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DISABILITY AND INCLUSION SURVEY

Malakal Protection of Civilians Site

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A boy with difficulties in walking partakes in a lesson at a school in Malakal Protection of Civilians site on March 6th, 2020. (Photo: Alex McBride)

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Acronyms

AA	Adjacent area
CBM	Christian Blind Mission
CCCM	Camp coordination and camp management
COVID-19	Coronavirus disease 2019
CRPD	Convention on the Rights of Persons with Disabilities
DRC	Danish Refugee Council
DTM	Displacement Tracking Matrix
FGD	Focus group discussion
FSL	Food security and livelihoods
GBV	Gender-based violence
GFD	General food distribution
GPS	Global Positioning System
HDC	Humanitarian Development Consortium
HI	Humanity and Inclusion
HIV	Human immunodeficiency virus
IDP	Internally displaced person
IFRC	International Federation of Red Cross and Red Crescent Societies
IMC	International Medical Corps
IOM	International Organisation for Migration
KII	Key informant interview
MHPSS	Mental health and psycho-social support
NGO	Non-governmental organisation
PoC	Protection of civilians
SNFI	Shelter and non-food items
UN	United Nations
UNHCR	UN High Commissioner for Refugees
UNICEF	UN International Children's Emergency Fund
UNMISS	UN Mission in South Sudan
VCT	Voluntary counselling and testing
WASH	Water, sanitation and hygiene
WGQ	Washington Group Questions
WHO	World Health Organisation

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Background and Aims

The International Organization for Migration's Displacement Tracking Matrix (IOM DTM), Protection and Mental Health and Psycho-Social Support teams joined efforts with Humanity & Inclusion (HI) to undertake an assessment of the level of access to services and the barriers faced by persons with disabilities within Malakal Protection of Civilian site (PoC site). The United Nations High Commissioner for Refugees (UNHCR) and the Danish Refugee Council (DRC) contributed to the qualitative component of the study as Protection and Camp Coordination and Camp Management (CCCM) actors operating within the PoC site. The study, based on data collected between March 2020 and June 2020, aims to improve the knowledge base available to the humanitarian community about access to services by persons with disabilities living in the site. It provides a quantitative estimate of the prevalence of disabilities among the IDP population and an assessment of the barriers faced by persons with disability in accessing humanitarian services across sectors. It also seeks to empower persons with disabilities living within the PoC site, giving them the opportunity to express their concerns and preferences with regards to possible solutions and targeted interventions. It is hoped that the resulting data will help camp management and other service providers operating within Malakal PoC site, including IOM, UNHCR and DRC, to better account for the concerns and needs of persons with disability in humanitarian programming and service delivery. This study builds onto and expands previous studies in Naivasha IDP Camp (formerly Wau PoC AA Site) and Bentiu PoC Site.

Key Findings

- ***19.1 per cent of survey respondents*** are persons with disabilities as identified by the Washington Group Short Set of Questions (see methodology), while an estimated ***18.3 per cent of households*** include at least one member with a disability.
- Among individuals with disabilities, ***44.5 per cent*** report ***at least one mental health concern***.
- Giving ***more support to family members and care givers*** (70.6%) and making ***access to basic services*** easier (45.9%) were the most suggested actions for more satisfactory and happier lives.
- The main barriers ***hampering access to services*** by persons with disabilities were lack of ***economic resources*** (39.3%), ***distance*** to service points (38.4%) and lack of ***physical access*** (34.0%).
- 10.4 per cent of respondents' fear forms of ***verbal violence*** when accessing services, while 7.4 per cent feared forms of ***physical violence***.
- Clarifying where to report protection incidents was most popular among potential solutions to improve safety (30.0%).
- Access ***to safe clean water***, ***assisted referral***, ***livelihood opportunities*** and ***general health services***, among other basic services, present particular challenges for persons with disabilities.

- The majority of persons with disabilities living in Malakal PoC site does not live in shelters that are suitable for their needs (52.0%).

Methodology

The Disability & Inclusion study followed a mixed methods approach designed to bring together representative statistics on the prevalence of disability and barriers faced by persons with disabilities, and contextual insights obtained through qualitative research methods, allowing for a more holistic assessment of the conditions of persons with disabilities in Malakal PoC site.

A ***quantitative survey*** was administered to all consenting individuals in 868 randomly sampled households between 6 March and 18 March 2020, before the imposition of COVID-19-related mobility restrictions[1]. A list of all shelters in the camp was obtained from footprints extracted from high-resolution satellite imagery and used as the sampling frame for the study. The number of shelters sampled in each block was proportional to the block's household population in the latest DTM biometric registration in January 2020. Shelters were sampled randomly using an R script[2]. Each of the 20 enumerators was assigned with block-level maps of the camp showing the location and GPS coordinates of the sampled shelters. In shelters occupied by multiple households, enumerators were instructed to select one using a random number generator on their mobile phone. The enumerators received protection and disability trainings, which included a session on mental health as part of the piloting of selected mental health indicators based on the Washington Group Extended Set on Functioning and WHO Disability Assessment Schedule.

All household members present at the time of the assessment and aged fifteen or above were requested to **self-report disability**[3] by reporting on their basic functioning and later the barriers they are facing. The short set of the Washington Group Questions (WGQs) were used as the self-reporting tool to identify persons who face a lot of difficulty to, or cannot carry out, the following activities: a) seeing (even if wearing glasses), b) hearing (even if using a hearing aid), c) walking or climbing steps, d) remembering or concentrating, e) washing or dressing, and f) communicating in one's customary language or being understood. Persons answering positively to any of these questions were then asked a series of follow-up questions on access to basic services,

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[1] 1,000 shelters were randomly sampled for the assessment. Of these, 18 were occupied by households who did not consent for the interview, and 114 were abandoned, non-residential or empty. Enumerators attempted to visit empty shelters a second time on a different day before recording them as such.

[2] R Core Team. (2020). R: A language and environment for statistical computing. R Foundation for Statistical Computing, Vienna, Austria. https://www.R-project.org/.

[3] In accordance with the UN *Convention on the Rights of Persons with Disabilities* (2007), the term "disability" is defined as follows: "disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others." (Preamble, e).

either in person or – if unable to do so – through their support persons. In total, 2,146 individuals completed the WGQ component of the survey, of whom 386 were persons with disabilities[4]. 374 persons with disability answered the access to services section of the survey[5].

The study also piloted the inclusion of three questions on mental wellbeing. Two indicators of mood were taken from the Washington Group Extended Set on Functioning, targeting the frequency of individuals feeling worried, nervous or anxious, and very tired or exhausted. Recognizing the stigma surrounding mental health issues in South Sudan, an additional question focusing on social interactions was taken from the WHO Disability Assessment Schedule, asking about the difficulty of individuals joining community activities. These questions were included to give an indicative overview of the prevalence of mental health concerns among persons with disabilities in the PoC site[6].

The 95 per cent confidence intervals were calculated using the R package *survey*[7], to account for sampling design factors such as stratification. Differences in household non-response rates by block were corrected using DTM's Biometric Registration household figures as weights in the analysis. In the survey, women and girls account for 71.4 per cent of all respondents, which is higher than their share in the camp's population (53.9%) as recorded in DTM's biometric registration data in January 2020[8]. This may be explained by a higher likelihood of female members of the household being in or around their shelter during daytime, as also observed in previous surveys. Individual-level figures should therefore be taken to be representative of the daytime population in the camp, rather than its overall population.

The ***qualitative aspect*** of the research was conducted through key informant interviews (KIIs) and focus group discussions (FGDs) with various stakeholders in the PoC site, as well as direct observation by the research team. Unlike the quantitative data collection that took place prior to the imposition of COVID-19-related restrictions, the KIIs and FGDs were conducted from May to June 2020, after the outbreak of the COVID-19 pandemic. COVID-19 prevention measures were followed which led to the revision of the number of FGD participants from ten persons to eight persons per group. Eleven FGDs were conducted with persons with

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[4] 359 individuals with disabilities responded directly, whereas 30 individuals with disabilities had their support persons respond on their behalf.

[5] For 12 individuals unable to answer the survey in person, it was also not possible to find someone able to answer in their role as caretaker. As a result, they were excluded from the section on access to services.

[6] These questions were initially included to provide a general overview of the prevalence of mental health concerns among persons with and without disabilities. However, the response-rate among the population without disabilities was anomalously low, and the results are therefore excluded from the analysis. This is likely due to stigma surrounding mental health disorders.

[7] Lumley. T, (2020) "Survey: analysis of complex survey samples". R package version 4.0.

[8] IOM DTM. (2020). *South Sudan — Biometric Registration Update: Malakal PoC Site (Jan 2020)*.

various forms of impairments, which were selected by local Protection and CCCM partners from each of the four sectors of the site. The impairments faced by participants included visual, physical, cognitive and speech impairments. Twelve KIIs were also conducted with informants from multiple humanitarian sectors operating in Malakal PoC site, including Protection, WASH, FSL, CCCM, Shelter-NFI and Health actors.

History and Context of Malakal PoC Site

Malakal PoC site was initially established in December 2013 when an estimated 12,000 IDPs fled violence and came into the United Nations Mission in South Sudan (UNMISS) base located in the Northern Payam of Malakal County. The IDPs entered the UNMISS base to seek safety as a result of the conflict which took place between Sudan People's Liberation Army and the Sudan People's Liberation Army – In Opposition forces in Malakal Town.

The current site structure was built in 2015 next to the UNMISS base in order to accommodate the number of IDPs which had increased to 20,000 by that time. As of August 2015, the IDP population of Malakal PoC site reached an estimated 47,000 individuals when households belonging to the Shilluk tribe entered the PoC to escape fighting in Malakal. At the beginning of 2016, the residents of Malakal PoC site mostly belonged to three major ethnic groups: Shilluk, Nuer and Dinka. However, in February 2016 the site came under attack, resulting in the death of at least 29 IDPs and the destruction of shelters mostly belonging to Nuer and Shilluk IDPs. After this incident, all IDP households who belonged to the Dinka tribe moved out of Malakal PoC site and into Malakal Town[9].

In January 2020, DTM biometrically registered 27,924 individuals (15,056 women and 12,868 men) from 8,520 households residing inside Malakal PoC site[10]. A later population count carried out by DRC as camp management agency in September 2020 estimated a larger population of 33,137 individuals (16,625 women and 16,512 men) from 5,545 households[11]. Triangulation with DTM gate counts and displacement site flow monitoring data suggests that, while there was an increase in the number of permanent new arrivals at the site since June, the difference between the two estimates is primarily due to the methodologies used[12]. Biometric registration is generally restricted to IDPs who slept in the camp the night before the exercise, although a help desk is organized in collaboration with Protection and CCCM partners to verify and register IDPs who found themselves outside the camp at the time of registration due to medical or other pressing reasons.

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[9] Protection Cluster. (2016). *Protection Situation Update: Violence in the Malakal PoC Site, 17-18 February 2016*.

[10] IOM DTM. (2020). *South Sudan — Biometric Registration Update: Malakal PoC Site (Jan 2020)*.

[11] DRC. (2020). *Malakal POC Headcount // September 2020.*

[12] IOM DTM. (2020). Displacement Site Flow Monitoring, June 2020 and Malakal Displacement Site Flow Monitoring, July – September 2020.

STANDARDS, GUIDELINES AND LEARNING ON DISABILITY INCLUSION

International humanitarian policies and standards are increasingly inclusive of disability and persons with disabilities. In line with the *2006 Convention on the Rights of Persons with Disabilities* (CRPD), numerous international humanitarian instruments require that humanitarian assistance and protection be inclusive of persons with disabilities. Inclusive humanitarian action is based on the humanitarian mandate to reach the persons most in need of assistance, without any type of discrimination (International Humanitarian Law principle of impartiality) and protecting persons at risk (International Human Rights Law, International Refugee Law, CRPD, *Convention on the Elimination of All Forms of Discrimination Against Women*, Convention on the Rights of the Child). It ensures the protection and inclusion of person with disabilities by addressing protection risk situations and the diverse needs of persons with disabilities, by removing barriers according to the principle of reasonable accommodation (art. 2 of CRPD), and by promoting meaningful participation in situations of humanitarian crisis (art. 3(3) of CRPD, see also art. 33(3) on involving persons with disabilities in monitoring processes and art. 29-30 on participation in political and public life and participation in cultural life, recreation, leisure and sport).

Accordingly, improving the extent to which persons with disabilities participate and are meaningfully included in humanitarian action is now recognized as a key priority by humanitarian actors, UN agencies and donors. The 2016 World Humanitarian Summit drew the attention of the international humanitarian community to the need to guarantee equal access to humanitarian assistance for persons with disabilities, and consequently to address their needs and priorities by adapting humanitarian programming and tools. This commitment is enshrined in the *2016 Charter on Inclusion of Persons with Disabilities in Humanitarian Action*, currently signed by over 200 stakeholders, which accelerated efforts to mainstream disability and persons with disabilities across the humanitarian system, programs and services.

A number of resources guiding humanitarian actors to ensure protection and non-discriminatory access to humanitarian assistance have been developed over the last few years, including UNHCR's *Working With Persons with Disabilities in Forced Displacement*, UNICEF's *Including Children with Disabilities in Humanitarian Action*, UNRWA's *Disability Inclusion Guidelines*, ADCAP's *Humanitarian Inclusion Standards for Older People and People with Disabilities* and DFID's *Guidance on Strengthening Disability Inclusion in Humanitarian Response Plans*. Disability inclusion has also been prominent in protection mainstreaming tools such as the *Core Humanitarian Standards*, the accompanying *SPHERE Handbook* and the protection mainstreaming guidelines. More recently, the Inter-Agency Standing Committee established a task team to develop the *Guidelines on the Inclusion of Persons with Disabilities in Humanitarian Action*, which were released in November 2019. The main objectives of the guidelines are to provide guidance and to build capacity of humanitarian actors, governments and affected communities to coordinate, plan, implement, monitor and evaluate essential actions fostering the effectiveness, appropriateness and efficiency of humanitarian action for persons with disabilities. Further, it aims to promote

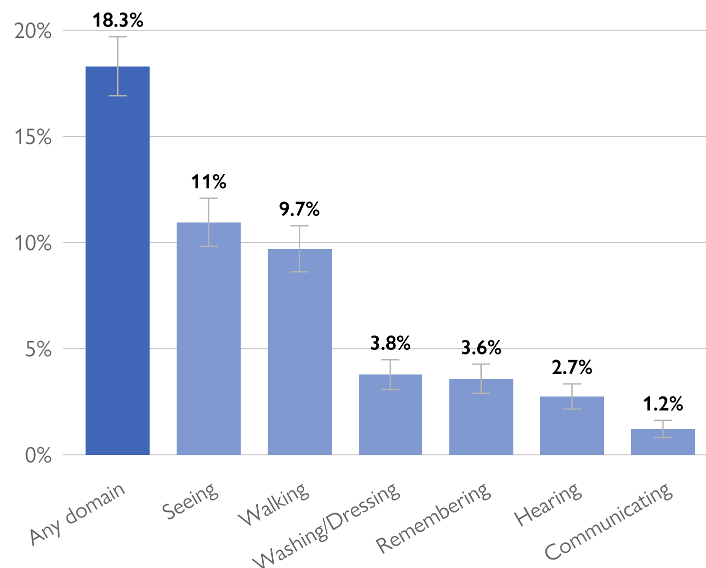
accountability and to increase and improve participation of persons with disabilities and their representative organisations in humanitarian action.

Various international standards and guidelines on 'Universal Access Design' also exist to ensure barrier-free infrastructure, built environment, information and communication systems, most notably ISO *21542:2011 Building construction - Accessibility and usability of the built environment* and British Standard *7000-6:2005 Guide to managing inclusive design*. A set of standards is also available to ensure barrier-free infrastructure in low-income countries, emergency shelter and settlements (HI, IFRC, CBM, *All Under One Roof Disability-inclusive shelter and settlements in emergencies*; HI, Guidelines for *Creating Barrier-free Emergency Shelters*; CBM, *Inclusive post-disaster reconstruction: Building back safe and accessible for all;* CBM, *Promoting Access to the Built Environment Guidelines*).

Persons with Disability in Malakal PoC Site

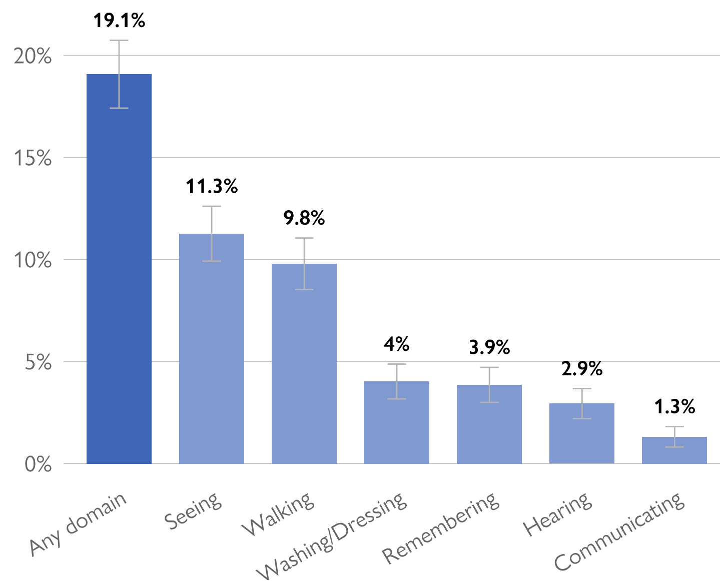
Based on the quantitative survey carried out as part of this study, 18.3 (± 1.4) per cent of households include at least one member with a disability identified by the Washington Group Questions (Figure 1). This corresponds to 19.1 (± 1.7) per cent of the individuals present in the camp at the time of the assessment reporting severe functional difficulties (Figure 2). Difficulties in the domains of vision and mobility are the most frequent, affecting respectively 11.0 (± 1.1) per cent and 9.7 (± 1.1) per cent of households, or 11.3 (± 1.3) per cent and 9.8 (± 1.3) per cent of individuals.

Figure 1: % households where at least one member reported difficulties in the respective domains of functioning [N households = 868]



Note: The error bars indicate the 95 per cent confidence intervals.

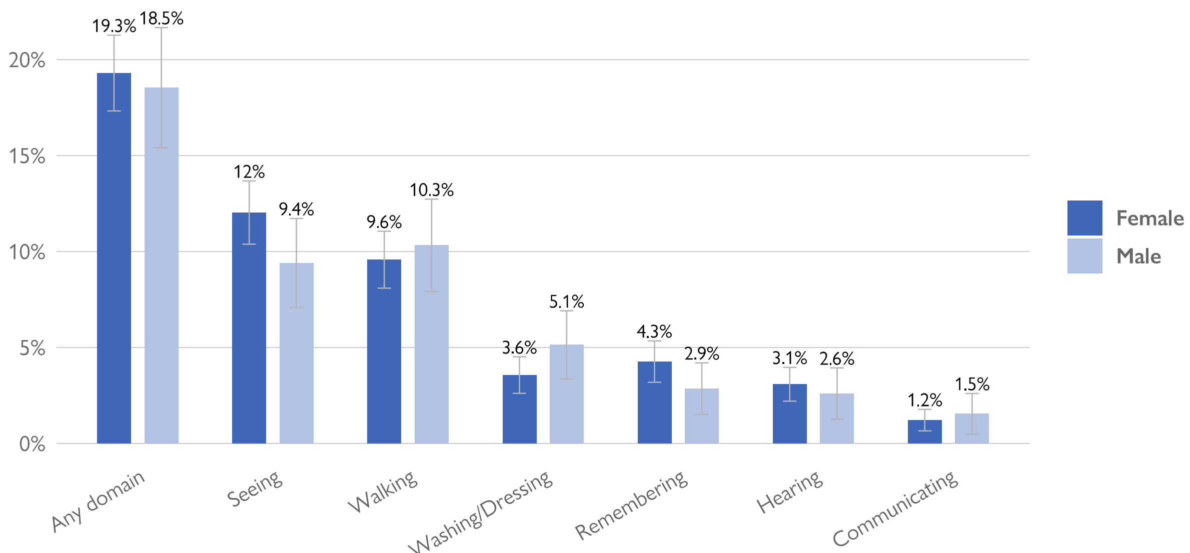
Figure 2: % respondents reporting difficulties in the respective domains of functioning [N = 2,146]



Note: The error bars indicate the 95 per cent confidence intervals.

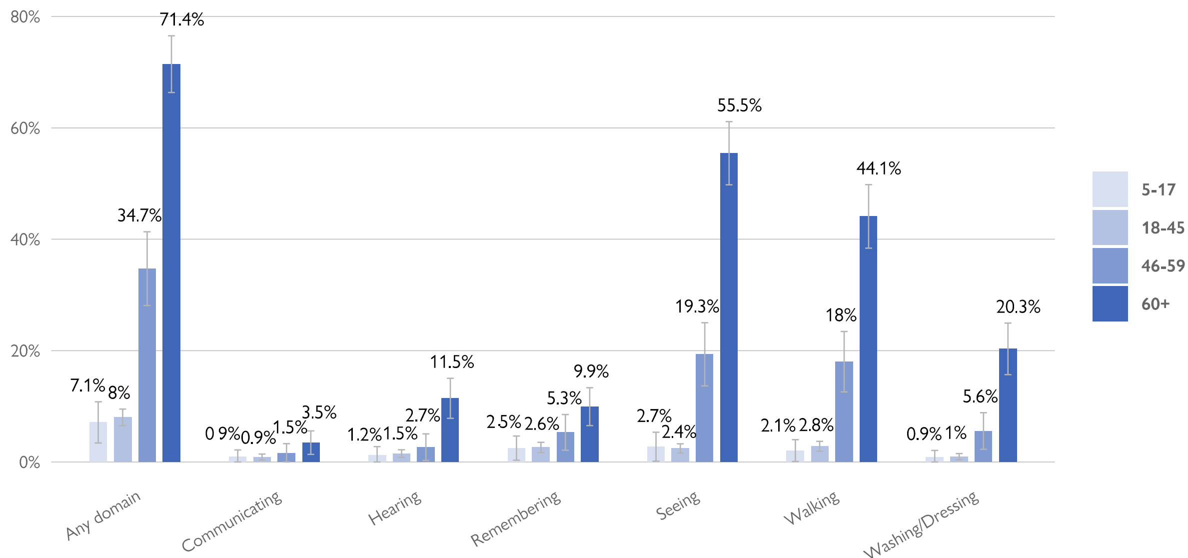
There are no statistically significant differences in the prevalence of disability between men and women, even though women and girls in this sample show a higher prevalence (Figure 3). On the other hand, the likelihood of acquiring a disability consistently increases with age of the respondents, reaching over 71.4 (± 1.2) per cent among persons over 60 years of age (Figure 4). The relative prevalence of different types of disabilities is broadly consistent across age and gender groups.

Figure 3: % respondents reporting difficulties in the respective domains of functioning by gender [N female = 1,533; male = 613]



Note: The error bars indicate the 95 per cent confidence intervals.

Figure 4: % respondents reporting difficulties in the respective domains of functioning by age [N 5-17 = 206; 18-45 = 1,445; 46-59 = 204; 60+ = 291]



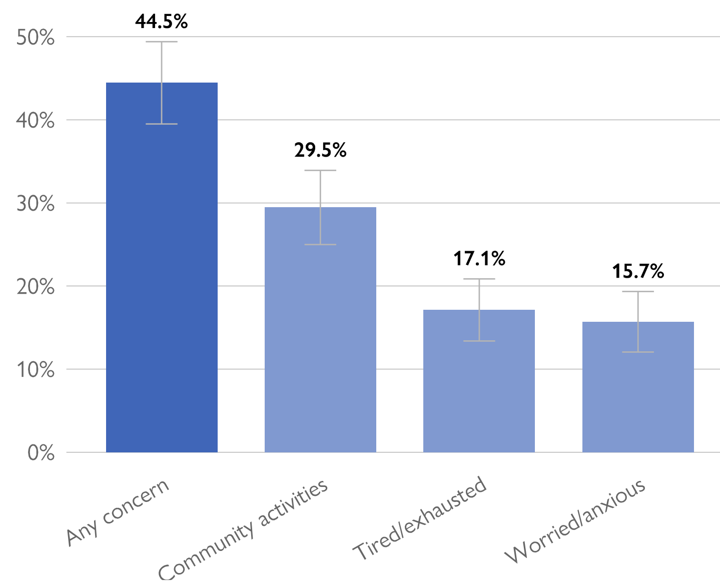
Note: The error bars indicate the 95 per cent confidence intervals.

Among individuals with disabilities, 44.5 (± 4.9) per cent report at least one mental health concern. The most common concern is difficulties in joining community activities, with 29.5 (± 2.3) per cent having a lot of difficulty or being unable to do them at all. 17.1 (± 3.7) per cent are often very tired or exhausted, and 15.7 (± 3.6) per cent frequently feel worried, nervous or anxious. There are indications that women (45.9%), adolescents between the ages 15 and 17 (48.7%) and elderly persons above the age of 60 (54.9%) with disabilities are more likely to experience mental health concerns (Table 1). Difficulties remembering or concentrating (59.8%), with self-care such as washing or dressing (74.8%) or communicating (83.6%) are functioning domains that are associated with mental health concerns, explaining the moderate degree of correlation.

The Washington Group Short Set of Questions do not specifically address intellectual disability but assess different areas of functioning that are associated with the same. Persons with intellectual disability often show cognitive, speech and behavioural problems and require additional assistance for self-care and to express themselves, participate in social life, and access (specialized) services. The present data confirms an elevated level of psychological distress among people with the above-mentioned functional limitations in Malakal PoC site. This may be linked to lack of social support, stigma and a high level of dependency on help from family and friends.[13]

[13] See Appendix for correlation between the different types of disabilities.

Figure 5: % respondents with disabilities reporting mental health concerns by domain [N = 386]



Note: The error bars indicate the 95 per cent confidence intervals.

Table 1: Prevalence of mental health concerns among persons with disabilities, by sub-group [N = 386]

Group	%	Confidence intervals
Women	45.9	40.1 - 51.7
Men	40.7	31.5 - 49.9
Ages 15-17	48.7	21.6 - 75.8
Ages 18-45	30.4	21.4 - 39.4
Ages 46-59	35.8	24.2 - 47.4
Ages 60+	54.9	48.1 - 61.7
Difficulties seeing	49.1	42.7 - 55.5
Difficulties hearing	48.3	35.6 – 61.0
Difficulties walking	52.7	45.9 - 59.5
Difficulties remembering	59.8	48.4 - 71.2
Difficulties communicating	83.6	70.5 - 96.7
Difficulties washing or dressing	74.8	65.5 - 84.1

Erin Louise Whittle, Karen R. Fisher, Simone Reppermund, Rhoshel Lenroot & Julian Trollor. (2018). Barriers and Enablers to Accessing Mental Health Services for People With Intellectual Disability: A Scoping Review, *Journal of Mental Health Research in Intellectual Disabilities*, 11:1, 69-102, DOI: 10.1080/19315864.2017.140872.

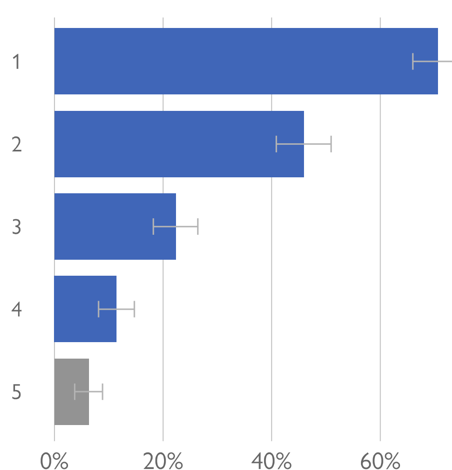
Haleigh M. Scott & Susan M. Havercamp. (2014). Mental Health for People With Intellectual Disability: The Impact of Stress and Social Support. *American Journal on Intellectual and Developmental Disabilities,* 119:6, 552–564.

Welfare of Persons with Disabilities

About half of all respondents with disabilities (49.8%) experienced major changes in their quality of life or level of independence since arriving in the camp, while 29.5 (± 5.0) per cent (31.1% of women and 28.6% of men) reported that they are not assisted in everyday life to meet their needs and live in a dignified way. When asked about solutions that could be taken in the PoC site to support persons with disabilities in leading life in dignity and autonomy, 70.6 (± 4.6) per cent requested more support to family members and care givers (Figure 6). Facilitating access to services is also a key priority, being mentioned by 45.9 (± 5.2) per cent of respondents.

Figure 6: actions that could be taken in the POC site to support persons with disabilities in leading life in dignity and autonomy (% of respondents with disability) [N = 374]

#	Action	%
1	More support to family members and care givers	70.6
2	Make access to basic services, e.g., latrines, easier	45.9
3	More recreational and cultural activities	22.3
4	Non-formal education and vocational trainings	11.4
5	Other	6.3



Note: The error bars indicate the 95 per cent confidence intervals.

Participation in Decision Making

27.1 (± 9.0) per cent of respondents with disabilities stated that they had been involved at some stage in the decision-making processes around the services delivered in the community, with only 4.5 (± 2.2) per cent reporting that they are often or always involved. The fact that the remaining 72.9 (± 4.8) per cent reported that they have never been involved in decision making highlights that more work needs to be done to facilitate the inclusion of persons with disabilities. This number was higher among women with 74.5 (± 5.4) per cent than men with 66.7 (± 9.6) per cent. There were no significant differences among the different types of disabilities. These findings signal a disconnect between the existing committee for persons with disabilities and the broader group.

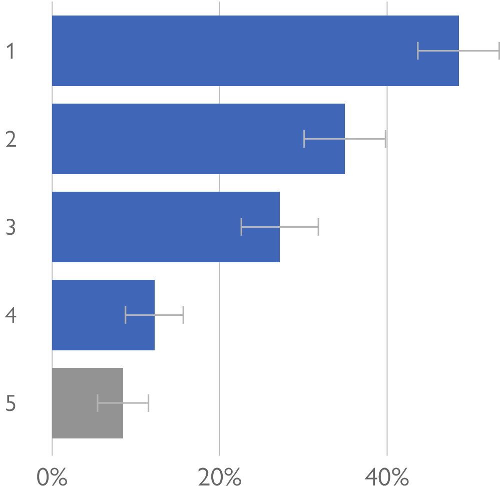
A significant share of respondents demonstrated scepticism about the possibility of influencing service delivery through feedback. While the Malakal PoC site has feedback and complaint mechanisms in place which allows persons with disabilities to lodge their complaints to camp management and other service providers, 35.1 (± 4.8) per cent nonetheless reported that there are no complaint mechanisms for them to refer to if unhappy about service delivery in their community, highlighting an important information gap in the community. Two thirds stated that the community's feedback and complaints more generally are not followed by action or response, highlighting a gap in closing the feedback loop.

> *"Why do you call us people with disabilities? All we need is for our rights to be respected."*

The main solutions suggested by persons with disabilities to better include their views in humanitarian programming are ensuring that information about feedback and complaint mechanisms is available to beneficiaries (48.5%) and setting up community-based groupings or committees (35%) (Figure 7), though a persons with disabilities committee already exists. However, only 10.5 (± 3.2) per cent of respondents are members of a community-based group or committee representing community member issues, and 70.6 (± 4.8) per cent stated that they do not desire to become members of such groups and committees. Key informants and FGDs revealed that, despite participation structures being available to persons with disabilities, a number of individuals found that their participation felt tokenistic as very little action is taken on their views and concerns. They also perceived persons with disabilities to not have access to these forums in general. These findings suggest a general preference for improving the availability of information about feedback and complaint mechanisms. At the same time, they also indicate a preference for including persons with disabilities at the centre of all decision making and increasing the decision-making power of the persons with disabilities committee itself.

Figure 7: suggested interventions to better include the views and perspective of persons with disabilities in humanitarian programming (% respondents with disability) [N = 374]

#	Action	%
1	Ensure information about feedback/ complaint mechanisms is available	48.5
2	Set up community-based groupings/committees	35.0
3	Set up peer support groups	27.2
4	Organize joint assessments	12.2
5	Other	8.5



Note: The error bars indicate the 95 per cent confidence intervals.

General Barriers in Accessing Services

The survey, FGDs and direct observation reports consistently highlighted barriers hampering access to basic services by persons with disabilities. While 59.7 (± 5.0) per cent of respondents reported that they were able to make use of the services provided by humanitarian workers whenever they chose or needed to, 35.0 (± 5.0) per cent indicated that they were unable to do so, with the proportion among both genders being roughly equal. The majority of respondents (60.9%) felt that services were being provided equally and fairly to all people, whereas 18.6 (± 4.0) per cent felt otherwise.

As shown in Figure 8, the main reported barriers were a lack of economic resources (39.3%)[14] and distance to services (38.4%). The lack of economic resources indicates that persons within the PoC site are unable to finance items through private funds in addition to what is distributed by humanitarian partners free of charge. While a lack of economic resources affected persons with disabilities roughly equally irrespective of the type of disability, distance and lack of physical access especially affected respondents with difficulties walking (49.7% and 36.8% respectively) and washing or dressing (44.5% and 41% respectively). FGDs highlighted that the COVID-19 pandemic has exacerbated the economic vulnerability of IDPs as a consequence of losses of income and movement restrictions. The fact that IDPs were prohibited by local authorities from leaving the PoC site from 6 to 18 April 2020, to limit viral exposure severely narrowed livelihood opportunities, such as firewood collection, charcoal making and gardening. The gates were reopened on 18 April 2020 but only for limited critical movement until 11 May 2020 after which all restrictions ended.

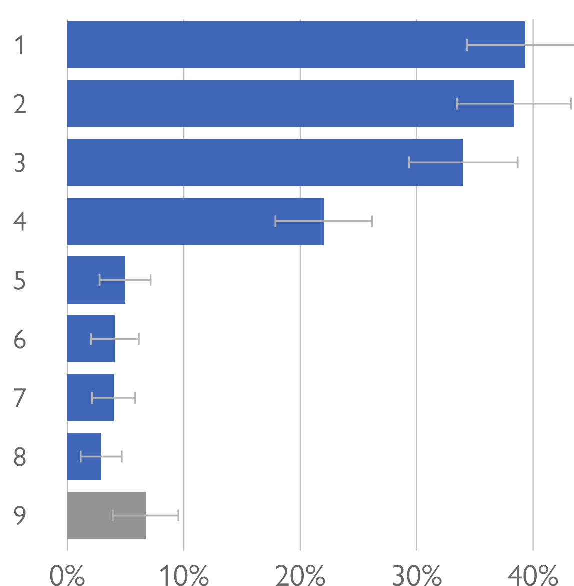
Physical accessibility of camp facilities

Persons with disabilities face multiple physical barriers in accessing services, causing difficulties to persons with reduced mobility in particular. FGD participants reported that WASH facilities at the health centre are generally physically accessible for persons with disabilities due to features, such as a flat ground or ramps in place of stairs, wide doors, and circulation space. However, they raised the issue that a key barrier is the distance to them is far. To mitigate this issue, CCCM tasked health promotion teams to identify households with difficulties in order to deliver services directly to them where possible. Other facilities, such as biometric registration and general food distribution centres, are inaccessible for persons with mobility difficulties although persons without access can submit a request to the protection desk which forwards the request to the dedicated partners. There are protection desks located in all blocks of the PoC and therefore are more accessible to people with mobility difficulties.

[14] The data collection of this survey took place before the imposition of mobility restrictions related to the outbreak of the COVID-19 pandemic. The proportion of survey respondents reporting a lack of economic resources would have likely been higher post-mobility restrictions.

Figure 8: % respondents with disabilities reporting a given difficulty in accessing services [N = 374]

#	Difficulty	%
1	Lack of economic resources	39.3
2	Distance	38.4
3	Lack of physical access	34.0
4	Lack of information	22.0
5	Services do not respond to my needs	4.9
6	Communication	4.1
7	Lack of safety	4.0
8	Discrimination and/or harassment	2.9
9	Other	6.7



Note: The error bars indicate the 95 per cent confidence intervals.

Safety Concerns

10.0 (± 1.6) per cent of respondents reported feeling unsafe when accessing services, whether at the points of delivery or on the way towards them, and 18.5 (± 3.8) per cent reported encountering actual dangers. The main reported dangers were verbal violence, mentioned by 10.4 (± 2.8) per cent of respondents (12.0% of men and 10.6% of women) followed by physical violence, mentioned by 7.4 per cent of respondents (8.0% men and 8.0% women) (Figure 9). When asked about potential solutions to improve safety in accessing services, 30.0 (± 4.6) per cent suggested clarifying how to report protection incidents while 29.9 (± 4.8) per cent could not think of a solution (Figure 10). A possible explanation for their perceived powerlessness is the pervasive stigma in the community, as pointed out in the FGDs.

In FGDs, persons with disabilities reported safety concerns in the process of accessing services in the PoC, specifically reporting facing emotional and physical abuse. The respondents cited incidents of harassment from their neighbours as well as incidents of children pelting them with stones and insulting their disabilities. Within the FGD, reports on the frequency and degree of abuse they faced differed depending on their type of disability and level of impairment, with severely impaired or bed-ridden persons with disabilities being less exposed to violence. This difference can be attributed to the fact that they cannot leave their shelters and are thus less likely to encounter the greater community. There were also disagreements within the FGDs on whether either gender is disproportionately affected. To alleviate this situation, the participants suggested to raise awareness and facilitate a dialogue between persons with disabilities and other IDPs while also enforcing law and order through the community watch group and community local court in order to prosecute perpetrators.

Figure 9: dangers encountered while accessing services (% respondents with disability) [N = 374]

#	Danger	%
1	No	81.5
2	Yes, verbal violence	10.4
3	Yes, physical violence	7.4
4	Yes, bribery	0.3
5	Yes, coercion	0.0
6	Other	2.5

Note: The error bars indicate the 95 per cent confidence intervals.

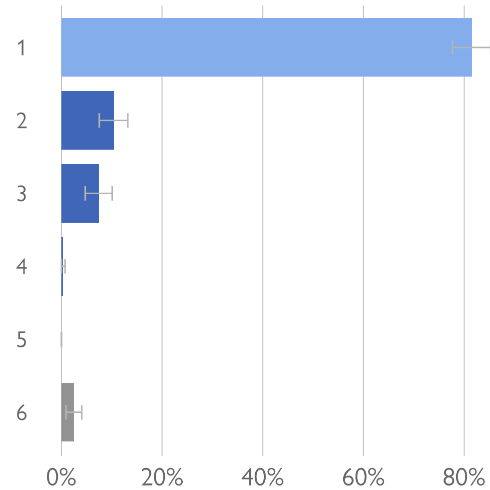
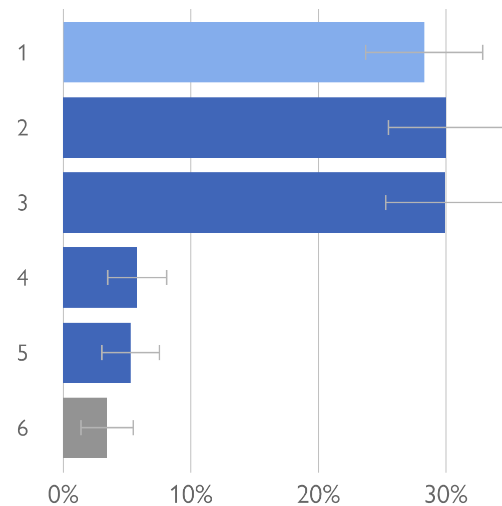


Figure 10: suggested solutions to improve safety in access to services (% respondents with disability) [N = 374]

#	Solution	%
1	No need for change, I feel safe	28.3
2	Clarify where to report protection incidents	30.0
3	Don't know	29.9
4	Change service hour	5.8
5	Change service location	5.3
6	Other	3.4

Note: The error bars indicate the 95 per cent confidence intervals.



Dignity and attitudinal barriers

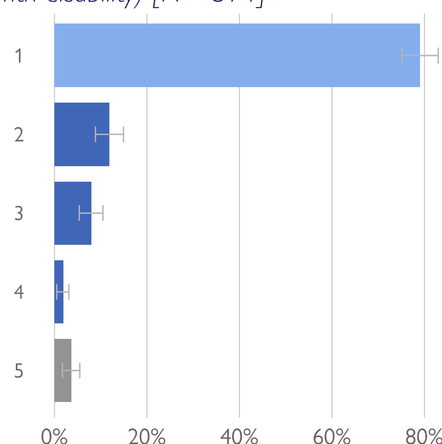
20.9 (± 4.0) per cent of respondents reported that they do not feel that their dignity is respected when accessing services, with men (23.9% ± 8.2%) being more likely to report this concern than women (19.7% ± 4.8%). These numbers were also higher for respondents with difficulties walking (24.4% ± 6.0%) and washing and dressing (24.8% ± 10.2%) than for respondents with difficulties in other domains although these figures are only indicative due to the small sample size of the sub-groups. The main complaints are lack of respect, reported by 11.9 (± 3.0) per cent of respondents, and lack of confidentiality, reported by 7.9 (± 2.6) per cent of respondents (Figure 11). Attitudinal barriers are also prevalent, with 14.9 (± 3.6) per cent of respondents with disabilities reporting negative attitudes from their family and neighbours as a result of their disability. Direct observation highlighted significant attitudinal barriers. Persons with disabilities face stigma, at times even at the

family level, which prevents them from obtaining assistance in everyday tasks. Both direct observation and FGDs emphasized that the PoC site staff actively advocated to stop discrimination.

Figure 11: dignity concerns in accessing services (% respondents with disability) [N = 374]

#	Concern	%
1	No dignity concern	79.1
2	Lack of respect	11.9
3	Lack of confidentiality	7.9
4	Discrimination	1.8
5	Other	3.6

Note: The error bars indicate the 95 per cent confidence intervals.



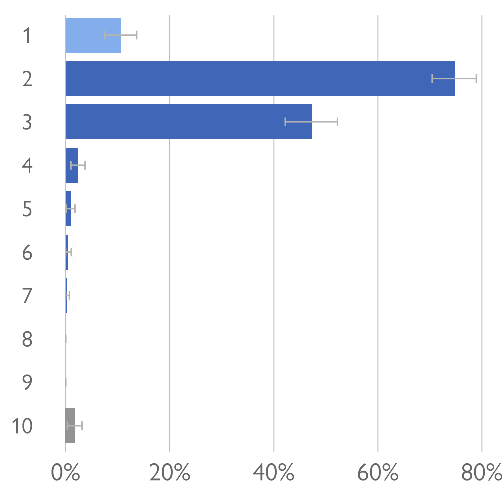
Access to Information

Information campaigns targeting persons with disabilities within Malakal PoC site are constrained by the fact that only 15.0 (± 3.8) per cent of respondents with disabilities can read and write, with an additional 2.4 (± 1.8) per cent who can only read. Local languages (Chollo and Nuer) are widely spoken (93.8% of respondents), but less than a third (27.3 per cent) speak Arabic and a minority (5.9 per cent) speak English. Persons with visual impairments in particular face barriers in accessing information shared in writing or through imagery.

Figure 12: main sources of information on community services and site updates (% resp. with disability) [N = 374]

#	Source of Information	%
1	Don't have access to any information	10.6
2	Megaphone/loudspeaker announcements	74.7
3	Radio	47.2
4	Signs/posters	2.4
5	Door to door campaign	0.9
6	Boda Boda Talk Talk	0.5
7	Television	0.3
8	Newspapers	0.0
9	Internet	0.0
10	Other	1.7

Note: The error bars indicate the 95 per cent confidence intervals.

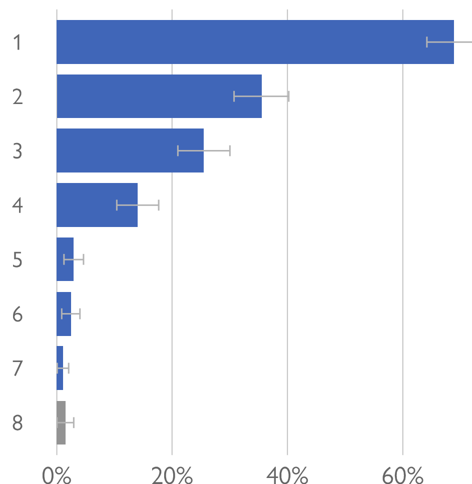


As shown in Figure 12, the most common sources of information among respondents to the survey were megaphone or loudspeaker announcements (74.7%) and the radio (47.2%). 10.6 (± 3.2) per cent of persons

with disabilities stated that they did not have access to any information, however. FGDs point out that persons with hearing impairments struggle with the reported most common sources of information. Community mobilisers were the main information providers (mentioned by 68.9% of respondents), followed by block leaders (35.5%) and friends or family (25.5%) (Figure 13). The most important information topics according to the respondents are news from family members and news about their home community / area of origin (Figure 13).

Figure 13: providers of information (% resp. with disability) [N = 374]

#	Provider	%
1	Community mobilisers	68.9
2	Block leaders	35.5
3	Friends/family	25.5
4	Don't know	14.0
5	Sector leaders	2.9
6	Religious leaders	2.4
7	Community High Committee	1.1
8	Other	1.5



Note: The error bars indicate the 95 per cent confidence intervals.

CHALLENGES IN ACCESSING INFORMATION

As discussed in the previous section, lack of access to information is the fourth main barrier hindering access to services by persons with disabilities, with 22.0 (± 4.1) per cent of respondents with disabilities reporting it as a challenge. Direct observation of service delivery within the camp site revealed that persons with different types of disabilities face different challenges. Because a large share of information dissemination relies on audio formats, individuals with hearing impairments face major communication barriers in accessing services. Long distances that prevent information from being received from service providers is a major roadblock as well. FGD highlighted that a major challenge that all persons encounter with accessing information is the lack of radios, which is a consequence of lack of economic resources. In the quantitative survey, the main reported challenges in accessing information were lack of economic resources (39.3%), distance to services (38.4%) and lack of physical access (34.0%) (Figure 15).

Since the outbreak of the COVID-19 pandemic, house-to-house visits were reduced and information dissemination through audio and visual formats were increased, posing problems for persons with disabilities who relied on the house-to-house visits. The limited mobility of persons with disabilities aggravates the effect

of this issue significantly. Moreover, the lack of diversification of information sources excludes certain persons with disabilities from accessing them. Posters and signs hinder persons with visual, intellectual or mental difficulties and radio announcements hinder persons with hearing difficulties from accessing the needed information.

Figure 14: most important type of information received (% resp. with disability) [N = 374]

#	Type of Information	%
1	News from family members	58.7
2	On home community/area of origin	53.3
3	Health and treatment advice	26.7
4	On service provision	19.2
5	On security and protection	141
6	Other	3.7

Note: The error bars indicate the 95 per cent confidence intervals.

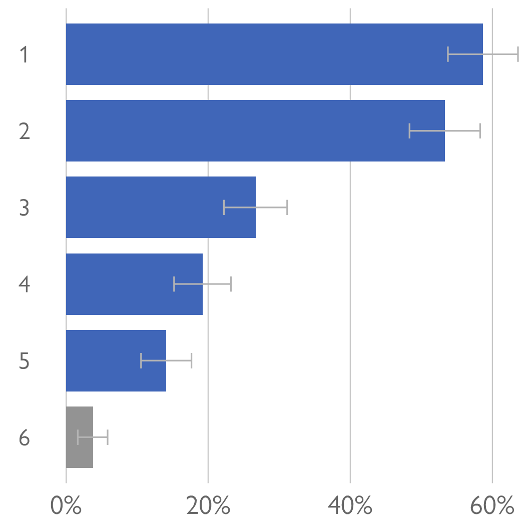
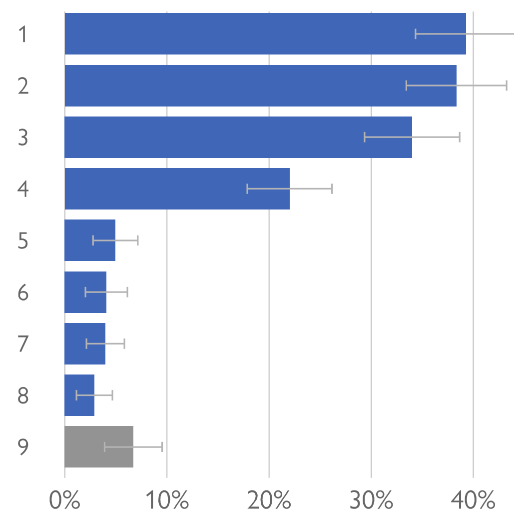


Figure 15: % respondents with disabilities reporting a given difficulty in accessing services [N = 374]

#	Difficulty	%
1	Lack of economic resources	39.3
2	Distance	38.4
3	Lack of physical access	34.0
4	Lack of information	22.0
5	Services do not respond to my needs	4.9
6	Communication	4.1
7	Lack of safety	4.0
8	Discrimination and/or harassment	2.9
9	Other	6.7

Note: The error bars indicate the 95 per cent confidence intervals.



Access to Service

Table 2 shows the availability and accessibility of services by persons with disabilities across multiple sectors, as reported by survey respondents. Highlighted cells signal particularly high shares of respondents indicating that the services are hard to reach or not available. NFI distribution (44.8% hard to reach, 33.4% not available) and cash transfer services (27.2% hard to reach, 42.3% not available) are hardest to reach or not available. There are no significant gender differences on average across all categories. Ten other basic services were reported to be hard to reach by over 40 per cent of respondents: safe clean water, toilet and sanitation, shelter, general health services, access to medication, assisted referral, protection services, livelihood opportunities (by respondents over the age of 18), education (by respondents under the age of 18) and reunification with family members or caregivers. Rehabilitation services, psychosocial support, assisted referral, livelihood opportunities and reunification with family members of caregivers were reported to not be available by over 10 per cent of respondents.

Comparing access to services by gender, men reported services to be less easily accessible than women on average. 32.8 (± 9.3) per cent of men with disabilities found HIV VCT services either hard to reach or not available compared to 23.2 (± 5.1) per cent of women with disabilities. Men also reported harder or no access to food distribution, safe clean water and livelihood opportunities by about seven per cent more than women. Women were more likely to report two services to be hard to reach or not available: NFI distribution (77.7% ± 5.1% compared to 69.0% ± 9.2% among men) and cash transfer services (68.5% ± 5.7% compared to 62.4% ± 9.6% among men).

Table 2: Availability and accessibility of services across sectors (% of respondents with disability) [N = 374]

Services	Available, easy to reach	Available, hard to reach	Not available	Not applicable/ Don't know
Food distribution	50.5 (± 5.0)	39.6 (± 4.9)	0.8 (± 0.8)	9.1 (± 2.8)
Safe clean water	38.6 (± 4.8)	55.5 (± 4.9)	1.1 (± 1.1)	4.7 (± 2.1)
Toilet and sanitation	51.2 (± 5.1)	43.7 (± 5.0)	0.0	5.2 (± 2.3)
Shelter	32.2 (± 4.6)	42.8 (± 5.0)	10.5 (± 3.2)	14.5 (± 3.3)
NFI distribution	7.8 (± 2.6)	44.8 (± 5.0)	33.4 (± 4.7)	13.9 (± 3.5)
General health services	45.3 (± 5.0)	47.9 (± 5.0)	1.0 (± 1.0)	5.8 (± 2.2)
HIV VCT services	16.9 (± 3.8)	17.2 (± 3.9)	9.7 (± 2.8)	56.1 (± 5.0)
Rehabilitation services	10.6 (± 2.9)	34.4 (± 4.8)	19.5 (± 3.8)	35.4 (± 4.9)

Services	Available, easy to reach	Available, hard to reach	Not available	Not applicable/ Don't know
Access to medication	41.0 (± 4.9)	43.1 (± 5.0)	5.7 (± 2.6)	10.2 (± 2.8)
Psychosocial support	24.1 (± 4.3)	21.9 (± 4.2)	17.7 (± 3.7)	36.3 (± 4.8)
Access to info on services	36.5 (± 4.8)	36.1 (± 4.9)	3.2 (± 3.2)	24.3 (± 4.3)
Assisted referral	14.6 (± 3.6)	49.8 (± 5.1)	17.8 (± 3.7)	17.8 (± 3.9)
Cash transfer services	7.5 (± 2.7)	27.2 (± 4.6)	42.3 (± 4.9)	23.0 (± 4.2)
Protection services	30.3 (± 4.7)	44.9 (± 5.0)	3.6 (± 2.0)	21.2 (± 4.0)
Reunification family caregiver	20.9 (± 4.1)	43.1 (± 5.0)	13.4 (± 3.2)	22.5 (± 4.3)
Education*	41.9 (± 28.8)	51.4 (± 29.5)	0.0	6.7 (± 6.7)
Livelihood opportunities**	10.1 (± 2.9)	47.4 (± 5.0)	17.7 (± 3.8)	24.8 (± 4.4)

Cells are highlighted if the share of respondents reporting that the service is available but hard to reach is higher than 40 per cent, or if the share reporting that the service is not available is higher than 10 per cent.

** Responses only from individuals aged 15-17. ** Responses only from individuals over the age of 18.*

WATER, SANITATION AND HYGIENE

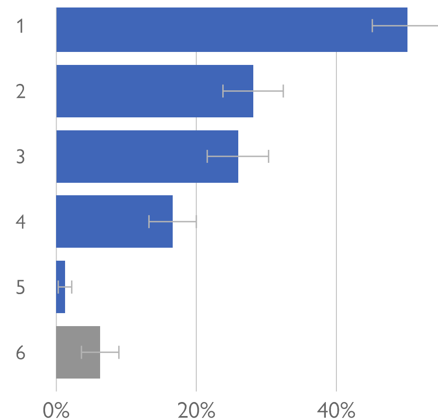
71.1(± 4.8) per cent of respondents with disabilities have access to enough water for drinking, washing, cleaning and cooking. Among the 28.9 (± 4.8) per cent who do not, the main reasons are lack of physical access (35.6%) and lack of economic resources (26.0%). By economic resources, participants were referring to money for purchasing additional water for use due to their needs exceeding the daily water ration of 18 litres per IDP in the camp that is provided to them free of charge. When asked about possible interventions to facilitate access to safe drinking water, 50.1 (± 4.9) per cent of respondents suggested locating water taps closer to their residence, 28.1 (± 4.4) per cent providing a special queue or priority lane to avoid long standing waits and 25.9 (± 4.4) per cent making water taps physically accessible (Figure 16).

Access to sanitation is slightly higher than access to water, with 27.0 (± 5.2) per cent of female and 18.6 (± 7.6) per cent of male respondents lacking access to a latrine or sanitation facility. The main reasons for lack of access are economic resources (47.2%; 31.0% men and 52.2% women), followed by lack of physical access (37.7%; 24.1% men and 42.7% women) and lack of hygiene or dignity (20.2%). As for water, IDPs commonly rely on personal expenditure to purchase soap in addition to the amount distributed freely by humanitarian partners on a monthly basis. As shown in Figure 18, the most popular suggested interventions to facilitate access to

sanitation reflects the main challenge above but also include providing additional information about services (28.0%).

Figure 16: suggested interventions to facilitate access to safe drinking water (% resp. with disability) [N = 374]

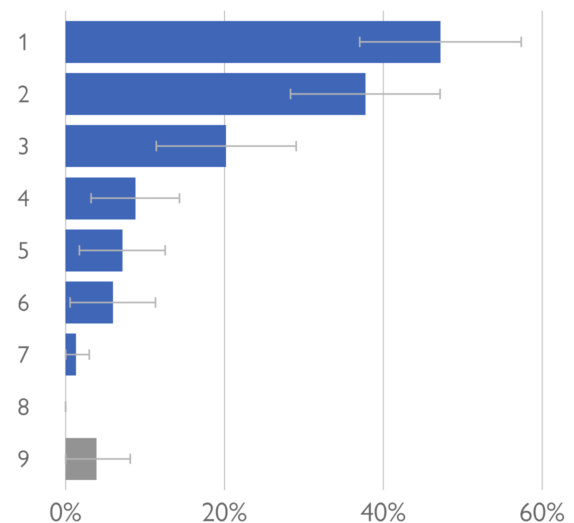
#	Intervention	%
1	Locate water tap closer to my residence	50.1
2	Provide special queue/priority lane	28.1
3	Make water tap physically accessible	25.9
4	Provide information about services	16.6
5	Remove threats of harassment/discrimination	1.2
6	Other	6.3



Note: The error bars indicate the 95 per cent confidence intervals.

Figure 17: reasons for lack of access to a WASH facility (% resp. with disability lacking access) [N = 91]

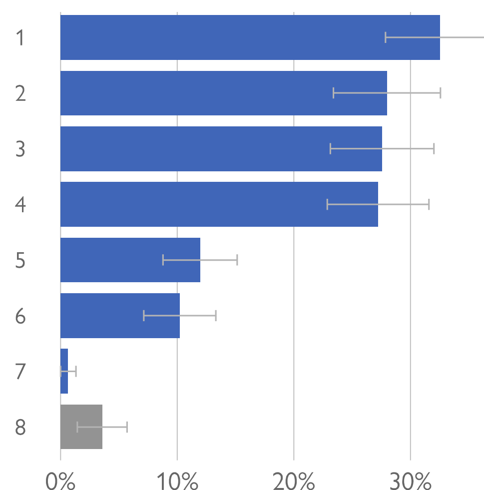
#	Reason	%
1	Lack of economic resources	47.2
2	Lack of physical access	37.7
3	Lack of hygiene/dignity	20.2
4	Distance	8.8
5	Lack of information	7.1
6	Lack of safety	5.9
7	Lack of privacy waits	1.3
8	Discrimination and/or harassment	0.0
9	Other	3.9



Note: The error bars indicate the 95 per cent confidence intervals.

Figure 18: suggested interventions to facilitate access to sanitation facilities (% respondents with disability) [N = 374]

#	Intervention	%
1	Increase physical accessibility	32.5
2	Provide information about services	28.0
3	Ensure cleanliness	27.6
4	Move sanitation facilities closer by	27.2
5	Provide specialized items to facilitate sanitation	12.0
6	Provide roof/door	10.2
7	Remove threats of harassment/discrimination	0.6
8	Other	3.6



Note: The error bars indicate the 95 per cent confidence intervals.

WASH FACILITIES

Direct observation of the site highlighted the availability of two accessible latrines per 20 latrines in each block, in addition to the extra latrines for children and elderly persons. They are equipped with a raised and moulded seat, rails on the side, locks and a small ramp made of timber. Cleaners also prioritize these latrines. There are additional materials provided for people who have difficulties using sanitation facilities or conducting personal hygiene practices, such as commode chairs, bedpans, diapers, buckets, soap and menstrual hygiene kits. Information and hygiene promotion messages have been diversified and are communicated through drama, mass education, meetings, door-to-door visits, schools hygiene clubs, hand washing champions leagues, menstrual hygiene focal persons for young girls and radio Nile FM.

While accessible WASH facilities, including water points, latrines and bathing shelters are available in Malakal PoC site, they are not easily accessible to all persons with disabilities. There is a lack of assistive devices as well as a lack of compatibility between them and available facilities. For some, the facilities can only be accessed with the assistance of a caregiver.

Paths towards the water points, toilets and bathrooms are uneven and narrow, especially worsening during the rainy season, making it highly difficult for wheelchair users and persons with mobility or visual difficulties to move across these paths. The lack of special queues for persons with disabilities also complicates their access to items during distribution. Moreover, key informants highlighted that the sanitation facilities are not always safe to access as travel at night in dim lighting can pose a risk due to long distances.

Recommendations by disability focal persons to address these barriers mainly revolve around strengthening the already existing accessibility efforts for persons with disabilities. They identified a need to increase the number of latrines and building latrines that follow universal standards to enable RECU (Reach-Enter-Circulate-Use)[15]. Paths towards the WASH facilities need to be repaired and have more lights installed to ensure safety at night. There is also a call to further diversify the means of information dissemination and to increase the number of scheduled targeted distribution of consumables, such as towels, soap and buckets. Furthermore, to promote sustainability and community empowerment, disability focal persons recommended increasing the caregivers' wages and employing capable persons with disabilities.

Perceptions of persons with disabilities from focus-group discussions

- *Participants complained that water points and latrines are especially challenging to use due to a lack of assistive devices and wheelbarrows. The height of the water taps and the steps surrounding them poses a problem as well.*
- *Female respondents were concerned about limited availability of sanitary towels for women.*
- *Persons with disabilities attempting to access WASH facilities fear abuse from members of the community who perceive that persons with disability are receiving preferential treatment at the expense of other IDPs.*
- *Adding to longstanding water supply issues, water and soap supplies no longer suffice because of increased usage in the wake of the COVID-19 pandemic.*

Food Security and Livelihoods

General food distribution (GFD) sites have dedicated help desks and focal persons to support and prioritize persons with vulnerabilities and special needs, including persons with disabilities. The focal persons also record the number of people who are unable to reach the distribution centres, passing on this information to protection partners to enable delivery of aid to their shelters. Moreover, food assistance providers conduct information campaigns for the general population of the camp to sensitize the residents about the need to prioritize persons with disabilities and elderly persons during food distribution, so as to enable them to obtain their GFD allowance and allow enough time for them to return to their shelters.

Nonetheless, persons with disabilities reported that they face significant barriers when accessing GFD. Persons with seeing and mobility difficulties are targeted by thieves due to their vulnerability and can be exploited by

[15] Humanity & Inclusion. (2018). *Humanitarian inclusion standards for older people and people with disabilities*. "Reach buildings, public spaces, communications, transportations and other services they wish to use. Enter buildings and other spaces, and have access to written materials and broadcasted messages. Circulate inside buildings and other places. Use all the services provided and use all communication materials." (p. 38-39)

community members who request money to support them to access the GFD centres. Disability focal persons also reported that wheelchairs are not widely available on site, and thus the biometric registration required for food rations poses an additional burden on persons with mobility difficulties. Even when asking for assistance at the help desk, the needs of persons with disabilities may not be fully recognised as the help desks are not staffed by persons with disabilities.

Disability focal persons' recommendations call for a need to continue raising awareness in multiple formats about the rights of persons with disabilities and elderly to access services. There is also a need to adapt distribution methods for persons with visual impairments to protect them being exploited by those who guide them to the GFD centres, such as door-to-door services. Lastly, an effort should be made to employ persons with disabilities at help desks.

General food distribution is carried out using biometric registration records from IOM DTM. 85.1 (± 3.6) per cent of respondents with disabilities reported being registered for food distribution since their arrival. Among those not registered, the majority stated that no registration exercise had taken place since their arrival in the camp (76.7%). Overall, 67.8 (± 4.6) per cent of respondents with disability reported benefiting from fast-tracked registration services as a result of their vulnerabilities or knowing someone who did.

Since the start of the pandemic, border closures and movement restrictions have brough about an increase in prices of food items and other non-food items[16], increasing the reliance of IDPs on food distribution.

Shelter and Non-Food Items

Only 54.9 (± 5.2) per cent of survey respondents with disabilities were satisfied with the condition of their shelter, and 93.7 (± 2.6) per cent stated that they were unable to improve their shelter condition by themselves. Direct observation shows that the congestion of the site does not allow for enough shelters to be constructed in a way that satisfies safety and dignity standards for their residents, an issue which has been compounded by a number of new arrivals since June 2020[17]. However, some FGD participants revealed that their shelters were adjusted to enlarge the entrance to fit a wheelchair and have enough space to

Perceptions of persons with disabilities from FGDs

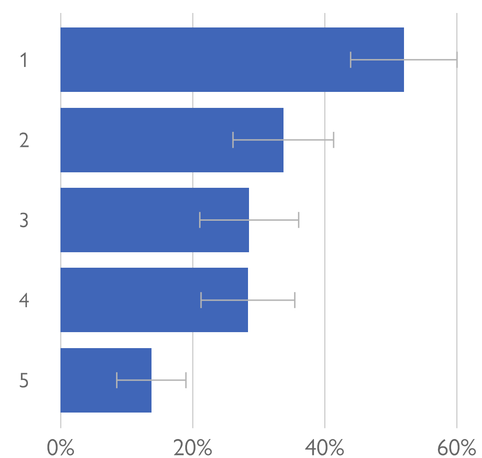
- *Since the outbreak of the COVID-19 pandemic, food rations were decreased, no longer sufficing for two months. They wish for them to be increased to its former quantity of 2kg.*
- *GFD are not always on time, resulting in increased waiting time and uncertainty.*

[16] IPC. South Sudan (2020). *IPC Acute Food Insecurity & Acute Malnutrition Analysis October 2020 – July 2021*.
[17] IOM DTM. (2020). Displacement Site Flow Monitoring, June 2020 and Malakal Displacement Site Flow Monitoring, July – September 2020.

accommodate one, allowing for secure storage without running into the risk of it being stolen overnight. 60.5 (± 5.0) per cent of survey respondents reported that they were able to easily enter and move around in their shelters, corroborating these efforts. Of those who responded that they were unable to easily enter and move around in their shelters, 52.0 (± 8.2) per cent stated that the shelter is not accessible, 33.7 (± 7.8) per cent that the shelter is too small and 28.6 (± 7.6) per cent that the shelter is not located in an accessible environment as the main challenges (Figure 19). Moreover, 46.4 (± 5.2) per cent of persons with disabilities indicated that they did not feel safe inside their shelter. To address these shortcomings, respondents suggested providing inner locking (55.2%) and providing lighting in or around the shelter (36.4%).

Figure 19: main challenges to move easily in and around one's shelter (% resp. with disability facing difficulty in and around their shelter) [N = 142]

#	Challenges	%
1	The shelter is not accessible	52.0
2	The shelter is too small	33.7
3	The shelter is not located in an accessible environment	28.6
4	Shelter items and furniture are too high or too low	28.4
5	No visual guidance is available in or around the shelter	13.7



Note: The error bars indicate the 95 per cent confidence intervals.

Most participants were unaware of shelter rehabilitation services and only knew about NFI distributions. More than half of the respondents confirmed that they had received specialized items/assistance targeted for person with disabilities, including the provision of assistive devices, such as wheelchairs, walking sticks and crutches. In FGDs, respondents voiced the need for further items, such as torches, blankets, mosquito nets, radios, sleeping mats and clothes, and cash assistance. In line with these requests, 82.3 (± 3.6) per cent of survey respondents stated that they did not have access to shelter materials, citing the lack of physical access (14.2%) and not being part of the target group (8.9%) as the main challenges. 30.4 (± 4.8) per cent of respondents indicated that they did not know about or have never tried accessing the NFI distributions.

Figure 20: suggested interventions to increase the respondents' feeling of safety in and around their shelter (% resp. with disability who feel unsafe inside their shelter) [N = 169]

#	Intervention	%
1	Provide inner locking	55.2
2	Provide lighting in/around the shelter	36.4
3	Install protection screen to increase privacy	17.9
4	Change shelter location	10.9
5	Other	26.5

Note: The error bars indicate the 95 per cent confidence intervals.

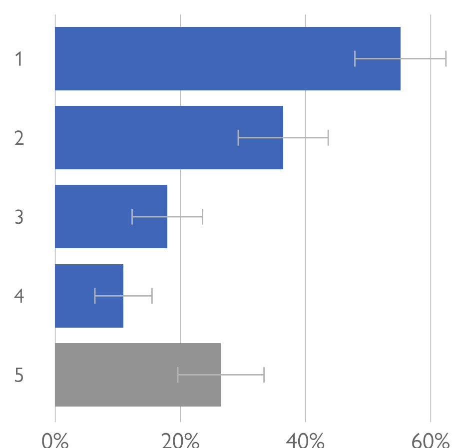
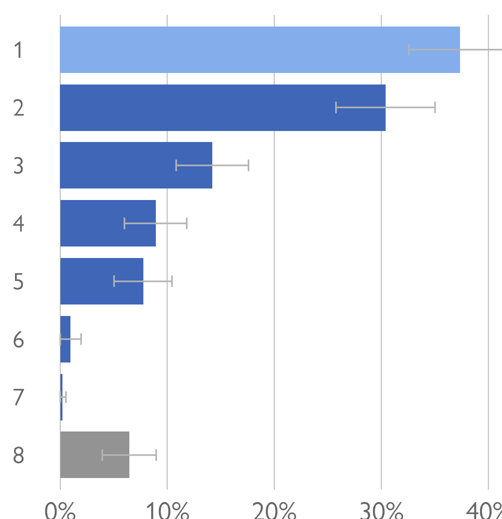


Figure 21: challenges to access and benefit from NFI distributions (% resp. with disability) [N = 374]

#	Challenge	%
1	No	37.3
2	Don't know/Never tried to access	30.4
3	Lack of physical access	14.2
4	I am not part of the target group	8.9
5	Distance	7.7
6	Communication barriers	0.9
7	Discrimination and/or harassment	0.2
8	Other	6.4

Note: The error bars indicate the 95 per cent confidence intervals.



FGD participants recommended to allocate shelters for persons with disabilities closer to key infrastructure and continue assisting elderly persons and persons with disabilities in constructing shelters if they are without family support. At a higher level, there is also a need to promote access of persons with disabilities to shelter committees and a need for camp management committees to consider rails, ramps, WASH facilities and other measures to promote independent access. A majority of FGD participants suggested that the best way to include the views of persons with disabilities was through humanitarian partners actively engaging them. Although a disability committee is already in place in the camp, these findings suggest that the existence of the committee is not enough to ensure effective participation. Persons with disabilities express a desire to be more integrated in the regular community coordination structures. This would enable them to incorporate their views and perspectives regarding humanitarian programming.

Health

Not all persons with disabilities living within the PoC site were able to access the health services they needed. 39.3 (± 4.9) per cent of respondents experienced medical needs over the six months preceding the survey, of whom over two thirds (70.8%) were able to address them and obtain the required medication. Among the 29.2 (± 7.4) per cent who could not, the main reported reasons were lack of economic resources (31.5%) and services not responding to needs (28.2%).

Direct observation and FGDs revealed that service providers still need to improve their efforts to spread awareness about the rights of persons with disabilities to health services by increasing outreach or door-to-door visits. Information sharing so far has been conducted via public address systems, local radios, posters, word-of-mouth and door-to-door awareness raising, which require further adaptation to cater to all types of disabilities. Moreover, there is a need for community awareness to increase through advocacy to the leaders to enhance communication to all populations including those hard to reach. There is also a need for staff providing these services to raise awareness in the community to improve attitudes towards persons with disabilities.

HIV Voluntary Counselling and Testing (VCT) Services

72.2 (± 4.8) per cent of respondents with disabilities were not aware of HIV prevention, VCT and treatment services. However, among the 13.7 (± 3.9) per cent who tried to access HIV services, 95.6 (+ 4.4; - 6.4) per cent (n = 54) were able to do so.

Access to rehabilitation care and assistive devices/technology

Among the 64.6 (± 4.9) per cent of respondents who need disability specific health services, only 37.1 (± 4.8) per cent were able to maintain it on arrival to the PoC site. About half (48.4%) also reported a need for specific nutritional supplies, mostly as a result of iron deficiency or diabetes. 59.4 (± 6.8) per cent of those in need are unable to access the required nutritional supplies, mostly due to lack of financial means or economic resources.

58.4 (± 5.0) per cent of respondents with disabilities report the need for assistive devices and technology. Table 2 presents the main items needed and the share in need who lack each item. These figures are only indicative due to the small sample sizes involved. 64.6 (± 5.0) per cent also need specific services due to difficulties they are facing, as outlined in Figure 22. Physiotherapy, occupational therapy and speech therapy is the main specialized service mentioned by the respondents (28.8%), followed by mental health and psychosocial support (23.7%) and social protection programming (23.2%).

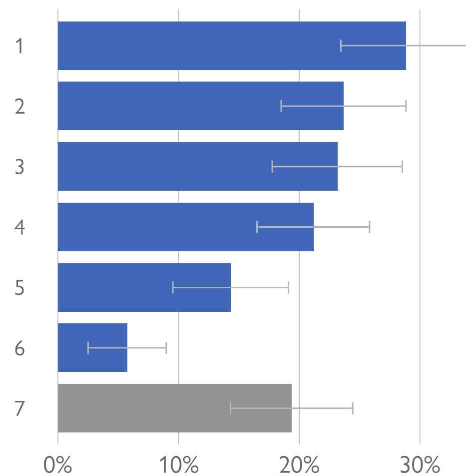
As shown in Figure 23, the two main solutions suggested by respondents to improve access to the services they need are increased free of charge provision of services or treatments (62.3%) and support of family and friends (48.5%).

Table 3: assistive devices needed (% respondents with disability in need of a supportive item)

Item	% In need [N = 222]	% Of whom lack them
Cane or walking stick	40.9 (± 6.5)	74.5 (± 9.4) [N = 91]
Walker or Zimmer frame	11.1 (± 3.9)	80.3 (± 13.7) [N = 28]
Crutches	2.7 (± 1.8)	58.1 (± 33.5) [N = 8]
Wheelchair or mobility scooter	10.6 (± 3.9)	76.2 (± 16.5) [N = 25]
Artificial limb (leg/foot)	2.9 (± 2.2)	86.6 (± 23.4) [N = 7]
Other	46.0 (± 6.5)	90.7 (± 6.1) [N = 95]

Figure 22: specialised services needed as a result of the impairment/health condition (% resp. with disability who are in need of specialized services) [N = 247]

#	Service	%
1	Physio-, occupational or speech therapy	28.8
2	Mental health and psychosocial support	23.7
3	Social protection programming	23.2
4	Prosthetics/orthotics	21.2
5	Support to employment	14.3
6	Support to education	5.7
7	Other	19.4

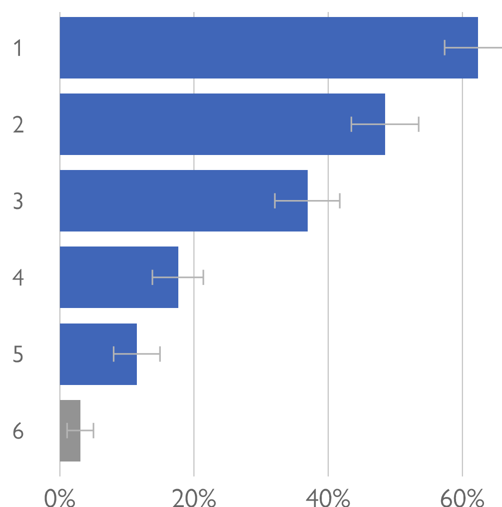


Note: The error bars indicate the 95 per cent confidence intervals.

Figure 23: suggested solutions to increase respondents' access to services provided (% resp. with disability) [N = 374]

#	Solution	%
1	Free of charge services/treatments	62.3
2	Support of family/friends	48.5
3	Transport	36.9
4	Outreach services	17.6
5	Community support	11.5
6	Other	3.1

Note: The error bars indicate the 95 per cent confidence intervals.



Mental Health and Psycho-Social Support

The Mental Health and Psychosocial Support (MHPSS) partners in Malakal (IOM, IMC, MSF and DRC, INTERSOS and WCH) provide community and family support, and focused support such as counselling and support groups at MHPSS centres or clinics, during home visits as well as via tele-counselling in the PoC. Furthermore, specialized services for persons with mental health problems are available. However, family and friends represent the main source of strength and support for 77.4 (± 4.4) per cent of respondents with disabilities. For comparison, NGO and service providers – the second most common answer – are mentioned by only 10.1 (± 3.2) per cent. Over half of respondents report a lack of access to any form of psychosocial support (63.7%), while 16.1 (± 3.9) per cent are able to access counselling. These figures are slightly worse for persons with disabilities with mental health concerns, with 66.8 (± 7.0) per cent being unable to access support services and only 11.6 (± 4.6) per cent having access to counselling. Formal and informal support groups (10.0% and 5.9% respectively) are relatively uncommon. Figure 24 shows the main reasons reported by those who lack access to psychosocial support, highlighting the importance of information and local provision of services.

The FGD participants revealed that considerable attitudinal barriers surrounding mental health and psychosocial support (MHPSS) exist. In the PoC site, persons with disabilities – especially those suffering from mental health concerns – face stigma. The community counselling and recreational centre is considered by many as a place for persons suffering from severe mental health issues, as manifested in the language used by the community to refer to these conditions ('madness'), discouraging persons in need from accessing the services because of their negative connotation. The work of MHPSS staff is similarly misunderstood by some in the community, although partners have been proactive in reframing it in more inclusive terms.

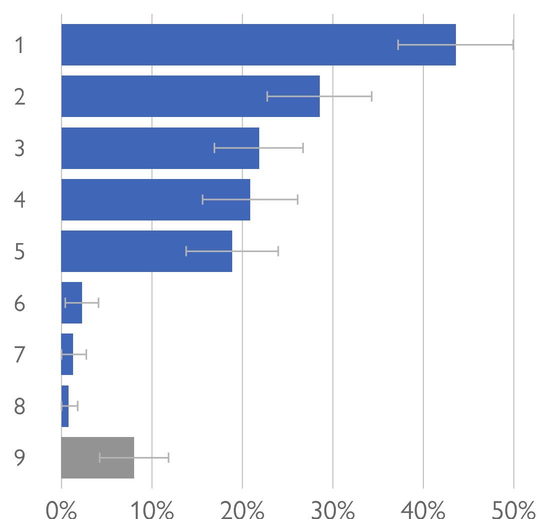
Accessibility is also limited by persons with physical impairments not receiving support to reach the centres. MHPSS staff still lack knowledge on how to adapt some activities to enable inclusion of persons with disabilities, such as skills and recreational activities for people with visual difficulties, although they are increasingly undergoing training.

> *"Children are not respecting those with mental illness, they used to say that they are mad people – children need to be taught to respect us."*

To alleviate these shortcomings, there are already some outreach services through house-to-house visits, referrals and follow-ups in place as well as inclusive feedback mechanisms in order to record concerns of persons with disabilities. It is suggested to diversify and adapt recreational activities, psychological support and psycho-educational activities further, also separating such activities by gender. There is also a need for continuous awareness raising to communities, staff and persons with disabilities themselves on the availability of the MHPSS services and the recreational centre activities.

Figure 24: reasons for lack of access to psychosocial support (% resp. with disability who lack access) [N = 235]

#	Reason	%
1	Lack of information	43.6
2	Not available locally	28.5
3	Lack of physical access	21.8
4	Distance	20.9
5	Lack of economic resources	18.9
6	Communication barriers	2.3
7	Discrimination and/or harassment	1.3
8	Lack of safety	0.8
9	Other	8.0



Note: The error bars indicate the 95 per cent confidence intervals.

Protection

Protection partners (INTERSOS, UNICEF, DRC, HDC, UNHCR, IMC) conduct protection monitoring through community-based protection networks, such as the persons with disabilities committee, women groups and leadership groups, who inform protection partners of any challenges. Services have been centralized and can be accessed near camp management, at the two protection desks and complaint boxes and through the persons with disabilities committee. There are also women and girls-friendly spaced that have been made accessible to women and girls with disabilities.

Most of the participants in FGDs affirmed that elderly persons and persons with disabilities face protection risks, such as theft, exploitation and abuse, and that those disproportionately affect women and girls. Key informants additionally highlighted gender-based violence, neglect, forced childbearing and arranged marriages for women with disabilities. A police post has been constructed inside the site in order to improve access for persons with mobility difficulties, and house-to-house outreach services were implemented as part of this effort as well. Moreover, solar lamps were distributed to improve security around the paths to latrines at night and the chairperson of the community action group asked the security personnel to supply torches.

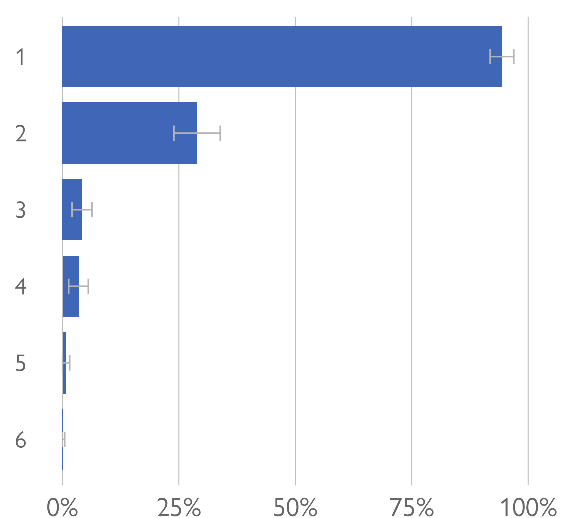
Most of the FGD participants were also aware of protection mechanisms and pathways, and of the presence of a representative for persons with disabilities at one of the protection desks, owing to the regular protection service information promotions by the protection staff. Participants also confirmed that these services are available and physically accessible to persons with disabilities, although a limited number was unaware of the existing pathways and relied on the community watch groups in case of incidents. These findings contrast with observation of limited access to these services by persons with disabilities, due to the distance to the protection desks and venues for security and safety meetings as well as a lack of information.

The survey findings corroborate this, indicating that 12.8 (± 1.7) per cent of respondents with disabilities are unable to share their concerns with somebody when needed. Those who can most often turn to family members (94.4% of those able to share their concerns) and friends (28.9%), while it is uncommon for persons with disabilities to turn directly to formal actors, such as camp leaders and service providers (Figure 25). The findings suggest that, in order to facilitate the use of protection services, they require a more central location that is closer to shelters of persons with disabilities and strengthened outreach activities.

Figure 25: persons/actors with whom persons with disability are able to share their concerns (% resp. with disability who can share their concerns when needed) [N = 324]

#	Person/actor	%
1	Family member	94.4
2	Friend	28.9
3	Camp leader	4.2
4	Service provider	3.5
5	Community volunteer	0.7
6	Peer support group or community-based group	0.2

Note: The error bars indicate the 95 per cent confidence intervals.



Camp coordination and camp management

CCCM has service desks in various locations inside the PoC site and has established 14 committees in the PoC site that concern themselves with different groups, including the elderly, women, person with special needs. These hold periodic meetings, which are attended by protection partners and GBV, general protection and child protection services who provide feedback. Protection partners collect data on persons with special needs annually while community structures also report on the condition of persons with special needs not accessing services. CCCM also disseminates information products, such as camp profiles and service maps (local structures, service availability on health, WASH, education and shelter), which are crucial for persons with disabilities to inform themselves about their routes to the service facilities. Moreover, Sector 2 of the PoC site has a one-stop-shop serving all sectors, which also hosts a protection shelter and CCCM staff to easily serve people's needs. There are also additional outreach workers who conduct service monitoring and participate in coordination meetings for the field staff to share information and refer cases to protection partners. In these meetings, information about the number and needs of persons with disabilities is disseminated with humanitarian providers across sectors.

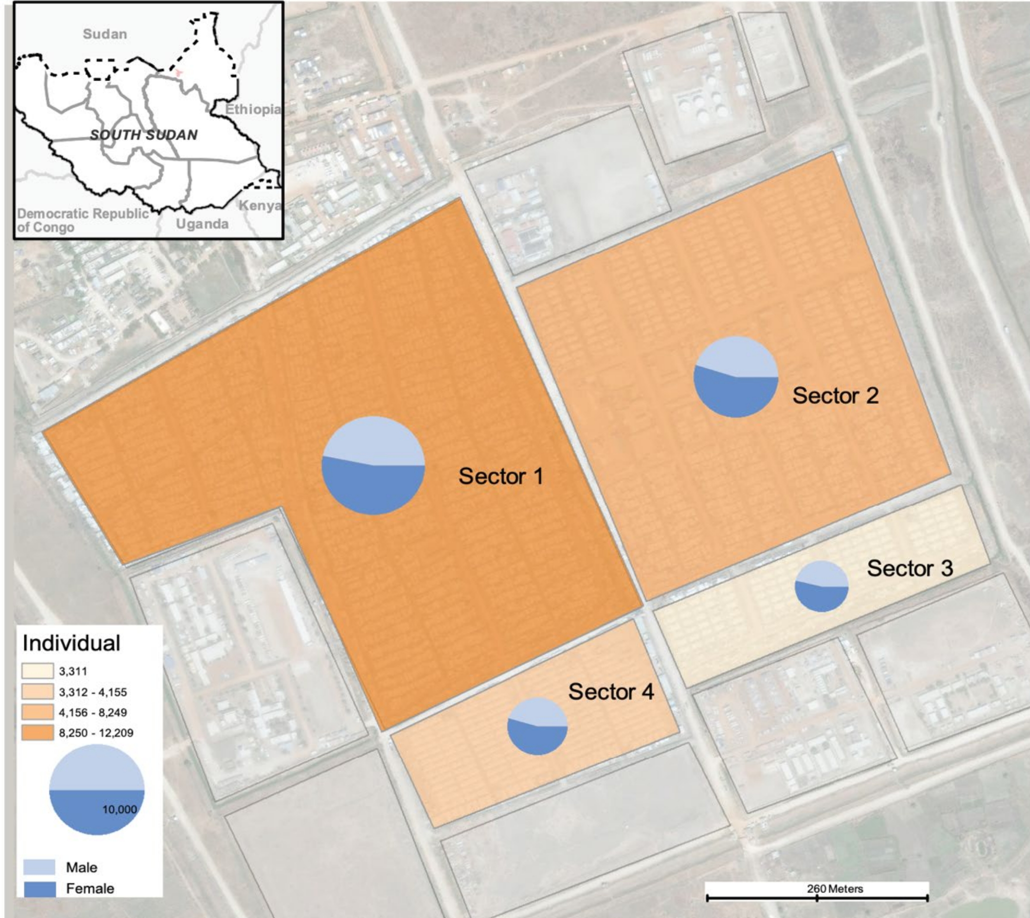
The main camp management committee has no representative for persons with disabilities although a separate committee for persons with disabilities exists. In FGDs, it was highlighted that persons with disabilities were excluded from decision-making pertaining to the COVID-19 contingency planning of the PoC site. Only 10.5 (± 3.2) per cent of survey respondents with disability reported to be members of a community-based group or committee representing community member issues, although 70.6 (± 4.8) per cent stated that they do not desire to become members either. The FGDs also noted the gender sensitivity of the committee, allowing women to partake in the decision making.

Although there are a variety of systems used in the site to identify persons who qualify for special needs shelters, including UNHCR's persons with special needs coding and household level vulnerability assessments, some of the participants in FGDs indicated that they had missed allocation of special needs shelters. It is important to ensure that persons with disabilities have access to these shelters because they are allocated near access roads and WASH facilities, minimising physical barriers.

Key informants suggest that the referral pathway should be strengthened to better address the specific needs of persons with disabilities, and that regular checks through community structures should be carried out to ensure that the community is informed of the needs of persons with specific needs. There is also a need for awareness raising efforts on the services offered by CCCM, for an increase in the frequency of update of service maps and for additional staff refresher trainings. On a managerial level, there is a need to increase partnerships and coordination, especially with regards to assistive devices, and to include a representative for persons with disabilities in the main camp management structure in addition to the already existing committee.

Lastly, key informants recommend moving away from the UNHCR's persons with special needs coding to the Washington Group Short Set of Questions for identifying persons with disabilities.

Map 1: Malakal PoC Site, Biometric Registration 27 January 2020[18]



[18] IOM DTM. (2020). South Sudan — Biometric Registration Update: Malakal PoC Site (Jan 2020).

Key Recommendations

Key informants and FGD participants have made the following recommendations to enable a more accessible, dignified and inclusive environment for persons with disabilities in Malakal PoC site.

General Recommendations

- Wide-range inclusion of persons with disabilities in camp governance structures and in humanitarian needs assessments, project design, planning, monitoring and evaluation.
- Continuing to raise awareness within the community, among humanitarian actors and among community leaders on the specific needs of persons with disabilities and the barriers they face in the site.
- Strengthening the community watch group and installing more lighting in the PoC in order to increase the safety of persons with disabilities.
- Increasing outreach services to facilitate access of persons with disabilities to key services through door-to-door service provision, improved infrastructure and transportation support.
- Diversifying the format of information sources, particularly catering to persons with seeing and hearing difficulties.
- Increasing paid work opportunities for persons with disabilities and their persons of support.

WASH

- Increasing the number of accessible latrines that follow universal standards and have connecting walkways to ease access for persons with mobility difficulties.
- Increasing the regular distribution of NFIs (such as towels, soap and buckets) for persons with specific needs that require a larger amount of these NFIs.
- Improving security and GBV risk mitigation measures around latrines, water points and other essential public services.

Food Security

- Adoption of alternative food distribution methods, such as food delivery to shelters, to protect vulnerable persons with disabilities.

Shelter

- Providing persons with disabilities with special needs shelters close to access roads and key services, especially water and sanitation.

MHPSS

- Diversifying and adapting recreational activities, psychological support and psycho-educational activities to enhance inclusion and accessibility for persons with disabilities.

- Training staff on the specific needs of persons with disabilities, including those with mental health or psychosocial problems.
- Creating awareness on the needs of persons with disabilities at community level to improve referral and access to existing specialized services, such as MHPSS.
- Providing persons of support and caregivers, as well as persons with disabilities themselves, with targeted psychosocial support activities.

Camp Coordination and Camp Management

- Providing staff refresher trainings on the needs of persons with disabilities and the barriers they face.
- Increasing partnerships and cooperation with organisations advocating for persons with disabilities to strengthen knowledge sharing and increase access to assistive devices and other NFIs.
- Mainstreaming usage of the Washington Group Short Set of Questions to identify persons with disabilities in the community in a non-stigmatising way.
- Increasing the frequency of service mapping to better inform persons with disabilities about the location and modalities of available services.
- Increasing awareness among persons with disabilities on available services and their basic rights and entitlements to empower them to access feedback and complaints mechanisms.

APPENDIX

Table 4: Correlation between different functional difficulties, mental health concerns and age

	Seeing	Hearing	Walking	Washing/ Dressing	Remem-bering	Communi-cating	Worried/ Anxious	Community Activities	Tired/ Exhausted	Age
Seeing	1	0.1832	0.4789	0.3047	0.1733	0.0715	0.229	0.4201	0.2749	0.573
Hearing	0.1832	1	0.1505	0.2099	0.189	0.323	0.1831	0.1736	0.1748	0.2045
Walking	0.4789	0.1505	1	0.4035	0.1985	0.094	0.221	0.4653	0.3141	0.4914
Washing/ Dressing	0.3047	0.2099	0.4035	1	0.2459	0.203	0.3716	0.4224	0.3294	0.3151
Remembering	0.1733	0.189	0.1985	0.2459	1	0.2825	0.4032	0.2398	0.3027	0.1634
Communicating	0.0715	0.323	0.094	0.203	0.2825	1	0.2231	0.2386	0.1907	0.1011
Worried/ Anxious	0.229	0.1831	0.221	0.3716	0.4032	0.2231	1	0.2761	0.3329	0.2002
Community Activities	0.4201	0.1736	0.4653	0.4224	0.2398	0.2386	0.2761	1	0.328	0.4186
Tired/ Exhausted	0.2749	0.1748	0.3141	0.3294	0.3027	0.1907	0.3329	0.328	1	0.2781
Age	0.573	0.2045	0.4914	0.3151	0.1634	0.1011	0.2002	0.4186	0.2781	1