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# VICTIM ASSISTANCE
## ASSESSMENT REPORT

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# EXECUTIVE SUMMARY

This report was commissioned by the United Nations Mine Action Service (UNMAS) Somalia and the Somali Explosive Management Authority (SEMA) to identify gaps in assistance to victims of explosive hazards which the mine action sector could help to fill. It examines support to victims of explosive hazards within the context of support to persons with disabilities (PwD) and their families. It draws on research conducted from mid-September to mid-December through document review, discussions via Skype and in-person with over 100 national and international stakeholders, and visits to the Federal Member States (FGS). The methodology adopted a gendered, inclusive and participatory approach to provide as representative a picture as possible, although insecurity and time constraints restricted how and where research could be conducted. Unless otherwise stated, the contents of this report is based on the views and information provided by respondents.

Victim Assistance is one of the five mine action pillars articulated in the Anti-Personnel Mine Ban Convention (APBMC), the Convention on Cluster Munitions (CCM) and related policy documents and UN Resolutions. The victim assistance concept is compatible with the social model of disability which focuses on removing the barriers preventing persons with disabilities from participating fully in socioeconomic life, and the rights-based model of disability promoted through the Convention on the Rights of Persons with Disabilities (CRPD). Mine action is regarded as an enabler of the Sustainable Development Goals (SDG) which have specific references to persons with disabilities. The legal and policy framework for victim assistance and assistance to persons with disabilities promotes inclusivity, equal access and appropriate gender and age interventions.

The mine action sector, comprising local and international partners, is coordinated by SEMA. Currently the sector is not active in victim assistance and does not have strong links with the disability sector or stakeholders outside the mine action sector. Coordination and information sharing within SEMA and among mine action stakeholders is inconsistent.

Victim assistance is holistic and includes medical care, rehabilitation, psychosocial support, and socioeconomic inclusion for the survivors and families that have lost relatives or are caring for relatives as a result of an explosives hazard incident, as well as affected communities. The comprehensive approach to victim assistance and support to persons with disabilities involves multiple sectors. The mine action sector contributes primarily to victim assistance through the collection of casualty data and advocating for support to victims from other sectors and from donors.

Somalia is a States Party to the relevant mine action instruments and signed the CPRD in October 2018 so there is a strong framework and mandate for promoting victim assistance and the rights of persons with disabilities. However, not all these instruments are enshrined in domestic law and systematic and institutional progress to implement commitments to families of victims, survivors and persons with disabilities are in their initial stages. There are numerous NGOs and disabled persons organizations (DPOs). Some appear to be very active and to have made progress in advocating for the rights of persons with disabilities and providing some practical support. However, overall, the situation for persons with disabilities and their families is difficult and there is little professional support, particularly outside the main urban areas. The key findings include:

- There are no accurate statistics for the number of victims of explosive hazards or the number of persons with disabilities in Somalia. The 2011 World Health Organization estimate that 15 percent of the world's population has disabilities is often quoted for Somalia.

- Persons with disabilities and their families are stigmatized. Persons with disabilities can feel worthless or are made to feel worthless and are excluded or exclude themselves from public life. They are a vulnerable and marginalized group, stigmatized by others including, sometimes, their own families. They face barriers in all aspects of their daily public and private lives and may be physically and sexually abused. They have limited access to professional support and consequently are prevented from accessing their rights.
- The marginalization and abuse of persons with disabilities varies according to sex, socioeconomic status and clan. For example, women and girls with disabilities are likely to face more difficulties than men and boys with disabilities, the poor and those from minority clans are likely to be discriminated against more than the wealthy and those from the major clans.
- The perception of disability also depends on its origins. Those who become disabled through an accident and have reduced mobility as a consequence are likely (although this is not always the case) to be viewed more sympathetically than someone who was born with a disability and to be supported to resume, as far as possible, their previous life. It is likely that people disabled later in life, rather than from birth, have more resources on which to draw as they were socialized from childhood and had equal access to education and employment opportunities.
- Attitudes to disability also seem to vary depending on the nature of disability. For example, hearing and visual impairment is seen as less severe than other disabilities and there is a view that with an education, someone who is visually or hearing impaired, can be integrated into socioeconomic life.
- Few respondents answered questions about perceptions of those with intellectual disabilities so it was not possible to draw conclusions about prevailing attitudes. Findings from other research suggests that intellectual disabilities are a taboo subject.
- It is recognized and understood that victims of explosive hazards have been through a traumatic experience and could experience mental health problems as a result. However, respondents also emphasized that, because of the protracted conflict, many Somalis have mental health and stress-related problems.
- DPOs and individual respondents with disabilities argue that perceptions of those with disabilities will only change if they are seen to be participating in and contributing to daily socioeconomic activities.
- Currently there is no clear overview of the health facilities. Access to healthcare is worse in rural areas than urban areas. Many primary healthcare clinics are mobile. The World Health Organization is planning to conduct a Health Resource Availability Mapping (HeRAM) in 2019.
- The availability of first aid and first responders was seldom mentioned by non-medical professionals. Medical professionals prioritized other medical needs over first aid although the lack of ambulances to transport patients to hospital was mentioned.
- Emergency trauma care, surgery and medical facilities are limited and usually basic with only a few hospitals being able to carry out surgery. Patients travel to Mogadishu, other large urban centres or abroad for surgery.
- Rehabilitation services including physiotherapy, occupational therapy and assistive devices are estimated to cover only 20 percent of the need. The need to expand rehabilitation services was identified by many respondents as the priority for persons with disabilities because immobility is the first barrier to participation in socioeconomic life.
- Psychosocial support is available from people who have received basic training working at local DPOs. Persons with disabilities also provide informal support to each other. Some survivors and persons with disabilities reported that family and friends had been supportive. There are a few

professionals to support more complex cases but there are not enough to meet the need.

- Respondents from local NGOs and DPOs were familiar with psychosocial support provided for people who have experienced some form of abuse. There did not appear to be any stigma attached to those who received psychosocial support.
- Children with disabilities are often bullied by teachers and other children. School buildings are inaccessible and, the few children with disabilities who attend school, rarely complete their education. Families can be reluctant to use their limited resources to send children with disabilities to school, especially if that child is female. Some children with disabilities miss education because they are receiving medical and rehabilitation treatment.
- Some respondents with disabilities reported positive experiences at school and a disability umbrella organization states that efforts to raise awareness among teachers in Kismayo about the rights of children with disabilities to an education resulted in more children with disabilities attending school.
- Students with disabilities rarely attend university although some of the respondents from local NGOs and DPOs had obtained university degrees.
- Persons with disabilities have limited income generation opportunities especially if they remain uneducated and immobile because of the lack of assistive devices. Workplaces are often inaccessible, and employers are reluctant to employ persons with disabilities believing that they are unable to work. Landlords are usually unwilling to rent business premises to persons with disabilities doubting their ability to pay the rent. Persons with disabilities cannot obtain bank loans to start a business although abled-bodied Somalis also struggle to secure loans.
- There are some small-scale livelihoods and vocational training projects implemented by local NGOs and DPOs with external funding. None appears to have sustainable funding and the success of these initiatives is unclear although some are known not to have resulted in long-term employment for participants.
- Programmes designed to promote income generation or provide vocational training in Tajikistan and Afghanistan among survivors and in Egypt among people with disabilities have had limited success. Other sectors, such as those responding to forced migration and disasters, also report poor results from income generation projects and vocational training among their target populations.
- Few persons with disabilities are able to access their political rights because of the physical barriers and misconception that they have no role to play in political life and nothing to offer society. Representatives from DPOs and persons with disabilities argue that more persons with disabilities should become politicians or be appointed to senior public positions to increase the visibility of persons with disabilities and show their positive contribution to public life. Voter registration in some areas has been designed to include persons with disabilities.
- There is frustration among victims of explosive hazards, persons with disabilities and the organizations providing assistance or advocating for disability rights about the number of surveys and pieces of research that have been conducted without seeing tangible results or an increase in assistance. Most national respondents stressed the desire to see some concrete outcomes from this study rather than workshops raising awareness among persons with disabilities about their rights. However, they thought advocacy among service providers, employers and government authorities about the rights of persons with disabilities would be helpful. They stressed the need for people in Somalia to see that persons with disabilities can contribute to society.

# RECOMMENDATIONS

These recommendations are for UNMAS and the mine action sector in Somalia.

## POLICY AND PLANNING

- Interventions should be tangible and visible to persons with disabilities and have immediate as well as long-term objectives. Interventions should facilitate inclusivity and be gender and age appropriate and recognize that some groups of people with disabilities are more vulnerable than others. Prioritization and detailed project design should actively involve persons with disabilities, although care is needed to avoid raising expectations if persons with disabilities are involved before funding has been successfully secured.
- The mine action sector should develop a joint victim assistance policy that defines the type and scope of victim assistance activities, establishes a mechanism for coordinating victim assistance activities and identifies where the mine action sector needs to strengthen its capabilities to support and develop victim assistance. The sector should decide whether it should have a policy for employing survivors and persons with disabilities.
- Based on the policy, the sector should agree a three-year action plan for victim assistance and allocate roles and responsibilities.
- UNMAS should integrate its victim assistance strategy into its existing strategies for miine action and support to SEMA.

## COORDINATION AND COMMUNICATION

- Strengthen communication within the mine action sector.
- Clarify the role of the mine action consortia in relation to SEMA - the aim is to separate roles and responsibilities between the local NGOs and SEMA to avoid a conflict of interests over implementation, and coordination and oversight.
- Ensure that all mine action staff at all levels are aware of the sector's commitments to victim assistance, its policy and action plan.
- Strengthen the mine action sector's network with other sectors. Coordinate with DPOs and other organizations supporting persons with disabilities and identify opportunities for joint initiatives. Attend protection cluster meetings or other coordination meetings.
- Ensure that external stakeholders understand the scope of victim assistance within the mine action sector and recognize that other sectors are responsible for providing the range of support intended for the families of victims, survivors and other persons with disabilities.
- The mine action sector should appoint a victim assistance focal point to: support developments at the policy level to fulfil the CRPD; to ensure that the rights of victims of explosive hazards are represented; and to update the mine action sector on their obligations under any disability legislation and policies developed in Somalia.
- Where appropriate and possible, the mine action sector could provide practical support for initiatives by other sectors to support disabilities. This might, for example, include deploying community outreach teams to collect survey data, providing casualty data or responding to requests for information about areas that are difficult for other actors to access.

## DATA COLLECTION

- Mine action stakeholders should establish a task force to improve the accuracy of the information about victims held in the national database. Data entries in all databases should be verified including those held by the Landmine and Cluster Munition Monitor.
- Ensure that victims forms are translated into Somali, that staff required to complete the forms understand how to do so, that the sector has clear procedures for collecting, submitting and verifying victims' data.
- In consultation with the health sector and DPOs, the mine action sector could develop a needs assessment form to be completed alongside incident and victim forms with the aim of developing an understanding of the support survivors and their families are most likely to need. Mine action staff will need training on how to complete the needs assessment forms.
- Continue to collect data about explosive hazards incidents and victims and enter into the Information Management System for Mine Action (IMSMA).
- Use the mine action sector's community liaison and outreach staff to support data collection by other sectors about persons with disabilities or services available to persons with disabilities to support the development of national databases and assessments.

## SUPPORT TO VICTIMS

- Focus on providing practical help that has an immediate impact and enables persons with disabilities to be more visible and active among the rest of the population.
- Ensure that SEMA offices and community liaison/outreach staff have information about assistance available locally to victims of explosive hazards and their families and develop referral pathways. The information, which should be checked and updated regularly, is given to new and newly identified victims and their families.
- UNMAS could consider mobilizing resources to expand the provision of rehabilitation and assistive devices to improve the mobility of those with disabilities so that they can participate more easily in socioeconomic life.

## ADVOCACY

- Advocate for inclusivity of persons with disabilities in the programming of other sectors.
- Coordinate advocacy activities with other sectors to ensure complementarity and avoid duplication. Support messaging developed to promote the implementation of the CRPD and rights of persons with disabilities.
- UNMAS, and other mine action stakeholders if they choose, could use the mine action sector's community liaison/outreach staff to relay messaging provided by OHCHR to institutions about their obligations to persons with disabilities and the importance of inclusivity.
- In coordination with UNICEF and risk education activities, raise awareness among teachers and the education authority that children with disabilities have a right to attend school. Sensitize teachers to treat children with disabilities respectfully and to ensure that other pupils treat pupils with disabilities respectfully.
- Use Mine Action Day to raise awareness about survivors and to host an event that raises a small amount of money for a local NGO supporting persons with disabilities. The NGO should be one

that would not normally be considered for funding because its requirements are too small to be able to apply for international funding.

## OTHER AREAS OF SUPPORT

- Respondents did not prioritize emergency or medical care. Some thought psychosocial support might be beneficial although the capacity to deliver this is unclear. However, among health needs, all respondents considered rehabilitation services to be a more immediate need and often prioritized rehabilitation above all other needs.
- Livelihoods activities for victims of explosive hazards have not been widely successful in other countries or among other sectors and some are known not to have been successful in Somalia. It is not recommended that livelihoods activities are supported unless a skilled and experienced partner organization can be identified.
- Avoid activities to raise awareness among the disabled of their rights because, if they cannot claim them, this will only cause frustration and DPOs already engage in these activities and would prefer external support to provide tangible, visible support.

## ASSUMPTIONS

- UNMAS and the mine action sector has the capacity to implement victim assistance.
- Adequate funding can be secure for victim assistance activities and to support SEMA.
- Communication within the mine action sector is strengthened so that policy and practice are uniform throughout the sector and information is shared in a timely manner.
- The relationships and communication between the mine action sector and the disability sector is strengthened.
- The security situation is stable enough for projects to be implemented.

# ACKNOWLEDGMENTS

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# 1. INTRODUCTION

## 1.1 RATIONALE

After decades of conflict, Somalia is contaminated with explosive hazards including landmines, unexploded cluster munitions, and explosive remnants of war (ERW). More recently improvised explosive devices (IEDs) are being used in the conflict. These explosive hazards kill and maim civilians, but the extent and type of support available to the survivors and their families, and the families of those who were killed is unclear. This report, commissioned by UNMAS and SEMA, is a first step in identifying existing resources and services available to victims and their families as well as persons who were born with disabilities or became disabled through illness or accidents other than those caused by explosive hazards. Persons with disabilities are defined as 'those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.'[1]

Based on discussions with Somali authorities and international and national respondents working for UN entities, non-governmental and civil society organizations, this report identifies gaps and prioritizes the needs in services for persons with disabilities. The research and the structure of the report are based on key components of victim assistance which are examined within the broader context of the rights of persons with disabilities and their access to support in Somalia. The following aspects of victim assistance and assistance to persons with disabilities are examined:

- Social inclusion, advocacy awareness raising and the legal and policy framework
- Coordination and communication within and among sectors providing assistance
- Information management
- Health care including first aid and medical care, rehabilitation and psychological and psychosocial support
- Education
- Economic inclusion

## 1.2 METHODOLOGY

The research for this report, conducted over a three-month period from mid-September to mid-December 2018, is based on document review and individual and focus groups discussions with over 100 national and international stakeholders. Visits to each of SEMA's offices were made to conduct research at the Federal Member State level as well as in Mogadishu. The research was designed to develop an overview of the assistance available to victims of explosive hazards and persons with disabilities throughout the country and to elicit views from a wide range of stakeholders. Respondents included government officials, international and national staff from the United Nations and non-governmental organizations, and representatives from DPOs and civil society. Women's groups and youth groups were included among the organizations represented as were persons with disabilities who were working for NGOs and DPOs.

Representatives from Somali organizations explained that persons with disabilities are weary of responding to questions about their needs and then receiving nothing. Some respondents from local NGOs and DPOs were angry at the lack of support for persons with disabilities, particularly as they

1 CRPD

feel they regularly respond to surveys and attend meetings to discuss needs yet see no tangible outcomes. Therefore, the research adopted a 'do no harm' approach and a deliberate decision was made not to include persons with disabilities in the research at this stage to avoid raising expectations as currently there are no projects planned and no funding has been secured. However, there were persons with disabilities among the respondents who participated in discussions as representatives of NGOs and DPOs. Other respondents comprised those who worked for NGOs at the community level and have good insights into the living conditions of persons with disabilities and the types of assistance available. If the mine action sector intends to proceed with victim assistance, detailed planning for project design and implementation should involve the participation of persons with disabilities to ensure that interventions are appropriate.

Ministries and local authorities were asked to participate in the research but most declined the invitation citing other commitments.

The information has been organized and analysed thematically based on the key components of victim assistance. The multiple sources of information enabled findings to be triangulated. Overall, despite the wide range of different skills and experiences, there was a strong consensus of opinion among all the respondents in identifying the priority needs and about the lack of support currently available. The key difference, which is not surprising, is that DPOs and NGOs supporting vulnerable groups were more aware of the limited assistance available than those outside these sectors.

Although the strong consensus among respondents made it possible to draw firm conclusions and make recommendations, this assessment is an overview rather than a detailed analysis of the assistance available. The insecurity and logistical challenges mean that no facilities or projects were visited so there is no understanding of the quality of assistance available and no means of independently verifying respondents' descriptions of support available. Many of the respondents work directly with vulnerable populations so have a first-hand perspective of the context, but their interpretation of the situation is not necessarily the same as the members of those population groups. All respondents were educated, many understood at least basic English and had experience of formal employment which means that they are not representative of population.[2] There were persons with disabilities and victims of explosive hazards among the respondents but they were educated, often working and had been able to access support. Therefore their experiences are unlikely to be representative of the majority of persons with disabilities.

The research had to be designed to fit the time available and the duration of visits to the states was dictated by the flight schedule rather than the time needed to conduct the research. Insecurity meant that most meetings were conducted inside secure compounds preventing any engagement with the population and daily life. As noted above, persons with disabilities or explosive hazards were not included in the research on the basis of their disability alone although some of the respondents working for DPOs and NGOs had disabilities, so the perspective of the most vulnerable groups with disabilities is potentially missing.

Despite the constraints, efforts have been made to gather as many different view points as possible and to note the differences of opinions and experiences where they occur. This report should be regarded as a foundation on which the mine action sector can strengthen its victim assistance work. As it does so, it can develop a more in depth understanding of the context in which persons with disabilities and victims of explosive hazards live and the action needed to ensure that they have equal access to their rights and to services.

2 See FGS n.d. and report below for information about literacy rates, school enrolment and employment rates

A list of respondents can be found in Annex 9.3. Several respondents chose to remain anonymous. No comments have been directly attributed to individuals. Unless otherwise stated, information in this report has been contributed by respondents.

Information collected during the State visits is summarized in tables in Annex 9.4.

## 1.3 MINE ACTION IN SOMALIA

Mine action in Somalia is managed by the Somali Explosive Management Authority (SEMA) which was created by Presidential Decree 107 on 6 August 2013. It comes under the Ministry of Internal Security (MoIS) and has its headquarters in Mogadishu and regional offices in Garowe in Puntland, Baidoa in South West State, Kismayo in Jubbaland, Dhuusamarreb in Galmadug and Beletweyne in Hirshabelle. The draft mine action law has not yet been passed by Parliament and SEMA receives no Government funding.

The regional offices were established at different times, the newest being in Beletweyne which was created in 2016. The SEMA office in Mogadishu was destroyed in an attack on 7 July 2018 and SEMA is currently co-located with Norwegian People's Aid (NPA). At the state level, SEMA has offices but no computers or proper internet access. SEMA staff do not have salaries although some of their travel expenses are covered by international partners. Communication and information sharing throughout SEMA needs to be improved.

In each SEMA office location, the local organizations have formed a mine action consortium. The role of the consortia needs to be further defined and elaborated. The international implementing partners include Danish Demining Group (DDG) HALO Trust, Mine Advisory Group (MAG), NPA and UNMAS. Humanity International (HI) is planning to establish an office in Mogadishu in 2019 and should be a valuable partner for the mine action and disabilities sector.

SEMA holds regular coordination meetings with the mine action sector and receives reports from its implementing partners. There appears to be little coordination between the mine action sector and other sectors, including the disabilities sector. The mine action database, Information Management System for Mine Action (IMSMA), was handed over from UNMAS to SEMA. The mine action sector does not have a victim assistance strategy, although some of the actors collect data, coordinate with disability organizations on an ad hoc basis and may provide transport to medical facilities for casualties. The victims' data is inaccurate, not all partners are aware that a victim form for IMSMA exists. This is possibly because it appears to be only in English and has not been translated to Somali.

### Somaliland

The Somaliland Mine Action Centre (SMAC) was originally established under the Office of the Vice President. Following the election of Muse Bihi's government in November 2017, SMAC was renamed the National Demining Agency (NDA) and moved to the Ministry of Defence. These changes came into effect in early 2018. There is no formal communication between SEMA and NDA.

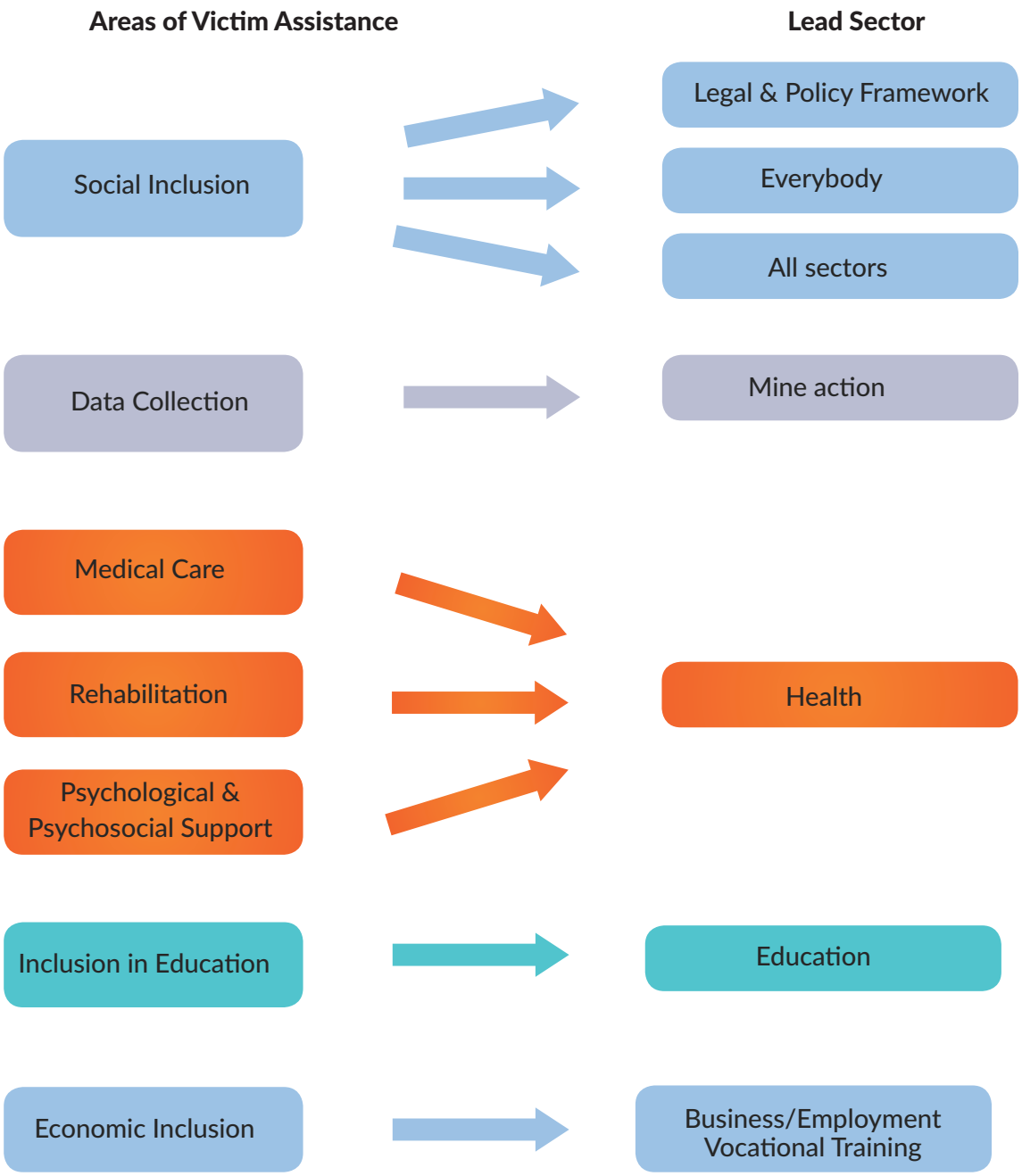
In Somaliland, the mine action sector reports all statistics and mine action activities to the NDA and submits weekly and monthly reports as well as workplans for approval. The NDA is responsible for the handover of released land to the community but the lack of capacity has led to delays in the official handover taking place although communities access the land as soon as it has been cleared.

Somaliland could be the first region of Somalia to be declared mine impact free.

## 1.4 VICTIM ASSISTANCE

The term 'victim' in mine action is the umbrella term for all those affected by explosive hazards directly and indirectly including those killed, the families of those who have been killed, the survivors and their families and those whose daily lives are negatively impacted by the presence or the fear of the presence of explosive hazards. The focus of this report is on the victims and survivors and their immediate families. Survivor is the preferred term rather than victim for those that survive an explosive hazards incident, although this report uses the term victim when speaking in general about those affected by explosive hazards.

The diagram shows the key areas of victim assistance and the lead sectors.



## Areas of Victim Assistance

Victim assistance involves different activities conducted by different sectors. Services and support can be provided formally by government and non-government organizations and informally by relatives and members of the community. Some in the mine action sector include activities that prevent accidents such as clearance of explosive hazards and risk education as part of victim assistance.

This report includes recommendations for the mine action sector to strengthen its own contribution to victim assistance and collaborate with or advocate among other sectors to improve assistance and thereby promote the ability of victims of explosive hazards and persons with disabilities to access their rights.

# 2. SOCIAL INCLUSION

Social inclusion for victims of explosive hazards and their families and persons with disabilities means ensuring that everyone has equal access to participate in all aspects of daily life, is treated with respect, without discrimination, and is able to access their rights. These rights are promoted and protected by international humanitarian and human rights law and the policy and practices for their implementation in Somalia. The development policies for Somalia and the international commitment to the Sustainable Development Goals (SDGs) also support the rights of persons with disabilities.

For persons with disabilities to be able to access these rights, not only must the legislation and policies be implemented, they must be respected by the population and enabled by social attitudes and practices. Simultaneously, programmes implemented by government, international and local organizations must be inclusive of all population groups including those with disabilities.

This section looks at the principles underpinning the assistance to persons with disabilities as well as the key legislation and policy documents underpinning interventions for victims of explosive hazards and persons with disabilities. It shows the compatibility of victim assistance with current best practice and legislation promoting and protecting the rights of persons with disability.

## 2.1 PRINCIPLES GUIDING APPROACHES TO DISABILITY

Inclusivity is the approach to disability being promoted by the international community through the Convention on the Rights for Persons with Disabilities (CRPD), best practice for humanitarian and development interventions and donor funding criteria. The objective is to ensure that in every aspect of life, the rights of persons with disabilities, alongside the rights of other population groups, can be achieved. Therefore legislation, policies, strategies, programme design and implementation should be developed to ensure that no one, regardless of gender, age, ethnicity, religion, socioeconomic status, physical or intellectual ability, faces discrimination and has equal access to services and opportunities. Within mine action, victim assistance has developed to promote inclusivity to ensure that victims and their families and communities have equal access to services and participation in socioeconomic life. The impetus for improving support for persons with disability stems from analysis showing that a disproportionate number of persons with disabilities tend to have other vulnerabilities including additional health problems, low educational attainment, higher rates of poverty and lower rates of participation in socioeconomic life than those without a disability.[3]

There are three main approaches to disability – medical, social and rights-based.

### Medical Model

A medical approach focuses on the differences or impairments of a person with disabilities and is often regarded as narrow, failing to address the needs holistically and within the context of daily life, and of creating low expectations which mean that persons with disabilities are marginalized, excluded from participating in society and lose their independence.[4]

3 WHO & WB, 2011: UNGA, 2018
4 Scope, n.d.

## Social Model

The current preference is to adopt the 'social model of disability' which argues that it is the interaction with the environment that makes a person disabled. The social model identifies 'disabling barriers' such as negative attitudes, lack of access to built environments, lack of services or inadequate policies and standards to meet the needs of persons with disabilities. Therefore, it is the environment in which we live that makes someone with physical, sensory or mental impairments disabled. The social model advocates a holistic approach to remove disabling barriers to enable persons with disabilities to participate actively in daily life.[5] The social model often refers to physical and mental impairments rather than disabilities although this use of terminology is sometimes criticised for understating the difficulties faced by persons with disabilities.[6]

## Rights-based Model

The rights-based approach is promoted by the CRPD. It 'is the first human rights instrument which acknowledges that all disabled persons are rights holders and that impairment may not be used as a justification for denial or restrictions of human rights.'[7] Article 1 states that the purpose of the Convention is 'to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity.' The rights-based model and social model are complementary and mutually re-enforcing as the rights of persons with disabilities and their rights to social relations are protected and facilitated.[8]

Victim assistance, as articulated in the Anti-Personnel Mine Ban Convention (APMBC) and Convention on Cluster Munitions (CCM) and related documents, advocates the social and rights-based model for disability. Over time, the promotion of the rights of victims in mine action policies and guidelines has become stronger, making victim assistance consistent with the CRPD. Mine action best practice is to mainstream victim assistance into assistance for persons with disabilities and to ensure that the cause of a disability does not disadvantage or favour a particular group of persons with disabilities over another. All victim assistance should be age and gender sensitive.

## Terminology

Current best practice advocates using terminology that de-stigmatizes disability and avoids labelling someone as disabled and the disability used as a means of identifying an individual. Therefore, a person has disabilities or a person with disabilities and not a disabled person or a person is disabled. There are physical, sensory as well as intellectual or learning impairments which refer to limitations in reasoning, learning and problem-solving. There are also mental health difficulties or problems which include depression, anxiety and post-traumatic stress disorder (PTSD). An individual can have a combination of physical, sensory and intellectual impairments and mental health problems.

Persons with disabilities are often included among vulnerable groups under the protection system, donor funding and the SDGs. Although, disability disproportionately affects vulnerable groups, vulnerable is generally a term that persons with disabilities or those working with persons with disabilities avoid.[9] Despite the term victim assistance, the mine action sector promotes the use of the term survivor. There are variations in the use of terminology for disabilities in different countries

5 WHO & WB, 2011
6 Deneger, 2016
7 Deneger, 2016
8 Deneger, 2016
9 IDDC & IDA, n.d.

and among different cultures and, although different views should be considered, it is important that terminology is used sensitively and promotes positive and inclusive attitudes towards disability. Above all it is important that the individuals with disabilities are able to use their preferred terminology.

## 2.2 LEGAL AND POLICY FRAMEWORK

The above principles underpin the international and national instruments and their related policy documents for providing assistance to and protecting the rights of victims of explosive hazards and persons with disabilities in Somalia. The various instruments provide a framework and mandate for interventions. They include:

### Antipersonnel Mine Ban Convention

The Federal Government of Somalia (FGS) acceded to the APMBC in October 2012.[10] Victim assistance is one of the five pillars of mine action and includes care, rehabilitation and social and economic integration of victims. Article 6.3 requires states parties in a position to do so 'to provide assistance for the care and rehabilitation, and social and economic reintegration of mine victims'. Assistance can be provided by a range of national and international actors operating multilaterally and bilaterally. Initially the focus of the Convention was on direct victims but, at the first review conference in Nairobi in 2004, this was expanded to include indirect victims.

### Convention on Cluster Munition

On 30 September 2015, the FGS ratified the CCM. This Convention promotes the rights of victims more forcefully and in more detail than the APMBC by ensuring 'the full realisation of the rights of all cluster munition victims and *recognising* their inherent dignity' through assistance to cluster munition victims, 'including medical care, rehabilitation and psychological support, as well as providing for their social and economic inclusion' The term cluster munition victim in the Convention refers to 'all persons who have been killed or suffered physical or psychological injury, economic loss, social marginalisation or substantial impairment of the realisation of their rights caused by the use of cluster munitions. They include those persons directly impacted by cluster munitions as well as their affected families and communities'

### Maputo Action Plan

The Maputo Action Plan, adopted 27 June 2014 at the third review conference of the APMBC and signed by the FGS, recommits States Parties to achieving the 'full, equal and effective participation of mine victims in society' and echoes commitments made by States Parties and the mine action sector to victims of explosive hazards through other processes such as the CCM.

### Countering the threat posed by improvised explosive devices

The General Assembly Resolution, Countering the threat posed by improvised explosive devices (IEDs) adopted on 5 December 2016, commits member states to providing victim assistance and

10 Officially, The Convention on the Prohibition of the Use, Stockpiling, Production and Transfer of Anti-Personnel Mines and on Their Destruction. It was adopted on 18 September 1997 and it entered into force on 1 March 1999. The Somali Government has not signed Protocol V of the Convention on Certain Conventional weapons which obligates conflict parties (not only States) to help clear explosive remnants of war (ERW) by sharing relevant information and cooperating in clearance processes.

member states in a position to do so, are urged to provide assistance to affected states to address the issues of IEDs, including victim assistance.

### Resolution 2365 (2017)

Adopted by the Security Council on 30 June 2017, Resolution 2365 is the first stand-alone United Nations Security Council Resolution (UNSCR) text on mine action. It expresses equal concern about IEDs, landmines and ERW and stresses the obligation of states, the international community and conflict parties to protect civilians and engage in activities to mitigate the threat of these explosive hazards including, 'relevant gender and age specific' 'assistance for the care, rehabilitation, and economic and social reintegration of victims and persons with disabilities'. The mine action sector has developed various guidelines and policies to promote best practice for the implementation of the mine action pillars, including victim assistance.

### Gender Guidelines for Mine Action Programmes

The Gender Guidelines for Mine Action Programmes were published in 2010 and are currently being revised. They stress the need to provide appropriate age and gender sensitive support and services for victims and explain some of the common inequities among men, women, boys and girls in accessing assistance and suggest ways to redress the balance.

### United Nations Policy on Victim assistance

The United Nations Policy on Victim Assistance, which was written in 2016 and, at the time of writing (December 2018) is being revised, defines the scope of victim assistance as:

- data collection, including context analysis and needs assessment for referral services;
- emergency and continuing medical care, including emergency first aid to the victim of the explosion and ongoing medical care;
- physical and rehabilitation services;
- psychological and psychosocial support;
- social and economic inclusion, inclusive education, as well as access to basic services and disability awareness;
- establishment, enforcement and implementation of relevant laws and public policies.

### United Nations Mine Action Strategy 2019-2023

The United Nations Mine Action Strategy reaffirms the commitment to victim assistance and states that victim assistance should be consistent with the CRPD and the SDGs. The strategic outcome is: 'Survivors, family members and communities affected by explosive devices have equal access to health and education and participate fully in social and economic life.'

## Convention on the Rights of People with Disabilities[11]

The FGS signed the CPRD on 2 October 2018. The Convention defines persons with disabilities as 'those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others'.[12] The Convention promotes the rights of persons with disabilities without discrimination through inclusivity. Rights include access to health, education, work, and participation in political, social and cultural rights. Article 32 calls upon international cooperation to fulfil treaty obligations including the provision of technical and economic assistance and ensuring that development programmes are 'inclusive of and accessible to persons with disabilities'.

## Convention on the Rights of a Child

FGS ratified the Convention on the Rights of the Child on 20 January 2015. Through the Convention States commit to protect the rights of all children without discrimination, including those with disabilities (Article 2), and to ensure that the best interests of the child are always the primary concern in decision-making that may affect them (Article 3). Article 23 states that 'Children who have any kind of disability have the right to special care and support, as well as all the rights in the Convention, so that they can live full and independent lives.

## Charter on Inclusion of Persons with disabilities into Humanitarian Action

The Charter on Inclusion of Persons with disabilities into Humanitarian Action was developed at the World Humanitarian Summit in 2016 and reaffirms commitments to International Humanitarian Law, Human Rights Law and the CRPD and promotes alignment with the SDGs. The Charter commits signatories to make humanitarian action inclusive of persons with disabilities through non-discrimination, participation, inclusive policy, inclusive response and services, and effective cooperation and coordination. Numerous United Nations entities have signed the Charter including UNMAS. Signatories include states, disability networks and DPOs and international organizations such as ICRC and HI.

## Sustainable Development Goals

The SDGs are comprehensive and include protection, access to services, employment and protection of the environment through sustainable development and economic growth. The goals promote inclusivity and protect the rights of all including vulnerable groups. Persons with disability are specifically mentioned in the SDGs concerning inclusive education including vocational training (SDG 4), access to employment and equal pay for equal work (SDG 8), reduction of inequalities through social, economic and political inclusion (SDG 10), accessible cities and communities (SDG 11) and inclusion of data on disabilities in partnership for goals (SDG 17). A United Nations report published in August 2018 expresses concern that the SDGs will not benefit persons with disability unless specific efforts are made to prioritize inclusive development and ensure that persons with disabilities are visible in policy making.[13]

The SDGs apply to all member states and all the goals are interlinked and reinforce existing human rights conventions including the Rights of the Child and the CRPD. The International Disability and

11 The convention builds upon the Standards and Rules of the Opportunities for Persons with Disabilities (1994) and the World Programme of Action on Disabled Persons (1982) neither of which is legally binding.
12 Article 1, CPRD.
13 UNGA, 2018

Development Consortium and the International Disability Alliance recommend that the CRPD is used to implement the SDGs. Mine action is regarded as an enabler of the SDGs.[14]

## Somali National Framework

Although the FGS has committed to the above conventions, and the resolutions, related policies and guidelines regarding support to victims of explosive hazards and persons with disabilities apply to Somalia, the processes to implement them or enshrine them in domestic law are ongoing.

## Victim Assistance

Under the Presidential Decree establishing SEMA, victim assistance is part of its mandate. Victim assistance is included as one of the five pillars of mine action in the National Technical Standards and Guidelines (NTSG) and described as including rehabilitation and reintegration. The mine action law is in draft waiting for Parliamentary approval and the NTSG, if endorsed by the Somali government, will become the National Mine Action Standards.

## Rights of Persons with Disabilities in Somalia

Article 11 of the 2012 Provisional Constitution prevents the state from discriminating against persons with disabilities and provides equal rights for them before the law.[15] In June 2018, the Cabinet approved the National Disability Bill which was passed by Parliament on 18 November 2018 after a month of debate.[16] It is consistent with the CRPD which the Minister for Women and Human Rights Development (MoWHRD) signed on behalf of the FGS. Within MoWHRD there is a disabilities focal point. At the time of writing (December 2018) planning for the implementation of the CRPD is ongoing. Under the General Obligations of the CRPD (Article 4) each State Party should 'develop the necessary legislation, policies, representative and coordinating bodies and capacity to fulfil its Treaty Obligations and to do so by consulting and actively involving persons with disabilities.' There are discussions about establishing a parastatal Disability Inclusion Agency, but details about how it would be funded and how resources would be coordinated among the different relevant ministries need to be developed.

## The National Development Plan 2017-2019

The National Development Plan (NDP) 2017-2019 is comprehensive and multisectoral. It acknowledges particularly vulnerable groups such as female headed households, internally displaced persons (IDPs) and persons with disabilities. It promotes an inclusive approach and makes provision for vulnerable groups in the social protection policy. They are specifically mentioned in youth and functional literacy programmes, housing strategies to ensure adequate housing for the expanding urban population, and livelihoods schemes. Jubaland state also commits to promoting the rights of persons with disabilities. The NDP is aligned with the SDGs and indicators for employment include disaggregated data for the youth and adults with disability who are in employment.[17]

14 GICHD & UNDP 2017
15 FRS, 2012
16 BBC 2018b
17 FGS (n.d.): 128; 140; 153; 161; 174; and 191

### Somaliland

The Constitution states that persons with disabilities have equal rights and opportunities. A National Disability Policy was developed under the Ministry of Labour and Social Affairs – now the Ministry of Economy, Social Affairs and Family. In September 2018, through a participatory approach, an action plan for 2018-2021 was launched to implement the disability policy. The Government and ninety-six NGOs and government partners have committed to ensure that services are inclusive to persons with disabilities.

## 2.3 POPULAR ATTITUDES

Having the necessary legal and policy framework in place to promote the rights of persons with disabilities is important and the responsibilities for this lies with governments and institutions. However, everybody is responsible for ensuring that they behave in a manner which is inclusive and non-discriminatory. Unfortunately, in Somalia, persons with disabilities and their families are often stigmatized. Persons with disabilities can feel worthless or are made to feel worthless and are excluded or exclude themselves from public life. In Somali culture it is traditional to give someone a nickname based on physical attributes. In the case of someone who is disabled the nickname will be a reference to their impairment. Physical and economic barriers, as well as prejudice exclude persons with disabilities from society. Persons with disabilities are a vulnerable and marginalized group that face barriers in all aspects of their daily public and private lives and may be physically and sexually abused.[18] They have limited access to professional support, are prevented from accessing their rights and are stigmatize by others including, sometimes, their own families.

There is a lack of awareness and understanding of disability among the general population and authorities and there are hierarchies of disability and levels of vulnerability.[19] For example, someone who becomes disabled rather than being born with a disability is likely to be better integrated into society and less vulnerable. This is because, before becoming disabled, they will have participated actively in daily life and have established themselves and developed a social network and means of emotional and practical support. Respondents explain that there is sympathy for anyone who becomes disabled later in life because it is understood that their life has changed and become more difficult. However, they are already integrated into society so their disability has less of a social impact than it might have for someone born with a disability.

However, respondents also cited a number of instances where women who become disabled are abandoned by their husbands. One young woman lost her leg in an IED incident and while she was in hospital her husband divorced her and took their baby. She is concerned about her future because she cares for her elderly father and has no regular source of income. She has considered remarrying but is unsure whether any man will want her or that, if she were able to remarry, she would be able to trust the man to support her and remain with her. She works in the local NGO sector but lack of sustainable funding means that she has no regular income.

Among the disabled population there are different levels of vulnerability depending on other socioeconomic factors. Factors associated with vulnerability are displacement, belonging to a minority clan and living in a female headed household. Research by Reach concluded that households often have multiple vulnerabilities and that those with a disabled or chronically ill relative are regularly

18 Amnesty International, 2015; Farah, n.d.
19 Tomlinson & Abdi, 2003

among the most vulnerable groups and usually have multiple vulnerabilities.[20] Supporting a disabled relative is an economic and emotional drain on the family. It can exacerbate poverty because of the medical costs or the cost of supporting someone who does not work and cause stress because of the financial worries or additional work of caring for a relative. It is usually the women who assumes the additional responsibility of caring for a disabled relative which adds to their already heavy workload of domestic duties and possible income generating activities. However, some respondents felt that the carer should be of the same gender after puberty.

Overall, women and girls with disabilities are likely to be more vulnerable than men and boys with disabilities and to receive less support and attention from their families. Women and girls with disabilities are also vulnerable to sexual abuse and exploitation and early marriage.[21] Women with disabilities are unlikely to marry and therefore will not have children which means when they are older there will be no one to take care of them. Traditionally Somalis see their children as an investment for their old age. Some respondents stressed that men are expected to be the main income generator so, if a man with disabilities is unable to work or to earn enough money, he ill be unable to fulfil his traditional role.

IDPs with disabilities are particularly vulnerable as they have fewer material and social resources than host populations. The poorer the family the less able it is to support a relative with disabilities and the greater the drain on resources that individual is for the family. Therefore, the lower the socioeconomic group, the greater the impact disability has on vulnerability. In some instances, poor families abandon their disabled child because they lack time or resources to care for them.

Any available resources in a family are likely to be invested in able-bodied children and priority is given to boys with disabilities over girls with disabilities. Some families are ashamed of having children with disabilities believing that it is some kind of punishment from God.[22] Respondents for this report felt that these ideas were outdated and un-Islamic. However, respondents were educated and their views may not be representative of the general population. If families feel shame, they may hide their disabled children. Some respondent reported that in female headed households, the mother is the carer and breadwinner, so when she leaves the house, she might lock the disabled child in a small room or chain them to the bed as a means of protecting them while she is out. Whether through shame or deliberate actions, children with disabilities are often hidden from society.

Although families might disown their disabled relatives or have a negative attitude towards them, the main source of support for a person with disabilities is their immediate family and their clan. Respondents provided examples of disabled relatives being married to members of the extended family to ensure their long-term care. Most support to people with disabilities is unofficial and provided within the home although respondents cited a number of instances where appeals are made for individuals and their families through the local media or mosque to raise funds on an ad hoc basis. Respondents, including those with disabilities noted that many people with disabilities are more dependent on their relatives than is necessary because of the lack of assistive devices, and appropriate access and modifications to the family home and public buildings.

Rohwerder concludes that intellectual disabilities are especially taboo in Somalia and that disability is generally associated with physically impairments rather than other types of disability.[23] Research for this report confirms that disability is understood primarily as physical impairments. Respondents were asked about attitudes towards and support for people with mental health difficulties and those with

20 Reach, 2018
21 Amnesty International, 2015
22 Amnesty International, 2015
23 Rohwerder, 2018: 2

intellectual disabilities. Respondents were familiar with trauma caused by violent or stressful events as many are from organizations that provide psychosocial support to those who have experienced sexual violence and abuse. It seems to be recognized and accepted that extreme experiences have a negative impact on mental health and that some people might need help to overcome these experiences. There did not seem to be any stigma attached to persons seeking psychosocial support.

There was no mention of mental health difficulties such as depression so Somali attitudes towards people with these difficulties are unclear. Despite posing questions about intellectual disabilities and providing definitions of the term in English and Somali, it was impossible to engage respondents on this issue other than to acknowledge that people with intellectual impairments were discouraged from going to school as it was generally believed they would be unable to learn. Further research is needed to understand attitudes towards intellectual disabilities.

There are numerous local NGOs and DPOs throughout the country.[24] The capacity of these organizations, their effectiveness in implementing projects and securing funding varies. They often work together under a disability organization umbrella which helps to coordinate and communicate activities as well as raise awareness among government authorities and donors. Again, their effectiveness seems to vary and, in some instances, there is an unwillingness to cooperate among the different disability groups. There is little or no contact between the mine action sector and disability sector.

## 2.4 INCLUSIVE PROGRAMMING

Among international donors and organizations, there is often emphasis on ensuring that persons with disabilities and other vulnerable groups are included in programme design and implementation. Many of the humanitarian organizations in Somalia include assistance to persons with disabilities in their protection activities. This approach limits the type of assistance provided which tends to be humanitarian or emergency response and short-term rather than developmental. The situation is compounded by the lack of development actors in Somalia. Protection assistance for persons with disabilities has included cash support for example among IDPs near Garowe and Baido. The cash assistance is provided by international NGOs and distributed by local NGOs. It is regarded by the local organizations as useful and needed but it is not sustainable and is provided for only a few months at a time.

Assistance to persons with disabilities during 'situations of risk and humanitarian emergencies' is an obligation under article 11 of the CPRD. Respondents noted that during the floods in Beletweyne, vulnerable groups, including people with disabilities received cash and food. They also explained that the floods affect people who rely on crawling to get around because there is a lack of assistive devices and access to transport. One donor reported that during the drought, persons with disabilities were left behind because it was too difficult to move them and sometimes one of the girls in the family stayed behind to look after the disabled relative. Abilis funded emergency support between 2016-2018 for persons with disabilities, many of whom were displaced, affected by drought in Kismayo, Baidos, Gardo, Galkayo and Afgoi Corridor. All assistance was distributed by Somali disability organizations. During the floods in the Afgoi corridor, the Somali Organization for Disabled Women's Empowerment secured funding from Abilis for 230 persons with disabilities living in IDP camps to repair their shelters with waterproof materials following flood damage and in preparation for the next rains.

24 Manku, 2018

Social inclusion includes the ability to participate in political life and access rights. Few persons with disabilities are able to vote because of the physical barriers and misconception that they have no role to play in politics and nothing to offer society. In Somaliland, DFID funded a voter registration process that explicitly included persons with disability. It is argued that such public activities help to reduce the stigma of disability and ensure that persons with disabilities are able to exercise their political rights to vote. Similarly, a UNDP access to justice programme includes supporting persons with disabilities to access the legal system so that they can achieve their legal rights.

## 2.5 IMPROVING SOCIAL INCLUSION

There is a clear legal framework and mandate for the mine action sector to engage in victim assistance in Somalia provided by international conventions which have been signed by the Somali government. Through its commitment to mine action, its ratification of the Convention on the Rights of the Child, signing of the CRPD and passing of the National Disability Act, the Government has stated its intention to promote the rights of persons with disabilities and improve the support available to them. Important development initiatives including the NDP and SDGs also promote the rights of persons with disabilities. The national and international instruments for victim assistance and persons with disabilities are mutually reinforcing, although plans to implement initiatives to meet the various commitments are yet to be fully developed.

There is little specific assistance for persons with disabilities but they are generally considered to be a vulnerable group marginalized from society.[25] DPOs and individual respondents with disabilities and most focus group discussions concluded that perceptions of people with disabilities will only change if they are seen to be participating in and contributing to daily socioeconomic activities. They specifically mentioned that more persons with disabilities should become politicians or be appointed to senior public positions to increase the visibility of persons with disabilities and show their positive contribution to public life.

Respondents recognized that international organizations aim to mainstream assistance for people with disabilities into their programming whereas few local organizations, unless they are DPOs, include people with disabilities in their activities. However, there was a general consensus that the assistance available to persons with disabilities was limited and insufficient to meet their needs or those of their families.

25 Amnesty International, 2015; Farah 2015; Manku 2018; Rohwerder, 2018; Tomlinson & Abdi, 2003;

# 3. DATA COLLECTION

Obligations to the APMBC and CCM include collecting and analysing data about the number of victims from explosive hazards and, similarly, obligations to the CPRD include collecting and analysing data about disability.[26] Under Goal 17 of the SDGs, members states should improve their capacity to gather accurate demographic data to monitor progress against the SGDs including statistics on disability.

There is no accurate demographic information so there are no accurate figures for the numbers of people with disabilities or the number of victims of explosive hazards. There is no comprehensive knowledge about the types of disability most commonly found in the country, so the volume and types of resources needed to support people with disabilities are unknown.

The mine action sector is responsible for collecting information about incidents and victims to inform operations and ensure that they are concentrated in the most heavily impacted area or on the most affected sector of the population. The information should also be used for monitoring the effectiveness of mine action and shared with other sectors to inform their programming. All the data should be entered into the national IMSMA database. Currently, there are discrepancies among the data held by UNMAS and those reported by the Landmine and Cluster Munition Monitor for Somalia and Somaliland. The Monitor identifies a total of 3,225 casualties between 1999 and end 2016 for Somalia,[27] excluding Somaliland and, 1,013 casualties for Somaliland from 2000-2017.[28] UNMAS identifies a total of 1,529 casualties in total for Somalia and Somaliland from 1977 to present.

Among the mine action sector in Somalia, some organizations are collecting incident and victims' data but are unsure whether it is being used to update IMSMA while other mine action stakeholders report that the incident and victims' forms are not being used or do not exist. Apparently, the forms are only in English so they should be translated into Somali. Within the mine action sector there is the capacity to collect the relevant data and maintain the database so processes should be reviewed to ensure a common approach and roles and responsibilities allocated according to resources. The sector should also work with the Landmine and Cluster Munition Monitor to verify data and agree statistics that can be used to inform mine action, the work of other sectors and for resource mobilization.

There has been no census for the number of persons with disabilities in Somalia. In the absence of accurate data, the 2011 WHO estimates are often used: 15 percent of the population has disabilities of which 2-4 percent has severe impairments.[29] However, there are studies of specific groups or regions that have concluded the number of persons with disabilities is as low as 4 percent,[30] while others argue that the figure could be as high as 42 percent because of the protracted conflict, high levels of poverty and poor healthcare or inability to access healthcare.[31] Local respondents doubted the willingness or understanding of Somalis to respond to survey questions on disability accurately.

Other sources of information that might provide indications on the number of persons with disabilities and their location include:

- UNFPA is conducting the Somalia Health and Demographic Survey (SHDS) at the household level in 18 regions which includes questions on disability. UNFPA says that the results, which are due by the end of 2019, should be statistically representative. The three questions aim to capture the type of disability, the cause of it and the type of assistance, if any, the individual has been able to access.

26 CRPD, Article 31
27 ICBL-CMC, 2018a
28 ICBL-CMC, 2018b
29 WHO & WB, 2011
30 UNDP, 2012: 2
31 CESVI & HI, 2012: 4

- The Joint Multi-Cluster Needs Assessment conducted in 2018 includes data and analysis on persons with disability. Reach, the organization that conducted the research, says that it can provide data for most districts on the population of persons with disabilities.
- The Humanitarian Call Centre, funded by DFID to monitor cash transfers, has information which suggests 22 to 28 percent of households might have a member who has disabilities.
- As part of their donor reporting, HALO and NPA are developing a methodology to identify the percentage of direct and indirect beneficiaries that have disabilities. This is information that could be useful to other sectors and possibly an initiative that could be supported by other mine action stakeholders.
- All respondents acknowledged the lack of statistical information about persons with disabilities but thought that the main state hospitals would retain some data, although this would include only those people who had sought medical help.
- The Somali Red Crescent Society collates all the data from its three rehabilitation centres at its office in Nairobi. The Society could be asked if it would be willing to share non-personal data from cases such as the types of impairments and gender and age of patients. Similarly, DanSomaliland and the umbrella DPO organizations could be sources of data on people with disabilities.

For future surveys by the mine action sector, it may be useful to consider incorporating The Washington Group Disability Questions. They are designed to gather statistical information about disability that can be compared internationally. They are intended to be simple and cost-effective to administer and to incorporate into a census or other data gathering exercise which is compatible with the ideology of promoting inclusivity of persons with disabilities, rather than implementing a separate survey concentrating on disability. The questions, which focus on functionality rather than requiring a medical definition of impairment, adopt the social model of disability. They are also promoted as the preferred tool for data capture and for measuring the progress against the CRPD and SDGs. There are suggestions about how to shorten and extend the questions and how to adapt them for use with children as well as guidance on linguistic and cultural translation.[32]

As part of data collection, the mine action sector could add a needs assessment form for victims and their families. This information could inform the work of other sectors assisting persons with disabilities and their families. The form would have to be developed in collaboration with different sectors and DPOs to ensure that language and concepts are culturally appropriate and to identify the information most useful to other sectors. A similar form has been developed and used in Tajikistan and stakeholders there suggest that it has been useful.

32 See Annex 9.5 for the short set of questions. Additional information is available at http://www.washingtongroup-disability.com/

# 4. HEALTH

The health services in Somalia are inadequate to meet the population's needs. Access is limited, and unequal, medical staff are too few in number and often not trained to a high level and there are a lack of medical supplies and medicines.[33] According to the National Development Plan, the government provides around 106 hospitals/referral centres, 361 mother and child/health centres and 620 health posts. In 2014 it was calculated that there were 9,856 medical practitioners in total including 621 physicians, 2,653 registered nurses, 365 registered midwives and 198 female health workers.[34] A range of other actors, NGOs, international organizations and private companies provide healthcare. For example, the Somali Red Crescent Society (SRCS) has 19 branches throughout the country including six in Somaliland providing primary health care, a hospital, a centre for women's health and three rehabilitation centres.

Some respondents stated that the NGOs and private and internationally supported healthcare were the main providers of health services. Currently, in the absence of development actors the humanitarian sector is providing a lot of the healthcare. The NDP focuses on preventative, reproductive, maternal and infant health as well as improving the management and funding of the health sector. Provision of support specifically needed by victims of explosive hazards and persons with disabilities such as habilitation and rehabilitation are not mentioned although there is a reference to establishing emergency operating and trauma care centres.[35] Overall the sector is unregulated although this might change after the Lower House of the Parliament approved the Medical Health Professionals bill on 14 November 2018 which aims to create a regulatory body for medical professionals in Somalia.[36]

There are health cluster meetings at the Federal level and within the member states which, according to respondents are attended by the relevant UN entities, SRCS and NGOs. As there is no clear overview of the number and quality of health services available, WHO is in the process of identifying funding to conduct a Health Resource Availability Mapping (HeRAMS) for community, primary, secondary and tertiary level healthcare. WHO anticipates being able to collect information on half the health resources through its current partners but is looking for external help to complete the survey.

Healthcare is not comprehensive and there is lack of continuity of care and referral systems. Many of the health facilities charge for their services so people delay seeking professional medical help because they lack the financial resources. There are also additional costs for transport to health facilities and for food and accommodation en route or while receiving treatment. Patients with financial resources travel to larger urban areas, Mogadishu, or abroad for treatment.

## 4.1 MEDICAL CARE

Emergency first aid and trauma care are currently available but limited and timely access is difficult in rural areas. Some first responders have been trained. For example, AMISON has trained the Somali police in first response in South West State and Aamin, the ambulance service in Mogadishu, delivered a month-long training course in first response at the end of 2017 to students. Hospitals provide trauma care but respondents indicated that the quality of these services is usually low. The hospitals perform surgery but complex surgery is not possible because of the lack of highly-trained surgeons and properly resourced operating theatres. It seems that victims of explosive hazards are stabilized at state level hospitals before being sent to Mogadishu for complex surgery and amputations. Patients

33 FGS, n.d. : 105; respondents for this report
34 FGS, n.d.: 123
35 FGS, n.d.; 107
36 Kalfadhi: for good governance https://twitter.com/Kalfadhi_SO accessed 17 November 2018

with the resources choose to travel abroad for more complex medical treatment.

In Mogadishu there is one free ambulance service, Aamin, run by volunteers which has been operating for 10 years. It is short of funding and faces closure. It offers emergency medical aid 24 hours a day and responds to explosions and complex attacks providing first aid and rushing the injured to hospital. It relies entirely on donations and has no sustainable source of funding.[37] Outside Mogadishu, respondents were unaware of any ambulance services and explained that lack of transport to medical facilities was a problem. The Ministry of Health in Puntland included lack of ambulances as one of the shortfalls in their service provision.

## 4.2 REHABILITATION

There is a lack of rehabilitation services including assistive devices, prosthetics, physiotherapy, and occupational therapy. The services that exist are mainly provided by private hospitals and NGOs. The only systematic and long-term support is provided by the SRCS which operates three rehabilitation centres providing physiotherapy, prosthetics and assistive devices located in Mogadishu, Hargeisa and Galkayo and DanSomaliland based in Hargeisa. The SRCS centres were established to assist the war-wounded although are open to persons with disabilities resulting from other causes. The people attending the rehabilitation centres in Hargesia and Galkayo tend to be primarily war-wounded but, in Hargeisa in recent years, the centre is treating more persons with disabilities from other causes. For example, an estimated 1,000 people a year in Somaliland are disabled by road traffic accidents.[38] All the staff in the SRCS centres are local and have received training in various countries. The rehabilitation clinics are funded by the Norwegian Red Cross (NRC) and supported in more complex cases by the ICRC MoveAbility Foundation's Tanzania branch. Galkayo, which is the smallest of the three clinics treats between 70 to 90 patients each month. Using the WHO 2011 estimate that 15 percent of the world's population is disabled and estimates of the population of Somalia, an independent consultant working for the NRC concluded that the three rehabilitation clinics were meeting 20 percent of the need in Somalia. No other organization, with the possible exception of DanSomaliland, provides this kind or standard of rehabilitation services on a permanent basis in Somalia so there is an estimated 80 percent shortfall.

The SRCS services are free but it is the responsibility of the patient to fund transport to the rehabilitation centres and cover the costs of their food and accommodation while receiving treatment. Fitting a new prosthetic limb and ensuring that the patient is comfortable and can use it properly takes up to three weeks. Patients with artificial limbs need continuous treatment over a life time so the costs of transport and subsistence during treatment are an ongoing financial burden.

The Saudi government and the Turkish Red Crescent have distributed wheelchairs in Mogadishu in 2018. Through the Somali Ministry of Health, the Saudi government distributed 100 wheelchairs, of which, 80 were given to IDPs.[39] The Turkish Red Crescent was approached by the Somali National Disability Council to provide wheelchairs and walking frames. It was explained that such assistive devices are a quick, simple and long-term solution and can be preferable for some Somalis to complex solutions such as prosthetic limbs which require ongoing and expensive care. According to respondents in Baidoa, a government representative from the Disaster Management Agency distributed 300 wheelchairs. The need for assistive devices was reiterated by most respondents. There does not seem to be any support for modifying homes to improve access for persons with disabilities and facilitate

37 BBC, 2018a: UNSOS, 2017
38 Figure provided verbally by respondent
39 Radio Ergo, 2018

their care by relatives. Respondents explained that modifications to homes would enable people with disabilities to be more independent as well as reduce the work of the carers who tend to be women.

## 4.3 PSYCHOLOGICAL AND PSYCHOSOCIAL SUPPORT

The concept of psychosocial support was well understood by national respondents and many were familiar with psychosocial support focusing on sexual and gender-based violence (SGBV) and female genital mutilation (FGM) funded by the international community. Overall, respondents were positive and felt that such services were valuable. There was less awareness about psychosocial support for victims of explosive hazards and person with disabilities and, the support that exists, is predominantly informal. Respondents from DPOs reported that persons with disabilities are supported by their families and by each other. Some DPOs provide psychosocial support based on their own experiences but they have limited training and capacity although, in a small number of cases, it is possible to refer complex cases to someone more highly trained.

## 4.4 HEALTH PRIORITIES

Although there is a lack of adequate health care for victims of explosive hazards and persons with disabilities, national and international respondents with a range of expertise consistently prioritized rehabilitation as the most important health need to address. This is because lack of mobility is the first barrier persons with disabilities face in trying to participate fully in everyday life. DPOs regularly noted the lack of crutches and basic wheelchairs as a significant problem.

There was also support among national respondents for providing psychosocial support for victims of explosive hazards and persons with disabilities. However, before additional support for psychosocial interventions is considered, more research is needed to establish the effectiveness of the psychosocial and psychological support available and the psychological needs of the victims of explosive hazards and persons with disabilities to ensure that interventions are properly designed and are culturally appropriate.

It was not thought that training more first responders was a priority although more sophisticated and accessible trauma care and surgery were identified as needs.

# 5. EDUCATION

There is no standard formal education system in Somalia, and the quality varies from one location to another. It is provided by a variety of stakeholders including the Government, private sector, NGOs, community education committees and religious groups. Enrolment for primary education is 30 percent and literacy rates among adults are estimated to be as low as 40 percent. Education levels are higher among men than women and higher among urban populations than nomadic populations which are the most poorly educated group.[40] In general, education has to be paid for and it is a cost many people cannot afford. A survey conducted by UNMAS in 2018 in Galmadug and Puntland found that one third of respondents had no formal education and gave the main reason for not attending school as the inability to pay the fees.[41]

Education is considered to be a fundamental human right. Through its interim constitution and commitments to the Convention on the Rights of the Child, the FGS is committed to providing free, compulsory and inclusive education for all children without discrimination.[42]

## 5.1 SCHOOLING

As parents cannot always afford to pay for able-bodied children to attend school, they can be reluctant to fund children with disabilities as it is seen as a waste of scarce financial resources. Practically, transport to school and access to school buildings is difficult for those with limited mobility. There is no prototype for accessible school buildings and latrines although UNICEF working with the Ministry of Education has helped to create some accessible schools. There are a few schools that cater for children who have visual and hearing impairments in some of the state capitals and in Puntland the Ministry of Education has provided examination papers in Braille since 2016. However, a DPO in Mogadishu believes that only a few children who are visually- and hearing-impaired attend school. Respondents in Beletweyne noted that the school for hearing impaired children had only 45 places, insufficient to meet demand. Many of the schools for visually- and hearing-impaired children are philanthropic ventures and rely on donations so respondents were concerned about the long-term ability to maintain the schools. In Beletweyne, the business community explained that they had chosen to support a school for hearing impaired children rather than another disability because they felt it was a small enough group to be able to finance and that their impairment was not severe so with an education they would be able to have an independent future. Respondents reported that there were no specialized school for children with other types of disabilities although it is important to note that current best practice promotes inclusive education with the aim of as many children as possible attending mainstream school. Few teachers have received any training to enable them to support children with disabilities appropriately. According to respondents, some children with physical and intellectual disabilities attend school but it depends on the resources of the parents and the value they give to education. In Garowe, a boy who lost his hands and sight in an explosion attends mainstream school although there are no resources to help him.

The experience of children with disabilities at school varies. During the assessment there were reports that children with disabilities are bullied by the teachers and other children. However, a few respondents disputed that bullying takes place. A female survivor of an explosive hazard lost her leg in 1996 when she was a child. She was supported by family and received rehabilitation, physiotherapy

40 FGS n.d., 112
41 UNMAS, 2018: 14
42 FGS n.d. 114

and an artificial leg which was replaced as she grew. She returned to school for a while and the initial curiosity and teasing of the teachers and children subsided as they accepted her. The school was supportive and waived the fee and she felt motivated to do well. However, ongoing treatment for her leg meant that she missed a lot of school and did not complete her education.

Few opportunities for adults with disabilities to access education were identified. Some of the women's centres encourage education for women with disabilities. Galmadug Disability Women's Organization (GAWDO) in Galkayo provides education to adults with disabilities including mathematics, English and Somali. However, it currently has no funding so is not providing any classes.

A joint UNICEF-WFP initiative focused on early child development aims to train community members to work with parents and other stakeholders to raise awareness about the importance of nutrition, health, water, sanitation and hygiene for the wellbeing and development of a child. Part of this project will raise awareness of child development milestones to help identify children who may have physical and intellectual development impairments and the additional support they might need.

Overall there was a consensus that few children with disabilities attend school because it is not regarded as necessary or important and, if they do, they rarely complete their education. However, disability organizations report positive experiences of promoting education for children with disabilities. They argue that it is a case of raising awareness among teachers and parents that all children, including those with disabilities have a right to education. The Somalia Disability Empowerment Network (SOWDEN) reports that after a week of awareness raising activities in Kismayo, they succeeded in enrolling 74 children with disabilities into mainstream schools and that they were still there after 1 year.

## 5.2 UNIVERSITY

Children with disabilities rarely complete their education and those that do are unlikely to attend university because they or their families cannot afford the fee. However, some persons with disabilities attend university including one of the respondents who was born with a disability and did not start to attend school until his teens. He became interested in education when his brothers returned from school talking about what they had learned. The respondent went on to obtain a Batchelors and a Masters Degree and works as an advocate for persons with disabilities and leads a network for disability organizations.

## 5.3 PRIORITIES IN EDUCATION

Respondents argued that without education, persons with disabilities are marginalized, unable to secure employment and likely to be dependent on relatives for the rest of their lives. They felt that it was important for as many children with disabilities as possible to attend school so that they can be independent. Some suggested that fees should be waived for children with disabilities and awareness raised among teachers that children with disabilities have a right to education. Training for teachers so that they are able to support children with disabilities appropriately was also suggested. University was not mentioned as a priority which is unsurprising as so few children with disabilities attend school that primary and possibly secondary education would be considered the first step.

# 6. ECONOMIC INCLUSION

Unemployment is high in Somalia[43] so lack of mobility and education among people with disabilities means that their employment opportunities are very limited in an already competitive market. Respondents reported that job advertisements often stipulate that applicants must be physically and mentally fit so anyone with a disability is immediately excluded. Establishing a business is difficult for persons with disabilities because initial funding and premises are needed. It is hard to secure loans in Somalia and people with disabilities find it particularly difficult. They cannot rent premises as landlords doubt the ability of a person with disabilities to pay the rent. Consequently, many people with disabilities stay at home relying on support from relatives while others are forced to beg.

## 6.1 LIVELIHOODS ACTIVITIES

Few examples of activities to promote economic inclusion among persons with disabilities were identified. The Somali Women's Disability Association in Mogadishu trains and provides materials for women with disabilities to produce handicrafts which are sold in the local market. The Finnish donor Abilis has funded DPO livelihoods activities including poultry farming for women and fishing nets and refrigerators for families with disabled relatives to catch, store and sell fish in the local markets. Occasionally there are opportunities for micro financing. In June 2018, 20 people with disabilities received 500 USD provided by Hormuud Telecomm Foundation.[44] It is not yet known what the impact of this project has been.

Experience in the mine action sector of providing livelihoods support for victims of explosive hazards has had limited success. In Tajikistan and Afghanistan, both of which are considered to have a strong victims assistance programmes, livelihoods activities have had limited impact. In Afghanistan, survivors were provided with training and tools to establish a small business such as tailoring. After a year it was found that most of the participants had been unable to make a living and had sold the tools that they had been given. In Tajikistan experiences were similar except when a livelihoods expert was hired to conduct market analysis and design and tailor projects to the needs of the participants. Overall, this initiative was considered to be successful, but it was a resource intensive approach. Livelihoods support to other vulnerable groups such as refugees and survivors of natural disasters have also had limited success. It is argued that market analysis is generally weak and efforts to establish small businesses for people who have no business experience and are already vulnerable and potentially disorientated by the new situation in which they find themselves, is not an effective intervention.[45]

With the above in mind, HI is planning to implement livelihoods projects that are tailored to the needs of the individual and their family. The aim is to increase independence of the person with disabilities and their families. The projects will be personalized and based on a vulnerabilities assessment and must be accompanied by an expression of desire to be involved in such an initiative from the potential participants. HI is adopting this approach because larger-scale livelihoods projects where groups of people are trained in the same skills do not seem to be very successful.

Some of the mine action stakeholders employ people with disabilities and try to maintain employment for those with chronic health problems. However, there is no requirement for organizations to hire people with disabilities and respondents suggested that a quota system might be helpful.

43 FGS, n.d.
44 SODEN, 2018
45 GRM, 2014

## 6.2 VOCATIONAL TRAINING

Respondents noted that there is a lack of vocational training opportunities. Some is provided by local DPOs but they lack sustainable funding. In Mogadishu, SANCA provides training in hairdressing and henna, computer skills and sewing depending on funding. In December 2018 there were 80 participants, 50 of whom were women and the training was in its fourth month. SANCA reports that previous course participants have not be able to use their skills because they have been unable to find an employer who would hire them or do not have the money to buy equipment. GAWDO in Galkayo offers similar training but currently has no funding so is not providing any classes. In Egypt, 700 persons with disabilities were trained and were unable to find work after completing the training. In Baidoa, vocational training in tailoring and computer skills was provided to people with disabilities based on the condition that, before they attended the course, they found secure employment for the future. Respondents reported that this approach worked well and that all participants were employed after completing their course.

## 6.3 PRIORITIES FOR ECONOMIC INCLUSION

Respondents cited the inability of persons with disabilities to generate an income as a cause of poverty, dependence and social exclusion so many advocated an increase in the number of livelihoods programmes. However, it appears that livelihoods projects must be carefully designed and implemented to have sustainable impact. Local organizations providing livelihoods support also lack sustainable incomes. Some respondents wanted to see more vocational training provided although they must be carefully designed to ensure they are filling a skills' gap and that employment opportunities exist for participants after completing their course. Lessons from HI about their planned livelihoods projects might provide useful insights into how such programmes could be more effectively designed.

# 7. CONCLUSIONS

This report provides an overview of the assistance available to victims of explosive hazards and persons with disabilities. It considered the legal and policy framework, healthcare, education and socioeconomic inclusion as well as coordination mechanisms. A range of national and international stakeholders were included and efforts were made to include Somali women although it was not possible to achieve a gender balance among respondents. Research was conducted at the Federal and State levels. The findings are consistent with previous research. Insecurity prevented visits to activities and engagement with the Somali population at large. Therefore, ongoing consultation with relevant stakeholders is necessary to design and implement interventions and further in-depth research should be conducted when the environment permits.

Current best practice approaches to disability advocate inclusivity, the rights for persons with disabilities and the removal of barriers preventing their full participation in daily life. All interventions should be gender and age appropriate and be developed with the participation of persons with disabilities.

There is a strong international framework to which the FGS has committed for ensuring that persons with disabilities can access their rights. In some instances, the international framework is yet to be enshrined in domestic law and plans for implementation are under development, but the mandate exists for interventions to support persons with disabilities. Furthermore, international mine action conventions and related policies are consistent with the CPRD. Services to all members of the population are limited, not just to those with disabilities, but the SDGs and the National Development Plan specifically advocate for the needs of persons with disabilities to be included. Mine action is regarded as an enabler of the SDGs and development.

In Somalia persons with disabilities are often stigmatized. The perception of persons with disabilities and the degree of their marginalization depends on the type and nature of their disability and other factors such as gender, clan, displacement and socioeconomic status that exacerbate levels of vulnerability. The main source of support for persons with disabilities is their family. Access to healthcare, education and social life depends on the family's ability and willingness to support relatives with disabilities. Respondents evaded questions about intellectual disabilities and further research is needed to understand prevailing Somali attitudes.

Assistance to persons with disabilities tends to be provided mainly through protection so there is a lack of longer-term development support. There are local NGOs and DPOs providing assistance to persons with disabilities and advocating for their rights. Some belong to umbrella disability organizations to coordinate activities and give themselves a louder voice, while other organizations are reluctant to coordinate. Some of the local NGOs and DPOs participate in the cluster system. Currently there is little or no contact between the mine action sector and organizations assisting persons with disabilities.

There is little formal support for persons with disabilities. Health and education services in Somalia are limited and there is little specific provision for persons with disabilities. Unemployment is high among the Somali population and there are few opportunities for those with disabilities.

Somali organizations reported that short and simple advocacy campaigns at local levels to promote education for persons with disabilities or disabled access to public buildings had been well received and had an impact. Respondents stressed the need for tangible support for persons with disabilities

and discouraged awareness raising about their rights among those who are disabled. Instead they proposed advocacy among institutions and professionals such as teachers to promote the inclusion of people with disabilities.

Although attitudes towards disability are generally negative, respondents believe that if people with disabilities are seen to be participating in and contributing towards everyday life, attitudes would change. For this reason, they prioritized interventions that removed barriers and enable people with disabilities to be more visible:

- Rehabilitation was consistently prioritized over other health interventions and often over all types of interventions by other sectors.
- Education, even at a basic level was regarded as important for persons with disability because without it, children are isolated from their peers and do not develop a social network and employment opportunities later in life are reduced.
- Finally, income generation opportunities were promoted for persons with disabilities to ensure their security and independence.

Overall, local respondents emphasized the need for persons with disabilities to be visible and to have the potential to be independent and self-reliant.

Currently the mine action sector is not undertaking victim assistance but there are opportunities to strengthen the victim assistance pillar to coordinate with other sectors and to advocate for the rights and needs of persons with disability. A full list of recommendations can be found in the executive summary.

# 8. ANNEXES

## 8.1 ACRONYMS

| | |
|---|---|
| APMBC | Anti-Personnel Mine Ban Convention |
| CCM | Convention on Cluster Munitions |
| CRPD | Convention of the Rights of Persons with Disabilities |
| DDG | Danish Demining Group |
| DPO | Disabled Persons' Organization |
| ERW | Explosive remnants of war |
| FGM | Female and genital mutilation |
| FGS | Federal Government of Somalia |
| GMAP | Global Mine Action Programme |
| GAWDO | Galmadug Disability Women's Organization |
| HeRAM | Health Resource Availability Mapping |
| IDP | Internally displaced person |
| IED | improvised explosive devices |
| IMSMA | Information Management System for Mine Action |
| IOM | International Organization of Migration |
| HI | Humanity and Inclusion |
| MAG | Mines Advisory Group |
| MoIS | Ministry of Internal Security |
| MoLSA | Ministry of Labour and Social Affairs |
| MoWHRD | Ministry of Women and Human Rights Development |
| NDA | National Demining Agency |
| NDP | National Development Plan |
| NPA | Norwegian People's Aid |
| NRC | Norwegian Red Cross |
| NTSG | National Technical Standards and Guidelines |
| PTSD | Post-traumatic Stress Disorder |

| | |
|---|---|
| PwD | Persons with Disabilities |
| SEMA | Somalia Explosives Management Authority |
| SGBV | Sexual and gender-based violence |
| SHDS | Somalia Health and Demographic Survey |
| SMAC | Somaliland Mine Action Centre |
| SOWDEN | Somalia Disability Empowerment Network |
| SRCS | Somali Red Crescent Society |
| UN OCHA | United Nations Office for the Coordination of Humanitarian Assistance |
| UNDP | United Nations Development Programme |
| UNFPA | United Nations Population Fund |
| UNICEF | United Nations Children's Fund |
| UNMAS | United Nations Mine Action Service |
| UNSOM | United Nations Assistance Mission in Somalia |
| UNSOS | United Nations Support Office in Somalia |
| WHO | World Health Organization |

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## 8.3 RESPONDENTS

### Four respondents wished to remain anonymous

| Date | Name | Position | Organization |
|---|---|---|---|
| 24 September | Christophe Beau | Head of Protection Cluster | UNHCR |
| 24 September | Claus Neilsen | Country Director | NPA |
| 24 September | Omar Mohammed | Country Director | MAG |
| 24 September | Craig Hampton | Head of Health Cluster | WHO |
| 26 September | Peter Heywood | Programme Manager | HALO Trust |
| 26 September | Justin Brady | Somalia Head of Office | OCHA |
| 26 September | Abdullahi Hassan Osman | Representative | Somali Disability Network (Mogadishu) |
| 26 September | Abdullahi Hussein Adan | Representative | Somali Disability Network (Mogadishu) |
| 27 September | Fiona Rushbrook | Representative | DFID |
| 27 September | Leon Thomas | Disability focal point | DFID |
| 27 September | Richard Scott | Programme Manager: Somaliland | HALO Trust |
| 27 September | Syed Saad Hussain Gilani | | ILO |
| 30 September | Dahir Ashkir Muse | Liaison and Training Coordinator | MAG |
| 1 October | Ali Jama | Director | DANSomaliland |
| 2 October | Abirahman | Administrative Officer | HALO Trust |
| 2 October | Istahil | Representative | Local NGO, Somaliland |
| 2 October | Armogast Mwasi | Director | HI |
| 3 October | Kirsten Young | Chief, Human Rights and Protection Group | OHCHR |
| 3 October | Samar | | Somaliland National Disability forum |
| 4 October | Habib Khan | Victim Assistance & MRE Officer | DMAC |
| 8 October | Ambassador Abdulkadir Abdulle Hoshow | Director General | SEMA |
| 8 October | Dahir Adbirahman Abdulle | Treaties Implementation and Victim Assistance | SEMA |
| 8 October | Abdulkadir Ibrahim Mohamed | SEMA Admin and Finance Officer | SEMA |

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|---|---|---|---|
| 9 October | Mohamed A Farah | Disable Activist and Founder of SODEN | Somali Disability Empowerment Network (SODEN) (Mogadishu) |
| 22 October | Shipra Bose | Senior Gender Advisor | UNSOM |
| 22 October | Aisha Ali | Deputy Chair Person | Somali Women's Disability Association ((Mogadishu) |
| 22 October | Felix Mulama (email exchange) | Demographer, P & D Unit | UNFPA |
| 23 October | Reykhan Muminova | UNDP support to the Tajikistan Mine Action Programme | UNDP |
| 23 October | Alisho Shomahmadov | Victim Assistance Officer | Tajikistan National Mine Action Centre |
| 23 October | Isack Nor Aadan | Director | SEMA Southwest State of Somalia |
| 23 October | Abdul Wahid Kakar | HMA Coordinator | DDG |
| 23 October | Mohamed Osman Ahmed | National Humanitarian Affairs Officer, Puntland | OCHA |
| 24 October | Aden Ahmed Yussuf | National Humanitarian Affairs Officer, Kismayo, Jubbaland | OCHA |
| 24 October | Eng Mohamed Ahmed Mohamud | Director | South West Mine Action Consortium (SOWMAC) |
| 25 October | Ali Abdulahi Salad | Chair | Somali National Disability Council (Mogadishu) |
| 25 October | Abdiwali Ali | Executive Director | Puntland Youth Peer Network |
| 25 October | Omar Mohamed | Regional Programme Coordinator | Kaalo Relief & Development (Puntland) |
| 25 October | Mohamed Amin Mohamud | Executive Director | Somalia Disability Rights Advocacy (SODRA) (Kismayo) |
| 28 October | Abdullahi Warsame Abdi | National Humanitarian Affairs Officer, Hirshabelle | OCHA |
| 28 October | Alasdair Burton | TFM-TL Somalia | MAG |
| 31 October | Mohamed Iman | Director | PMAC |
| 31 October | Mohamed Said | Head of Consortium | Mine Action Consortium |
| 31 October | Mr. Soleiman Haji Abdulle | Director General | Ministry of Security and DDR |
| 31 October | Abdirizak Hersi Hassan, MD | Director General | Ministry of Health Puntland state of Somali |
| 31 October | Jamad Isse Mohamed | Chair woman | Somali Women's Vision |

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|---|---|---|---|
| 31 October | Nahiima Mohamed Jama | Case Manager | Puntland Students' Association |
| 31 October | Fadumo Mohamed Salad | Representative | Puntland Youth Peer Network |
| 31 October | Salma Mohamoud | Representative | Kaalo Relief and Development (Puntland) |
| 31 October | Fartuum Ali Jama | Representative | Puntland Non-state Actor Association |
| 31 October | Abdirkadir Khadar Yusuf | Representative | Explosive Hazard Protection Initiative (EHPI) |
| 31 October | Omar Sheikh Hamud | Representative | Kaalo Relief and Development (Puntland) |
| 31 October | Said Xirse Farah | Representative | CSO |
| 31 October | Farah Jama Boss | Lawyer | |
| 31 October | Abshir J Cadde | Puntland Liaison Manager | Mines Advisory Group |
| 31 October | Shirwac Jama Hirsi | Representative | Centre for Policy Alternatives |
| 31 October | Shu'ayb Said | Vice Chairman | Puntland Social Welfare Agency (GO) |
| 31 October | Mohamed Jama Mohamed | Representative | Puntland Non-state Actor Association |
| 5 November | Dr Mohamed Egal | Deputy Director | SEMA |
| 7 November | Mohamed A Ali | Project Manager | Puntland Disabilities Organization Network |
| 13 November | Mohamed Elmi | Human Rights Advisor | Human Rights and Protection Group, UNSOM |
| 13 November | Hassan Odawa | CRS Officer, Hirshabelle | WHO |
| 13 November | Dr Ibrahim Moalim Nur | South West State | WHO |
| 14 November | Tuula Heima-Tirkkonen (via email) | Programme Coordinator, Fragile States | Abilis Foundation |
| 14 November | Ismail Yagci | Director, Southeast Anatolia Regional Disaster Management | Turkish Red Crescent |
| 14 November | Hakan Gunbulut | Head of Finance | Turkish Red Crescent |
| 15 November | AbdiKadir Noor Mohamed | Project Officer, Kismayo, Jubaland | UNDP |
| 19 November | Maryan Hassan Hirabe | Chair Woman | Somali Organization Disabled Women Empowerment (SODWE) (Afgoi District) |

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| 19 November | Sherif el Tokali | Innovation Specialist | UNDP |
| 19 November | Abdel Hamid Ezzat | | UNDP |
| 20 November | Adnan Ali Adan | Deputy Mayor of Baidoa | District authority |
| 20 November | Mohamed Adnan Mohamed | Chair person | District youth council |
| 20 November | Adnan Moalim Abdirahman | Director | District youth council |
| 21 November | Ali Nor Mohamod | Project Officer | Deegroor Medical Organization (DMO) |
| 21 November | Dr Abdilahi Abdikadir Ali | Medical doctor | Rural Education and Agriculture development Organization (READO) |
| 21 November | Mohamed Isak Abukar | Representative | Bay Women Development Network (BWDN) |
| 21 November | Abdulahi Abdirahman Abdi | Armed Violence Reduction Officer | DDG |
| 21 November | Abukar Abdi Abdullah | | SSYO (LNGO) |
| 21 November | Mohamed Sheikh Abdi | Child Protection | IPD (LNGO) |
| 21 November | Mukhtar Ali Isak | Chairman | Disability organization |
| 21 November | Adnan Mohamed Yusuf | Representative | IHRO (Human Rights) |
| 21 November | Ruqiya Mahamed Ali Isack | Representative | Disability organization |
| 21 November | Binti Olad Hussein | Representative | AYDE (CSO) |
| 21 November | Shukri Ismail Ahmed | Representative | CSO Youth |
| 21 November | Amina Abdirahman Jamac | Representative | ICRDO |
| 22 November | Waris Abdulahi Shorwac | Director | Galmudug Disability Women Organization, GAWDO |
| 26 November | Yusef Hassen | Director | SHOMAC |
| 26 November | Sheikhdon | Community Liaison Officer | SEMA-Hirshebelle |
| 26 November | Abdulle Ali waasuge | Director | SEMA-Hirshebelle |
| 27 November | Deko Abdi Ware | Representative | Women's Association of Hiran |
| 27 November | Nasteho Rashid Ugaas | Representative | CSO |

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| 27 November | Sahra Farah Hussein | Representative | CSO |
| 27 November | Nuur Omar | Business representative | Beletweyne |
| 27 November | Mohamed Bare Isak | Representative | HALO Trust |
| 27 November | Galbeed Abukar | Survivor, manual worker | |
| 27 November | Mohamed Ahmed Sheyke | Chairman | Action on Disability and Development Organization |
| 27 November | Ibrahim Hassan Adow | Director | Wardi Impact and Development Initiatives |
| 29 November | Abdi Hussein Ahmed | Representative | SANCA (vocational Training Centre)[1] |
| 29 November | Deko Abdi Hassan Maow | Representative | SANCA (vocational Training Centre) |
| 29 November | Beatrice Blythe | Programme Officer Somaliland | HALO Trust |
| 4 December | Yusuf Ahmed Hagar (via letter) | Hiran Governor | |
| 4 December | Abdifatah Shukri Farah | Operations Officer | JUMAN[2] |
| 4 December | Ubax Mohmaed Sigaad | member | Women Group-CSO |
| 4 December | Najmo Abdirahman Mohamed | member | Women Group-CSO |
| 4 December | Ifrah Mohamed Adani | member | Women Group-CSO |
| 4 December | Fardowso Ali Farah | | KISIMA-Protection |
| 4 December | Umul Kheyr Ali Mohamed | Operations Manager | SEMA-Jubaland Office |
| 5 December | Abdiaziz Mohamed Hassan | MRE TL | JUMAN |
| 5 December | Abshir Osman Mohamed | Community Liaison Officer | UOS |
| 5 December | Abdiweli Ibrahim | | Kismayo Youth Group |
| 5 December | Abdirahman Ismael Hashi | | Kismayo Youth Group |
| 5 December | Kaaha ahmed waladi | | SAADO-NGO |
| 5 December | Mohamed Deeq Ibrahim | MRE TL | JUMAN |
| 5 December | Sheikh Nuor Abdi Osman | Member Disability Network | Disability Network |
| 5 December | Shukri Saciid Ahmed | Chair Women | Jubaland Disability Association |
| 5 December | Sidey Muse Makome | Chairperson of Nasiib IDP Camp | IDP |

1 The meeting on 29 November was conducted by Amina Hassan

2 The meetings on 4 and 5 December except meeting the Hiran Governor were conducted in Kismayo by Hussein Ibrahim Ahmed from UNMAS and Hassan Abdinur Mohamed from SEMA

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|---|---|---|---|
| 5 December | Abdullahi Hassan Jama | Member | Jubaland Disability Association |
| 6 December | Phoung T Nguyen | Chief of Education | UNICEF |
| 19 December | Abdi Mohamed Iye | Protection Officer | NGO-TUOS (Protection organisation) |
| 19 December | Mahad Mohamed Salad | Member of Youth Group | Youth Group |
| 19 December | Mahdi Ali Hersi | Member of Youth Group | Youth Group |
| 19 December | Abdinur Khalif Mohamed | Member of Youth Group | Youth Group |
| 19 December | Mohamed Ahmed Hassan | Teacher | Teacher |
| 19 December | Abdiweli Ahmed Isse | Member of Youth Group | Youth Group |
| 19 December | Safiya Hersi Ali | Health Practitioner | Health Practitioner |
| 19 December | Farhiya Abdi Farah | Health Practitioner | Health Practitioner |
| 19 December | Khadija Farah Abdiweli | Member of Women Group | Women Group |
| 19 December | Mohamoud Ahmed | Laision Officer | NGO- CESMAC |

## 8.4: FIELD VISIT SUMMARIES

The visits to the States of Puntland, South West and Hirshabelle were led by Dr Rebecca Roberts who was accompanied by Hassan Abdinur Mohamed from SEMA headquarters and Hussein Ibrahim Ahmed from UNMAS. The visits to Galmadug and Jubaland were conducted by Hassan and Hussein. The information collected from each of the field visits is summarized in tables in annex 8.4. The summaries were shared with the participants of the focus group discussions to verify findings and promote transparency and accountability.

Open-ended questions were used in individual and focus group discussions to avoid limiting the scope of the research by asking questions based on preconceived ideas that might bias the findings. Focus groups discussions enable participants to discuss and analyse the issues and provide considered and nuanced responses that capture a range of views and help to highlight those most commonly held. Being part of a group discussion can be less intimidating for some individuals, especially if most of the discussion is held in the native language. This enables equal participation regardless of foreign language skills and lack of confidence to speak in public. There is a risk that focus groups can be dominated by some individuals so good facilitation is needed to minimize this risk.

### Dhusamareb, Galmudug: Situation Analysis

| Area of Victim Assistance | Lead Sector | Current Situation | Suggestions to Strengthen Responses |
|---|---|---|---|
| Data collection | Mine Action | • No data collection<br>• No coordination outside mine action sector<br>• No coordination amongst the Mine Action sector<br>• SEMA has no office and office equipment<br>• SEMA has Only 2 staff | • Improve data collection<br>• Improve coordination and communication with other sectors<br>• Provide office and equipment for SEMA |
| Medical care | Health | • Very limited health care service in the region<br>• Local hospitals can't provide surgery<br>• Emergency medical care is provided by local hospital<br>• Hospitals exist but can only provide maternity and MCH<br>• No emergency medical support for EH victims | • The region needs well-functioning hospitals which can provide basic surgeries<br>• Establish medical centres that can provide special treatment for PwD<br>• Need external support with special attention on effected communities |

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|---|---|---|---|
| Rehabilitation | Health | • ICRC supported rehabilitation centre in Northern Galkaio, Puntland, people travel there to receive support.<br>• No mental hospital in the region, people with mental health problems are treated in Mogadishu.<br>• No known or regular support for PwDs | • Rehabilitation centre for disabilities and victims of explosive hazards |
| Psychosocial Support | | • No Psychosocial support is provided for explosive hazard victims and PwDs in the region.<br>• No counselling support for PwDs in the region<br>• Families provide basic psychosocial support for victims | • Need external support |
| Inclusion in Education | Education | • No specific educational support for PwDs in the region.<br>• Fewer children with disabilities attend schools with other children despite discriminations.<br>• Children with learning difficulties are kept at home and miss education opportunities.<br>• No known I/NGO education support for PwDs in the region.<br>• Parents neglect children with disabilities and miss education opportunities. | • Provide education opportunity for children with disability.<br>• Vocational training for adults<br>• Improve participation of children with disabilities in schools<br>• Facilitate access for disability in schools and public places<br>• Raise awareness parents with children PWDs to seek education for them. |
| Economic inclusion | Employment<br>businesses | • No job opportunities for PwDs in the region<br>• Some people with physical disabilities participate public life<br>• Disabled people face discrimination in the workplace. | • Advocate job opportunities for PwDs in the public<br>• Provide vocational training for adults to participate the public and earn income.<br>• Provide income support for families with PWDs. |

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| Social inclusion | Everybody/ protection | • Mothers face more burden than fathers of families with person with disability.<br>• Female with disability face more challenges than male with disability due to vulnerability.<br>• Female with disability face marriage challenge due to their impairments<br>• No self-mobilized community supporting PWDs.<br>• PwDs don't have office and centres<br>• The collapsed government in 1990s established centre for PWDs but current administration has taken over the building and use for other purposes.<br>• There is no records of the number of PWDs in the region.<br>• No support from the state for PWDs.<br>• Certain persons from NGOs claim to be supporting PWDs but provide no support.<br>• Most buildings are not accessible including governmental and public buildings<br>• PwDs face day to day discrimination such as calling them nicknames that they don't like.<br>• Those born with disability face more discrimination and exclusion than those | • Awareness raising for PWDs is needed.<br>• Communities to stand for PWDs in the region mainly youth groups<br>• Advocate for equal employment and reduce workplace discriminations<br>• People with mental health problems specific challenge and need immediate assistance<br>• Trauma healing and motivation for PWDs to participate public life is needed. |
| | Legislation & policy | • No legal provision by the state for PWDs in the region. | • Improve engagement of PwDs in domestic legislation establishment processes. |

## Additional Notes

The region faces explosive hazard problems mainly landmines and ERW and require emergency medical care provisions. The Mine Action sector is to map out existing hospitals with ambulance that can provide support to the victims and share with affected communities. Improving external coordination and internal coordination of the Mine Action sector is crucial in the region.

## Priorities

Respondents said that awareness raising and provision of education opportunities for PWDs is number one priority, they have also emphasized importance of centres for people mental health problems and emergency medical care for explosive hazard victims.

## BELETWEYNE, HIRSHEBELLE: SITUATION ANALYSIS

| Area of Victim Assistance | Lead Sector | Current Situation | Suggestions to Strengthen Responses |
|---|---|---|---|
| Data collection | Mine Action | • Data inaccurate<br>• Little formal coordination outside the sector although informal and social connections among sectors for mine action, disabilities and business | • Improve data collection and coordination with other sectors. |
| Medical care | Health | • No free medical care<br>• Skills and facilities limited to less complex cases<br>• Trauma care available but basic<br>• Necessary to travel to Mogadishu for complex treatment<br>• No transport or ambulances<br>• Red Cross and SRC provide basic and primary healthcare | |
| Rehabilitation | | • None<br>• Sometime assistive devices are provided by NGOs<br>• Locally made assistive devices have been known to cause injuries and are not as effective as imported devices | • Distribute assistive devices<br>• Modify houses to improve access and mobility for the PwD and reduce the work of the carer. |

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|---|---|---|---|
| Psychosocial Support | | • No formal psychosocial support for PwD and victims of explosive hazards. The only support available comes from families. | |
| Inclusion in Education | Education | • No free education<br>• No particular education for children with disabilities. Some children with disabilities attend mainstream school. It depends on the severity of their disability<br>• Class of 45 hearing impair children supported by the business community. Teachers recruited from Mogadishu. Pupils 40% female and 60% male. There are concerns this support is not sustainable.<br>• No special facilities for PwD to attend higher education and university. Costs are too high and families supporting a PwD tend to be poor because of the cost of medical care. PwD unlikely enter higher education.<br>• Children with learning difficulties unlikely to attend school and will be discouraged from learning as it is believed they are not capable.<br>• No vocational training for PwD | • Improve access to primary, secondary and higher education and vocational training to reduce dependency of PwD in the long-term. |

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| Economic inclusion | Employment<br>businesses | • No job opportunities. Many advertised jobs insist on physically able employees.<br>• Some PwD work and have professional jobs<br>• Some employees are sympathetic and employ PwD<br>• Many PwD usually dependent on their relatives | • Job creation<br>• Micro financing<br>• Joint business ventures for PwD |
| Social inclusion | Everybody/<br>protection | • PwD feel that they are discriminated against. Called insulting names. Some PwD are more resilient than others and cope with the insults. Women are likely to be more sensitive than men and avoid public life so become more marginalized.<br>• Those PwD who work are respected<br>• PwD very dependent on their families<br>• No human rights organization focusing on rights of PwD<br>• Protection provided for PwD during crises<br>• No regular support for PwD and their families. | • Reduce the work of the women caring for disabled relatives by providing labour saving devices so that she have more time to focus on disabled relatives.<br>• Imporve access to buildings |

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| Social inclusion | Everybody/ protection | • International NGOs include PwD in projects, the local NGOs tend not to.<br>• PwD were not mobile during the floods. Those that depend on crawling were immobile<br>• Toilets not easily accessible<br>• Women are mainly responsible for the care of a disabled relative. Some households with a disabled relative are female headed and she will also be working outside the home to generate an income. If the woman is out of the house there is no one to care for the disabled relative.<br>• Caring for disabled relatives can be stressful and cause mental health problems and financial hardship<br>• As the PwD reaches puberty they will need a carer of the same sex<br>• Lack of mobility makes PwD dependent<br>• Some PwD marry but depends on the disability. The man must be able to provide for his family. | |

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| Social inclusion | Everybody/<br>protection | • People with physical and learning disabilities are called names and verbally abused. Not everybody does this, some people behave respectfully.<br>• Respondents were not aware of organized coordination meetings for the different sectors providing assistance | |
| | Legislation & policy | • Not mentioned | • Not mentioned |

## Additional Notes

Respondents emphasized the importance of providing sustainable support for PwD and the need for PwD to be as independent as possible in the long-term.

Women respondents stressed that women are mainly responsible for caring for disabled relatives. Women's workload could be reduced if the needs of PwD were addressed effectively

## Priority

Main priority for PwD was identified as improving job opportunities (education, vocational training and improving physical access and mobility for PwD were also considered important.

Respondents did not suggest improvements for all sector.

## GAROWE, PUNTLAND: SITUATION ANALYSIS

| Area of Victim Assistance | Lead Sector | Current Situation | Suggestions to Strengthen Responses |
|---|---|---|---|
| Data collection | Mine Action | • No accurate database of victims to provide statistics or nature of injuries and needs<br>• No new data being collected | • All mine action stakeholders in Somalia to verify existing victims' data<br>• Puntland Mine Action Centre (PMAC) and the Puntland mine action consortium to discuss how to manage future data collection and maintain accurate information for addition to the national database<br>• All mine action stakeholders in Somalia to add needs assessment to the current IMSMA victims' forms 3<br>• The mine action sector should develop a policy to agree the scope and components of its response to victim assistance and sensitize all staff to the policy |
| Medical care | Health | • Limited healthcare for four million population and one million displaced population. Health facilities include 8 hospitals, health centres, primary healthcare units and other specialist health services<br>• Lack of adequate trauma facilities<br>• No intensive care units<br>• Lack of adequately trained staff to deal with trauma and perform surgery<br>• Shortage of medical supplies and ambulances to transport patients in remote areas. | • External funding and support needed |

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|---|---|---|---|
| Medical care | Health | • No emergency mobile teams<br>• Lack of standard operating procedures and referral systems<br>• Medical facilities no accessible to PwD<br>• Healthcare is not free and people do not have money | |
| Rehabilitation | | • SRC has a rehabilitation clinic in Galkayo. Insufficient to meet all needs and not local to Garowe.<br>• No wheelchairs, crutches or assistive devices<br>• Difficult for patients to afford the transport to the clinic and cost of food and accommodation while attending the clinic. It can take up to three weeks for a prosthetic to be successfully fitted.<br>• Physical barriers to participating in society prevent PwD participating in all aspects of life | • Assistive devices needed<br>• Expansion of services needed. Support for transportation and cost of food and accommodation during treatment would have a significant impact<br>• President being lobbied by CSO to provide funding for a rehabilitation centre in Garowe |

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| Psychosocial Support | | • All eight hospitals provide psychosocial support<br>• Local NGOs provide psychosocial support<br>• Psychosocial support for GBV seems to be the main focus | • Expand existing psychosocial support to include persons with disabilities and their families |
| Inclusion in Education | Education | • Some PwD excluded from education and bullied by teachers and other pupils. A respondent from a disability organization argues that teachers were positive towards children with disabilities but school buildings and materials were not inclusive<br>• Children with disabilities rarely attend school because parents focus on educating the able-bodied children and prioritize boys' over girls' education<br>• Ministry of Education (MoE) being lobbied to provide inclusive education<br>• MoE examinations have been available in Braille from 2016<br>• limited vocational training through some of the disability NGOs<br>• some training in sign language provided<br>• Institute for the blind offers cookery courses<br>• No specially trained teachers of designed schools for PwD except for visually impaired | • Raise awareness of rights of children with disabilities in school. Integrate dissemination of rights training into syllabus<br>• Raise awareness about the importance of education, especially for girls<br>• Provide more vocational training<br>• Training teachers in with the necessary skills to teach children with disabilities |
| Economic inclusion | Employment<br>businesses | • Excluded from the work places. Employers see PwDs as a burden | • Employment opportunities should be advertised encouraging PwD to apply |

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|---|---|---|---|
| Social inclusion | Everybody/ protection | • PwD stigmatized and bullied. Traditional to use nicknames based on physical attributes to identify individuals. Therefore, PwD known by their disability<br>• PwD reliant on support from their families, limited official/formal support mechanisms or services<br>• Many female-headed households (FHH) in Puntland. Women take care of the home, the children and go out to work because they have no husband, or he is unemployed or out chewing qat.<br>• Disabled children might be left at home during the day and locked in a small room or chained up because there is no one to watch them.<br>• Children complain if they have to care for a disabled sibling. Sisters are expected to provide more support for a disabled sibling than brothers<br>• Mothers who become disabled or have mental health problems can be deserted by their husbands and their children removed. In some cases, the husbands care for their wives.<br>• FHH are vulnerable and more vulnerable if there is a PwD in the household.<br>• Displaced households are particularly vulnerable because they have fewer material and social resources. Displaced population has higher number of PwD than the host population because they come from areas where there has been fighting and that are contaminated with explosive hazards.<br>• More social barriers for a person with learning difficulties and mental illness than a person with physical difficulties | • Develop an awareness strategy. Promote inclusion thought targeted campaigns to raise awareness of rights of PwD. Use social media for youth, radio and tv for older population groups.<br>• Islam prohibits discrimination. Imams and Sheikhs could raise awareness about the rights of PwD and discourage the use of nicknames<br>• Some success over 30 years in reducing FGM cases through awareness raising and explaining that it is a cultural and not an Islamic practice<br>• Educate mothers/families on how to raise and support their children with disabilities<br>• Provide cash assistance to households caring for a relative with disabilities |

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| | Legislation & policy | • Puntland has legislation to protect the rights of PwD but it is not enforced and the necessary resources do not exist. They have rights to access education for free and healthcare<br>• Puntland Disability Organization Network (PDON) attended the Protection Cluster for the first time in October 2018 and plans to continue to attend. PDON gave a presentation<br>• PDON raises awareness among Ministries of Health, Education, Women, Justice and the Human Rights Commission about the rights and needs of the disabled but there are no resources. | • External funding and support needed<br>• All polices regarding persons with disabilities should be implemented |

## Notes

The Puntland Disability Network comprises 13 organizations providing a range of services. Some cover different types of impairments, others focus on a specific impairment such as visual or mobility.

## Priorities

Respondents identified healthcare as the first priority for strengthening victim assistance – rehabilitation, followed by surgery and intensive care

Psychosocial support was also considered important. The formal healthcare sector and local NGOs already provide psychosocial support for SGBV

People should be educated about the importance of including PwD in daily life.

## Challenges

Government services lack funding and human resources

Local NGOs are finding it increasingly difficult to secure funding. They have long gaps between funded projects. Apparently commercial organizations are becoming implementing partners of international donors and organizations. Some local NGOs raising money for individuals and their families through the Mosques, local businesses and the diaspora.

People have to be compensated for attending workshops, training or any kind of event otherwise they cannot afford a day away from work. 5 USD or a day's food for the family are considered to be adequate compensation. Hygiene and dignity kits may also be distributed.

## BAIDOA, SOUTH WEST STATE: SITUATION ANALYSIS

| Area of Victim Assistance | Lead Sector | Current Situation | Suggestions to Strengthen Responses |
|---|---|---|---|
| Data collection | Mine Action | • No data collection<br>• No coordination outside mine action sector<br>• SEMA Poorly equipped office<br>• SEMA Only 2 staff<br>• SEMA occasionally attends protection meetings | • Improve data collection<br>• Improve coordination and communication with other sectors |
| Medical care | Health | • Not enough healthcare in the region<br>• Hospital unable to provide any complicated treatment. Patients must go to Mogadishu or abroad, especially victims of explosive hazards who need complex surgery | • External support needed |
| Rehabilitation | | • No rehabilitation centre<br>• Some distribution of wheelchairs and prosthetics but not sustainable<br>• No physiotherapy so a simple problem that could be treated becomes a lifelong disability | • More rehabilitation services for people with disabilities because if they are more mobile and able to participate in daily life they will be visible and be seen contributing to and participating in daily life |
| Psychosocial Support | | • No psychosocial support for victims of explosive hazards although there is psychosocial for other groups of people | • Organizations that already provide psychosocial support to other groups could provide it for persons with disabilities and victims of explosive hazards |

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|---|---|---|---|
| Inclusion in Education | Education | • Limited education for people with disabilities<br>• School for the deaf but no sustainable funding. Children are motivated. Each child place 100 USD<br>• Established as a community-based school<br>• School for the blind<br>• No sustainable funding for children with disabilities to attend school. Some transport to school provided by donations from local communities<br>• Girls less likely to attend school than boys | • Education important. More education for children with disabilities so that they can participate work and be included in daily life when they are older<br>• Educated parents about the importance of education for their children |
| Economic inclusion | Employment businesses | • No equal employment opportunities<br>• No support from businesses for people with disabilities<br>• Disabled men discriminated against by employees because it is thought that they will not be able to work<br>• Some vocational training provided based on sponsorship so employment guaranteed after training<br>• Disabled people deliberately excluded from the work place<br>• There is a cooperative farm for people with disabilities but no sustainable funding<br>• Cash assistance from an international NGO for four months for families with disabled relatives. Not sustainable<br>• Under a previous government there was a factory run by the disabled | • Establish a newspaper where people with disabilities can work and can also sell the newspaper<br>• Need to see more disabled people working so that everyone sees that people with disabilities can work<br>• The UN and NGOs should employ more people with disabilities<br>• Establish quotas for people with disabilities to work in businesses, the public sector and government<br>• Provide vocational training and access to employment (for example, bee keeping and poultry farming) |

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|---|---|---|---|
| Social inclusion | Everybody/ protection | • Awareness raising campaign to improve disabled access to public spaces.<br>• Disability organization to advocate for rights of disabled but no sustainable funding and no permanent office. 380 people in Baidoa registered as disabled with this organization<br>• People with disabilities are isolated.<br>• Support for the disabled comes from the family. Families may try to ensure social inclusion for their relatives.<br>• Little official support for the disabled<br>• More difficult for women with disabilities than for men.<br>• Nicknames referring to disability used to identify individuals<br>• Most buildings no accessible<br>• Caring for a disabled relative is a lot of work for a family over the long-term<br>• Female members of the family are the main carers<br>• No specific government institution or international organization providing assistance to the disabled. Reliant on community contributions and community-based organizations | • Raise awareness about the rights of persons with disabilities and show that they can contribute to society and should be included. Raise awareness among individuals and organizations.<br>• Roundtable discussion to raise awareness<br>• Advocacy through public meetings and use of media and bill boards<br>• If someone is rehabilitated then they will not be considered disabled because they are participating and contributing<br>• Women with disabilities unlikely to marry, then they will not have children and they will be vulnerable when they are older because there will be no one to take care of them.<br>• People who become disabled later in life have more opportunities because already educated or can earn and income so often can carry on participating and contributing |
| | Legislation & policy | • Interim constitution | • Constitution should be implemented for persons with disabilities |

## Priorities

Respondents said that it was important to raise awareness about the rights of persons with disabilities and to ensure that people with disabilities are visible and able to participate in and contribute to daily life. When persons with disabilities are seen to be active among the population attitudes towards them will become more positive.

## KISMAYO, JUBALAND STATE: SITUATIONAL ANALYSIS

| Area of Victim Assistance | Lead Sector | Current Situation | Suggestions to Strengthen Responses |
|---|---|---|---|
| Data collection | Mine Action | • No data collection, since MAG project ended.<br>• No coordination outside mine action sector<br>• No coordination amongst the Mine Action sector<br>• SEMA has no equipment<br>• SEMA has Only 2 staff<br>• SEMA is hosted by local NGO office building<br>• SEMA and NGO consortium attend protection cluster meetings regularly | • Improve data collection<br>• Improve coordination and communication with other sectors<br>• Provide SEMA office and equipment |
| Medical care | Health | • Not enough healthcare in the region<br>• ICRC supports partially the General Hospital<br>• Complicated injuries were evacuated outside the country supported by the state<br>• Emergency medical care is provided by local hospital<br>• Hospital provides limited physiotherapy<br>• Some PwD are transported to Dhadhab refugee camps in Kenya to receive support. | • External support needed<br>• Establish medical centres that can provide special treatment for PwD |
| Rehabilitation | | • No rehabilitation centre for explosive hazard victims<br>• Community based hospital for people with mental health problems<br>• Ad hoc distribution of limited number of wheelchairs and prosthetics | • Rehabilitation centre for disabilities and victims of explosive hazards |

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|---|---|---|---|
| Psychosocial Support | | • Psychosocial support is provided for children with disabilities and GBV victims and no services available for explosive hazard victims.<br>• No counselling for PwDs in the region | • Organizations that already provide psychosocial support to other groups could provide it for persons with disabilities and victims of explosive hazards<br>• Improve the existing psychosocial support |
| Inclusion in Education | Education | • Self-mobilized youth group established school for blind and deaf children but only cover limited number about 80.<br>• Children with disabilities attend schools with other children despite discriminations.<br>• Children with learning difficulties are kept at home and miss education opportunities.<br>• ADRA and LWF (INGOs) provide education opportunities for children with disabilities<br>• Finland provided educational support for 40 children with disabilities<br>• Some private schools offered free education for disable children | • Improve participation of children with disabilities in schools<br>• Facilitate access for disability in schools and public places |
| Economic inclusion | Employment businesses | • Ministry of Women HR provide some ad hoc support<br>• No employment opportunities<br>• Families with disable person face poverty and deprivation of income<br>• No job opportunities for PwDs in the region<br>• Limited number of PwDs participate daily life markets<br>• Disabled people face discrimination in the workplace. | • Advocate job opportunities for PwDs in the public<br>• Reserve job opportunity quotes for PWDs in private and public sectors<br>• Provide vocational training to participate the public and earn income.<br>• Provide shelter, water and food to PWDs in IDP communities |

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|---|---|---|---|
| Social inclusion | Everybody/ protection | • Female members in the families face burden of caring disable persons<br>• Female disable persons face marriage challenge due to their impairments<br>• No support from the state and local authorities.<br>• Self-exclusion by PwDs<br>• PwDs are organized with office and chairperson<br>• Number of registered PwDs are 2,800 in Jubaland state.<br>• Civilians are better in social inclusion comparing to the government<br>• There is need of more disability awareness campaigns through the public media<br>• Most buildings are not accessible including governmental and public buildings<br>• There is no state office dealing with issue of PwDs<br>• PwDs face discrimination and isolation<br>• Those born with disability face more challenges in social inclusion<br>• People with mental health problems face specific challenges | • Raise awareness about the rights of persons with disabilities and show that they can contribute to society and should be included, mainly during 3rd December commemorations.<br>• Raise awareness of the state authorities and humanitarian agencies to include their planning and service deliver.<br>• Job creation for PwDs and advocate through the public and private entities hire staff.<br>• UN to take the lead for advocating PwDs as well as international NGOs working in the field of protection.<br>• Establish PwD centres were their activities are coordinated. |
| | Legislation & policy | • Participated continuation review workshop in Mogadishu invited by government and disability agencies in Mogadishu. | • Constitution should be implemented for persons with disabilities<br>• Improve engagement of PwDs in domestic legislation establishment processes. |

## Additional Notes

Only DDG partnering with local NGO consortium operate in the region and currently VA data is not being collected. VA data collection took place up until mid 2018 when a MAG project ended. UOS supported by UNMAS deploy several CLOs in the region

## Priorities

Respondents said that it was important to train female carers, education and provide assistive devices , training and education, livelihoods, shelter those in IDP camps,

## SOMALILAND[1]

| Area of Victim Assistance | Lead Sector | Current Situation | Suggestions to Strengthen Responses |
|---|---|---|---|
| Data collection | Mine Action | • The sector in Somaliland collects victims' data<br>• Coordination among mine action stakeholders in Somaliland<br>• Coordination between mine action and disability sector<br>• Contact details of organizations relevant to persons with disabilities compiled | |
| Medical care | Health | • There are three trauma hospitals in Somaliland in Borwama, Burbura and Berow. From there patients can be transferred to Hargeisa. This is an international hospital and it charges for its services. There is also a free hospital which is acceptable. | |
| Rehabilitation | | • The Disability Action Network was established in 2002 to run rehabilitations centres established by HI. There are several centres and the main one is in Hargeisa. The centres provide rehabilitation, prosthetics, physiotherapy and ongoing care for children and adults.<br>• Disability Action Network promotes heath care for PwD<br>• and health and raises awareness about the human rights of PwD among other actors. | |

1 Table completed based on information collected during remote interviews.

| | | | |
|---|---|---|---|
| | | • SRCS operates a rehabilitation clinic. It was established to treat war wounded, in recent years, the majority of patients have injuries of impairments from causes other than conflict.<br>• Swedish International Aid Services has distributed assistive devices<br>• Despite rehabilitation centres and distribution of assistive devices still a shortage of rehabilitation services. | |
| Psychosocial Support | | • Basic psychosocial support provided by LNGOs and DPOs. Limited resources available for more complex cases | |
| Inclusion in Education | Education | • Few children with disabilities attend school<br>• Disability Action Network promotes inclusivity for education for PwD<br>• Africa Education Trust provides assistance to PwD.<br>• Swedish International Aid Services advocate for inclusive education and have trained teachers to support children with disabilities. Refurbished classrooms and sanitation facilities for disabled access | |
| Economic inclusion | Employment businesses | • Limited employment opportunities<br>• Respondents with disabilities worked for a local NGO but currently no funding. | |

| | | | |
|---|---|---|---|
| Social inclusion | Everybody/ protection | • HI advocating for the rights of persons with disabilities, helped to established disability networks and a rehabilitation centre.<br>• The Somaliland Disability Forum was established in 2004 as an umbrella organization for organization providing support to PwD. The Forum has 32 member organizations providing support to people with all kinds of disabilities. It advocates for the rights of PwD and builds the capacity of DPOs to help PwD claim those rights. To date the Forum states that:<br>  • It has increased the number of children with disabilities attending school by advocating for their rights and educating the children, families and population that PwD has potential.<br>  • Ensuring that the Government of Somaliland included Article 8 in the Constitution [check] which provides for a quote of PwD to be included in the economy and stressed the right of any graduate from school or university to a job.<br>  • There is a lack of physical accessibility and construction is not planned for PwD<br>  • PwD are barred from Ministries because they cannot physically enter the buildings<br>  • Women with disabilities do not marry<br>  • People in rural areas cannot access services and are stigmatized. | • There is an intention to adopt accessibility standards from Uganda with support from UNSOM.<br>• Government lacks funding to promote services for people with disabilities<br>• Organizations need expertise about how to promote inclusivity.<br>• To date, DANSomaliland believes that there has been limited impact in improving the human rights of PwD so more work is needed. |

| | | | |
|---|---|---|---|
| Social Inclusion | Legislation & policy | • The Constitution states that PwD have equal rights and opportunities<br>• Somaliland has a National Disability Inclusive Policy developed under the Ministry of Labour and Social Affairs – now the Ministry of Economy, Social Affairs and Family and in September 2018 completed an action plan for the policy for 2018-2021. There was a participatory process involving the UN, government agencies to develop the plan and a public launch ceremony. Ninety-six NGOs and government partners have to ensure that services are inclusive to PwD.<br>• There is a department for disability chaired by a person with disabilities | • Government needs to do more to date to promote persons with disabilities in line with the constitution. |

## 8.5 THE WASHINGTON GROUP SHORT SET OF QUESTIONS ON DISABILITY

The next questions ask about difficulties you may have doing certain activities because of a HEALTH PROBLEM.

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

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

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

4. Do you have difficulty remembering or concentrating? a. No – no difficulty b. Yes – some difficulty c. Yes – a lot of difficulty d. Cannot do at all

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

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


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