well organized and how it can reduce feeling of helplessness and develop solutions to frustrations/issues faced by refugees with disabilities.

## 6. Shelter and Surrounding Areas

*“The camp is slippery when raining, I’ve fallen many times. Shelter is not good and too small for a family of 12, in the winter it fills with rain and a strong air come and falls on our head” (45 y.o. male with a disability, head of household).*

*“Daily life in winter time is like a prison, we stay inside the shelter” (25 y.o. female).*

### Key Findings

- In Domiz Camp, the large majority of PWD surveyed (69%) live in tents, some live in a house (16%), and others live in partially damaged/repared homes (10%).
- PWD living in tents report being dissatisfied and anxious about wintertime.
- In Domiz Camp, 10% of PWD have difficulty moving inside their shelter, primarily due to doors being too narrow and a small floor space. In urban areas, 20% of PWD have difficulty moving in and around their home, mainly because of the stairs leading to their apartment.
- A “disability sector” (i.e., concentration of PWD placed to live in specific area) emerged in Phase 7 located at the far end of Domiz and far from the main road and services. This practice is not a recommended model by UNHCR, as it is a protection risk and creates further inaccessibility and segregation.
- Long waiting times were reported to receive an improved shelter (e.g., brick, metal, concrete) when a family cannot afford to build their own new/improved shelter. Many PWD have gone to different agencies to request an improved shelter, been put on list, and are still waiting. As many PWD are not working and cannot afford to buy construction materials, they feel very helpless, frustrated and worried.

**Figure 10: Variety of shelters found in camp. From right to left: brick shelters, UNHCR tents (most common for PWD), bridal shop set up by Kurdish business person, metal sheet shelter**



### Available Services

- In coordination with camp management, UNHCR has allocated land and distributed tents to refugees. One of their implementation partners is Qandil who built shelters as per the priority list they were given by UNHCR/camp management.
- NRC supported vulnerable families with improving their existing shelters to make them more insulated and provide privacy.

### Access to Services

- Anecdotally, PWD reported having poor access to shelter services and not knowing where to go to seek assistance, as many have approached numerous actors (e.g., camp management, NGOs) and were left unsuccessful.

### Barriers

- Main road of Domiz Camp was being paved, it is unclear to what extent the rest of the camp will be paved. Camp terrain is hilly, rocky, uneven, filled with potholes –making safe mobility challenging for persons with mobility difficulties who use aids.
- In camp, there are several cases of 2-3 households sharing a shelter, making living/sleeping arrangements very crowded.
- Outside camp, PWD are pleased with their homes, but not with the cost. They feel it unfair and inflated to pay \$350 for 4 bedrooms in Var City when prior to the refugee influx, the same housing was reported to be \$50/month and hardly inhabited.
- Many reported lack of green spaces in camp, to sit and calm nerves. This is especially hard for people with mobility limitations where family worries if they walk they may get hit by a vehicle, trip, or fall. As a result, many stay inside shelter.

### Facilitators

- PWD reported Var City is a better set-up than the camp and that they can “move more”.
- One family of persons with disabilities had the majority of their construction materials donated to them and received the help of neighbors to build the shelter.
- 100% of persons in urban areas live in an apartment and reported general satisfaction with the housing quality.
- UNHCR offered space/shelter to persons of concern, including PWD, in new, emerging phases before they were built. However, families typically declined as they did not see any water system, shelters, electricity, and so were afraid to move to these unknown areas. Once such areas were completed, PWD went back to UNHCR to request housing but by then it was too late.
- UNHCR reported that 25% to 33% of camp space/shelters were allocated to vulnerable persons to ensure they all received a space.
- Summerization projects of NRC targeted people with mobility difficulties and who were restricted to their tents.
- NRC used customized approach to working with families, and foresee possible funding coming through where they would be able to allocate a certain amount of shelter improvement projects (i.e., their current approach as opposed to new shelter building) and could look to target a few families with PWD or hot spots that need to be reinforced.

## Recommendations

1. **Winterization/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. Identify **construction companies that may be able to be paired up with low-income families** of persons with disabilities to donate construction materials.
3. Rental rates in Var City may need to be revised especially for low-income families of PWD whose head of households are struggling to find work and dependent on loans. **Supportive housing sections or having a sliding scale rental scheme** that considers/assesses the socio-economic status of each family would ease financial stress off households of PWD.
4. **Ensure partnerships and collaborations with organization such as NRC** who are willing to work on targeting PWD upon getting the right information/assessments and recommendations.
5. **Ensure PWD are priority for relocation to more central areas of camp** if and when such shelters become available. Avoid placing PWD in phases far from the center of camp where they cannot travel long distances in uneven, hilly and pot-holed camp area. Generally, house persons 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.
6. **Ensure construction of new shelters for PWD 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).
7. **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.

## 7. 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).

### Key Findings

- In camp: 85% of people utilize drinking water, though 24% have difficulty because water points are not physically accessible. Some PWD who are living at the top of the hill have poor water access, sometimes only for 30 minutes a day. 64% of PWD access toilets, 19% use latrines, and 16% defecate openly or in their tent. 20% have difficulty using constructed latrines due to distance or inaccessible features. PWD reported that using their tent for toileting had a negative impact on their family.
- In urban area: 81% of PWD access drinking water, though 34% have difficulty, in part, because water points are not physically accessible. 100% of respondents reported using the toilet, though 7% have difficulty due to lack of adaptations.

### Available Services

- Camp management and NGOs (e.g., NRC) support the building of communal WASH points. Some of the phases have better availability of WASH than others (e.g., 1 latrine per 2 families compared to being shared between 4-5 families).

### Barriers

- Top priorities of camp management were sewage systems, septic tanks, shelter and water networks that don't exist in some areas. And so, discussions on disability and accessibility are more micro compared to macro focus of camp management. There is a need to find common ground in such discussions.
- Problems of physical accessibility are often more challenging for refugees living in urban areas, where the opportunities to adapt or modify physical infrastructure is more limited, than in camps.

### Facilitators

- Ramps are being built into shelters in refugee camps Irbil, the same could be done in Domiz.
- Families have been a huge facilitator in helping persons to access water in Domiz.
- Outside camp, WASH accessibility was reported to be good.



**Figure 11: Latrine in Phase 7, built up higher to be safe from flooding, extra step makes it inaccessible for many with mobility difficulties or those who use wheelchairs/mobility aids**

### Recommendations

1. **Adapt inaccessible latrines** for people who cannot access them.
2. In summer months or during high temperatures, ensure persons with severe mobility problems have adequate **access to cool spaces and clean drinking water**.
3. **Solutions for water access** and working with persons with disabilities:
  - Minimize distance to clean water point
  - Include PWD in water committees to test accessibility and advising
  - 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](http://www.handicap-international.de/fileadmin/redaktion/pdf/disability_checklist_booklet_01.pdf) and <http://www.inclusivewash.org.au/>

## 8. 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

- 78% of persons in the camp have access to food distribution compared to 61% in the urban area, with women (78%) having greater access to food distribution than men (69%).
- 24% of people in the camp have difficulty accessing food, compared to 57% of persons in the urban area, with women (30%) having less difficulty accessing food than men (44%).

### Available Services

- WFP is available to persons living in the camp, but not to those in urban areas.
- Persons with residency cards in urban areas can access food rations like other Kurdish nationals.

### Access to Services

- For PWD, food access is facilitated due to close distance and the support of family/friends to transport food.
- PWD in the urban area who arrived after the Domiz camp was closed for new arrivals, do not have residency cards and so cannot access food rations like other nationals. They share food with extended family that has residency cards.

### Barriers

- Buses/trucks that take people to food distribution points are inaccessible.
- In the camp, for those with difficulty accessing food it is primarily due to needing help with getting to/from food distribution points and help with carrying food back. In urban areas, the main difficulty is distances to get to/from food distribution points.
- 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/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.
- Food access outside camp is challenging (i.e., lack of residency card, no access to WFP).

### Facilitators

- WFP is decentralizing food services to 3 shops inside the camp by March 2014.
- In other countries, WFP has used community volunteers to help transport food for PWD, but no such mechanisms exist yet in Domiz.



**Figure 12: Fruit shop near central road of camp, accessible to those who have additional money to buy directly from shop, most access food via WFP food distribution point**



### Recommendations

1. To ensure **full food allocation reaches family** (i.e., families not forced to use food ration to pay for transportation back to home), create initiative where staff/volunteers are hired and support family with transportation/carrying the food.
2. **Study food security outside Domiz**, especially for PWD not working and without residency cards, to see what kind of support can be given.
3. Ensure **separate queues, smaller food parcels, or shelter-to-shelter distribution** for PWD as needed.
4. Ensure 3 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.

## 9. Transport

*“I spend a lot of money for getting services like (health and food) because I often need to go by motor-bike” (mother of a 9 y.o. boy with a disability).*

*“People on motor-bikes help me access a clinic or place, when they see me on the streets, sometimes without asking for money” (56 y.o. man with a disability).*

### Key Findings

- In camp, 18% of respondents reported difficulties accessing community spaces and services, 10% did not know where to go, 5% did not have money for transportation, 5% had difficulty travelling to the space, 3% did not have money to access services, and a few people experienced negative attitudes and lack of sign language translation.
- PWD need transportation more than non-disabled people due to mobility problems and because 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 also interlinked with transportation.

### Available Services

- Ambulance transportation for people needing medical services at Dohuk hospitals is provided by MSF.
- Motor-taxis and car-taxis are situated outside the gate of Domiz camp and often travelling inside the camp. For urban refugees in isolated areas, taxis are harder to come by and not as readily available as in camp.
- Public buses pass near camp a few times a day but long wait times are reported, so bus frequency may not be high.
- Total absence of all terrainwheelchairs or tricycles that are durable and context appropriate.
- No reported availability of volunteers trained 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.
- Physical inaccessibility of trucks that transport persons to food points is reported. Sometimes people rent taxis for food transportation, but again this incurs a cost.

**Figure 13: Most people with mobility impairments have received generic wheelchairs with small castor wheels that break after a few weeks use in camp. Notice there is a broken wheelchair on top mid-left of picture used to stabilize the roofing and is a common predicament of low quality wheelchairs distributed.**



### Barriers

- PWD are using poor quality mobility aids considering terrain of camp.
- In urban areas, 26% of respondents reported difficulties accessing community spaces and services, 1/3 of those did not know where to go, 1/3 did not have money for transportation, and 1/3 did not have money to access services.
- Uncoordinated and unsystematic distribution of low quality mobility aids like wheelchairs, and lack of follow-up of wheelchairs usage/repairs.
- Families met had up to 3 wheelchairs distributed to them, with 2 typically being broken due to low quality.

### Facilitators

- In both camp and urban areas, people that accessed community spaces successfully did so because either the spaces were nearby, family accompanied them, or because there were no fees to pay to enter.

### Recommendations

1. **Distribute tricycle or all terrain wheelchairs** to manage muddy/bumpy/hilly camp for sustainable use and less need for repair.
2. **Develop diverse transport solutions** such as; increase frequency of bus services to camp to delay wait times, coupons for motor-taxi use for PWD who cannot use buses, tricycles.
3. Ensure **support for persons with visual impairments** to mobilize around camp, if family members are not available. Support could be provided by volunteers.

## 10. Registration

*“We can see physical impairments easily but we are not understanding or identifying others”* (service provider, female).

*“Sometimes we take PWD to shelter/tent and try to orientate a bit, but it's sporadic and not systematic”* (service provider, male).

### Key Findings

- In camp areas, 41% were not asked about their difficulties/disability during registration. In urban areas, 42% were not asked about their difficulties/disability during registration. The gaps in data create challenges in future planning for services and long-term health strategies.
- Disability is identified sometimes visually upon the intake interview; however, there is an absence of a consistent and complete set of questions to ask about disability (i.e., similar to Washington group questions used in this assessment) that is systematically used in intake interviews.
- 78% of PWD were not informed of or referred to any services during registration.

### Available Services

- UNHCR registers refugees at the border and once again upon arrival at camp after conducting an in-depth family interview. Interviews were rushed in periods where there was a bigger influx of refugees (e.g., August 2013).
- There is a staff at UNHCR dedicated to registering vulnerable persons and being the focal point to ensure their needs are included in camp activities.

### Access to Services

- 79% of PWD in camp are registered with UNHCR, while 70% of urban refugees are registered, with no significant difference by sex (79% of males, 73% of females) or type of difficulty.
- 76% of children and youth are registered with UNHCR, with children between the ages of 5-11 years old the least likely to be registered (65%) in comparison to boys and girls 0-4 years old (88%) and youth 12-17 years old (83%).
- 25% of PWD in camp were referred to other services on registration, while only 11% of refugees in urban areas received such referrals.
- Persons with disabilities are reported as not being as visible within the vulnerability population as unaccompanied children and/or female headed households.

### Barriers

- PWD are grouped under heterogeneous persons of concern/vulnerability category, often not disaggregated and having their issues examined, which makes it hard to develop targeted activities to address their issues and help people overcome them.
- Collected data is not disaggregated by disability or shared widely amongst service providers.

- The knowledge of registration staff towards persons with disabilities vary, some registration staff lack awareness about the rights of persons with disabilities and tend to adopt a charity model of disability, primarily referring for devices.

### Facilitators

- UNHCR reports providing a separate line-up for PWD to be served quicker.
- In-depth interview done with family upon arrival to get a sense of issues to help determine needs.

### Recommendations

1. Work on **systematically and consistently incorporating disability questions** into intake interview with families and forms used – we recommend us of Washington group question as used in this RNA (e.g., do you have difficulty with seeing even when wearing glasses?). By categorizing PWDs within a clearer classification system and through the sharing of their statistics, UNHCR could develop a more comprehensive database of the refugees that is at the same time inclusive.
2. As recommended under the protections section, at registrations provide information on services via a brief **local service directory** (sample for Dohuk available HI/Nujeen Disability Information point, simpler version can be created for Domiz).
3. Train staff to **go beyond charity model to rights based approach** so referrals of PWD go beyond just those to health services.
4. Ensure training to staff on **how to identify and register persons with visual, hearing, and speech impairments** who may not be as visible.
5. **Encourage regular disaggregation and analysis of data for persons with disabilities** within the larger POC data, to see scale of disability and help determine priority demographics and needs.
6. Ensure that **questions on disability are included in all subsequent data collection of service providers**, population census or registration exercises.

## 11. Cross-cutting

*"I don't think about disability too much, as I have so much of my own work"* (service provider, male).

*"Initially a disability coordination group existed and was an agenda item in the cluster meetings but then was taken off the agenda as nothing was ever being reported, which means it should have become a priority instead of being taken off the agenda. At meetings, disability was discussed but as no in-house disability resources existed, we are stuck"* (service provider, female).

*"We see many organizations just come here for spying and even you are here for the same reason "handicap international. We don't believe on anybody because nobody helped us"* (men's focus group participant).

### Key Findings

- Most service providers passively exclude PWD in their work, there are few mechanisms to address barriers faced by people to access services and there is minimal active inclusion.
- Among PWD, boredom and lack of meaningful activities is common.
  - 88% in camp and 96% in urban areas do not participate in any community activities.
- Most service providers (63%) have not consulted PWD in planning/designing of services, nor do they have targets numbers of PWD to reach in activities, this is passive exclusion as service providers do not acknowledge that PWD face barriers to access services.
- Most actors focused on training as the solution to the disability problem; few mentioned changes in policy/targets and internal procedures to have more sustainable incorporation of disability into work.
- Services are centralized to 1-2 areas of the camp and not decentralized to newer parts.
- No organization dedicated to disability or highlighting needs of PWD.
- Service providers surveyed thought the following actions could positively impact programming to be more inclusive: make office accessible (63%), consulting refugees with disabilities (50%), including disability in M&E actions and tools (50%), offer staff disability equality training (50%), find out the location of PWD (37%), implement a barriers/facilitators audit (25%), and adapt communication materials into braille/sign language/ pictorial (25%).

### Available Services

- Many actors are offering protection services and child programming but there are few organization offering livelihood support.
- Services are more easily accessible within camp area where many service providers have staff, compared to urban areas where refugees need to use transportation to access services.

## Barriers

- PWD have a generalized lack of awareness of services in the camp.
- Challenges that service providers face to work with PWD are the following, in order of priority: no knowledge on how to make their services accessible, no financial resources available, do not have resources to reach PWD individually, not sure how to communicate with PWD, and no knowledge of where PWD are.
- When needing to meet targets under time pressure, there are reports that service providers find that disability slows down the work of the organizations and may be why some organizations steer clear of disability.
- Children with disabilities are reported to be more visible than the frail elderly who are more secluded in tents, whereas CWD are taken out from time to time.
- Few links with disability movement in Dohuk.
- Refugees are not eligible to join KRG DPOs as membership is open only to KRG residents.

## Facilitators

- Cooperative and accessible actors in Domiz
- Widespread desire/demand by service providers to learn more about helping persons with Autism.
- One of the main actions taken by about half of service providers surveyed is giving basic disability training to staff, including how to work with people who may have communication difficulties; half of service providers surveyed provide outreach service to persons who cannot come to central location.
- ACTED has offered basic disability training to various actors in Dohuk including their own volunteers and staff of other organizations/ authorities. They are also working to do a mapping of Domiz camp and help get a better sense of the situation of persons with disabilities.
- Activities pairing children/youth with the elderly were suggested as one solution, but little funds available by service providers to implement.
- Strong KRG Government leadership.

## Recommendations

- Charity/assistance mindset is the prevalent approach towards PWD, and may be linked with religious principles. Idea of inclusion and equal participation is novel. A change of attitudes requires **strong and clear communication with public and service providers**.
- Major facilitator to accessing service is **knowing where to go**; therefore, information and accompaniment (i.e., as provided by DVFPs, see recommendation further down) is needed.
- 130,000 refugees with disabilities live outside Domiz, compared to 45,000 in Domiz, therefore **the needs of PWD in urban areas warrant further study**. Studies are also warranted in other camps in and around KRG where the situation is different from Domiz, including where people have recently located, are not able to leave camp as easily, and are far from cities to work.
- There are widespread perceptions among PWD of misuse of power by sector leaders. Therefore, it is important to encourage **PWD to take part in committees**, to see how decisions are made.

### *Actions for service providers and local authorities*

- Within their broader operational plan include targeted actions (**active inclusion**) to address the specific needs of persons with disabilities (WRC, 2013). **Set indicators that identify 10-15% of the target group as persons with disabilities and older persons.** Disaggregate data to monitor how effectively the program is reaching this group. Examples of indicators are:
  1. Number of persons with disabilities and /or their family members approaching mainstream service providers for information and assistance
  2. Number of barriers to access services assessed and removed
  3. Number of persons with disabilities and /or their family members receiving assistance and services directly from service providers (disaggregated by type of assistance or service)
  4. Proportion of refugee outreach volunteers who are persons with disabilities
  5. Number of community center, NGO outreach staff and refugee outreach volunteers who received training on disability inclusion from HI or other credible sources.
- **Long-term planning** (6-10 years), with some refugees having sold their homes and family gold, they intend to stay in KR-I for the next 6-10 years. Long-term projects to improve the socio-economic of PWD would be the most fruitful compared to disjointed, short-term quick fixes.
- **Appoint a task force to monitor disability issues** (ideally hire a PWD) among NGOs, local authorities, services providers, and camp committees with the role to mainstream disability and ensure that other team members or colleagues are sensitive to the importance of including refugees with disabilities equally and avoiding discrimination (UNHCR, 2011).
- **Hire persons with disabilities**, as community volunteers, parents of CWD as volunteers in child-friendly spaces, and so forth. Collaborate with PWD 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 refugees who are in the lowest income groups and have difficulty finding work.

### *Actions for disability specialized organizations*

- **Support livelihood access** as it has an impact on other PWD priorities, such as shelter improvements, transportation, and medication purchase.
- **Provide training to mainstream service providers on how to create internal disability target/measures in M&E and how to monitor inclusive activities.** Possible resource: <http://www.make-development-inclusive.org/toolsen/pcm2.pdf>
- **Identify members of the refugee or local community** who are **skilled in using Braille, sign language** and other methods of communication and can be resource persons for community leaders, UN and NGO service providers (e.g., doctors/health workers/teachers/community workers) in these methods.
- **Work with DOLSA staff for implementation of activities**, as their human resources are available and willing to collaborate.
- To help coordination of disabled refugee services in and around Domiz, **set-up stationary or mobile DVFPs as part of the general referral system**(disability and vulnerability focal points in collaboration with above taskforce/ focal points) to help orientate and



accompany refugees towards other service providers or accompany them to achieving small goals and projects using a personalized approach (PSS). DVFPs can also act as communal spaces. DVFPs can achieve all of the following:

- **Information and orientation center** where PWD learn what they have a right to and information on how to access services: medical, educational, rehabilitation, training and livelihood.
- Using a service directory, **initiate referrals** to other actors.
- **Provide an accurate assessment of vulnerable PWD's life situation**, and can provide case management support in working towards their goals and independence.
- **Offers a reliable database** suitable for use by other operators to build up a reliable profile of affected vulnerable populations and their needs.
- **Establishment of support networks, or peer counseling space** for PWD of similar gender, age, background, or impairment types.
- **Create meaningful activities that people can engage in**, as most people are very bored.

## Summary of Priorities

When asked about the priorities of PWD, there was general consensus about the following order amongst service providers and PWDs, with some exceptions as stated below:

1. **Livelihood access** was identified as the number one overall priority for PWD living in and outside of the camp. Work opportunities could improve overall quality of life as monies earned impacts on the other identified priorities, including shelter improvements and transportation access.
2. Due to mobility problems and because of financial barriers to accessing transportation, **affordable and diverse transportation** was identified as a top priority for PWD living in and outside of the camp. PWD need affordable and diverse transportation options to access education and health services.
3. **CWD participation** in the community in and outside of the camp, particularly in school and child-friendly spaces as the majority of CWD have not been seen to attend school or play in common areas.
4. **Insulation of shelters** was identified as a key priority for refugees living in camp, but was less of a priority understandably for people living in urban areas due to their accommodation type (i.e., apartments). 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.
5. **Physical accessibility** to camp spaces for PWD living inside of the camp. The principle of Universal Design should guide all site planning and design—this means that infrastructure and facilities should be designed to be usable by all people, to the greatest extent possible, without the need for adaptation or specialized design. Taking a universal design approach to construction in the camp benefits everyone.
6. **Coordination around disability issues** are completely absent at this time. Mechanisms to ensure disability issues are discussed at various committees and interagency meetings will help create a change in service delivery for refugees with disabilities. The support of a DVFP in and around Domiz is a concrete mechanism to complement (not replace) the coordination needed amongst other service providers.

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