DISABILITY SURVEY REPORT

Disability Assessment among internally displaced persons (IDPs) in 3 Ninewa camps

ECHO | Iraq
Report
March 2019

handicap international
humanity & inclusion

Contents

1. INTRODUCTION

1.1 BACKGROUND

The military operations to retake Mosul city between October 2016 and July 2017 had a great impact on communities living in the city and its neighborhoods. Most of the western part of the city was destroyed and more than 21,000 injured people were treated through the trauma referral pathway. Traumatic injuries included large numbers of burn, spinal cord, severe orthopedics, and neurological injuries. It must be considered that casualties didn't finish with the end of the offensive. In areas surrounding Mosul and inside the city itself, retreating Islamic State (IS) militants left behind thousands of improvised explosive devices (IED's) and other explosive remnants of war (ERW) following the air and ground offensive.

According to the Mosul Rehabilitation Center (MRC) database, the total number of amputees living in Ninewa is 4,493, among them 668 are victims of the recent conflict with IS[1]. It is important to mention that this number includes only the amputees already registered in the MRC patients' database. Considering the difficulties of population movement and the presence of ERW and IED, it is plausible that the total number of amputees living in Ninewa is significantly higher.

Delivering aid to the most vulnerable continues to be a challenge for humanitarian organizations and government stakeholders. With thousands of civilians injured assessing specific needs and adapting services to meet them is a priority for service providers. However, the lack of information on vulnerable populations including persons with disabilities has consistently been an impediment in providing inclusive and adapted services.

REACH initiative conducted a household survey within formal camps in July and August 2018 without incorporating the Washington Group short set of questions in this round. However, the survey included questions about disability and provided enumerators the definition of "disability" from the UN Convention on the rights of persons with disabilities.
Answers to the question "Does this person have any disabilities?" were the following:
- In Qayarah camps: 10% of the total population reported to have a disability and 17% chronic illnesses;
- In Hamam Al Ali 2 camps: 4% of the total population reported a disability and 8% a chronic illness.

[1] OCHA, HNO, November 2018

Furthermore, results of a rapid needs assessment[2] conducted by HI in November 2016 in selected IDP camps in Mosul revealed that there was a gap in the capacity of camp management to identify persons with specific needs and services were commonly inaccessible. Gender and age disaggregated data on persons with disabilities, including data on the types of impairments, would provide insight into specific needs and scale, however this information is often inadequately collected. During the assessment phase of the secondary data collection for this survey it was confirmed by the camp managers, that the initial screening of new arrivals is very limited and their staff are not trained to assess or identify the different types of impairment.
A further survey completed by HI in January 2018 using the Washington group questions to identify persons with disabilities across two camps in Ninewa showed that 17% of the population surveyed had been identified as having a disability[3], a significantly higher percentage than that shown in formal camp registration data at the time.

In order to enable NGOs and other stakeholders to understand and address the needs of persons with disabilities in Ninewa camps, HI conducted a detailed assessment of persons with disabilities profiles and the barriers to access services for all camps inhabitants, with a highlight on persons with disabilities.

1.2 OBJECTIVES

Concerning the lack of disability data in Iraq post-conflict context, HI conducted the study aimed at the following:

1. Provide statistically reliable prevalence of disability as well as disability disaggregated data indicators.

2. Increase understanding of the situation of persons with disability and their households among the IDP population. Assess access to services and identification of the different barriers, with focus on physical rehabilitation services and other mainstream services including WASH, Health, NFI/Food and Education.

3. Recommend inclusive actions to be prioritized by humanitarian actors.

2 Handicap International, Rapid Needs Assessment, Jed'ah IDP Camp and Haj Ali Schools and IDP Camp, November 2016
3 Handicap International, Disability in a Humanitarian Context, a case study from Iraq, March 2018.

1.3 METHODOLOGY

1.3.1 SAMPLING AND INCLUSION CRITERIA

The study was conducted in three locations: Hamam Al Alil 2, Jaddah 4 and Jaddah 5 camps. A random sample of 507 shelters was selected using available data relating to the structure of the camps. The full sample included a total of 1,713 persons.

Enumerators were instructed to visit the identified locations and interview the household closest to the location. If the head of the household (HH) or the potential respondents present in the tent gave consent, the enumerators would proceed with the survey. Information on all members of the HH was collected.
The questionnaire was translated into Arabic. 12 enumerators were recruited and trained on how to communicate with the interviewees and how to ask the Washington Group Questions (WGQ) and how to use the data collection tools. The enumerator teams received three days of training and administered the questionnaire on tablets. Each team consisted of one male and one female enumerator, in order to ensure quality and gender sensitive interviews.

The disability identification was based on WGQ and asked to all the individuals from 5 years old and above. The questions related to access to Education services were asked only children from 6 to 17 years old and the questions on NFI/Food access were asked at household level, not individually, as distribution is delivered per family.

1.3.2 SURVEY QUESTIONS

The survey questionnaire (see Annex) was designed to elicit responses relating to the degree of access to different services with specific focus on rehabilitation and P&O services at the household and individual level, as well as responses relating to the perceptions of barriers. In order to identify the different barriers faced by the IDP population with the highlight of the persons with disability, barriers especially for rehabilitation and P&O services were examined between persons with and without disabilities. Following guidance from the Convention on the Rights of Persons with Disabilities (CRPD), this study defines disability as resulting from the interactions between personal and environmental factors. From this perspective, a person with a

given medical condition will not automatically be considered to have a disability. For example, a man with lower limb amputation could be a person without a disability if he lives in an enabling environment and is able to participate in society. One way of identifying the people at risk of not participating in society is to understand the level of difficulties a person faces when performing basic activities regardless the impairment using the Washington Group short set of questions (WGQ).

The Washington Group Short Set of Questions

The WG short set of questions used for persons from 5 years old and above, consists of six core questions aimed at identifying the degree of difficulties experienced in six different domains: seeing; hearing; mobility; remembering; self-care and communication. For purposes of analysis, the domains will be referred to as vision, hearing, mobility, cognition, self-care, and communication. The questions further aim to identify people within the population who are at greater risk of experiencing limited or restricted participation in society.[4] Those who will be considered as a person with disability are the respondents who answered "Yes a lot" and "Cannot do at all" as level of difficulty.

The questions and response choices are as follows:

Do you have difficulty seeing, even if [when] wearing glasses?
a. No – no difficulty
b. Yes – some difficulty
c. Yes – a lot of difficulty
d. Cannot do at all

2. Do you have difficulty hearing, even if [when] using a hearing aid?
a. No – no difficulty
b. Yes – some difficulty
c. Yes – a lot of difficulty
d. Cannot do at all

3. Do you have difficulty walking or climbing steps?
a. No – no difficulty
b. Yes – some difficulty
c. Yes – a lot of difficulty
d. Cannot do at all

4. Do you have difficulty remembering or concentrating?

4 Understanding and Interpreting Disability as Measured using the WG Short Set of Questions, Washington Group on Disability Statistics (WG), April 2009

a. No – no difficulty
b. Yes – some difficulty
c. Yes – a lot of difficulty
d. Cannot do at all

5. Do you have difficulty (with self-care such as) washing all over or dressing?
a. No – no difficulty
b. Yes – some difficulty
c. Yes – a lot of difficulty
d. Cannot do at all

6. Using your usual (customary) language, do you have difficulty communicating, for example understanding or being understood?
a. No – no difficulty
b. Yes – some difficulty
c. Yes – a lot of difficulty
d. Cannot do at all

Questions were added to identify people with amputation. Causes of the amputation were categorized as below:

a. Other causes (congenital …)
b. Illness (Diabetes …)
c. Weapons related violence
d. Accident (RTA …)

Questions on Access to Services

Questions on access to rehabilitation (physiotherapy sessions, prosthetics and assistive devices) and basic services (water, sanitation and hygiene (WASH), Health, NFI/food and Education) were asked during the survey to further assess and highlight the barriers and gaps faced by persons with disabilities. Barriers were categorized as follows:

a. The facility/service is too far
b. The facility/service is not adapted/accessible
c. The persons do not have any means of transportation to reach the facility/service
d. There are not enough facility/services available for those who need it
e. The persons do not know that such services exist
f. The service not functional
g. The person do not need the services
h. The facility/service is unsafe
i. Others

The categorization of the access barriers are based on geographical, physical and security components where the different questions are related to the individual and environmental factors.
As examples:
Option b – service is not adapted refers to the physical accessibility of the service especially for persons with difficulties.
Option h – service is unsafe refers to the individual's own observation, experiences and perceptions of safety and security when accessing the services.

2. MAIN FINDINGS

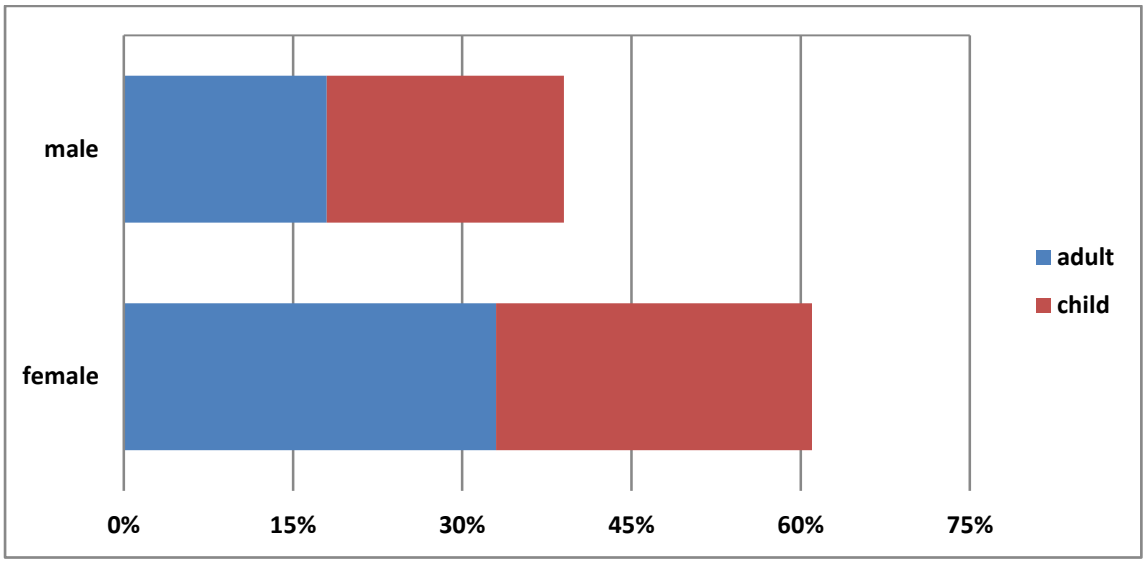
2.1 DEMOGRAPHICS

A total of 507 households with 1,713 individuals in Hamam Al Alil 2, Jaddah 4 and Jaddah 5 IDPs camps were interviewed for the survey.

Table 1: Distribution (nb and %) of respondents by age groups and gender (a)

Age group	Female		Male		Sub total	
	Nb	%	Nb	%	Nb	%
5 to 17	472	45.2	366	54.7	838	48.9
18 to 59	516	49.4	272	40.7	788	46
60 and above	56	5.4	31	4.6	87	5,1
Sub Total	1044		669		1713	
						100

Table 1: Distribution (%) of respondents by age group and gender (b)



Overall gender disaggregation (table 1 a) and b)) shows that 61% of the respondent populations are females and 39% are males. In terms of age disaggregation, 51% are adults and 49% are children. The number of members per household ranges an average household size of 4.13 persons.

Table 2: Distribution (nb and %) of all interviewed population by Camp

Camps	Household		Individual (age +5)	
	Nb	%	Nb	%
Hamam Al Alil 2	216	42,6	665	38,8
Jaddah 4	68	13,4	282	16,5
Jaddah 5	223	44	766	44,7
TOTAL	507		1713	100

According to the total number of population in each camp, 44% of the households interviewed were from Jaddah 5 camp, 42.6% in Hamam Al Alil 2 and 13.4% in Jaddah 4 (table 2). This is reflective and proportionate to camp populations.

2.2 DISABILITY

2.2.1 OVERALL PREVALENCE OF DISABILITY

Table 3: Prevalence of Disability – Individual Level

Total population	1713
Total PwD	245
Percentage PwD	14.30

Table 4: Prevalence of Disability (Households with at least one member with disability) – Household level

Total Households	507
Total HH with person with disability	206
Percentage of HH containing at least one person with disability	40.6%
Average Nb of people with disability per HH	1.3

Results of the survey show that 245 people have a disability which represents 14.3% of the respondents (table 3). 206 households have a least 1 person with a disabilities, which represents 40.6% of total households participating in the survey. On average, there are at least 1.3 persons in each household identified with functional difficulties in varying degrees (table 4).

The high prevalence of disability highlights the importance of mapping and addressing the different barriers that might affect the camp populations. With 40.6% of HH reporting at least one member with a disability the wider impact of disability should also be considered, as it is known that additional care duties are often bestowed on HH members and subsequent costs linked to health care and specialized needs are frequently experienced by these HH. This impact is summarized per camp surveyed in table 5.

Table 5: Distribution in camps - Tent average People with Disabilities (PwD)

	Average HH with PwD in each camp	Nb of PwD per camp	
	%	#	%
HAA 2	36.1	95	13
Jaddah 4	42.6	44	13
Jaddah 5	44.4	132	15

Table 6: Population, number and percentage of PwD by Age Group and Gender

	All Population					With disabilities									
	Child		Adult		Total	Child		Adult						Total	
Sex/age group	5 to 17	18 to 59	60+	All adult		5 to 17		18 to 59		60+		All Adult			
	#	#	#	#	#	#	%	#	%	#	%	#	%	#	%
Male	366	272	31	303	669	35	9.5	40	14.7	21	67.7	61	20.1	96	14.3
Female	472	516	56	572	1044	36	7.6	79	15	34	60.7	113	19.8	149	14.2
Total	838	788	87	875	1713	71	8.5	119	15.1	55	63.2	174	19.9	245	14.3

Table 7: Rate (%) of prevalence of disabilities by Age group and Gender

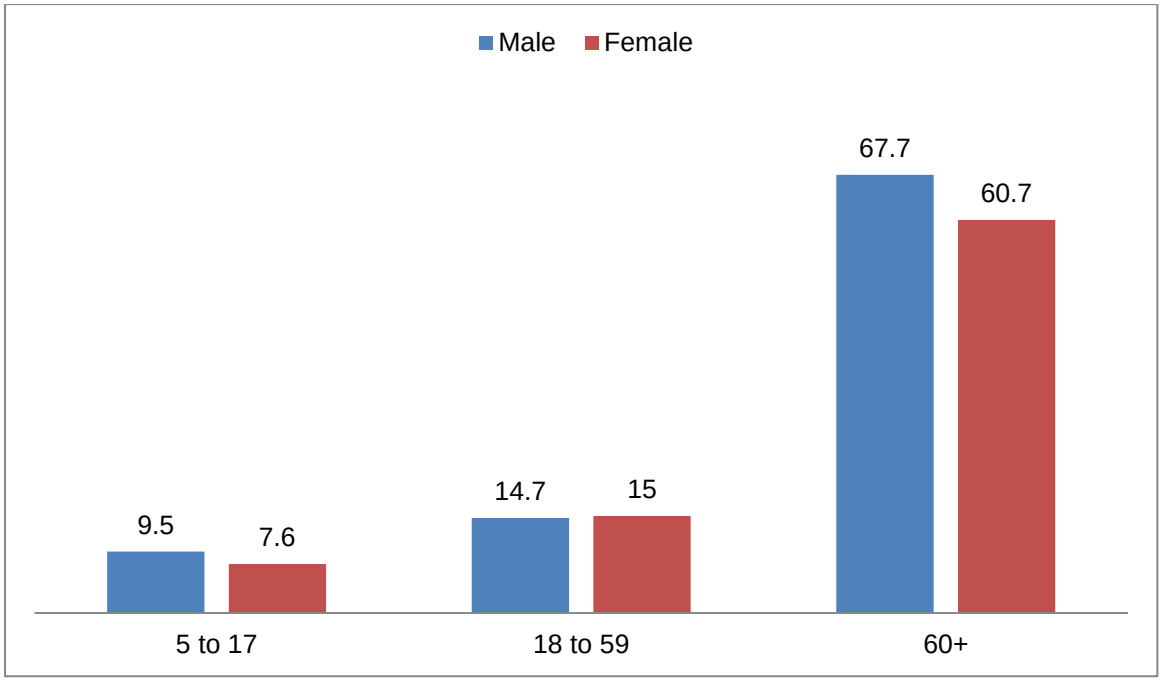


Table 6 and 7 presents the population, number and percentage of persons with difficulties by age group and gender. There is no significant difference in disability prevalence among males and females except regarding people over 60 years old (7% more for male than female).

Results of the survey show that the prevalence of difficulty increases with age, with a sharp increase for persons aged 59 years and above. 63% of the population aged 60 years and above experience some form of difficulty compared to 8.4% of the population below 18 years. This result can be explained by the fact that the difficulty is often related to illness and chronic health conditions which makes the access to quality health services including management of chronic disease and rehabilitation a priority for this category to prevent the creation of disability.
The low prevalence of difficulty among those aged 5 to 17 years may be associated with limitations in identifying difficulties experienced by children as disability identification among young populations requires a more complex process. Children constantly undergo different transition phases from infancy to adulthood hence the selection of basic activities could change from one phase to another.

2.2.2 PREVALENCE OF DISABILITY IN SINGLE DOMAIN

Table 8: Total Population by Type and degree Difficulty (a)

Degree	Type of difficulty (including multiple conditions)					
	Vision	Hearing	Mobility	Cognition	Self-care	Communication
Some	221	128	184	235	101	71
A lot	75	42	103	44	35	20
Cannot do at all	7	5	20	2	42	11
Sub-Total	303	175	307	281	178	102
Total A Lot + Cannot do at all	82	47	123	46	77	31

Table 9: Prevalence by Domain and Age (Nb)

	Child	Adult			Total
Age Group	5 to 17	18 to 59	60+	All Adult	
Vision					
Hearing	13	33	36	69	82
Mobility	7	21	19	40	47
Cognition	27	51	45	96	123
Self-Care	8	31	7	38	46
Communication	36	13	28	41	77
	16	9	6	15	31

Table 10: Prevalence by Domain and Age (%)

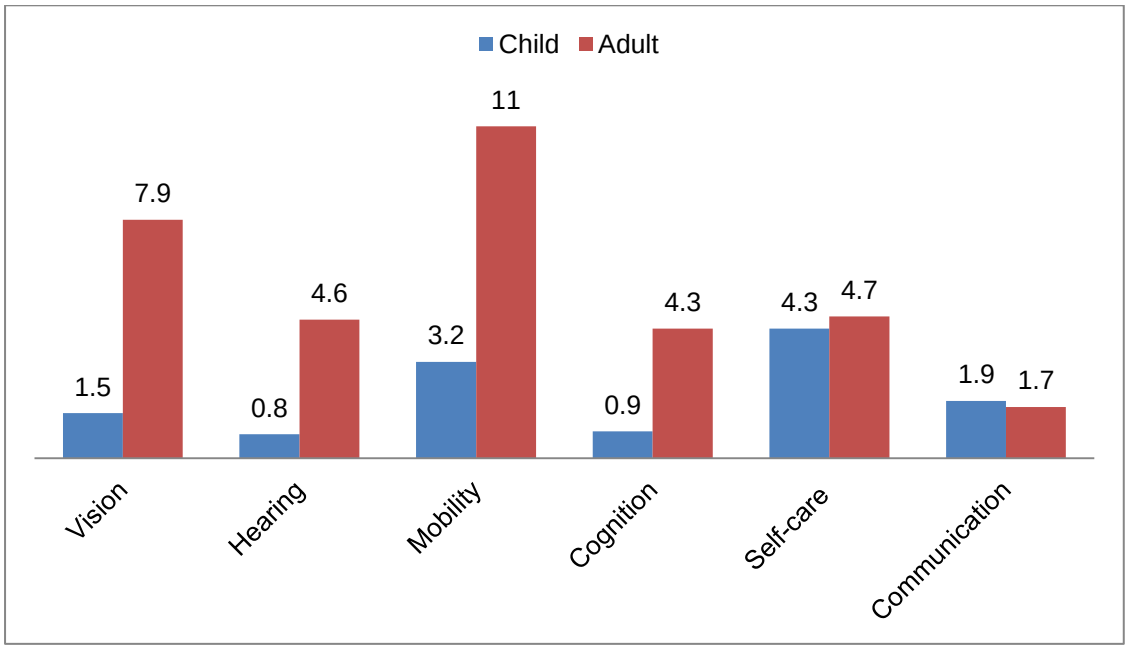


Table 8 presents the degree of difficulty by type of impairment among those who were reported as having difficulties. For the majority of impairments, most people reported "Some" level of difficulty.
As explained in the methodology, those with "Some" level of difficulties are not considered for our analysis as persons with disabilities. This response is likely to be attributed to the living conditions within the camp setting and generalized challenges to access services.

Results of the survey reveal that out of the total population of respondents and across the different core domains and degrees of disabilities, disabilities associated with mobility

have the highest prevalence rate (7.2%) followed by disabilities with vision (4.8%) and cognition(2.7%). Disabilities associated with communication have the lowest prevalence (1.8%) (tables 8 to 10).
Since the disabilities associated to mobility are one of the highest prevalence identified, it reveals the high need of physical rehabilitation services including the provision of assistive devices. This result also highlights the need to ensure accessible services and an inclusive approach from the service providers and facilities. The mobility difficulties experienced by adults can become a barrier to access to essential services while children can still often be supported by the family.

Table 11: Prevalence by Domain and Gender (%)

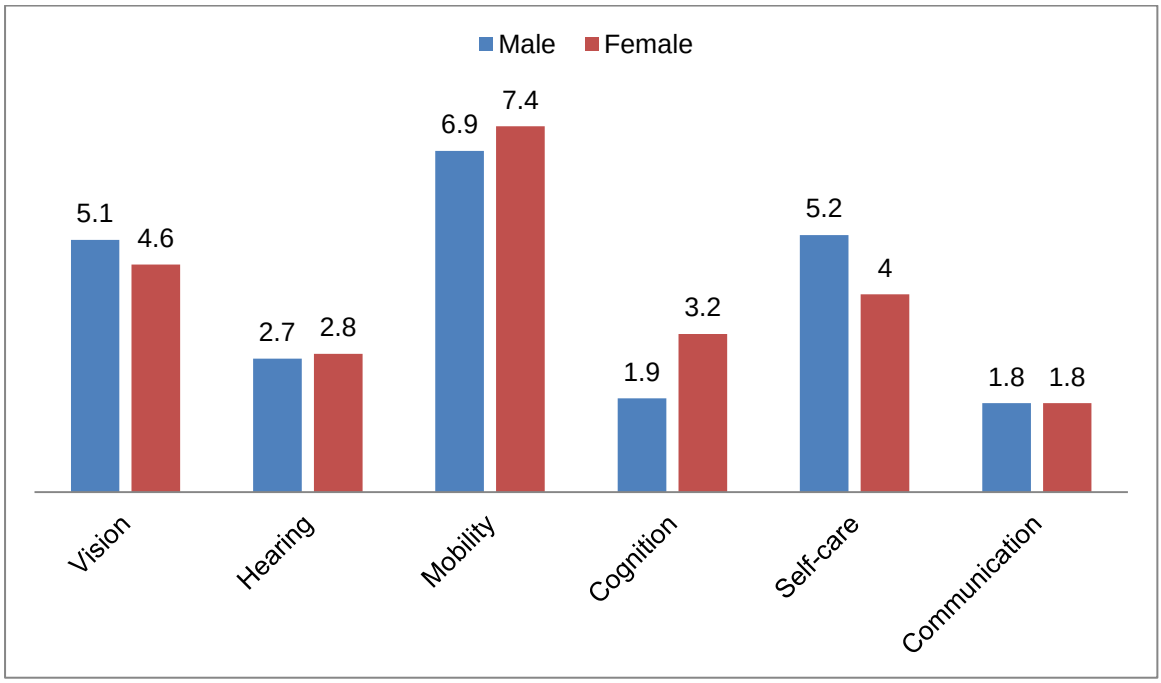


Table 12: Type of disability distribution per Gender (nb and %)

Gender	Male		Female		Total	
	#	%	#	%	#	%
Vision	34	21.5	48	19.4	82	20.2
Hearing	18	11.4	29	11.7	47	11.6
Mobility	46	29.1	77	31	123	30.3
Cognition	13	8.2	33	13.3	46	11.3
Self-Care	35	22.2	42	16.9	77	19
Communication	12	7.6	19	7.7	31	7.6

The prevalence by type is similar for males and females. Table 12 shows that mobility impairment is the most prevalent for both genders, however difficulties relating to self-care for males are high (22.2%) while showing slightly lower for females (16.9%). This could be linked to the severity of disability experienced between genders or cultural attributes to self-care. Females showed a higher proportion of cognitive disability (13.3%) than males, who have a rate of 8.2%. This can possibly be explained by the fact that cognitive disability is culturally less accepted for men so likely to be less reported than for women.

2.2.3 PREVALENCE OF DISABILITY IN MULTIPLE DOMAINS

Table 13: Prevalence of people with multiple disabilities

Total PwDs	# of people with multiple disability	% of people with multiple disability
245	174	71%

Results of the survey show that 71% of the persons with disabilities have more than one disability (table 13).

The high prevalence of multiple disabilities is explained by the interaction of different difficulties with the environmental factors in the social model of disability defined at the beginning of the report. An example of this might be a person having mobility or visual impairment is likely to additionally have difficulty with self-care routines.

2.2.4 PERSONS WITH AMPUTATION

Table 14: Number of People with amputation by Age Group and Gender

Child	Adult			
5 to 17	18 to 59	60+	All Adult	Total
1	0	0	0	1
0	1	1	2	2
1	1	1	2	3

Table 15: Disaggregation Cause of Amputation per Age

	Child	Adult	
	5 to 17	18 to 59	60+
Other causes	0	1	0
Illness	0	0	1
Weapon	0	0	0
Accident	2	1	0

One of the major aims of the survey was to better understand the disability-related needs in the camps with a focus on P&O. The results show that among the 1,713 interviewed, 5 persons with amputation were identified, which represents 0.29% of the total of respondents. As the sample of 507 households is a representative random selection of the 10,250 households present in the three camps, we can assume statistically that out of the 44,500 total population, 133 individuals might have an amputation and potentially be a person in need of rehabilitation support including physical rehabilitation and P&O.
2 among the 5 persons reported with an amputation are children (1 male and 1 female) and 3 are adult males. 2 of them are wheelchairs users. The others have no assistive devices. None of them has prosthetics. The majority have an amputation due to an accident (3 out of 5).

It is relevant to point out that 100% of persons with amputation don't have prosthesis. Even if the prevalence of person with amputation is not very high in the sample surveyed, the gap in access to services is clearly identified. The lack of prosthesis access explains the high dependence level of the persons with amputation to mobility aids, 40% of the persons with an amputation are using wheelchair likely due to lack of access to P&O and rehabilitation services. While facilitating immediate access, the use of a wheelchair will have an impact on muscle tone and fitness of existing limbs, reducing the long term recovery potential and increasing the risk of longer term complications and disability.

2.3 ACCESS TO SERVICES

2.3.1.1 OVERALL ACCESS TO PHYSIOTHERAPY

Table 17: Disaggregation people with mobility difficulty by Age and Gender

Gender/age group	Child		Adult						Total	
	5 to 17		18 to 59		60+		All Adult			
	#	%	#	%	#	%	#	%	#	%
Male	31	8.47	38	14	26	83.9	64	21.1	95	14.2
Female	25	5.3	140	27.1	47	83.9	187	32.7	212	20.3
Total	56	6.7	178	22.6	73	83.9	251	28.7	307	17.9

Table 17 reveals that the number of persons with some mobility difficulties reaches 17.9% and that, females of all age categories are more affected by mobility difficulties than males (14.2% for males against 20.3% for females).
The high percentage of persons above 60 years old (nearly 84% for both males and females) can be easily justified by the aging process combined by the difficult living environment in the camps, especially during the winter when the camps are covered with mud or flooded areas. Children are less concerned by mobility difficulties, reaching 6.7% as an average for both males and females.

Table 18: People accessing physiotherapy by Age (nb and %)

	Child		Adult						Total	
	5 to 17		18 to 59		60+		All Adult			
	#	%	#	%	#	%	#	%	#	%
Received	6	10.7	29	16.3	11	15.1	40	15.9	46	15
Don't Receive	50	89.3	149	83.7	62	84.9	211	84.1	261	85

89.3% of children and 84.1% of all adults with mobility difficulties did not receive physiotherapy services.
This figure highlights a high need for more specialised health services such as physical and functional rehabilitation. Impairment combined with the gap in specialised rehabilitation services results in more of the population unable to access basic services thus creating a disabling environment for these populations.

Table 19: People accessing physiotherapy by Gender

Gender	Male		Female		Total	
	#	%	#	%	#	%
Received	21	22.1	25	11.8	46	15
Did not Receive	74	77.9	187	88.2	261	85

88.2% of females with mobility difficulties didn't receive the physiotherapy sessions comparing to 77.9% of males. This might be explained by cultural factors, as women are often not able to move outside of camp settlements alone and the cost of transport is very high. This highlights the need for services to be provided at camp level to ensure equal access for both men and women.

Table 20: People accessing to prosthetics by Age

	Child	Adult			Total
	5 to 17	18 to 59	60+	All Adult	
Received	0	0	0	0	0
Did not Receive	2	2	1	3	5

None of the people identified with amputation received prosthesis (table 20) while all identified they would like to. This shows a clear gap in access to this specialised service. Factors affecting access could be lack of information about availability, lack of service provision, cost to reach services, poor referral and follow up processes. Services provided outside the camp setting are expensive to reach due to the high cost of transport.

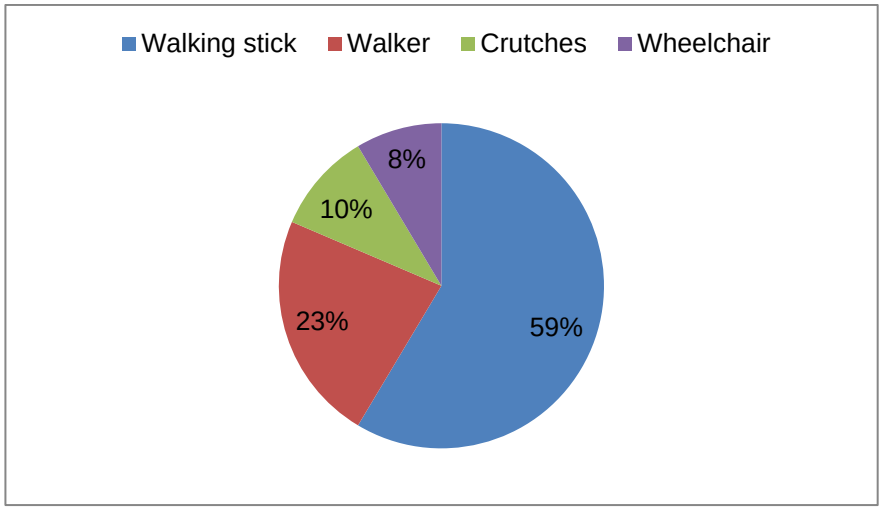
2.3.1.2 ACCESS TO ASSISTIVE DEVICES

Table 21: Percentage of people with mobility difficulties using AD

People that declared to have a mobility difficulties	307
# of people using ADs	48
% of people using ADs	15.6

The results in table 21 reveal that 84.4% of the people with some mobility difficulties are not using assistive devices. While it is recognized that assistive devices may not be required by all experiencing mobility difficulties, this percentage likely highlights a gap in availability of devices and a need for further assessment and access to specialized health care.

Table 22: Percentage per type of Assistive Devices



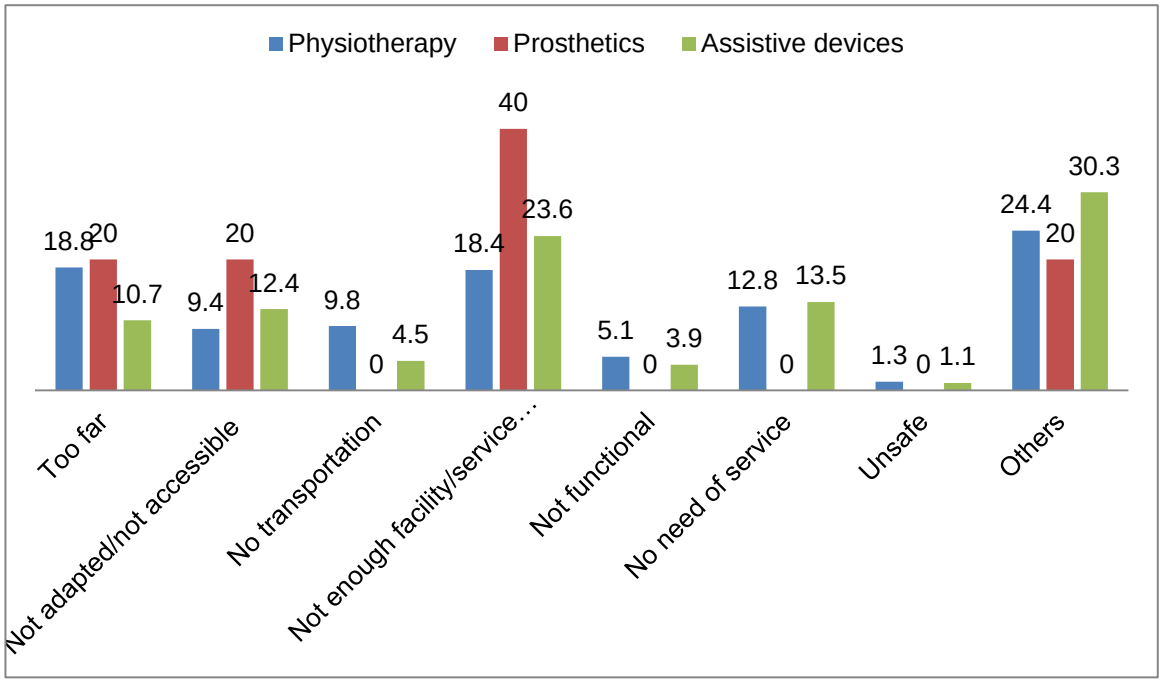
All the assistive devices mentioned by the interviewed are mobility aids to facilitate the movement of people with disabilities. However the physical environment continues to be a barrier for the access to services especially for wheelchair and walker users who need specific adaptations to camp services and facilities.

2.3.1.3 BARRIERS TO ACCESS REHABILITATION SERVICES

Table 23: Overall barriers to access rehabilitation services, including receiving prosthetics and assistive devices (%) (a)

Barriers	Physiotherapy	Prosthetics	ADs
Too Far	18.8	20	10.7
Not adapted/not accessible	9.4	20	12.4
No Transportation	9.8	0	4.5
Not enough facility/service available	18.4	40	23.6
No knowledge about existence of service	0	0	0
Not functional	5.1	0	3.9
No need of service	12.8	0	13.5
Unsafe	1.3	0	1.1
Others	24.4	20	30.3

Table 23: Overall barriers to access rehabilitation services, including receiving prosthetics and assistive devices (%) (b)



These results show the most prevalent barrier to be the distance to reach services. Knowing that most of the persons with disability identified have difficulties in mobility, this barrier is more significant given the lack of the service providers in close proximity. This is likely to be exacerbated by the lack of availability and affordability of transportation services.
Based on the factors mentioned above the main barriers are a combination of physical impairment and lack of environmental adaptation, which demonstrates the disability definition from the UNCRPD.

These barriers combined with the identified difficulties are evidence for the high needs in terms of access to specialised services, such as rehabilitation and P&O services. The non-availability or total absence of a service is additionally likely to result in lack of awareness compounding the reduced access shown through these results.

2.3.2.1 ACCESS TO MAINSTREAM SERVICES

Table 24: Prevalence of people with and without disability access to services by type and Gender (Nb and %)

Do Not Have Access	WASH				Health				Education (Only child 6-17)				NFI/Food			
	male		female		male		female		male		female		male		female	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
W/o disability	25	4%	65	7%	24	4%	48	5%	139	48%	222	57%	54	9%	97	11%
With disability	36	38%	52	35%	32	33%	48	32%	19	73%	17	57%	15	16%	20	13%
Total population	669		1044		669		1044		319		424		669		1044	

The results of the table 24 show that persons with disabilities have significantly less access to WASH and health services across both male and female populations. Access to education varies significantly between males and females, with/ without disability which could be interesting to explore further and potentially linked to cultural beliefs or the context and safety. The lack of access to health and WASH services for persons with disability signifies the likelihood

of increased secondary health risks for this population. Previously highlighted environmental barriers and lack of specialized adaptation are likely to account for the barriers to accessing services for the population with disability.

The equal access to NFI/Food is likely to be explained by this service being accessed at HH level so it's possible that persons with disability have a HH member facilitating. A limiting factor to the study is that the study did not assess the service provision so it is unable to identify if adapted services have been provided to facilitate and account for higher % access.

2.3.2.2 BARRIERS TO ACCESS TO MAINSTREAM SERVICES

Table 26: Barriers to access mainstream services faced by persons with and without disabilities (%)

	WASH		Health		Education		NFI/Food	
Barriers	**PwD**	**Pw/oD**	**PwD**	**Pw/oD**	**PwD**	**Pw/oD**	**PwD**	**Pw/oD**
Too Far	37.8	17.3	50.4	31.7	9.8	20.4	23.1	28.5
Not adapted/not accessible	22.2	34.1	3.5	4.2	12.2	3.9	9.6	10.0
No Transportation	8.9	1.6	15.9	1.7	2.4	0.0	0.0	1.0
Not enough facility/service available	3.7	8.1	12.4	17.5	0.0	3.6	50.0	47.0
Not functional	0.7	3.2	0.9	4.2	2.4	9.7	7.7	5.0
No need of service	0	0	1.8	0.8	19.5	25.5	0.0	0.0
Unsafe	11.9	25.9	0.0	1.7	2.4	5.6	0.0	0.0
Others	14.8	9.7	15.0	38.3	51.2	31.3	9.6	8.5

Comparing the barriers faced by persons with and without disabilities as shown in Table 26, results reveal that for those with and without disabilities distance, unsafe services and lack of available services are the top 3 most common barriers. These results suggest a generalized lack of service availability and safe access among the whole population surveyed.

Among the persons without disabilities, safety and adapted services was also a primary barrier, while safety and lack of adaptation was identified as a barrier by persons with disabilities, the physical distance to reach the service remained the most significant barrier.

Distance from the service, was a primary barrier to accessing healthcare for the whole population surveyed. Children being unable to visit facilities alone, or unavailability of specific medication was another significant barrier for the whole population surveyed. With half of the population of persons with disabilities identifying distance as a barrier, they additionally highlighted a lack of available transportation to access these services.

Regarding access to education, the highest % response from both populations with and without disabilities answered they do not need the services or mentioned other reasons, mainly for personal/family reasons, financial reasons or related to security or ID documents missing.
Describing access to NFI services, populations with and without disabilities identified similar barriers, lack of availability of service or that the service is too far. Is it relevant to highlight that the majority of responses for both populations with and without disabilities answered other reasons (75%) reporting a perception of discrimination during distributions.

3. CONCLUSIONS AND RECOMMENDATIONS

The survey explored the prevalence of disability among the population of Hamam Al Alil 2, Jaddah 4 and Jaddah 5 camps, and provided a number of insights into the level of access to rehabilitation, P&O and mainstream services with statistical data disaggregated by disability, gender and age.

The main findings are the following:

- 14.3% of the camp population surveyed have a disability.
- 40.6% of HH surveyed have at least one person with a disability.
- There is a high prevalence of multiple disabilities (71% of people with disabilities have more than one disability) that is due to the interaction of different impairments with environmental factors.
- 17.9% of the total surveyed population has mobility difficulties[5]. Of the population aged 60+ this % increases to 84% with mobility difficulties.
- From the surveyed population, 100% of persons with amputation do not have, but would like, prosthesis
- 84.4% of the people identified with mobility difficulties are not using assistive devices or received rehabilitation services.
- People with disabilities have less access to mainstream services than people without disabilities which signifies a need for more focus on adapted facilities and services.
- The main barriers to access services are environment, such as distance, physical accessibility, lack of transportation, and limited availability of services.

[5] Responded, Some, a lot or cannot do at all (Noting that as per WGQ guidance only those responding a lot or cannot do at all are recorded as having disability).

These findings highlighted a number of aspects to be taken into consideration by the humanitarian and development stakeholders in the Ninewa response.

1. **Understanding disability from a human rights perspective and build the capacity of stakeholders to collect disability data using the Washington Group Questions.**

The study applied the rights-based model of disability by using the WGQ tool to identify persons with disabilities regardless of their impairments and contextual factors. Persons with disabilities identified were people at risk of not participating in society (including humanitarian action). Using this rights-based understanding of disability, the study found that 14.30% of IDPs surveyed have disabilities. Other surveys in the same camps by the REACH Initiative identified significantly lower prevalence. This difference in prevalence among similar surveyed populations suggests the necessity for stronger advocacy to promote improved data collection on persons with disabilities to ensure all needs are identified and met. In particular in the camp context it is important to ensure knowledge and implementation of WGQ among humanitarian actors.

2. **Increasing the availability of rehabilitation services in the camps in order to prevent further secondary health complications and mitigate the impact of impairment on access to essential services.**

The survey identifies that the needs in terms of physical rehabilitation, P&O and provision of assistive devices remain critical in the camps for persons with disabilities. In addition, the needs of persons with difficulties are not addressed due to a combination of the lack of adapted environment in camp settings which can become disabling when considering access to essential services.
HI physical rehabilitation teams currently have a waiting list of more than 650 persons and cannot reach all the identified needs in the camps due to the limited resources at its disposition. In addition to these needs, this survey highlighted additional needs such as P&O services which are not currently accessible to many of the camp population.

3. **Developing accessibility and inclusiveness of services.**

The results of the study show that the main barrier to access mainstream and specialised services such as physical rehabilitation is distance and lack of transportation. Mobile teams within the camp setting are relevant for those beneficiaries whose impairment doesn’t allow them to move, while others should be encouraged to go out of their homes in

order to access services and claim their right to inclusion in the community.
It is a priority for humanitarian actors to ensure the availability of adapted services with the increase of fixed points, transportation to existing services or cash for transportation, simultaneously ensuring protection of movements outside the camps. Accessibility of services can be addressed with simple modifications such as building ramps, improve the roads conditions (especially in the winter when pathways become impractical with mud and flooding), and including markings for people with visual impairments. Responses need to be tailored based on the needs identified through reliable disaggregated data and coordinated through service mapping and information sharing at camp level.

ANNEX

Survey questionnaire