DTM
IOM DISPLACEMENT TRACKING MATRIX
SOUTH SUDAN

humanity &inclusion

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DISABILITY & INCLUSION SURVEY

Wau PoC AA

Publication 31 October 2019, data collection February 2019

A pathway between shelters in Wau PoC AA. Photo taken February 2019, © International Organization for Migration, Displacement Tracking Matrix.

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Background & aims

The International Organization for Migration's Displacement Tracking Matrix (IOM DTM) and Humanity & Inclusion (HI) joined efforts to undertake an assessment of the level of access to services and the barriers faced by persons with disabilities within Wau Protection of Civilian Adjacent Area site (PoC AA or PoC site henceforth). The study, based on data collected in February 2019, aims to improve the knowledge base available to the humanitarian community about access to services by persons with disabilities living in the PoC 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 disabilities in accessing humanitarian services across sectors. It also seeks to empower persons with disability 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 Wau PoC AA site, including IOM, to better account for the concerns and needs of persons with disability in humanitarian programming and service delivery.

Key findings

- ***14.4%*** of survey respondents are persons with disabilities as identified by the Washington Group Short Set of Questions (see methodology), while an estimated ***18.7%*** of households include at least one member with a disability.
- The main reported barriers ***hampering access to services*** by persons with disabilities were ***distance*** to the service points (45.3%), ***lack of information*** (42.3%), lack of ***physical access*** (19.7%) and ***discrimination/harassment*** (16.8%).
- A quarter of respondents reported fearing forms of ***physical abuse when accessing services (24.8%)***. Changing the location of services was most popular among potential solutions to improve safety (32.1%).
- Among basic services, access to livelihoods, NFI and food distribution, toilets and sanitation, medication and general health services present particular challenges for persons with disabilities.
- Many persons with disabilities living in Wau PoC AA site lack access to the specialised services and assistive devices they need.

Methodology

The Disability & Inclusion study followed a mixed methods approach designed to bring together representative statistics and contextual insights derived from qualitative methods, allowing for a more holistic assessment of the conditions of persons with disabilities in Wau PoC AA site.

A ***quantitative survey*** was administered to all consenting individuals living in 726 randomly sampled shelter units, approximating individual households. All household members present in the sampled shelter units were requested to self-report disability. The Washington Group Questions (WGQs) were used as the self-reporting tool to identify persons with disabilities, who are defined as persons who report being unable to carry out, or face a lot of difficulty in carrying 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. Persons answering positively to any of these questions were then asked a series of follow up questions on access to basic services, either in person or – if unable to do so – through their caretaker. In total, 982 individuals completed the WGQ component of the survey, of whom 141 were persons with disabilities. 137 persons with disability answered the access to services section of the survey[1].

In the survey, women and girls account for 69.5% of respondents, which is higher than their share in the camp's population (57.8%) as recorded in DTM's biometric registration data. The gender imbalance is driven by the lower number of adult men as compared to adult women. A fifth of the survey respondents were children aged below 18 (19.2%) and 7.7% were persons of sixty or more years of age.

Twenty additional persons with disability were identified through snowball sampling and surveyed to increase coverage of the relevant population. Insights from this additional sample are presented separately from those collected through randomized sampling.

Six focus groups discussions (FGDs) were carried out across the three zones of the camp (A, B and C), separately for men and women, in order to collect in-depth qualitative information on the barriers faced by persons with disabilities and their level of inclusion in activities and services offered by humanitarian actors. Persons with different types of physical, mental and psycho-social disabilities took part in the FGDs, including persons with visual, hearing and communication/speech impairments. Participants were mobilized by the main protection partner working in the PoC AA, Women Development Group, and the WGQ were used to identify individuals with different types of disabilities. When necessary, persons with disabilities were accompanied by their caretakers. Community perceptions from the FGDs are highlighted in separate text boxes with the aim of amplifying the voices of persons with disabilities living in the PoC site.

Direct observation and ***key informant interviews*** with service providers and service users with disabilities provided further information on service provision, the diversity of persons found within structures, the presence of access and attitudinal barriers, the ability of existing facilities to guarantee the

[1] For four 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.

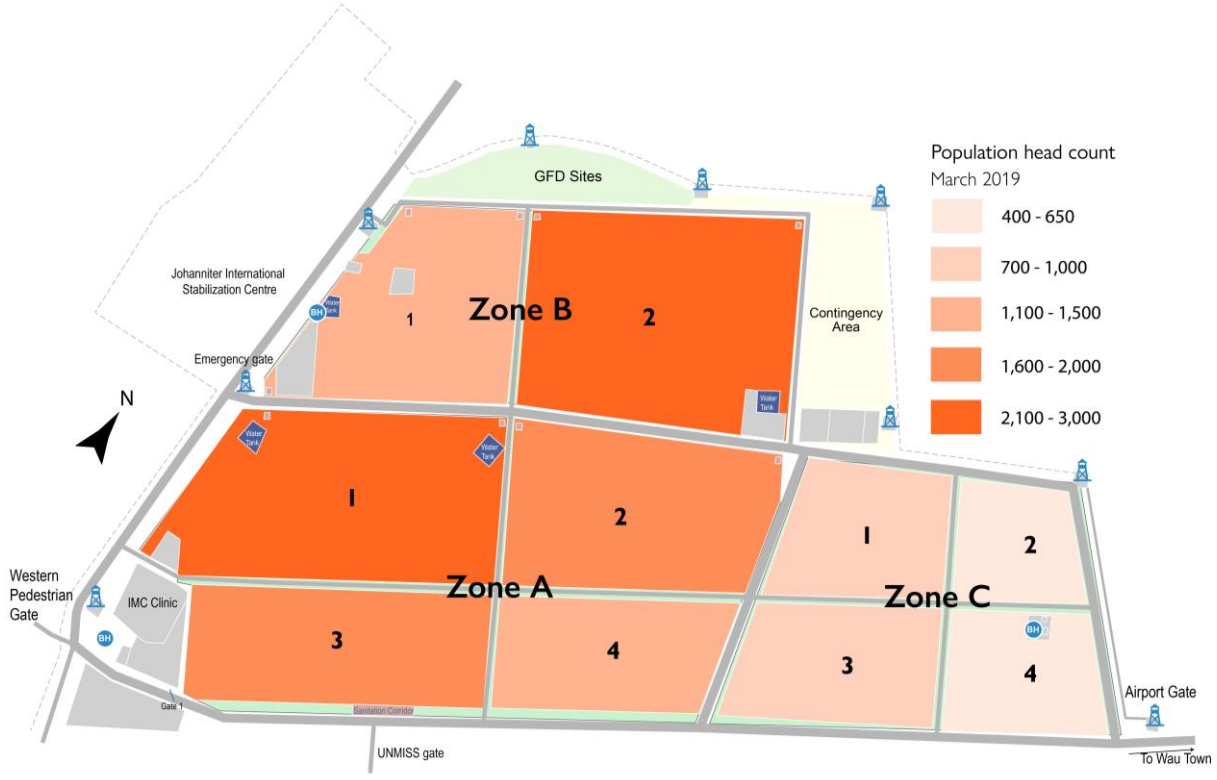
safety and dignity of persons with disability, the physical accessibility of structures and facilities within the camp, and the level of access to information and communication. The following structures and facilities were selected for observation:

- Distribution centers for food and NFIs
- WASH facilities
- IOM, International Medical Corps and Johanniter health centers
- Information sharing hubs
- Blocks of residential shelters

History and context of Wau PoC AA

Standing at an ethnic and linguistic crossroads in the Western Bahr el Ghazal region, Wau has been the site of large conflict-related displacements since September 2016. The largest of numerous displacement sites in the city, Wau PoC AA hosted a population of 14,226 individuals at the time of data collection based on the March 2019 DTM headcount (see Figure 1 for the population distribution across the three zones of the camp). The PoC AA stands as a refuge for civilians who have fled armed conflict and communal clashes in the neighborhoods of Wau as well as towns and villages throughout the region.

Figure 1: population of Wau PoC AA by zone (March 2019 DTM headcount)



Due to restrictions on land availability, Wau PoC AA remains one of the most congested IDP sites in South Sudan, with the average resident living in only 10.83 m2 of land[2], a fraction of the Sphere humanitarian standards of 45 m2. This population density has led to site layout and design features that intend to balance the paramount need to accommodate displaced persons seeking physical protection with upholding accessibility, hygienic living conditions, security, and dignity.

Wau PoC AA's current design and infrastructure dates from a large-scale site rehabilitation completed in early 2018 in response to a massive, conflict-driven influx in mid-2017. In April 2017, renewed fighting in close proximity to Wau town forced close to 14,000 persons from numerous communities to flee to the Wau PoC AA site for protection, increasing the population of the camp by 55% to 39,165 IDPs[3]. As IDPs streamed into the site, new arrivals were forced to crowd into existing family dwellings or built makeshift shelters along drainage ditches, near latrines and sanitation facilities, and on access roads. Given the already severe congestion in the site and following the failure of negotiations for additional land for site expansion, this arrival posed serious safety, health, security, and dignity risks to the site population.

In response and in consultation with the community and in cooperation with Shelter, WASH, Protection, and Health partners, Camp Management agency IOM mobilized site planning and engineering teams, heavy machinery, and community outreach workers to undertake a major decongestion and site rehabilitation operation. Concluded in mid-2018, this large-scale site reorganization and infrastructure installation succeeded in equitably distributing limited shelter space, creating camp infrastructure and common services, reducing fire and flooding hazards, drastically improving health, safety, and sanitary conditions; and improving physical accessibility through a regular road grid and drainages. However, the site remained with limited space for pedestrian corridors, densely inhabited shelters, and centrally located service points.

Since this site rehabilitation, humanitarian agencies have conducted improvements geared towards addressing accessibility and protection risks stemming from inherent site design features necessitated by population density. IOM Camp Management has installed solar lighting at WASH areas and high traffic corridors, improved foot bridges with more even surfaces and railings for better accessibility and put in place accessible latrines and bathing stances in consultation with persons with disabilities.

Throughout its life cycle, accessibility in Wau PoC AA has been shaped by severe congestion and rapid population influxes as the critical need to accommodate newly displaced persons is balanced against preserving space for physical infrastructure. Since the data collection for this report, yet another rapid population influx of close to 5,000 IDPs occurred in Wau PoC AA, as persons fled armed conflict in Jur

[2] As of May 2019.

[3] IOM DTM, Wau Town Population Update (25-27 April 2017).

River County (see DTM's report on *Jur River Displacement to Wau*). This prompted new shelter construction in contingency areas and the cancellation of planned shelter demolition and service corridors widening.

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 (WHS) 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 (IASC) established a task team to develop the

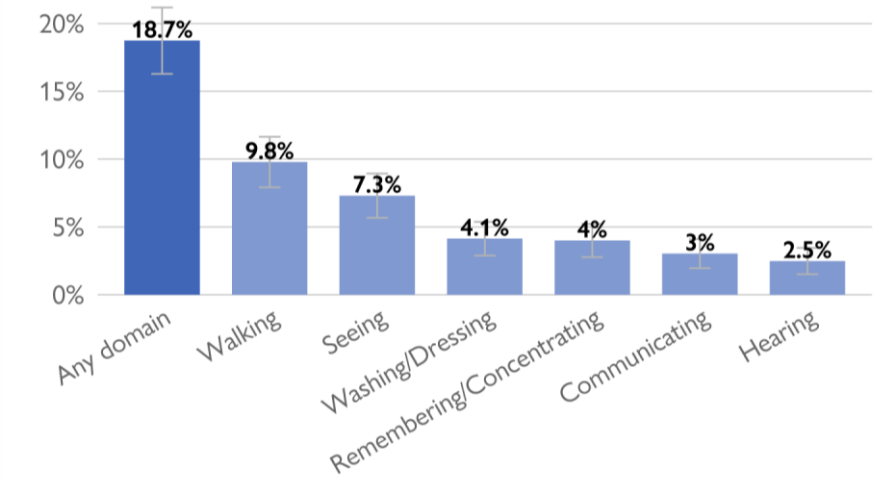
Guidelines on the Inclusion of Persons with Disabilities in Humanitarian Action, which are expected to be released in autumn 2019. The guidelines will assist humanitarian actors, governments and affected communities to coordinate, plan, implement, monitor and evaluate essential actions fostering the effectiveness, appropriateness and efficiency of humanitarian action for persons with disabilities.

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 WAU POC AA SITE

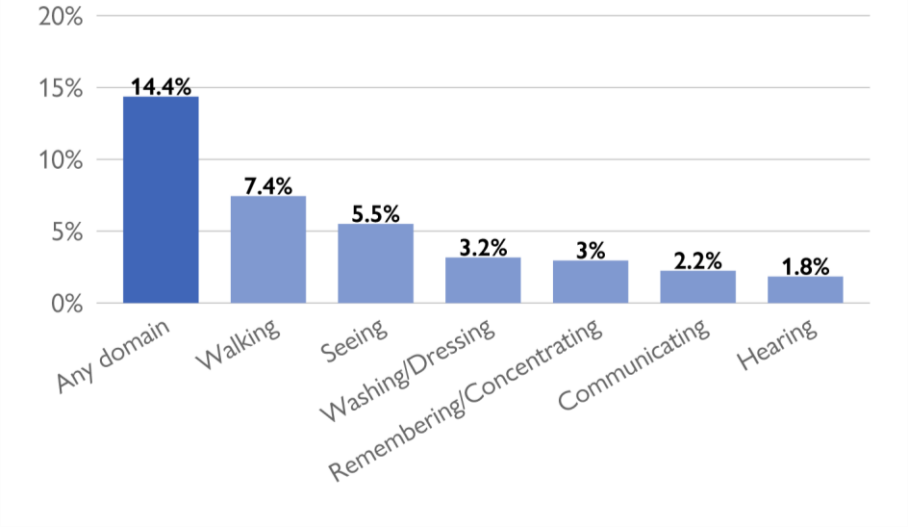
Based on the quantitative survey carried out as part of this study, 18.7% of households include at least one member with a disability as identified by the Washington Group Questions (Figure 2). At the individual level, this corresponds to 14.4% of all respondents being persons with a disability (Figure 3). Difficulties in the domains of mobility and vision are the most frequent, affecting respectively 7.4% and 5.5% of respondents, or 9.8% and 7.3% of households.

Figure 2: % of households where at least one member reported difficulties in the respective domains of functioning with 95% confidence intervals[4] [N households = 726]



[4] Binomial proportion confidence intervals.

Figure 3: % of respondents reporting difficulties in the respective domains of functioning [N individuals = 982]



There are no statistically significant differences in the prevalence of disability between men and women, even though women and girls have a slightly higher prevalence within the sample (Figure 4). On the other hand, the likelihood of having a disability consistently increases with the age of the respondent, reaching 50% among persons of 60+ years of age (Figure 5). The relative prevalence of different types of disabilities is broadly consistent across age and gender groups.

Figure 4: % of respondents reporting difficulties in the respective domains of functioning by gender [N female = 682; male = 300]

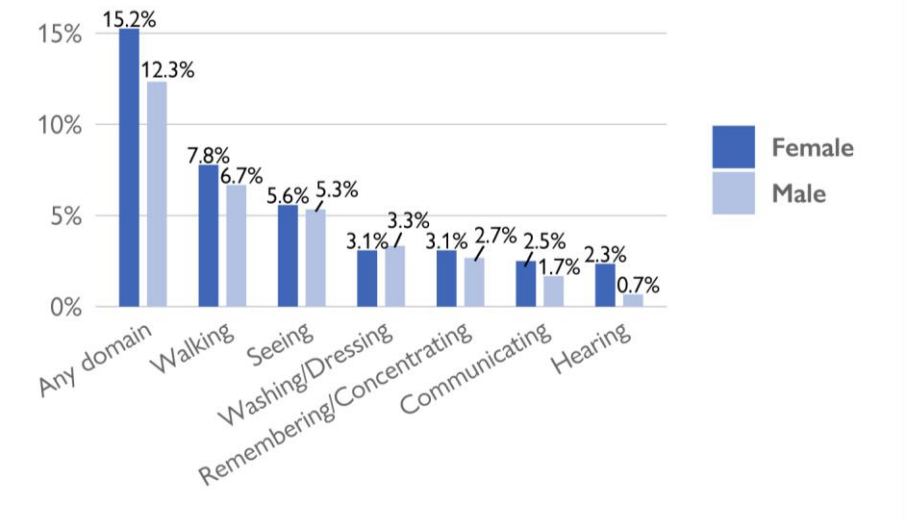
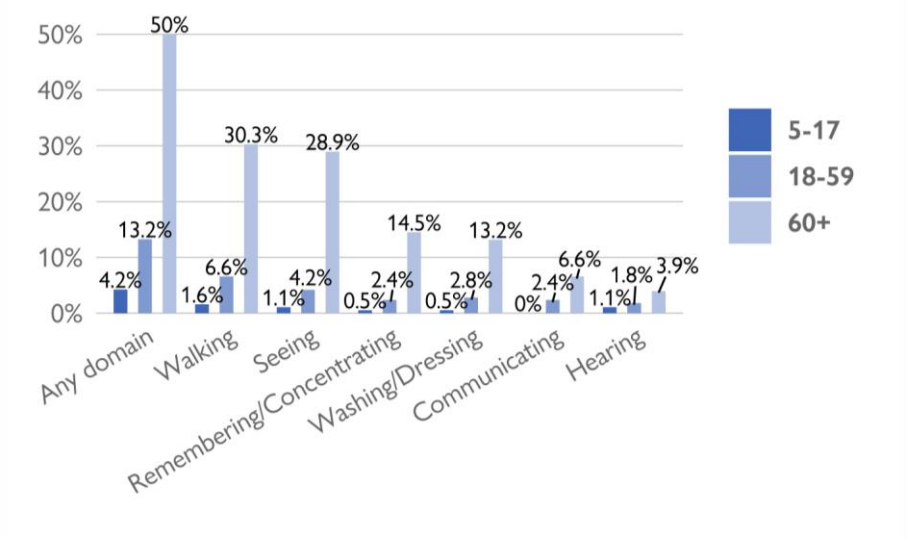


Figure 5: % of respondents reporting difficulties in the respective domains of functioning by age [N 5-17 = 189; 18-59 = 717; 60+ = 76]

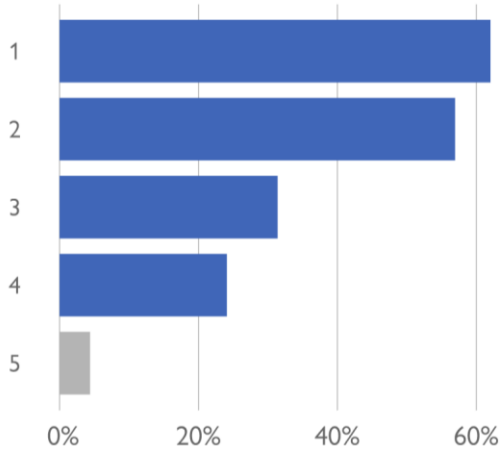


WELFARE OF PERSONS WITH DISABILITIES

51.8% of respondents with disabilities experienced major changes in their quality of life or level of independence since arriving in the camp and only 43.1% reported that they are assisted in everyday life to meet their needs and live in dignity. 40.1% reported that their situation also has a negative impact on their family/household. Indeed, when asked about solutions that could be taken in the PoC site to make the lives of persons with disabilities happier and more satisfactory, 62.0% requested more support to family members and care givers (Figure 6). Facilitating access to services is also a key priority, being mentioned by 56.9% of respondents.

Figure 6: actions that could be taken in the POC site to strengthen and make the lives of persons living with disabilities happier and more satisfactory (% of respondents with disability) [N = 137]

#	***Action***	**%**
1	More support to family members and care givers	62.0
2	Make access to basic services, e.g. latrines, easier	56.9
3	More recreational and cultural activities	31.4
4	Non-formal education and vocational trainings	24.1
5	Other	4.4



PARTICIPATION IN DECISION MAKING

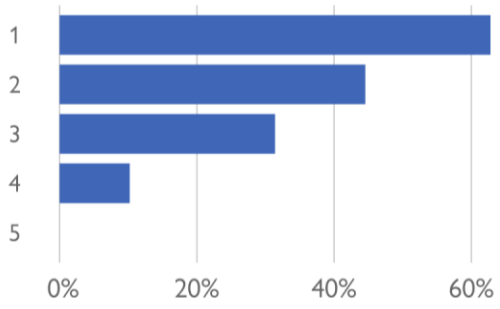
57.7% of respondents with disabilities stated that they had been involved at some stage in the decision-making processes around the services delivered in their community, including 34.3% reporting that they are often or always involved. On the other hand, the fact that the remaining 42.3% reported having never been involved in decision-making highlights that more work needs to be done to facilitate the inclusion of persons with disabilities. While the difference is not statistically significant, women and girls with disabilities appear to fare worse than men in terms of participation, with 56.4% of female respondents stating that they had been involved in decision-making processes against 61.1% of men.

A significant share of respondents was skeptical about the possibility of influencing service delivery through feedback. 35.7% reported that there are no complaints mechanisms for them to refer to if unhappy about service delivery in their community and 38.0% stated they felt that the community's feedback and complaints more generally are not taken seriously.

The main solutions suggested by persons with disabilities to better include their views in humanitarian programming are setting up community based groupings or committees (62.8%) and ensuring that information about feedback and complaints mechanisms is available to beneficiaries (44.5%) (Figure 7). The call for groupings and committees representing the interests of the community and expressing the voice of persons with disability is reflected in the desire to take an active role in such institutions. 32.1% of respondents are already members of community groupings/committees representing community issues, and 33.6% are not currently part of any but would like to be.

Figure 7: suggested interventions to better include the views and perspectives of persons with disabilities in humanitarian programming (% respondents with disability) [N = 137]

#	***Intervention***	**%**
1	Set-up community based groupings/committees	62.8
2	Ensure info. about feedback/complaints mechanisms is available	44.5
3	Set-up peer support groups	31.4
4	Organize joint assessments	10.2
5	Other	0.0



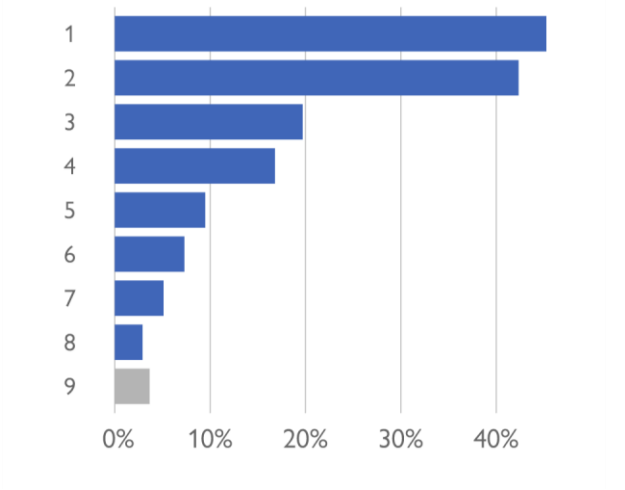
GENERAL BARRIERS IN ACCESSING SERVICES

The survey, FGDs and direct observation consistently highlighted significant barriers hampering access to basic services by persons with disabilities. 48.2% of respondents reported that they struggle to make use of the services provided by humanitarian workers whenever they choose or need to, while 38.7% complained that services are not being provided equally and fairly to all persons. Women and girls with disabilities were more likely to complain about unfair service provision (41.6% of female respondents against 30.6% of male)

As shown in Figure 8, the main reported barriers were distance from services and facilities (45.3%) and lack of information (42.3%). Direct observation of the blocks hosting persons with disabilities revealed that they are rarely seen moving outside of their shelters, and interviews highlighted that distance from service providers and the presence of physical barriers affect them disproportionately relative to other persons of the same age and sex. Indicatively, respondents with difficulties hearing and communicating are more likely to report information (52.9% of respondents with difficulties hearing, 52.3% of respondents with difficulties communicating) and communication (respectively 23.5% and 23.8%) barriers than other respondents with disabilities.

Figure 8: % respondents with disabilities reporting a given difficulty in accessing services [N = 137]

#	***Difficulty***	%
1	Distance	45.3
2	Lack of information	42.3
3	Lack of physical access	19.7
4	Discrimination and/or harassment	16.8
5	Communication barriers	9.5
6	Lack of economic resources	7.3
7	Services do not respond to my needs	5.1
8	Lack of safety	2.9
9	Other	3.6



A lower proportion of respondents reported difficulties in access to services within the snowball sample as compared to the random sample. For instance, only 35% of the 20 respondents with disabilities in the snowball sample reported being unable to access services when they choose or need to, against 48.2% in the random sample. The same pattern applies consistently to most other indicators. While the difference is not statistically significant due to the small size of the snowball sample, this finding suggests that relying on humanitarian workers' social networks to identify persons of concern may overestimate their level of

inclusion. Humanitarian workers and community mobilisers are more likely to be aware of persons with disabilities who are more socially integrated and already accessing services.

Physical accessibility of camp facilities

Many shelters hosting persons with disabilities are located far from the main service providers and the paths connecting them often have uneven surfaces, causing difficulties to persons with reduced mobility. Direct observation of the camp site revealed that few bridges connect shelters with the main road and even fewer are suitable for use by persons with disabilities. Drainage along the smaller paths connecting shelters is also a challenge for wheelchair users, especially those living far from the main roads.

Safety concerns

43.8% of respondents reported feeling unsafe when accessing services, whether at the point of delivery or on the way towards them, and 40.1% reported encountering actual dangers. The main reported danger was physical violation, mentioned by 24.8% of respondents with disabilities (Figure 9). When asked about potential solutions to improve safety in accessing services, 32.1% suggested changing the location of service facilities and 24.1% clarifying how to report protection incidents (Figure 10).

Figure 9: dangers encountered while accessing services (% respondents with disability) [N = 137]

#	***Danger***	%
1	No	59.9
2	Yes, physical abuse	24.8
3	Yes, bribery	10.2
4	Yes, coercion	7.3
5	Yes, other	8.0

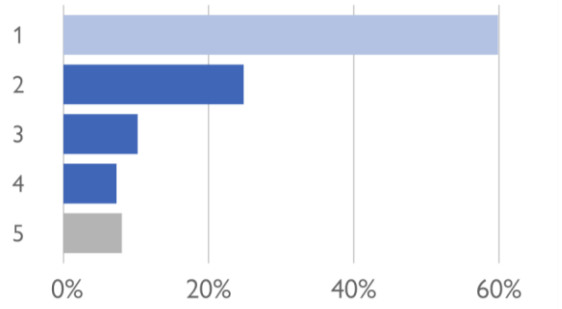
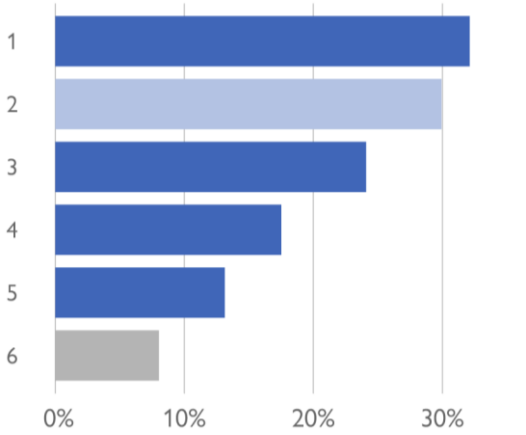


Figure 10: suggested solutions to improve safety in access to services (% respondents with disability) [N = 137]

#	***Solution***	%
1	Change location of the service	32.1
2	No need for change / I feel safe	29.9
3	Clarify where to report protection incidents	24.1
4	Change service hours	17.5
5	Don't know	13.1
6	Other	8.0

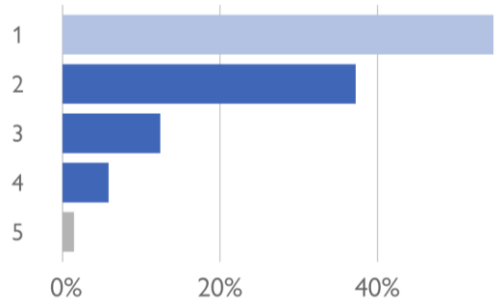


Dignity and attitudinal barriers

45.3% of respondents reported that they do not feel that their dignity is respected when accessing services. The main complaints are lack of respect, reported by 37.2% of respondents, and discrimination, reported by 12.4% (Figure 11). Attitudinal barriers are also prevalent, with 44.5% of respondents with disabilities reporting negative attitudes from their family and neighbours as a result of their disability. Direct observation of the site and key informant interviews consistently revealed a lack of community-based and outreach protection activities such as community safety networks, assistance/peer support groups, community safety awareness campaigns or provision of protection kits. Messages highlighting the needs and promoting the inclusion of persons with disabilities are hardly visible in the PoC AA site. On the other hand, most facilities within the camp are provided with private rooms or cubicles, which can help guarantee the dignity and confidentiality of persons with disability while accessing services.

Figure 11: dignity concerns in accessing services (% respondents with disability) [N = 137]

#	Concern	%
1	No dignity concern	54.7
2	Lack of respect	37.2
3	Discrimination	12.4
4	Lack of confidentiality	5.8
5	Other	1.5



ACCESS TO INFORMATION

Information campaigns targeting persons with disabilities within Wau PoC AA site are constrained by the fact that only 19.0% of respondents with disabilities can read and write, while another 6.6% can only read. Arabic is widely spoken (81.8% of respondents) but only 5.1% speak English. Persons with visual impairments in particular face barriers in accessing information shared in writing or through imagery.

As shown in Figure 12, the most common sources of information among respondents to the survey were megaphone/loudspeaker announcements (66.4%) and boda boda talk talk (49.6%), a broadcast radio service relying on loudspeakers mounted on the back of quad bikes and motorcycles. Audio-based awareness campaigns would however fail to reach the 1.8% of respondents with hearing impairments.

14.6% of respondents reported lack of access to any source of information. Community mobilizers were by far the main information providers (mentioned by 72.3% of respondents), followed by block leaders (35.0%) and friends/family (27.7%) (Figure 13). The most important topics according to the respondents are information on service provision and health and treatment advice (Figure 14).

Figure 12: main sources of information on community services and site updates (% respondents with disability) [N = 137]

#	Source of information	%
1	Megaphone/loudspeaker announcements	66.4
2	Boda Boda Talk Talk	49.6
3	Don't have access to any information	14.6
4	Signs/posters	13.1
5	Radio	8.8
6	Door to door campaigns	3.6
7	Television	0.7
8	Newspapers	0.7
9	Internet	0.0
10	Other	0.0

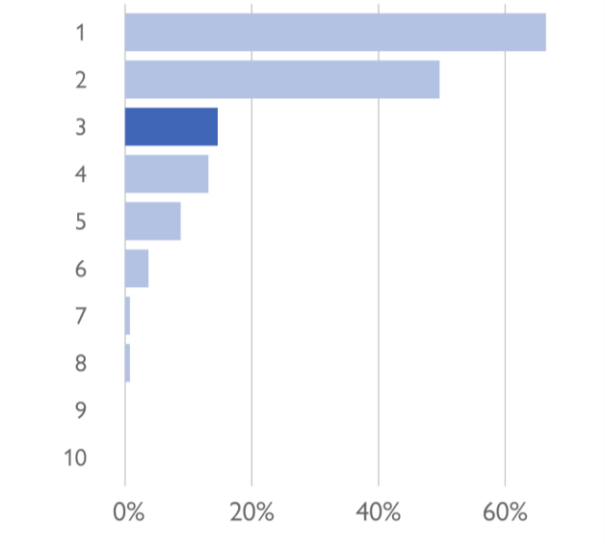


Figure 13: providers of information (% of respondents with disability) [N = 137]

#	Provider	%
1	Community mobilizers	72.3
2	Block leaders	35.0
3	Friends/family	27.7
4	Don't know	7.3
5	Sector leaders	5.1
6	Community High Committee	4.4
7	Religious leaders	0.7
8	Other	8.0

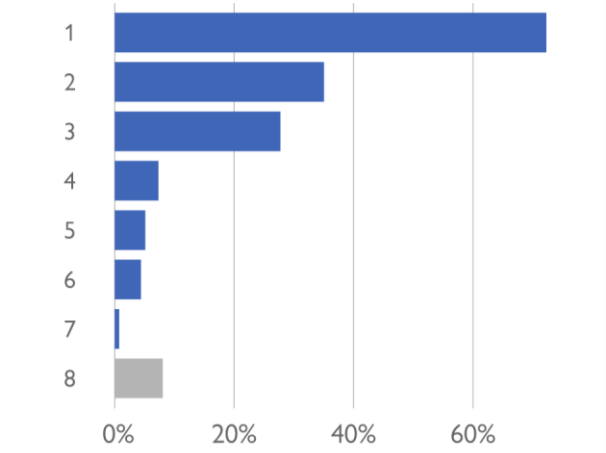
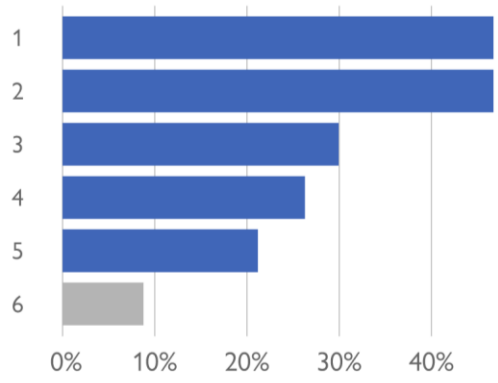


Figure 14: most important type of information received (% respondents with disability) [N = 137]

#	Type of information	%
1	On service provision	46.7
2	Health and treatment advice	46.7
3	On security and protection	29.9
4	On home community / area of origin	26.3
5	News from family members	21.2
6	Other	8.8

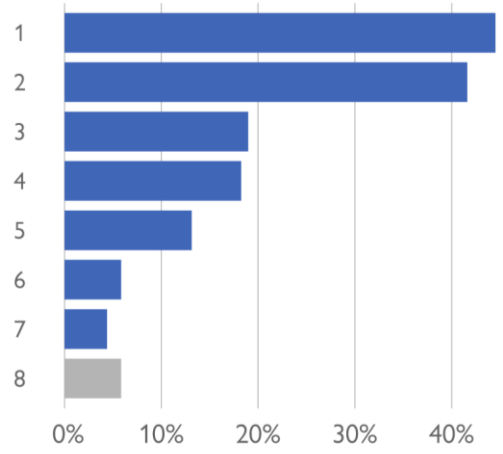


Challenges in accessing information

As discussed in the previous section, lack of access to information is the second main barrier hindering access to services by persons with disabilities, with 42.3% of respondents with disabilities reporting it as a challenge. Direct observation of service delivery within the camp site revealed that communication, education and information materials available in the PoC site do not usually take into account the needs of persons with disabilities. Information material is not generally available in multiple formats or in accessible formats such as braille, sign language, large print, contrasting colours or simplified language. In particular, persons with hearing and speech impairments face difficulties in accessing information related to humanitarian services in the camp unless translated by caregivers. The absence of formal training in sign-language and sign-language interpreters in the PoC site represented a challenge in the data collection process, making it difficult to interview persons with hearing and speech impairments and to facilitate their participation in the FDGs. In the quantitative survey, the main reported challenges in accessing information were distance (44.5%) and lack of information itself (41.6%) (Figure 15).

Figure 15: challenges in accessing information (% respondents with disability) [N = 137]

#	***Challenge***	**%**
1	Distance	44.5
2	Lack of information	41.6
3	Lack of physical access	19.0
4	Communication barriers	18.2
5	Discrimination and/or harassment	13.1
6	Lack of economic resources	5.8
7	Lack of safety	4.4
8	Other	5.8



ACCESS TO SERVICES ACROSS SECTORS

Table 1 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. Livelihood opportunities and access to NFI distributions are the hardest to access for persons with disabilities. Indicatively, women and girls with disabilities fare worse than men and boys in terms of access to livelihoods, with 47.5% of female respondents reporting that livelihood opportunities are hard to reach (41.7% for male respondents) and 18.8% reporting that they are not available (13.9% for male respondents). Four other basic services were reported to be hard to reach by over forty percent of respondents: food distribution, toilets and sanitation, access to medication and general

health services. HIV VCT, assisted referral, cash transfer services, protection services, education and reunification with family members / caregivers were reported to be not available by over 10% of respondents.

Table 1: Availability and accessibility of services across sectors (% of respondents with disability) [N = 137]

Service	Available, easy to reach	Available, hard to reach	Not available	Not applicable Don't know
Food distribution	43.8	46.0	3.6	6.6
Safe clean water	69.3	24.8	2.9	2.9
Toilets and sanitation	49.6	43.1	4.4	2.9
Shelter	62.8	30.7	4.4	2.2
NFI distribution	19.0	44.5	17.5	19.0
General health services	45.3	40.9	5.8	8.0
HIV VCT services	31.4	20.4	10.2	38.0
Rehabilitation services	35.0	35.8	8.0	21.2
Access to medication	31.4	43.1	5.8	19.7
Psychosocial support	29.2	32.1	9.5	29.2
Access to info on services	59.1	21.2	6.6	13.1
Assisted referral	22.6	32.8	14.6	29.9
Cash transfer services	9.5	30.7	26.3	33.6
Protection services	51.1	19.7	13.1	16.1
Livelihood opportunities	14.6	46.0	17.5	21.9
Education	31.4	31.4	16.1	21.2
Reunification with family members / caregivers	27.7	37.2	17.5	17.5

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

WATER, SANITATION AND HYGIENE

89.1% of respondents with disabilities have access to enough water for drinking, washing, cleaning and cooking. Among the 10.1% who do not, the main reasons are distance and lack of physical access. Even among those who do have access, distance and physical access – together with information about facilities – are the main priorities. When asked about possible interventions to facilitate access to safe drinking water, 57.7% of respondents suggested locating water taps closer to their residence, 48.9% providing information about services and 30.7% making water taps physically accessible (Figure 16).

Figure 16: suggested interventions to facilitate access to safe drinking water (% respondents with disability) [N = 137]

#	***Intervention***	**%**
1	Locate water tap closer to my residence	57.7
2	Provide information about services	48.9
3	Make water tap physically accessible	30.7
4	Provide special queue / priority lane	9.5
5	Remove threats of harassment/discrimination	3.6
6	Other	2.9

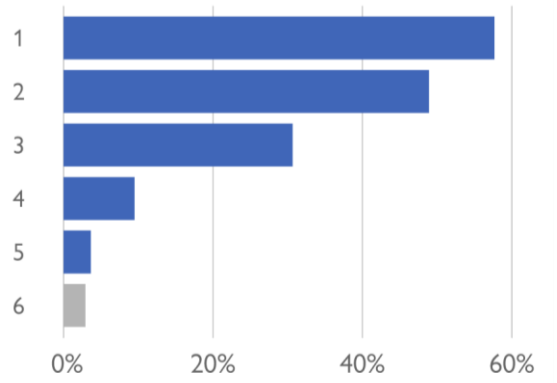


Figure 17: reason for lack of access to a latrine or sanitation facility (% respondents with disability who lack access) [N = 53]

#	***Reason***	**%**
1	Distance	58.5
2	Lack of hygiene/dignity	47.2
3	Lack of physical access	28.3
4	Lack of privacy	20.8
5	Lack of safety	15.1
6	Lack of information	11.3
7	Discrimination and/or harassment	9.4
8	Lack of economic resources	5.7
9	Other	0.0

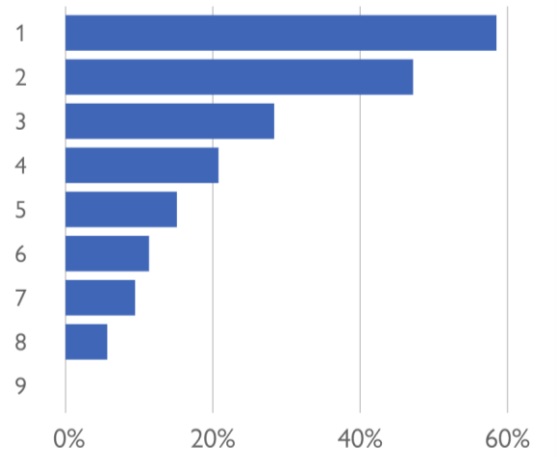
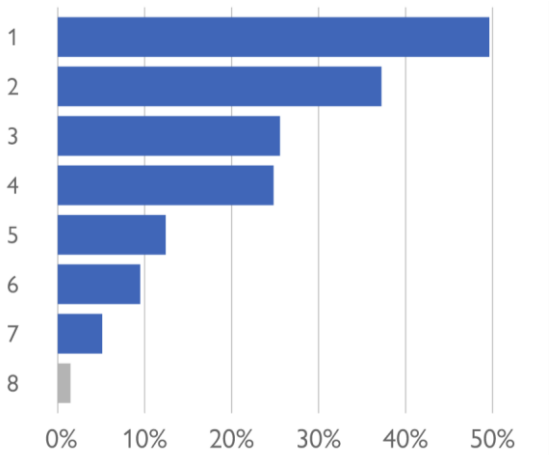


Figure 18: suggested interventions to facilitate access to sanitation facilities (% of respondents with disability) [N = 137]

#	***Intervention***	**%**
1	Move sanitation facilities closer by	49.6
2	Provide information about services	37.2
3	Increase physical accessibility	25.5
4	Ensure cleanliness	24.8
5	Provide roof/door	12.4
6	Provide specialized items to facilitate sanitation	9.5
7	Remove threats of harassment/discrimination	5.1
8	Other	1.5



Access to sanitation is noticeably lower than access to water, with 40.6% of female and 33.3% of male respondents lacking access to a latrine or sanitation facility. Once again, the main reason for lack of access is distance (58.5% of respondents), followed by lack of hygiene / dignity (47.2%) and lack of physical access (28.3%) (Figure 17). Lack of safety is mentioned by 17.1% of female and 8.3% of male respondents without access, suggesting a possible risk of GBV. Indicatively, persons with difficulties washing and dressing are more likely than average to report lack of safety (21.4%) as an issue preventing access to sanitation, while persons with difficulties communicating are more likely to report discrimination and/or harassment (33.3%). As shown in Figure 18, the most popular suggested interventions to facilitate access to sanitation reflect the challenges above, but also include providing additional information about services.

WASH facilities

Accessible WASH facilities, including water points, latrines and bathing shelters, are available in Wau PoC AA site.

Most tap stands for drinking water do not present physical barriers to use by persons with disabilities. The water pump handles are built following an accessible design and fulfill the standard of 80-90 cm height from the ground. Long queues are uncommon given that there are usually at least two water points per block (34 in total), and the points are generally reported to be safe to access during the day and at night. A challenge, however, is represented by the drainage system stretching between blocks, which represents a barrier for persons using mobility devices, such as wheelchair users, in particular those living further from the water points. Moreover, no provisions are made for persons who are unable to reach the water distribution points, and there are no strong social networks assisting persons with disabilities to access water. Laundry points appear rarely used by the camp residents irrespective of disability.

Based on direct observation of the camp during the assessment, approximately one in ten sanitation facilities is accessible to persons with disabilities, being provided with grab bars,

Perceptions of persons with disabilities from focus-group discussions

- *Some of the plastic sheets used in the construction of accessible latrines and bathing shelters have been cut, compromising the dignity of those using these facilities.*
- *Participants complained that some of the latrines and bathing shelters are too dirty to use.*
- *Some accessible latrines and bathing shelters are not gender separated; men sometimes prevent women with disabilities from using them.*
- *Some persons with disabilities face difficulties with personal hygiene. No targeted support is available to address the specific needs of persons with disabilities and their caretakers, and they requested sanitation and hygiene items such as gloves, soap and dignity kits for women.*

portable ramps, lifted toilet seats and fixed handrails. However, this is not the case in all blocks, with some lacking reasonable accommodation and accessibility requirement for those using mobility devices and their caregivers. There is no provision of private sanitation facilities for those who have a lot of difficulties and cannot move around at all (home-based solutions)

The observed level of cleanlines in and around shelter blocks is satisfactory, reflecting successful hygiene and health promotion efforts. However, persons with disabilities often struggle with personal hygiene. Their specific hygiene needs are not addressed by the hygiene kits distributed across the camp, which do not include items such as diapers and portable urinals, and there are no targeted hyiene messages for persons with disabilities or caregiver support programmes focusing on the hygiene and sanitation needs of persons with disabilities.

Characteristics of accessible sanitation facilities

Signage: no signs providing directions towards accessible latrines were noticed in the PoC site; there is no tactile signage identifying toilets.

Entry: there is adequate maneuvering space for a person using mobility devices and for their care-givers

Doors: 1 m width per 1.8 m height, with lips facilitating access from the ramp; the doors of most accessible latrines operate without grasping, twisting or turning, but some open outwards.

Ramp: the ramps to the latrines are not slippery; there is a resting space at top of the ramp but no at the bottom due to the short length of the ramp (1 m length, 1 m width and 15 cm height).

Handrails: hand rails are available on both sides of the ramp.

- Upper handrail: 0.8 m
- Lower handrail: 0.5 m

Toilets: toilet seats are positioned at a height of 0.45 – 0.5 m and grab bars are available; there is a space a 0.9m beside the toilet seat for wheelchair parking

Showers: accessible showers are equipped with grab bars positioned at an appropriate height but most are difficult to access by wheelchair; most showers are not equipped with shower seats.

FOOD SECURITY AND LIVELIHOODS

Food security and livelihoods activities within Wau PoC AA site are conducted by WFP and its partners, in particular ACTED. The majority of persons living in Wau PoC AA site, including persons with disabilities, rely on the monthly general food distributions – which include cereals, beans, cooking oils and salt – as their primary livelihood. Recently, the food ration has been reduced for all beneficiaries including persons with disabilities, and there is no charcoal distribution. Persons with disabilities, who have limited access to other income generating activities, must sell some of their food ration to buy charcoal.

Tailored assistance in food distribution, and food quality and diversity does not reply to the needs of person of different ages and having different dietary requirements, such as provision of additional foods or special diets for persons with difficulties chewing and swallowing, or those with allergies, or specific dietary needs based on their health status (person with chronic illness, is not available in the camp. While persons with disabilities benefit from food distribution as part of the general population, there is no targeted outreach, support or monitoring system to ensure they effectively access food.

There is only one distribution centre in the PoC site, which is used for food, NFIs and other kits and which serves all categories of camp members including persons with disabilities. No alternative collection systems – such as home delivery, multiple delivery in small bags and provision of wheel barrows – are available for persons with disabilities.

The centre is close to persons living in zone B but further away from zones A and C. Persons with difficulties to move around and see therefore face challenges in transporting food from the distribution centre to their residences. They must often sell part of their food to pay for transportation, leaving an insufficient amount to last until the next distribution cycle. They are also at risk of having their food rations stolen on the way back to their shelters. Persons with difficulties in hearing, understanding and communicating, as well as those with learning difficulties, can miss key information about the food distribution schedule. Shelters' distance from the centre, long queues and the lack of resting spots in the shade add to the difficulties faced by persons with disabilities.

Perceptions of persons with disabilities from focus-group discussions

- *The lack of shade, benches or a fast-track queue make accessing food distribution strenuous for many persons with disabilities.*
- *Persons with disabilities are often forced to sell part of their food rations to pay for transportation, leaving them with insufficient food to reach the next distribution circle.*
- *Since persons with disabilities often have limited opportunities to engage in income generating activities, they must sell part of their food rations to buy charcoal. Some requested for charcoal to be distributed together with food, and suggested that persons with disabilities should receive larger food rations as well as complementary food items such as salt, sugar and CSB.*
- *Participants reported the need for capacity building and livelihood programmes targeting persons with disabilities, which would enable them to have access to income generating activities.*
- *Persons with psychosocial and intellectual disabilities sometimes have food taken away from them by caregivers without authorization.*

General food distribution is carried out using biometric registration records from IOM DTM. 81.8% of respondents with disabilities reported being registered for food distribution since their arrival.

Among those who were not registered, the majority stated that no registration exercise had taken place since their arrival in the camp. Overall, 56.9% of respondents with disability reported benefiting from fast-tracked registration services as a result of their vulnerabilities, or knowing someone who did.

SHELTER AND NON-FOOD ITEMS

Shelter and NFI services in Wau PoC AA site are provided by IOM. As part of the 2017 shelter reconfiguration, IOM constructed a shelter for every household residing in the PoC site, including households with persons with disabilities.

70.8% of survey respondents with disabilities are satisfied with the condition of their shelter. This was confirmed in FGDs, which revealed that renovations are carried out whenever requested through camp management. However, the limited ability of persons with disabilities to improve the conditions of their shelters is a potential concern with the 2019 rainy season. Only 35.0% of respondents can access shelter materials and even fewer, 21.9%, are able to improve their shelter by themselves.

> *"I have to keep my wheelchair outside of my room because of the narrow door – I am always in fear that it might be stolen one day".*

In the survey, 71.5% of respondents reported that they are able to easily enter and move around in their shelter. Among those who cannot, 19.0% face some difficulty and 9.5% a lot of difficulty. The main reported constraints relate to the inaccessibility of the surrounding environment, that of the shelter itself and the limited size of the shelter (Figure 19). In FGDs, however, the size of the shelters appeared to be the main issue of concern, limiting air circulation and the residents' movements. In particular, persons with disabilities living with large families complained that the shelters are not large enough to accommodate all household members. Direct assessment of the shelters also revealed that the doors are too small for wheelchairs to be brought inside, exposing users to the risk of them being stolen while stored outside. Outside the shelters, uneven surfaces in the pathways connecting the shelters with the main road are also a concern for persons with difficulties to move around. Over three quarters of respondents (75.9%) feel safe within their shelters, with those who do not suggesting improved lighting and changes in their shelter's location as possible solutions (Figure 20).

39.4% of respondents reported no challenges in accessing NFI distributions. However, another 33.6% never tried to access NFI distributions, which suggests that existing programmes may be insufficiently advertised

among beneficiaries. The rest of the respondents faced barriers to access, in particular exclusion from the target group for distributions (Figure 21). The FGDs revealed that persons with disabilities commonly lack NFIs such as sleeping mats, blankets and cooking utensils.

Figure 19: main challenges to move easily in and around one's shelter (% of respondents with disability facing difficulties moving in and around their shelter) [N = 39]

#	***Challenges***	**%**
1	The shelter is not located in an accessible environment	56.4
2	The shelter is not accessible	46.2
3	Shelter is too small	43.6
4	Shelter items and furniture are too high or too low	12.8
5	No visual guidance is available in or around the shelter	7.7

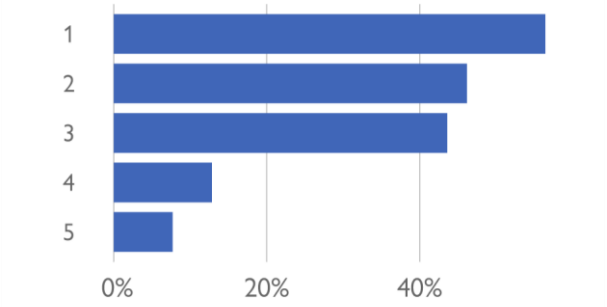


Figure 20: suggested interventions to increase the respondents' feeling of safety in and around their shelter (% of respondents with disability who feel unsafe inside their shelter) [N = 30]

#	***Intervention***	**%**
1	Provide lighting in/around the shelter	70.0
2	Change shelter location	50.0
3	Provide inner locking	26.7
4	Install protection screen to increase privacy	16.7
5	Other	3.3

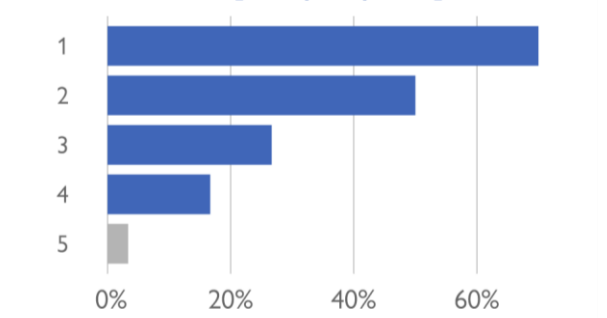
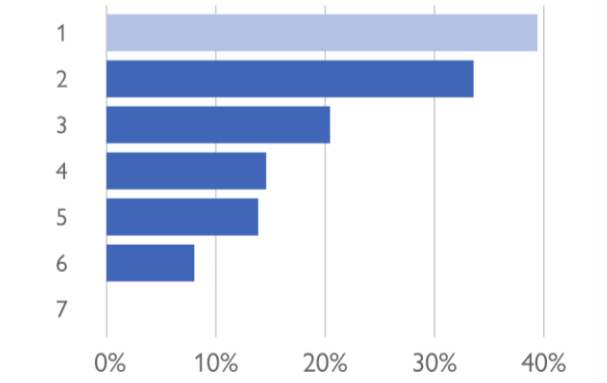


Figure 21: challenges to access and benefit from NFI distributions (% of respondents with disability) [N = 137]

#	***Challenge***	**%**
1	None	39.4
2	Don't know / never tried to access	33.6
3	Not part of the target group	20.4
4	Lack of physical access	14.6
5	Distance	13.9
6	Discrimination and/or harassment	8.0
7	Other	0.0



Shelter characteristics

Doors: the doors are usually 0.6 m wide, and in most cases less than 1 m wide, which does not allow wheelchair users to get in with their wheelchairs; only few door handles can be operated without grasping, twisting or turning.

Connecting paths: The pathway from the shelters to the main road has an estimated length of 20 m and the connecting paths are usually wide enough (1.2 -1.6m) for persons with disabilities using mobility devices and their caregivers. However, the underground drainage system stretching through the middle of these connecting paths represents a challenge for persons with disabilities using mobility devices and their caregivers since it splits the total width in half, making the usable surface of the path less than the recommended 90 cm.

Stairs: stairs were not observed in shelter blocks.

Perceptions of persons with disabilities from focus-group discussions

- *The small size of the shelters limits the ability of persons with disabilities to move within them.*
- *Participants complained that wheelchairs cannot be brought inside the shelters, exposing them to the risk of being stolen.*
- *Persons with disabilities have limited opportunities to generate income to buy NFIs such as cooking utensils, which are not distributed.*

HEALTH

Not all persons with disability living within Wau PoC AA site were able to access the health services they needed. 62.5% of respondents experienced medical needs over the six months preceding the survey, of whom 62.5% were able to address them and obtain the required medication. Among the 37.5% who could not, the main reported reason was lack of economic resources. Lack of information and lack of services suited to the person's needs were also mentioned frequently.

"I have had a condition affecting my hands for a long time, and it has become difficult to push my wheelchair. I have asked multiple times for a referral, but was unable to get one".

Health services for residents of Wau PoC AA site are provided by IMC and IOM. The IMC facility is located within the PoC site while the IOM one is off-site. There is also a stabilization center run by Johanita, a local NGO, where nutrition services are provided to acutely malnourished children under five years of age**.** All facilities are accessible but present some physical barriers creating challenges for persons with limited

mobility. Interviews with persons with disabilities revealed that the distance from the IOM facility represents a key access challenge, while staff at the clinic highlighted that its position outside the camp can constitute a security risk for patients. Moreover, most staff leave the clinics by 9:30 pm, limiting the availability of health services at night time. There are no provisions for alternative health service modalities, such as mobile service provision and outreach clinics, which would facilitate access to health services by persons with disabilities

The FGDs expressed a consensus that the staff working in the health facilities are respectful towards persons with disabilities, and staff of both genders is available at each facility. Consultations are carried out in private spaces that guarantee privacy and confidentiality. However, it was noted that persons with disabilities have to go through the same queue as other persons, with no fast-track system available in the facilities. Participants flagged that drug supplies often run out, particularly in the facility within the camp, and some complained that lab tests are not carried out before prescribing medicine.

Information and education materials provided in the health clinics are not available in formats facilitating their use by persons with disabilities, such as voiceover videos and audio messages, braille or sign language, messages in simplified language or visual signs (drawings, pictures and photos). This is especially challenging for those with hearing and vision impairments. Messages highlighting the health needs and promoting the inclusion of persons with disabilities are hardly visible in the PoC site.

Perceptions of persons with disabilities from focus-group discussions

- *Women with disabilities face difficulties during delivery.*
- *Persons with disabilities often find it hard to obtain referrals to specialized services, including nutrition advice and treatment for complex or uncommon conditions.*

Specialized health services addressing the needs of persons with disabilities are limited. Access to assistive devices, medication for complex or uncommon conditions and referrals to specialized facilities are rare. The patient registries kept in the health facilities do not include records of disabilities and are limited to basic demographic data.

HIV Voluntary Counselling and Testing (VCT) Services

54% of respondents with disabilities were not aware of HIV prevention, VCT and treatment services. However, among the 32.1% who tried to access HIV services, 90.9% were able to do so.

HIV services are provided in the general health facilities above, meaning that the same general considerations apply, with the exception that HIV VCT centres close earlier than the general health clinics, around 3:30 pm. Nurses working in the clinics reported that while there are VCT services guided by health workers, medication is not provided directly but patients are referred to Wau Teaching Hospital or to other hospitals of their choice.

The services are not tailored to suit the needs of persons with disabilities. There are no programmes to facilitate access by persons with disabilities, such as mobile service provision, outreach clinics, reimbursement of transportation fees or provision of accessible transportation. HIV services are provided in private rooms that guarantee user dignity and confidentiality, but the spaces dedicated to treatment and prevention sessions are not well equipped to welcome children and adults with disabilities, lacking mattresses, wedge pillows, inclusive toys and accessible information material. Information about disability is also not included in patient records.

ACCESS TO REHABILITATION CARE AND ASSISTIVE DEVICES / TECHNOLOGY

Among the 97.1% of respondents who need disability specific health services, only 39.1% were able to maintain it on arrival to the PoC site. 57.7% also reported a need for specific nutritional supplies, mostly as a result of iron deficiency or diabetes. 69.6% of those in need are unable to access the required nutritional supplies, mostly due to lack of financial means.

70.8% of respondents with disabilities report the need of 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. 57.7% also need disability specific health services, as outlined in Figure 22. Mental health and psycho-social support is the main specialised service mentioned by respondents.

As shown in Figure 23, the main solution suggested by respondents to improve access to the services they need is increased provision of free of charge services and treatments.

Table 2 : specific devices needed as a result of the person's impairment or disability (% of respondents with disability who are in need of supportive items)

Item	In need [N = 97]	Of whom lack item
Cane or walking stick	47.4%	50.0% [N = 46]
Walker or Zimmer frame	16.5%	56.2% [N = 16]
Crutches	20.6%	65.0% [N = 20]
Wheelchair or scooter	30.9%	50.0% [N = 30]
Artificial limb (leg/foot)	11.3%	72.7% [N = 11]
Other	26.8%	73.1% [N = 26]

Figure 22: specific services needed as a result of the impairment / health condition (% of respondents with disability who are in need of specialized services) [N = 79]

#	Service	%
1	Mental health and psychosocial support	46.8
2	Support to employment	27.8
3	Social protection programming	27.8
4	Physiotherapy, occupational therapy, speech therapy	17.7
5	Support to education	17.7
6	Prosthetics/orthotics	15.2
7	Other	6.3

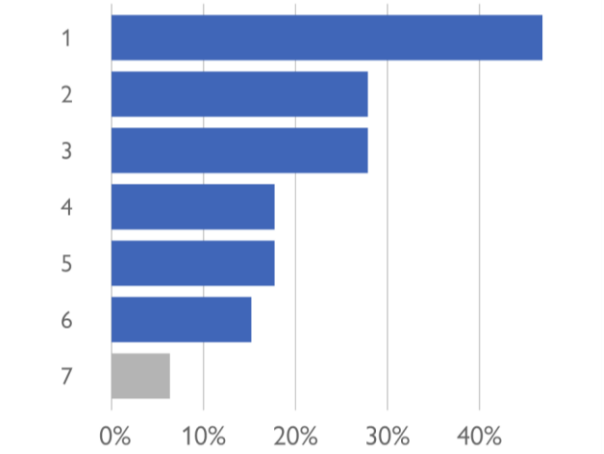
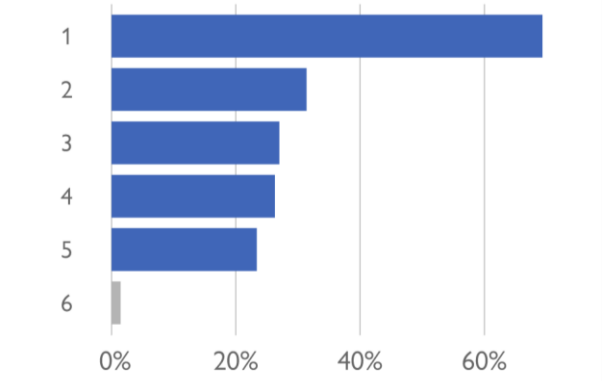


Figure 23: suggested solutions to increase the respondents' access to services provided (% of respondents with disability) [N = 137]

#	Solution	%
1	Free of charge services/treatments	69.3
2	Support of family/friends	31.4
3	Community support	27.0
4	Transport	26.3
5	Outreach services	23.4
6	Other	1.5



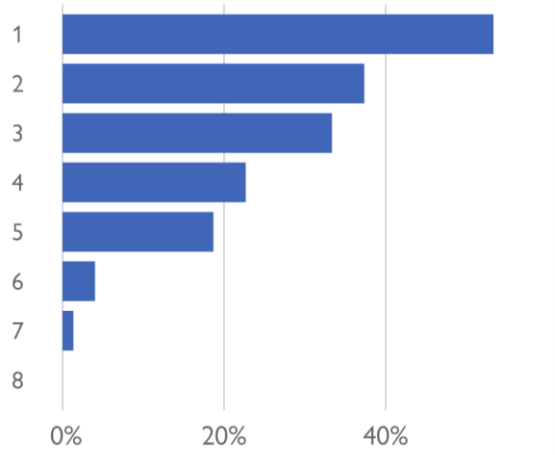
MENTAL HEALTH AND PSYCHO-SOCIAL SUPPORT

Family and friends represent the main source of strength and support for 72.3% of respondents with disabilities. For comparison, NGO and service providers – the second most common answer – are mentioned by only 11.7%. Over half of respondents report they lack access to any form of psychosocial support (54.7%), while 27.7% are able to access formal support groups. Informal support groups (8.8%) and counselling (8.0%) 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. Direct observation and FGDs confirmed the lack of accessible information and education material on mental health and psychosocial support (MHPSS) in the PoC site. There is also a lack of messages and information campaigns transmitting a positive image of persons with disabilities, and promoting their participation, integration and inclusion.

Figure 24: reasons for lack of access to psychosocial support (% of respondents with disability who lack access) [N = 75]

#	Reason	%
1	Lack of information	53.3
2	Distance	37.3
3	Not available locally	33.3
4	Discrimination and/or harassment	22.7
5	Lack of physical access	18.7
6	Lack of economic resources	4.0
7	Lack of safety	1.3
8	Other	0.0



Wau PoC AA site is served by an MHPSS clinic and three MHPSS service centres, all of which are run by IOM and which close at 3:30 pm. The service centres are located within the three zones of the camp, with the aim of facilitating access by beneficiaries – including persons with disabilities – by reducing distance. MHPSS facilities provide counselling, peer support sessions and recreational activities that are accessible for persons with disabilities. Mobile services dedicated to persons with disabilities are available and advertised through billboards in the centres, but many persons with disabilities are unaware of this modality of service provision.

Perceptions of persons with disabilities from focus-group discussions

- *Participants reported that persons with psychosocial impairments often struggle to take care of their health and hygiene.*
- *The lack of formal sign language training and sign language interpreters makes MHPSS services hard to access for persons with hearing or speech impairments.*

Lack of information about existing activities and spaces results in low participation rates among persons with disabilities. Only 24.8% of respondents with disabilities reported that they participate in key community activities and spaces as much as they wish, while 16.1% participate but not as much as they would like and 59.1% do not participate at all. The unavailability of formal training in sign language and of sign language interpreters hinders the provision of targeted psychosocial support and recreational activities to persons with difficulties hearing or speech impairments.

Both male and female PSS workers are available to provide peer support sessions and individual counselling. Group sessions are divided by gender. The spaces used for the sessions are equipped to welcome all persons in need, including those with disabilities. The rooms have mattresses, wedge pillows, some toys, and some musical instruments for recreational activities.

PROTECTION

Women Development Group (WDG) provides protection services in Wau PoC AA site, including an established protection desk gathering protection-related complaints and concerns from camp residents and outreach protection monitoring in all the three zones of the camp. The services target the entire population of the camp, including persons with disabilities. Some persons with disabilities complained about a lack of responsiveness by camp authorities towards concerns raised with the protection desk.

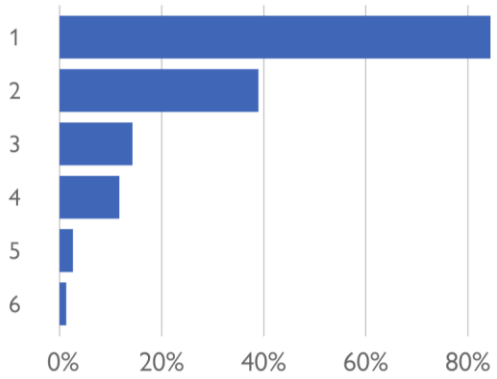
In FGDs, it was brought up that women and children have to travel long distances in search of firewood, exposing themselves to risk, because there is no charcoal distribution. Persons with disabilities who have no other means of generating income sell their food rations to buy charcoal, which leaves them more vulnerable and with an insufficient amount of food. Moreover, the lack of a fast track queue at general food distribution means that some persons with disabilities are forced to sleep in the queue in order to access the distribution centre on time. Food stealing, made more likely by the lack of transportation provisions for persons with disabilities, is also a concern.

Perceptions of persons with disabilities from focus-group discussions

- *Protection concerns were raised by some participants around access to general food distribution. Multiple persons with disabilities reported sleeping around the distribution areas because of the lack of a fast track queue. Others requested that transport should be provided to reduce the likelihood of theft and avoid the need to sell food rations.*
- *Participants requested more inclusion of persons with disabilities in community leadership structures.*
- *The protection, complaints and information desk was requested to be more responsive towards complaints from persons with disabilities, forwarding them to camp management in a timely way.*

Figure 25: persons/actors with whom persons with disabilities are able to share their concerns (% of respondents with disability who can share their concerns when needed) [N = 77]

#	Person/actor	%
1	Family member	84.4
2	Friend	39.0
3	Camp leader	14.3
4	Service provider	11.7
5	Peer support group or community based group	2.6
6	Community volunteer	1.3



The survey revealed that 35.8% of respondents with disabilities are unable to share their concerns with somebody when needed. Those who can most often turn to family members (84.4% of those able to share their concerns) and friends (39.0%), while it is uncommon for persons with disabilities to turn directly to formal actors such as camp leaders and service providers (Figure 25).

CAMP COORDINATION AND CAMP MANAGEMENT

IOM is the camp management agency in Wau PoC AA site and runs a CCCM complaints and information desk where any resident of the camp can register their complaints/concerns or request them to be forwarded to other service providers. In coordination with the protection partner (Women Development Group), a Persons with Disabilities Committee was established to enable persons with disabilities to communicate their needs, concerns and views to camp management and the other service providers.

Information on service provision in the PoC site is communicated to persons with disabilities through the persons with disabilities committee, the complaints/information desk and the protection desk, as well as through public announcements made throughout the camp. Persons with difficulties hearing have limited access to this information due to the lack of formal sign language training and sign language interpreters, and must rely on translations by caregivers.

In FGDs, persons with disabilities suggested that their concerns, complaints and requests should be channeled directly to camp management and not through the Persons with Disabilities Committee and protection desk. There is a shared feeling that their concerns are not attended to when channeled through the committee. Late registration of new arrivals was also raised as a concern, since it limits their ability to benefit from service provision.

Perceptions of persons with disabilities from focus-group discussions

- *Persons with disabilities requested more inclusion in camp leadership structures to enable easier access to information on access to services.*
- *Persons with disabilities would like to channel their complaints directly to camp management, without going through the PWD committee and the protection partner.*
- *Participants reported that information about services is not usually available in an accessible format for persons with disabilities, in particular those with difficulties hearing and communicating.*

Since the data collection for this report, further initiatives have been launched by CCCM to facilitate the inclusion of persons with disabilities and improve the accessibility of camp facilities. A key example was the inclusion of users with disabilities in the design and testing of new accessible latrines, showers and footbridges.

ANNEX: ADDITIONAL RESOURCES ON DISABILITY & INCLUSION

Age and Disability Capacity Programme (ADCAP). 2018. *Humanitarian inclusion standards for older people and people with disabilities*.

CBM. 2017. *Humanitarian Hands-on Tool*.

Humanity and Inclusion. 2015. *Disability in humanitarian context: views from affected people and field organisations*.

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International Organization for Migration (IOM), Displacement Tracking Matrix; Humanity and Inclusion. 2018. *Access to Humanitarian Services for People with Disabilities: Statistical Analysis in Bentiu Protection of Civilians Site, South Sudan*.

Republic of South Sudan, Ministry of Gender, Child and Social Welfare. 2013. *South Sudan National Disability and Inclusion Policy*.

UK Department for International Development. 2019. *Guidance on strengthening disability inclusion in Humanitarian Response Plans*.

United Nations Children's Fund (UNICEF). 2017. *Including children with disabilities in humanitarian action*.

United Nations High Commissioner for Refugees (UNHCR). 2011. *Working with persons with disabilities in forced displacement*.

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World Health Organization. 2011. *World Report on Disability*.

World Health Organization. 2013. *Guidance Note on Disability and Emergency Risk Management for Health*.