Humanity & Inclusion South Sudan, tips on including persons with disabilities and elderly in your COVID-19 health response

During epidemics, as is with COVID-19, persons with disabilities and elderly in humanitarian settings are disproportionately at risk. This ‘tips sheet’ provides an insight in particular risks and barriers that persons with disabilities and elderly may face during health response for COVID 19, and practical action to address these risks. This note draws on the IASC Guidelines on Inclusion of Persons with disabilities and elderly in Humanitarian Action, applying these to the COVID-19 pandemic, the WHO guidance for Disability inclusion in COVID-19 response and practical tips from experience of HI and collaborating partners in South Sudan.

Introduction
After years of conflict and upheaval, public health and service provision in South Sudan remains extremely constrained, where functional, service provision has focused only intermittently on services needed by communities faced with various access barriers, therefore, lack of services tailored to the needs of diverse population groups, including older persons, women and girls, with and without disabilities or persons with chronic illnesses, remains a problem.

Despite the massive scale up of humanitarian assistance response, the worst affected excluded, marginalised population including boys and girls, men and women with disabilities and IDPs are reported to have lower access to healthcare and social services than others. With a population of 13, 300,730, it can then be assumed that at least 1,995,000 of South Sudan population are boys and girls, men and women with disabilities who experience on average poorer health access and, therefore, have greater general health needs, higher costs for medical care compared to others in the population.

Globally, early data suggest that a majority of COVID-19 deaths have occurred among elderly and among persons with serious underlying health conditions. In South Sudan, UNFPA estimates 3% of 13, 300,730 South Sudanese population to be above 65 years of age. Hence, there are over 399,021 elderly in South Sudan. This is owing to realities that they experience socio-economic disadvantage, inadequate legislation, policies and strategies, limited awareness and understanding about disability inclusive services, negative attitudes and discrimination; lack of accessibility and specific barriers that exist in relation to persons with disabilities and elderly being able to express their opinions and seek, receive and impart information and ideas on an equal basis with others and through their chosen means of communication.

COVID-19 has occurred in an atmosphere where Health and WASH coverage is very low;

- 56 per cent of the South Sudan population are without access to primary health care services.
- Out of approximately 2,300 health facilities, more than 1,300 (57%) of facilities are non-functional.
- The facility surveillance gap is at 40 per cent.
- WASH infection prevention and control is at 7 per cent.

1 http://uis.unesco.org/en/country/ss
2 World Health Organization (WHO) estimates 15% of every population to be persons with disabilities and elderly.
3 The UN has not adopted a standard criterion, but generally use 60+ years to refer to the older population (personal correspondence, 2001) - https://www.who.int/healthinfo/survey/ageingdefnolder/en/.
4 https://www.unfpa.org/data/SS
5 http://uis.unesco.org/en/country/ss

Epidemics like Covid-19 can significantly increase the fragility, discrimination and violence already experienced by vulnerable people.

Handicap International South Sudan, tips on including persons with disabilities and elderly in your COVID-19 health response

During epidemics, as is with COVID-19, persons with disabilities and elderly in humanitarian settings are disproportionately at risk. This ‘tips sheet’ provides an insight in particular risks and barriers that persons with disabilities and elderly may face during health response for COVID 19, and practical action to address these risks. This note draws on the IASC Guidelines on Inclusion of Persons with disabilities and elderly in Humanitarian Action, applying these to the COVID-19 pandemic, the WHO guidance for Disability inclusion in COVID-19 response and practical tips from experience of HI and collaborating partners in South Sudan.

Introduction
After years of conflict and upheaval, public health and service provision in South Sudan remains extremely constrained, where functional, service provision has focused only intermittently on services needed by communities faced with various access barriers, therefore, lack of services tailored to the needs of diverse population groups, including older persons, women and girls, with and without disabilities or persons with chronic illnesses, remains a problem.

Despite the massive scale up of humanitarian assistance response, the worst affected excluded, marginalised population including boys and girls, men and women with disabilities and IDPs are reported to have lower access to healthcare and social services than others. With a population of 13, 300,730, it can then be assumed that at least 1,995,000 of South Sudan population are boys and girls, men and women with disabilities who experience on average poorer health access and, therefore, have greater general health needs, higher costs for medical care compared to others in the population.

Globally, early data suggest that a majority of COVID-19 deaths have occurred among elderly and among persons with serious underlying health conditions. In South Sudan, UNFPA estimates 3% of 13, 300,730 South Sudanese population to be above 65 years of age. Hence, there are over 399,021 elderly in South Sudan. This is owing to realities that they experience socio-economic disadvantage, inadequate legislation, policies and strategies, limited awareness and understanding about disability inclusive services, negative attitudes and discrimination; lack of accessibility and specific barriers that exist in relation to persons with disabilities and elderly being able to express their opinions and seek, receive and impart information and ideas on an equal basis with others and through their chosen means of communication.

COVID-19 has occurred in an atmosphere where Health and WASH coverage is very low;

- 56 per cent of the South Sudan population are without access to primary health care services.
- Out of approximately 2,300 health facilities, more than 1,300 (57%) of facilities are non-functional.
- The facility surveillance gap is at 40 per cent.
- WASH infection prevention and control is at 7 per cent.

1 http://uis.unesco.org/en/country/ss
2 World Health Organization (WHO) estimates 15% of every population to be persons with disabilities and elderly.
3 The UN has not adopted a standard criterion, but generally use 60+ years to refer to the older population (personal correspondence, 2001) - https://www.who.int/healthinfo/survey/ageingdefnolder/en/.
4 https://www.unfpa.org/data/SS
5 http://uis.unesco.org/en/country/ss

Epidemics like Covid-19 can significantly increase the fragility, discrimination and violence already experienced by vulnerable people.
COVID-19 trade restrictions has negatively impacted disability assistive devices, medicines and medical supplies imports thus restricting access to essential life-saving health care services.

- Over 50% of the population in South Sudan lacks access to safe water and a mere 15 per cent of the population have access to latrines.
- In South Sudan Non-Communicable Diseases (NCDs) are estimated to account for 27% of all deaths.
- Also, until very recently the government and humanitarian actors did not view accessibility of services for persons with disabilities and elderly as being a priority and as consequence pro-disability legislative frameworks are still evolving.

The Covid-19 epidemic places a huge strain on an already weakened social, economic and healthcare system, with huge economic and social consequences. South Sudan presents persons with disabilities and elderly with greater barriers and vulnerability in accessing health care services as the health system response is challenged by limited infectious disease surveillance, weak community based outreach systems and response capacities, as well as critical shortages in trained healthcare workers at all levels. Poor sanitation protocols and isolation practices within health facilities, coupled with community resistance to putting into practice public health recommendations and seeking treatment, can fuel a rapid spread in transmission.

Specific risks faced by persons with disabilities and elderly in the health sector during Covid – 19

- **Information barriers - Public health messages are not inclusive and accessible** to all and are not sufficiently diverse (child-friendly, gender, age and disability sensitive). Adults and children with disabilities, children and older persons in general, those with low literacy levels or only speaking languages other than the main local language, might not have sufficient access to information or communication modalities used (radio message, mass media, social media). Information about health services might not be accessible to persons with disabilities and elderly. Health staff may not be skilled in inclusive communication and know how to accommodate critical consultations such as organizing sign language interpretation during testing and treatment. Telephone networks in South Sudan may also not reach some parts of the nation. Persons with hearing impairments are also not able to access the 6666 hotline as it only allows for calls and not texts.

- **Attitudinal barriers - Increased discrimination, misperceptions, stigma by community, service providers and systems** against persons with disabilities and elderly and other groups are further heightened in a pandemic situation (persons with disabilities and elderly could for example be perceived as more contagious) placing them at higher risk of isolation, physical or verbal violence and denial of access to prevention and response services. Persons with disabilities and elderly are also at risk of being deprioritized or denied access to treatment for COVID-19 based on the assumption that their chances of survival are less compared to those without disabilities. Extra burden and risks also affect women and girls with disabilities due to the confinement and extra care duties related to confinement, potentially leading to GBV and increased stress and anxiety - while community based psychosocial support systems and MHPSS services are often not accessible nor adapted to persons with disabilities and elderly.

- **Physical barriers -** Persons with disabilities and elderly might face additional barriers in adopting COVID 19 protective measures due maybe to inaccessible hand washing stations, inaccessible latrines and bathrooms and long distances to water points. Public health campaigns might not reach persons with disabilities and elderly in distant locations or those isolated at home. They may also face physical barriers in accessing testing and treatment facilities.

- **Institutional barriers -** Lack of policies and operational procedures to ensure that access to prevention and response mechanisms are accessible to persons with disabilities and elderly. Health staff at different levels are not trained to accommodate specific needs of persons with disabilities and elderly while inclusive support systems are not established (health information

---

6 2016 South Sudan Non-Communicable Diseases (NCDs) https://www.who.int/nmh/countries/ssf_en.pdf

Humanity & Inclusion: Disability Inclusion Technical Advisor, HI: Christina Wanjohi, w.christina@hi.org, Country Director Armogast MWASI, a.mwasi@hi.org and Head of Programmes James Avery, j.avery@hi.org
Recommendations: Disability Inclusion in planning, preparedness & response

- Appoint a focal point in your organization and in every program on disability/inclusion to provide leadership for inclusive health programming for at-risk groups and to be in contact with networks and organizations of persons with disabilities and elderly.
- Ensure meaningful participation of persons with disabilities and elderly during health assessments. Design health response by identifying networks and organizations of persons with disabilities and elderly within the different areas of intervention and provide them with necessary information and resources to further reach out to persons with disabilities and elderly.
- Identify health needs and risks of persons with disabilities and elderly, by including data on disability specific health risks due to virus and collapse of health and social services (impact of disruption of care and mediation, increased infections, aggravation of mobility restrictions, additional anxiety, depression) and of barriers and facilitators of access to health prevention and response mechanisms (such as formats and channels for health information, and locations such as isolation and treatment centers).
- Assess and adapt standards and protocols for testing, isolation, quarantine and treatment centers in consultation with persons with disabilities and elderly, support persons and/or organizations with technical expertise. This to ensure health referral pathways and health information is inclusive of persons with disabilities and elderly and their support persons and that health centers are accessible and equipped to accommodate persons with disabilities and elderly and their support persons. Equip those centers to ensure continuity of care (specific food, assistance, medication), protection and maximum autonomy.
- Adapt public health messages in meaningful consultation with persons with disabilities and elderly to ensure accessibility and networks with relevant expertise: provide Easy Read formats, use pictograms and drawings, use local language, use of sign language and captioning for mass media and social media. Highlight their capacities and challenge the understanding that persons with disabilities and elderly transmit the virus.
- In your campaign, share information on accessible health services and services that are adapted to the needs of persons with disabilities and elderly. Talk about the additional risks faced by persons with disabilities and elderly and their support persons, as well as other persons who rely on support for daily life activities, due to the barriers and/or their health conditions.
- Mobilize and recruit persons with disabilities and elderly for public health messaging and risk education and in each of your teams appoint a focal person for sensitization on inclusive community, non-discrimination and disability-inclusion. Engage networks of persons with disabilities and elderly in your public health campaigns in order to adapt materials and reach to their networks with inclusive communication.

7 See a first list of contacts at the end of the document.
8 Augmentative and alternative communication, are various methods of communication that can help people who are unable to use verbal speech to communicate.
messages. Ensure any changes in health service delivery are communicated to persons with disabilities and elderly in multiple formats and support systems are put in place.

**Recommendations: Inclusion in the COVID-19 Response**

- Facilitate rapid online sensitization sessions for frontline health workers on: Inclusive communication, accessibility of interventions, how to ensure protective environment during consultations and treatment.
- Adapt makeshifts hospitals, isolation centers and quarantine spaces to be accessible to persons with disabilities and elderly and their care-givers and put in place reasonable accommodation to ensure critical health referrals are accessible to persons with disabilities and elderly (pay for transportation, sign language interpreters, support person accommodation costs; allocate additional protective measurements for persons with disabilities and elderly and support persons - masks, sanitizer to clean assistive devices, soap).
- Collect disaggregated data on disability, gender, age and other relevant criteria to monitor and address the gaps in the response and disaggregate health indicators by disability (such as the number of persons with disabilities and elderly reached in RCCE, access testing and/or treatment).
- Ensure primary health, and MHPSS services are accessible and adapted to persons with disabilities and elderly, including quarantine spaces and/or hospitalization (e.g. sign language interpreters or family members, care givers and sighted guides or social workers).
- Engage persons with disabilities and elderly during monitoring of response e.g. through committees, during spot checks, during post-distribution monitoring.

**Recommendations for frontline staff, including health and hygiene promotors, and health workers at testing and treatment facilities**

- Ensure health outcomes for persons with disabilities and elderly are responsive, fair and efficient by identifying persons with disabilities and elderly that might be isolated, left out and in need of preventive and curative services. This can be done by reaching out to them through door to door campaigns when feasible; collaborating with networks of persons with disabilities and elderly10 to ensure health information is reaching them; reaching out to hospitals that provide mental health care, or to care institutions, day-care centers, prisons and/or directly to those persons with psychosocial disabilities living on the street or in the markets.
- Register disability, gender and age in COVID-19 monitoring systems and records (preferably using the Washington group set of questions). Document additional support needs or any suspected protection risks and ensure health referral is done to the appropriate partner or government office.
- Consider telephone consultation, text messaging and video conferencing for the delivery of other health care needs for people with disabilities.
- Provide additional targeted information on COVID-19, highlighting disability specific information relevant to people with disabilities and their support networks (e.g.: locations where hygiene items, such as soap and detergent, and/or sterilizing equipment can be accessed when their supplies are low, or information on outreach or distribution services being conducted near their areas)
- Ensure MHPSS via phone, or other means, is accessible and adapted to men, women, boys and girls with disabilities. Consider different forms of disabilities and their specific needs and adapt to these needs - for example through:
  - Use of counsellors and PSS workers who can speak local languages.
  - Use of simplified language to cater for people with intellectual impairments
  - Guidance on ethical considerations when there is need to use translators
- Ensure reasonable accommodation11 such as:

---

9 See a first list of contacts at the end of the document.

10 See initial list with contact details at end of Document.

11 Reasonable Accommodation is an individual measure that benefits a specific person – but may also bring wider benefits. For instance, a path that is made accessible for one person can subsequently be used by many. The same may be true of changing the procedure for obtaining cash Humanity & Inclusion: Disability Inclusion Technical Advisor, HI: Christina Wanjohi, w.christina@hi.org, Country Director Armogast MWASI, a.mwasi@hi.org and Head of Programmes James Avery, j.avery@hi.org
• Offer payment for sign language interpretation during critical consultations (have a sign interpreter on standby or a family member/caregiver to support on this).
• Provide transportation costs for support persons. Ensure support persons are available when persons with disabilities and elderly require this - during quarantine or when in isolation.
• Ensure protective gear is provided to care givers/support persons and persons with disabilities and elderly
  o Allow one family member or care-giver appointed by person with disability to join sensitization events, consultations, and/or treatment. Ensure caregivers have access to personal protective equipment including masks, soap, gloves and hand sanitizers.
  o Ensure COVID-19 related health facilities are close by and can be accessed by persons with disabilities and elderly; use universal design principles\(^{12}\) when designing and building temporary hospitals so that they can be accessible.
  o Monitor and address barriers that hinder access and autonomy for persons with disabilities and elderly. Ensure the accessibility of hand sanitization stations, clear obstacles and ensure walking distances are reasonable. Provide wheelchairs or walkers inside hospitals to facilitate transportation and clean those regularly.
  o Ensure attitudinal barriers and protection risks such as stigma, misperceptions and denial of access to health services reported by persons with disabilities and elderly in South Sudan are identified in risk assessments and not perpetuated. This can be done through sensitization sessions to health care workers and clear and accessible beneficiaries’ feedback mechanisms.
  o Engage persons affected by stigma in the RCCE teams and messaging and ensure protection actors reach out equally to persons with disabilities and elderly at risk of neglect, isolation and/or abuse.

\(^{12}\) Universal Design is an approach that advocates that “the design of products, environments, programs and services [should] be usable by all people, to the greatest extent possible, without the need for adaptation. The principles of universal design facilitate accessibility, including for persons with disabilities. IASC Guideline Disability Inclusion 2019.
**B-SAFE | Basic Services Access For Everyone**

**STAY SAFE AT HOME**
- Livelihood/Food/Multipurpose Cash Assistance
- Prevention/Hygiene
- Mental Health Psychosocial Support/Protection

**SAFE IDENTIFICATION**
- Identification
- Detection
- Evaluation
- Orientation
- Referral

**SAFE WORKER**
- Personal Protective Equipment

**STAFF CARE**
- Logistics assistance

---

**B-SAFE: HI’s operational response to the pandemic**

HI’s operational approach aims to provide a holistic response to the crisis. **B-SAFE: Basic Services Access For Everyone.**

**1 / SUPPORT THE HEALTH RESPONSE 🌟**
- Promote access to hygiene for basic services, communities and households (promote hygiene, distribute hygiene kits, soap, etc.)
- Identify and refer cases or suspected cases of Covid-19.
- Transport cases to health centres, as we did during the Ebola epidemic in Sierra Leone.
- Provide psychosocial support to health workers.

**2 / MITIGATE THE IMPACT OF THE PANDEMIC 🎧**
- Identify vulnerable people most at risk and refer them to essential services.
- Address basic needs through food distributions and cash transfers. People left without work can no longer meet their needs and risk dying of malnutrition.
- Protect people most at risk and provide them with psychological and psychosocial support.

**3 / IMPROVE INCLUSIVE ACCESS TO ESSENTIAL SERVICES 🌟**
- Improve access to essential services by using Atlas Logistique expertise to support the emergency response to the pandemic.
- Support the development of an inclusive response.

**Groups targeted by HI projects**
- People and households adversely impacted by the pandemic from an economic and/or health and psychosocial point of view.
- People with disabilities, isolated people, victims of chronic diseases and at-risk in terms of protection, including women, children, and refugees.

HI’s teams work in health facilities and essential services to assist emergence response actors - NGOs, UN, and ministries - in communities, and in aid of individuals adversely impacted by the crisis and their families. Where access is not possible, we implement specific response, including by using the media, websites, etc.

**Covid-19 increases the isolation of people with disabilities**

80% of people with disabilities in the world live below the poverty line, according to the World Health Organization. They face multiple obstacles to accessing health services, including transport costs, healthcare expenses, access to information and stigmatisation. Covid-19 exacerbates existing health issues. People with disabilities, older people or people with chronic diseases are at a greater risk of developing serious complications if infected by the virus.

**The crisis requires targeted responses adapted to the needs of people affected**

Prevention information must be distributed in accessible formats and health workers must specifically target vulnerable groups. Telehealth, including tele-rehabilitation, is vital for people with injuries or disabilities to ensure continuity of healthcare and services.

---

Humanity & Inclusion: Disability Inclusion Technical Advisor, HI: Christina Wanjohi, w.christina@hi.org, Country Director Armogast MWASI, a.mwasi@hi.org and Head of Programmes James Avery, j.avery@hi.org
## Contact List: Organizations of persons with disabilities and elderly (DPOs/OPDs) both at County and at National levels

<table>
<thead>
<tr>
<th>S/n</th>
<th>Name of DPO</th>
<th>Contact person</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>South Sudan Association of Visual Impaired (SSAVI)</td>
<td>Secretary general: Agostino Longulo - 0924568036. Visually Impaired (voice calls only)</td>
<td>Juba</td>
</tr>
<tr>
<td>2</td>
<td>South Sudan National Association of Deaf (SSNAD)</td>
<td>Chair Person: Kachinga Peter -0926448029 Hearing Impaired only SMS Hearing Impaired</td>
<td>Juba</td>
</tr>
<tr>
<td>3</td>
<td>South Sudan Women with Disability Network (SSWWDN)</td>
<td>Chair Person: Roda Atanacio -0911888399 Visually Impaired (voice calls only)</td>
<td>Juba</td>
</tr>
<tr>
<td>4</td>
<td>South Sudan Wheel Chair Basketball Association (SSWCBA)</td>
<td>Chair Person : Kim Bany Jaak -092238928</td>
<td>Juba</td>
</tr>
<tr>
<td>5</td>
<td>Juba State Union of Visual Impaired Person (JSUVIP)</td>
<td>Chair Person: Robert Ladu 0923511114 Visually Impaired (voice calls only)</td>
<td>Juba</td>
</tr>
<tr>
<td>6</td>
<td>Equatoria State Association of Deaf and Dumb (ESADD)</td>
<td>Chair Person : Joseph Loro -0916692248 Hearing Impaired only SMS</td>
<td>Juba</td>
</tr>
<tr>
<td>7</td>
<td>Union of Physical Disabled (UPD)</td>
<td>Chair Person: Sebit Ezibon-0921085005</td>
<td>Juba</td>
</tr>
<tr>
<td>8</td>
<td>Disable Action Group (DAG) Association</td>
<td>Chair Person : Duku Dickson -0924099087</td>
<td>Yei Town</td>
</tr>
<tr>
<td>9</td>
<td>Community Disabled Committee(CDC)</td>
<td>Chair Person: Zachaius Chuol Phone: +211915859291</td>
<td>PoC - Rubkona County</td>
</tr>
<tr>
<td>10</td>
<td>Union of Persons with Disability (UPD)</td>
<td>Name: David Wal, Phone:+211912999877</td>
<td>Rubkona - Bentiu State</td>
</tr>
<tr>
<td>11</td>
<td>Disable Union-Aweil East</td>
<td>Name: Diing Akol weiu Chair person, Phone: 0914507339</td>
<td>Aweil East</td>
</tr>
<tr>
<td>12</td>
<td>South Sudan people with Physical Disability (SSPD)</td>
<td>James Atem Secretary, Phone: 0925661390 and/or 09106140070 Chairman - Arkangelo Abini 0917372578</td>
<td>Wau POC</td>
</tr>
<tr>
<td>13</td>
<td>Young Voices Torit</td>
<td>Chairperson Patricia Laduma, 0927334688 Jimmy Oromo 0925886473</td>
<td>Torit</td>
</tr>
<tr>
<td>14</td>
<td>South Sudan Association of Visual Impaired (SSAVI) Torit branch</td>
<td>Chairperson Susan Ifuho 0925240183 (visually impaired hence voice calls only)</td>
<td>Torit</td>
</tr>
<tr>
<td>15</td>
<td>Union of Persons with disabilities and elderly (UPD)</td>
<td>Chairperson William British Joel, 0921701827 (visually impaired hence voice calls only)</td>
<td>Torit</td>
</tr>
<tr>
<td>16</td>
<td>Yambio DPO (new group)</td>
<td>Leader – Phillip Patrick 0917139550</td>
<td>Yambio</td>
</tr>
</tbody>
</table>

## Selected global resources, specifically on COVID-19 and persons with disabilities and elderly:

- the IASC Guidelines on Inclusion of Persons with disabilities and elderly in Humanitarian Action

Humanity & Inclusion: Disability Inclusion Technical Advisor, HI: Christina Wanjoji, w.christina@hi.org, Country Director Armogast MWASI, a.mwasi@hi.org and Head of Programmes James Avery, J.avery@hi.org