

## Chapter 1: INTRODUCTION:

### 1.1 Preface of Disability:

The majority of people with disabilities are living in developing countries. Their numbers are rising due to conflict, malnutrition, accidents, violence, communicable and non-communicable diseases including HIV/AIDS, aging and natural disasters. Disabled people are often subject to stigmatization, excluded from schools or the workplaces, and often end up depending on others in the family and community for physical, social and economic support. In addition to being vulnerable to exclusion, according disabled people are disproportionately poor, and poor people are disproportionately disabled.

One of the reasons for the dearth of efforts to include disability in international programs is the lack of understanding of how this distinct vulnerable population—people with disabilities and their families—has on advancing the development process. The Millennium Development Goals (MDGs), which represent key policy directions for targeting income, poverty reduction, health, environment, and other sectors, do not specifically reference the needs of people with disabilities, even though a third of disabled people are children. Many consider that reaching the Millennium Development Goals is unlikely to be achieved unless the rights and needs of people with disabilities are considered in the process of development Box 1.

#### Box 1. People with Disabilities and the MDGs: Examples of Linkages

- **Eradicate Hunger and Poverty**  
Disabled people make up as much as one-fifth of the poor worldwide.
- **Achieve Primary Universal Education**  
Forty million of the 115 million children not attending primary school in developing countries have disabilities.
- **Promote Gender Equality and Empower Women**  
Disabled women and girls are more likely to be victims of sexual abuse. Violence against women causes psychological disabilities. Certain health conditions, such as obstetric fistula, are particularly stigmatized leading to disability.
- **Reduce Child Mortality**  
Children with disabilities are at a higher risk of dying because of medical conditions, but also due to lack of access to public services and intense stigma—even within their own homes.
- **Improve Maternal Health**  
Disabled women have less access to public health and information, placing them at greater risk of unwanted pregnancies, poor maternal health outcomes and HIV/AIDS/STIs.
- **Combat HIV/AIDS, Malaria, TB and Other Diseases**  
AIDS and other infectious diseases can be disabling in and of themselves. Further efforts to control these diseases frequently do not encompass disabled people, putting them at higher risk of contracting these diseases.
- **Ensure Environmental Sustainability**  
Environmental health problems can lead to the onset of many types of disabilities; inaccessible environments prevent disabled people from taking part in economic and social activities.
- **Develop a Global Partnership for Development**  
A partnership implies inclusion, which means everyone.

Source: Guernsey, Nicoli, and Ninio (2006)

One of the most significant recent developments is the UN Convention and the 58th World Health Assembly (2005) resolution on "Disability, including prevention,

management and rehabilitation" calls for improved harmonization for inclusive development and improved access to quality rehabilitation, mental health and other essential services for all. This requires joint global action. International working groups consisting of major bilateral and multilateral donors, NGOs (including Disabled Peoples Organizations) and the private sector have been established to develop core strategies on the health and rehabilitation requirements of persons with disabilities and others. The international plays a key role for inclusive development, due to its prominent role in the global inclusion of disability into development, knowledge, a large lending portfolio and strong technical expertise within the area of sustainable economic growth and poverty alleviation. Often the UN plays a very central role at country level, as a key partner to the Ministry of Finance and Planning with a strong potential for enhanced cross-sector coordination and collaboration. The UN is a natural partner to facilitate and support the recipient government in its attempt to minimize duplication and strengthen harmonization among all partners within the respective country's national policy, strategy and legal framework.

To date, many programs targeted to people with disabilities are found in civil society and NGO-based activities. Although many of these programs remain limited in scope, major development agencies are demonstrating efforts to raise the profile and importance of addressing the needs of people with disabilities in development planning and programming. This survey seeks to assess the number of disable people in Somalia and the assistance they require.

## **1.2 Definitions of Disability**

How one defines disability depends on the reasons for defining it (e.g., establishing a disability pension program versus making public services accessible). Disability is often defined as a physical, mental, sensory, or psychological condition that limits a person's activities. Previously, medical models of disability viewed disability as a deficiency embodied in an individual. More recently, however, the social model of disability conceptualizes disability as arising from the interaction of a person's functional status with the physical, cultural, and policy environments. If the environment is designed with appropriate accommodations and supports those people with functional limitations, then they would not be "disabled" in the sense that they are able to fully participate in society.

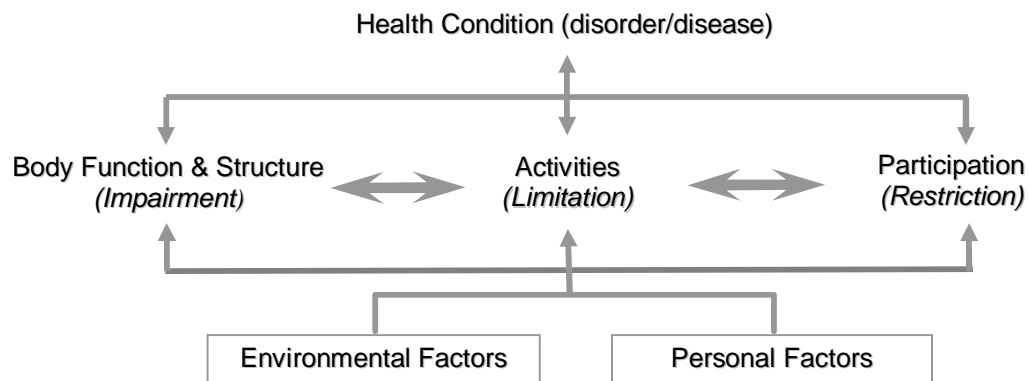
Within established economies, the prevalence rate varies from eight percent to over 20 percent. Much of this variance can be explained by how different countries define disability. In some countries, a person who controls diabetes with diet alone is considered disabled. Whereas in other countries, a person is disabled only if she has impairments that permanently and completely prevent her from working. In addition to definitional difficulties, difficult measurement problems inhibit the ability of creating a solid statistical foundation about disability in developing countries.

According to the social model, identifying disability consists of examining the participation levels of people with different functional statuses. The ICF Classification of Functioning, developed by the World Health Organization, has made significant progress in measuring functional capacity. Disability is not an "all or nothing" concept, but instead people with disability may be classified according to a detailed description of their functioning capacity within various domains, with the perspective that disability arises when barriers exist to participation.

- Body Structure and Function --refers to the physiological and psychological functions of body systems (including age and gender);
- Activities--pertain to a range of individual deliberate actions, such as getting dressed or feeding oneself; and,
- Participation-- refers to activities that are integral to economic and social life, such as being able to attend school or hold a job.

Disability in the International Classification of Functioning (ICF), Disability and Health arises out of activity limitations and participation restrictions that grow out of the interaction and limitations in an unaccommodating environment. These interactions are summarized in Figure 1.

**Figure 1. The ICF Model**



Quality data on disability does not generally exist for many developing countries. Even when data exist, official statistics vary greatly --- not just because different countries use different data instruments (e.g., a census, survey or administrative data) but also because they can have different methodological approaches and capacities for measurement and different capacities for measurement. To address this issue, the Bank has been working with the United Nations Washington Group on Disability Statistics and the World Health Organization (WHO) to establish an internationally comparable approach to measuring the general prevalence of disability. This approach draws on the functional framework embodied in the International Classification of Functioning, Disability and Health (ICF) developed by the WHO. In the few developing countries in which this approach has been implemented, findings indicate a disability rate of about 10 to 12 percent, with about two to four percent of the population having significant disabilities. This estimate is in line with the often-cited United Nations figure of a 10-percent disability rate (although this rate is best understood as an “informed guess,” based on data available from developed country sources).

The following represents among the most accepted definitions currently promoted.

**Disability:** the outcome of the interaction between a person with impairment or health condition and the negative barriers of the environment (including attitudes and beliefs, etc.).

**Disabled person/people:** a person or people (group of individuals) with an impairment or health condition who encounters disability or is perceived to be disabled.

**Environmental factors:** factors that make up the physical, social, and attitudinal environment in which people live and conduct their lives.

The reality is that everybody has limitations—but these only become disabling the environment are non-supportive. For instance, a person in the United Kingdom with impaired vision would receive glasses and not be considered or feel himself/herself to be a disabled person. However, a person in rural Africa with the same visual impairment might not have access to ophthalmic care, and therefore might become categorized as a “disabled person” because of the impairment.

### **1.3 General Background of Somalia:**

Somalia, situated in the Horn of Africa has undergone a major civil war during 1990-92 leading to the fall of the government of Siad Barre, and the subsequent balkanization of the country. Although all Somalis belong to one religion and speak the same Somali language, the Somali society is divided into numerous clans and sub-clans and each sub-clan is sensitive about its economic interests and this is compounded by the vested interests of the clan/sub-clan leaders.

The situation is even now unstable with frequent inter-clan fighting erupting in one area or other for the flimsiest reason. This situation has resulted in far-reaching demographic changes including refugee migration to neighbouring countries, considerable internal displacement of population, and presumably a fall in fertility and an increase in mortality as a result of the difficult economic situation. There has been no Central administration since the collapse of the Siad Barre government in 1991. Consequently, there is no statistical machinery to collect and compile data on a systematic basis, so as to be useful to local administration, NGOs and international agencies.

The United Nations Development Office for Somalia (UNDOS), a project of UNDP and executed by the Office of Project Services (OPS) of UNDP has attempted to collect and compile data on key areas such as number of settlements, population, household income and expenditure, prices of essential commodities, agriculture, education and health in areas that could be reached. In addition several international NGOs engaged in humanitarian activities collect data pertaining to the areas of their interest, particularly education and health. UNDOS is making efforts to compile, evaluate and analyze these data to provide a picture of the demographic, economic and social situation in the different regions of the country. Under the auspices of UNDOS a Statistical Working Group has been established to harmonize the concepts and procedures of data collection, and to establish a data base on the current economic, social and demographic situation and trends in Somalia. UNDOS has prepared the statistical profiles of five regions (Bay, Middle Shabelle, Bari, Nugal and Mudug). Using the settlement statistics on the number of houses and the estimates of average population per house obtained from the family budget survey, UNDOS has prepared population estimates for these regions. These activities are extremely important in the absence of any official machinery for data collection and dissemination.

Demographic data are scanty and incomplete for Somalia, although two censuses have been carried out during the prewar period. The first census carried out in 1975 was not published, and only an analytical report based on the census results was brought out in 1984. A national demographic survey was carried out in 1980-81, but the data were not processed, barring a few hand-tabulations. Another census was carried out in 1985-86, and once again the census got bogged down in doubts about its accuracy, and was not published. There are varying accounts of the census count of population, one giving a figure of 5.8 million and another 8.5 million. The only published set of demographic data comes from the 1980-81 POPLAB survey of three regions – Banadir, Bay and Lower Shabelle – carried out in collaboration with the University of North Carolina.

Data deficiencies are particularly severe for the nomadic population, who constitutes about half the population of Somalia. Data on fertility and mortality were collected in the 1975 census but for only the sedentary population. As a consequence of the civil war during 1990-92, there has been great disruption of population through out the country. It

is believed that about a million people left the country during the war, and about 750000 are said to have perished during the war. There are no independent sources of information to confirm these estimates. Even today there are close to half million internally displaced persons (IDPs) inside Somalia, and about half million refugees outside the country, principally in Kenya and Ethiopia but also in far off places like Canada, Europe and Australia. Other human costs of the civil war have been equally enormous. There are many abandoned women, and there are large numbers of men and women whose marriages have been disrupted. Apart from the deaths caused by the war, there has been an increase in mortality as a result of the economic crisis and malnutrition and disruption of health services. People who are left disabled due to war are many.

The population of Somalia is about 10 million. Languages spoken are generally Somali and Arabic. The vast majority of the population share the same language, religion, and culture but are divided by a rigid structure of six clans. Somalis give importance to tracing their genealogies and have a sense of belonging to one of the six major clan families: the Darood, Hawiye (predominantly from the south), Isaaq (from the north), Dir, Digil and Rahanwayn. Belonging to a clan has political implications as well. An awareness of this might help avoid situations where interpreters cannot interpret because of lack of trust. A teacher's knowledge of a student's background will doubtless help foster trust. A small minority of Bantu-speaking people live in the southern part of the country. Other minority groups include Arabs, Indians, Italians, and Pakistanis.

**Geography:** Somalia is a semi-desertic country with a large population of nomads. The north is mountainous, descending gradually from the Galia-Somali plateau to the coast on the Gulf of Aden. The south is almost entirely desertic with the exception of a fertile area crossed by two rivers originating in Ethiopia, the Juba and Shebeli. Over pasturing has exacerbated drought, endemic in this region. A drastic increase in livestock has led to desertification. Fishing using explosive charges has damaged coral reefs and aquatic vegetation. The destruction of these fish habitats may have put stocks and future catches of many species at risk.

**Education:** Until civil war broke out in the early 1990s, education was free and compulsory for children between the ages of 6 and 14. In the 1980s adult literacy had reached 60 per cent; in 1995 it was 24.1 per cent. In 1990 primary schools had about 377,000 pupils, general secondary schools had 44,000 students, and vocational and teacher-training institutions 10,400. As a result of the civil war, the educational system collapsed and most schools were closed, including the Somali National University (1954) in Mogadishu, which previously had an enrolment of about 4,600.

**Economy:** Somalia is one of the world's poorest countries. Since the early 1990s its economy has been in a state of collapse because of civil war and its aftermath. Previously, the economy was based primarily on livestock raising, which accounted for 40 per cent of gross domestic product (GDP). There are severe shortages of most commodities, except munitions. Crop farming is important only in the south. Until the early 1990s, efforts to diversify and modernize the economy were directed by the government through a series of development plans, assisted by foreign grants and loans. In 1990 the gross national product (World Bank; 1988-1990 prices) was estimated at US\$946 million, which is only US\$150 per capita.

**Civil War and Famine:** Following the peace accord, the dissident Somali National Movement continued its military campaign against the Barre government, capturing parts of the north. New opposition movements—each drawing support from a different clan—also emerged in the late 1980s. The civil war intensified, and Barre was forced to flee the capital in January 1991. During the last two years about 50,000 people were killed in factional fighting, and an estimated 300,000 died of starvation as it became impossible to distribute food within areas of the war-ravaged nation.

In 1993, after two years of civil war and total anarchy, Somalia still had no central governmental structures. The traditional authorities, unable to handle these unprecedented conditions, had abandoned their normal functions, leaving clans and sub-clans unrestrained. In some regions, though, the local population still respected the traditional authority of the tribal elders. However, in the vacuum created by the absence of central administration, power remained in the hands of the warlords and of heavily armed bands of looters. Under pressure from the United States, the UN sent 28,000 troops to assist. This was the first time the world organization had intervened militarily in the internal affairs of a nation. At the suggestion of the UN, in March 1993 military chiefs, councils of elders and prominent citizens agreed to create a provisional government and a National Transition Council. Aideed's forces confronted the UN blue helmets with losses on both sides. The elite US Rangers failed in their attempt to capture Aideed. In March 1994, the UN withdrew 10,000 European troops, leaving 19,000, mostly Africans and Indians. The peace efforts did not prosper, despite a meeting organized in Nairobi, Kenya, between the main opponents: Aideed and Ali Mahdi. The last contingent of UN troops left the country in March, protected by a force of 1,800 marines. And even though the regional conflicts continued, the civil war did not spread and economic life seemed to recover.

The Republic of Somaliland broke away from Somalia and declared independence in 1994. The fledgling republic - comprising about 30 per cent of Somalia's territory - is not officially recognized. The port of Berbere, on the Gulf of Aden, forms its economic base. With the economy in ruins, it sheltered a million people displaced from the southern zone (Somalia). Divided and still without international recognition, the Republic of Somaliland continued to function.

Like a lot of the world, Somalia has many people who are living at or below the poverty level, drinking contaminated water, living in poor sanitary conditions, and have limited access to basic health care. Like many countries, Somalia lacks the financial means and necessary infrastructure to establish a good health care system to address the medical needs of the country. The climate is very tropical which can lead to a variety of health conditions, such as malaria, and the topography can make travel difficult which inhibits people from extensive travel and developing the rural communities. Other factors such as geographic location, endemic disease, ecological destruction, challenging conditions for food production, bureaucracy and lack of awareness to problems such as disabilities have been difficult to overcome when trying to address poverty and health in Somalia.

There are multiple dimensions of disability that affect the individual. Among these dimensions are social and cultural exclusion, denial of opportunities to work and receive an education, and reduced ability to participate in household and community decisions. For example, many people feel the elderly are neglected in the villages because they are often unable to contribute to the family physically. Others feel they are neglected in

larger communities because many of the family members have moved away for better opportunities and have left the person to fend for themselves. Either of these scenarios can leave the elderly isolated from society and left to fend for themselves which can be very difficult when their health and physical strength is limited.

Costs can also be incurred by households of the persons with disabilities. These costs can be financial costs directly related to the disability; cost to the caregiver in terms of time and effort required to provide assistance; and the social and emotional costs that come with social isolation and vulnerability to depression, fatigue and hopelessness. The impact of disability is not only experienced by the individual and family, but also by the community. A community with members who are unproductive and uneducated does not develop as well economically or socially. It has fewer people contributing to farming, business and industrial activities, fewer people planning for the community's future, and fewer contributing financially. Unemployment and lack of education may also contribute to increased crime in communities, which can ruin the sense of community and divert the use of limited and valuable resources.

For many years Somalia has been under war which has made Somalia government to do very little in addressing these issues. Somalia has few laws protecting the rights of people with disabilities and there is no entity in place charged with protecting these people. As a result, no strategy is set up in case of an emergency for people with disabilities, no subsidies are available for parents of children with disabilities, schools must enroll students with disabilities but are not required to provide assistance, 75% of the public buildings are not handicap accessible, no system of transportation is wheelchair accessible and there is no national policy for the employment of people with disabilities, private or governmental.

Because the government is not very active in the treatment of people with disabilities, NGOs have taken it upon themselves to serve these people in many different ways. Unfortunately many of these organizations struggle to find funding or technical resources to implement and sustain many programs.

In summary, Somalia is a country that has many challenges when attempting to meet the basic needs of the people, especially the disabled. People with disabilities don't have equal opportunities for employment, transportation, civic duties, and education which have an impact not only on the person but their family and community. No national coordinating agency is taking responsibility for establishing disability policy and there is no national disability action plan for the country. Several NGOs are attempting to influence governmental actions in addition to attempting to meet the needs of people living with disabilities. Despite the limited resources and other challenges, more can be done to meet the needs of the disabled if someone would listen and discover their needs and attempt to coordinate the available resources.

## **Chapter 2 SURVEY BACKGROUND:**

The 2007 Institute of Education For Disabled People of Somalia motto demonstrates the attitude and struggle of people living with disabilities. These people have the same desires to win, earn a living, get ahead, and contribute to society as all people in Somalia. Because of the lack of opportunities and resources available to them, these desires are not always met, and often times they must be extremely brave when attempting to survive within their communities. These people are very courageous and inspirational and they deserve every right and opportunity as the common man. No paper can describe the life of someone living with a disability yet this assessment attempts to listen to the people and answer the question “What are the needs of people living with disabilities in Mogadishu capital city of Somalia, and what can be done to address these needs so that they may have equal opportunities and full integration into their communities?”.

The following report is written based on observation of and interaction with patients, caregivers, medical providers, local leaders, teachers and lay people and attempts to be a “voice” for the people living with disabilities. The goals for this assessment are to increase the communities awareness to the different types of disabilities and how these disabilities affect people’s lives; increase awareness of the barriers to receiving the proper medical care needed for self-actualization; and propose recommended actions to ensure that disabled people with special needs are integrated into a network for rehabilitation services provided by the IEDSOM and other participating organizations.

The first objective of this project was to survey at least 5000 people living with disabilities to learn what types of disabilities they have and the struggles they face. The second objective was to determine the disability by sex, age and place of residence. Finally, the third and fourth objectives were to determine the specific needs and major problems and the coping mechanisms of the disabled people.

### **2.1: Rationale of the survey**

Because disability is one of the major issue in Somalia - a country of strong legacy of armed conflicts and violence that has been affecting people's lives for many years and that will continue to traumatize the survived victims, their families, friends and communities - attention should be paid to address it based on reliable and exploitable data. Unfortunately those data still need to be generated and organized in a more scientific and comprehensive way. This gap is the main obstacle to any efficient and rational decision-making, strategic planning, monitoring and evaluation of the intervention to address the situation of the disabled persons, including resource allocation and services.

Although a number of surveys have been conducted by various agencies and organizations it is acknowledged that socio-economic and demographic data related to the disabled persons is far from being consistent and accurate. In addition, the categorization of disabilities varies from one institution to another, impeding any comparison, verification, analysis and interpretation of the information, very often fragmented and generated from diverse sources. Furthermore, the situation of the disabled persons is not wholistically addressed so far due to the lack of centralized,

structured and accessible information related to the wide range of services provided by the stakeholders in Somalia.

## **2.2 Objectives**

The Pilot Disability Demographic Data Base Project is aiming at - through on-going and systematic surveys - allowing coherent and interactive data gathering tools and methods, real possibility for analysis, interpretation, updating and dissemination to relevant stakeholders for planning, action, resources allocation, monitoring and evaluation of the impacts.

## **2.3 Specific objectives:**

1. To determine the number of disabled persons in Mogadishu
2. To determine the disability by sex, age and place of residence, i.e. location
3. To determine specific needs of the disabled persons
4. To establish the major problems faced by the disabled and their coping mechanisms.

## **2.4 Scope and covering:**

Coordinated by the IEDSOM Secretariat with the collaboration of field officers and affiliated members, the survey took place in eight districts of Mogadishu city on a household basis, using a nominative questionnaire as a tool of a structured interview in English language which was translated into Arabic language to the illiterate participants by the interviewers. The eight survey sites encompassed sixteen district of Mogadishu. A population of 8,436 disabled persons had been counted and among them, 3,055 (i.e. 68%) had been interviewed (database of statistic of disabled person interviewed during the pilot survey Mogadishu 16 Sep-19 Oct 2007 has been provided).

## **Chapter 3: RESOURCES**

### **3.1 Human resources:**

The survey design and the project supervision and monitoring were made by the project manager of IEDSOM. Another consultant was hired to work in closed collaboration to deal with the technical aspects of the data entry, processing and analysis. The IEDSOM Secretariat appointed a technical coordinator to coordinate this project.

It is important to note that IEDSOM Mogadishu office appointed 24 surveyors to participate in the survey. The IEDSOM Secretariat was represented by a coordinator and IEDSOM Mogadishu by two facilitation officers.

The IEDSOM Secretariat and IEDSOM Mogadishu with the support of other stakeholders in Mogadishu constituted the core of this program.

Field travels during the monitoring were made possible thanks to two drivers appointed by IEDSOM Secretariat.

### **3.2 The material resources:**

- A four-wheel drive car (IEDSOM)
- A second four-wheel drive car (Well-wisher)
- Two sets of computers (IEDSOM)
- One set of computer (Well-wisher)
- Two sets of computer plus one printer (purchased under the IEDSOM budget)
- A white board
- Two desks
- IEDSOM Mogadishu rent a room for the 2 days training of surveyors and one day evaluation workshop in Mogadishu.
- Data entry tasks were achieved at the IEDSOM Secretariat Database Section in Nairobi.

## **Chapter 4: METHODOLOGY**

The study was divided into two main components: The first component consisted of field visits to the homes of families in which discussions were held to determine the difficulties they experience and an interview survey was used to act as a guide to facilitate discussions aimed at collecting data on the demographics of people living with disabilities, types and causes of disabilities, functional limitations as a result of disability and medical intervention and access. The participants were selected primarily as a convenience sample determined by the surveyors and the relevant people within the organisation.

The second component to the study was a rehabilitation organizational assessment in which numerous governmental and NGOs were investigated to determine the extent of their involvement in supporting people with disabilities and their caregivers. The organizations assessed the Community Agency for Rehabilitation and Education for Persons with Disabilities (CARE-Somalia), The Somalia Council for the Visually Impaired, Helpage and Martini Hospital.

This pilot study was performed to aid in the assessment of the needs of people, the number and problems faced by people living with disabilities in the Mogadishu. It was also performed to determine the effectiveness of the survey and to determine if a larger scale study would be feasible in the future.

## **Chapter 5: ORGANIZATION OF THE SURVEY AND FIELD OPERATIONS:**

### **5.1 Survey Organisation**

The survey was designed and implemented by the IEDSOM and IEDSOM representative from Mogadishu and a consultant under the supervision of the project manager IEDSOM Kenya office.

24 surveyors plus IEDSOM senior team leader participated to the survey. In each district, the trained surveyors collected data under the close monitoring of a team leader. 21% of the surveyors were already involved in the previous survey in Mogadishu. The most talented ones had been identified during this survey to follow further training so that they will be able to work as Trainer of Trainers (ToT) on a national basis.

Surveyors were provided with 2 days training prior the data collection task and one day workshop to evaluate the constraints of the data collection. The training contents comprised the understanding of the questionnaire, the survey procedure and methodology, the disability socio-cultural insights and basics on rural economics. Role plays were organized to get the surveyors familiar to the field work they had to achieve with maximum quality and reliability.

The government and the administrative officials from Mogadishu were informed of the survey prior to the actual interview. The letter of introduction to which the survey intends to achieve was developed and submitted to the concern authorities. Arrangements were made with the security personnel with the surveyors not to cause any case of insecurity through false propagandas or any mischief information which could cause conflict between the disabled persons.

Efforts had been developed to communicate with the different levels of the local administration, including the provincial, the district, the commune and the village, despite the poor administrative linkage between the district, the commune and the village levels. Very often, the information reached the commune and the village heads through direct intervention of the surveyors themselves. However, despite some communication delay, the collaboration between the local administrative bodies was positively assessed by the participants during the closing meeting.

### **5.2 Field operations**

The details pertaining to field operations have been grouped into different sub-sections, one each dealing with logistic concerns, training of field staff, pre-testing of survey instruments, and organization of field work.

### **5.3 Logistics Concerns**

Before data collection was started the following logistic procedures were followed:

- Consultation with the existing regional administration or local authorities and the district commissioner of each district.
- Elders in the communities were approached and informed of the objectives of the survey and the work to be undertaken. Their approval and support were sought.

- Facilitators were identified at the district level to accompany the field staff to the selected settlement.
- Facilities and supplies for the training session were arranged for the supervisors and enumerators in each zone/ region etc.
- Logistical arrangements and transportation was confirmed.
- Approval/ support for the settlements to be surveyed was obtained from the concern authorities.
- Mobilization and information dissemination was done through a local media called Hornafrice a widely listened radio station.

## **Chapter 6: SURVEY STRATEGY**

### **6.1 Sampling and identifying the survey population:**

The size of the survey population in each region was determined by the consultant by taking into account the sample representation and the relevance of geographical coverage.

The selection criteria of the target villages are as follow:

- Close to the capital city of Mogadishu
- Accessible by secondary road
- Service centers/provider
- War affected area
- Population density
- Province/District border.

The features of the selected villages were checked out with the field geographical insights of the surveyors during the 2 days training. Minor changes had been made and a final list of target district was established (names and administrative location of the surveyed villages is available on request). Table 1 displays the number of target district according to the criteria and number of household interviewed.

A total number of 5,000 disabled persons had been interviewed and we were able to register a total number of 8,436 in the whole of Mogadishu city and as compared to 8,000 disabled persons according to the provincial statistics (2000-2001 report). Prior to the survey, the respondents were screened by the key informants at the village level, e.g. the village leader, the elderly, the traditional birth attendants, the teachers, the mobile sellers, etc... Based on the screening list, the surveyors used a nominative questionnaire to interview every single disabled person's in the target villages. Each surveyor was able to interview and received correctly filled up questionnaire of 50-100 disabled person's household per day, under the close supervision of a field team leader. A surveillance officer (IEDSOM's senior facilitator) also monitored the field team leaders and the surveyors to ensure that the survey procedure had been strictly followed and the data properly gathered, and to solve any administrative or logistical problem encountered with the support of the local authorities.

### **6.2 Data collection:**

The data collection phase lasted 29 days included the service provider survey, involving 24 surveyors appointed by Mogadishu office logistics department. The surveyors

interviewed the disabled persons in the target districts in their respective regions. Given the size of the region - thus the number of target villages- the number of surveyors and monitors was not proportional to the huge task they had to achieve during the data collection phase. This problem occurred in two districts where the monitors spent quite a lot of time to ensure maximum accuracy and consistency to data collected.

Data gathered were checked, classified and centralized in Mogadishu. Data entry and analysis were made possible at the IEDSOM Secretariat database office in Mogadishu that had been equipped with computerized data entry tools and relevant facilities. IEDSOM secretariat Nairobi in collaboration with an external consultant to prepare a final report based on the data received from Mogadishu.

### **6.3 Data entry:**

As soon as the data gathered are classified and centralized, 2 data entry clerks (DEC) were selected among the 24 surveyors and 4 other clerks were recruited from both affiliated NGOs, based on their skills in computer science and survey background to receive 3 days training prior the data entry work. The training was provided by a database design specialist, combining IMPS and SPSS software.

The data entry lasted 14 days which officially started 15 days after the survey had began when adequate interview had been carried out. As expected, each DEC was able to enter an average of 10-15 questionnaires per day.

### **6.4 Data processing, analysis and interpretation:**

This technical phase is a joint task involving the senior database consultant and the database design specialist.

Data were processed and analyzed according to the requirements of the IEDSOM Database Working Group. Variables were analyzed separately (single variable analysis) or in correlation with other relevant variables (multi-variable analysis). Single variable analysis gives for instance the distribution of respondents by age group, gender, occupations, marital status, type of disability, educational level, etc...

Multi-variables analysis help to understand and verify some links between different aspects e.g. the relationship between the prevalence of disabilities and the occupations, the discrimination due to gender, the effect of parents' disability on children's schooling, etc..

Another category of data provides qualitative information on the access of disabled persons to services in terms of difficulties, mobility, discrimination, self-exclusion...

## Chapter 7: SURVEY FINDINGS:

### 7.1 Survey assessment

The purpose of the survey was to gain first-hand insight into the lives of people living with disabilities to learn about the challenges they face and the needs they have in order to improve their lives. The results of the survey are as follows:

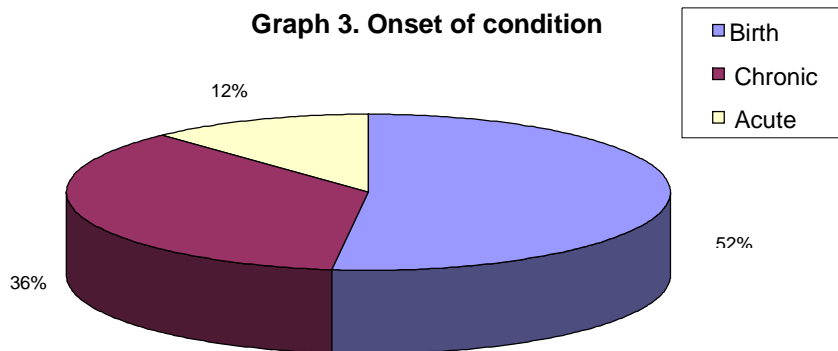
### 7.2 Demographics

A total of 8,436 people were interviewed and 60 % were male and 40% were female. 70% were from the five major districts while 30% were from the rest of the districts. Mogadishu is very unique in that many different ethnic groups (clans) reside there as was evident in the diversity of the people involved in the survey.

Of the 8,436 participants, only 32% were able to communicate independently, the others required assistance from a family member who claimed to be the primary caregiver. Finally, 56% of the disabled ranged in ages between 0-18 years (see graph 1 disability distribution).

### 7.3 Types and Causes of disability

Diverse samples of ailments were noted in the study (see table 2). Up to 17 different conditions were reported and most of them were not formally diagnosed but were selected based upon observation or patient/caregiver report. Twenty four percent of the people presented with orthopedic type problems while the rest presented with visual, neurological or medical type conditions of which cerebral palsy, stroke, and developmental delay were the most prevalent. 52% of the respondents related their condition to problems occurring at bullet injury while 32% related their disability to illness and 12% to other conditions related to. Only one respondent did not know the cause of their disability. Finally, the onset of the conditions ranged from being chronic or acute in nature to problems occurring at birth (graph 3).



### 7.4 Functional and cognitive limitations

The survey asked questions specific to the effect of disability on the patient but affects on the family and community were considered during discussions. Many of the conditions noted during the study resulted in functional and cognitive limitations which impacted the lives of the individuals, families and communities. Of the people

interviewed, the most prevalent limitations were issues of self-care, mobility, communication and cognition (table 3).

### **7.5 Medical intervention and access**

Despite the challenges of transportation and limited medical services, all 4,500 participants sought out care for their condition. 88% of the people had gone into Martini hospital for treatment while 4% saw a local healer or went to a community health center. Several different types of medical professionals were consulted. It is important to note that the people who saw a rehabilitation specialist did not have to seek them out or travel to see them. The specialist came to them from a variety of referral sources.

Rarely did people seek medical care for conditions they deemed minor. They either had to be very sick, in a lot of pain, or unable to perform an important part of their life for them to struggle through the challenges of travel and spending money to see a provider (table 4).

The two questions of the survey were open-ended questions regarding the needs of people with disabilities and the difficulties of accessing care for their problems. The overwhelming majority of the people voiced frustration with the previously mentioned issues of transportation, lack of confidence in the medical providers and lack of caregiver and social support. Other needs were assistive equipment to help them perform daily activities, special education services, social outlets for the elderly, and even a visa to get to the United States for better treatment options.

### **7.8 Summary of survey findings**

In summary, the findings of the survey assessment show basic activities such as self care, mobility and cognitive functions are most limited as a result of disabilities. Early disability screening and public education could help reduce the effect of disabilities seen in the young and old populations. Poor access due to limited services, transportation difficulties and multiple challenges at home all hinder the ability of people to receive care for their disabilities. Additional perceived needs of the people are assistive equipment, special education, and social outlets. There is high dependency ratio among the disable people many of them depending on their families while the rest depend on begging.

Te education level of women has been noted to be very low. According to the interviews taken, only 2% are literate as compared to men 4%. Most of the disabled people got their disability since the beginning of war. A higher number of disabled people are dependent (8428) while rest are independent.

## **Chapter 9: MONITORING AND EVALUATION**

### **9.1 Monitoring:**

At the central level the IEDSOM Data Base Working Group plays the role to monitor and evaluate the project in close consultation and cooperation with surveyors.

The progress had been steadily reported by the consultants to the IEDSOM Merka office Nairobi through informal and formal meetings, under the coordination of the IEDSOM Secretariat.

At the field level team leader was in charge to monitor the progress of the survey through its deputy director who actively traveled in the survey areas with the IEDSOM Secretariat's coordinator and the consultant during the data collection phase.

### **9.2 Evaluation:**

A one-day workshop organized in project coordinator Mogadishu office at the end of the survey phase allowed the participants to evaluate the difficulties and successfulness of their mission. Also meetings of project team leader to present preliminary key findings, draft report and final report to IEDSOM Merka office Nairobi for the final report was organized.

## **Chapter 10: OUTCOMES**

Key findings of the survey include:

1. Most of the disabled persons got their disability due to war
2. Disabled persons are discriminated in the society
3. Women who are disabled are the most vulnerable group and normally their rights are violated.
4. Disabled children within the capital city are less educated as compared to the rest of the children.
5. Disabled pregnant mothers receive less health services due to their marginality
6. War disabled victims' fails within the age of 15-40 years.
7. Employment discrimination is prevalence to most of the disabled persons.

## **Chapter 11: PROPOSED DATABASES:**

### **11.1 The Socio-Economic and Demographic Database (SEDEDA):**

A nominative database encompassing a population of more than 12,000 disabled persons of sixteen regions of Mogadishu will be generated. This database will provide key information about their socio-economic situations as well as their type(s) of disability.

Raw data will be registered into a software called IMPS (Integrated Micro-computer Processing System). Data Processing and analysis will be made possible through a SPSS (Social Package of Statistical System) software so that cross-tabulation and correlation analysis could be done by advanced users. For common users, a set of pre-processed data is made available in a menu encompassing tables and charts to enable them to access to the key findings and/or to duplicate those materials according to the purposes.

Capacity building for the data entry officers from IEDSOM is necessary to equip them with SPSS and IMPS software knowledge to improve the accuracy of the data entered and accurate reports.

### **11.2 The Service Availability Database (SADA):**

This database will be made available in the near future which will contains practical and up to date information on the relevant service providers e.g. location, distance from the nearest commune administrative center, treatment fees, schedule, contact persons, accommodations facilities, referral system,...

The geographical location of the service providers is translated into a mapping included in the database. Eight maps of the eight districts surveyed are available in the database with a legend of formal and non-formal service providers ranging from health centers to traditional healers and traditional birth attendants (Maps of the sixteen districts with location of the service providers is available on request)

### **11.3 The Service Accessibility Database (SACCEDA):**

This database intends mainly to provide information on possibilities and difficulties encountered by the disabled persons to access to services. It informs us for instance about:

- Where the disabled persons receive treatment or service related to their disability,
- How long did the treatment last,
- The kinds of service received,
- How much did they pay for the treatment,
- What are their major problems to access to services
- Wishes on how to improve accessibility to services...

### **11.4 A Resource Manual on Disability Issues (REMADIS):**

The Resource Manual on Disability Issues was designed and is being developed as a complementary component to the Disability Data System. This computerized "encyclopedia" offers users of the socio-economic/Demographic and Services Availability Database a tool for a comprehensive and informed approach to research,

problem solving and understanding the variable issues concerning persons with disabilities and disability issues.

Designed similar to a Web Site, users are able to access needed information on a wide range of topics concerning disabilities. The Resource manual is available on CD Rom, making access to needed information available without having to utilize the database program. It can actually be used as an integral part of the data system or as a stand-alone program. However, links are provided both programs assisting the ease of use.

Currently there is just a small amount of information ready to include into the manual. It is intended, however, that within the DAC Sec. a system will be developed to regularly update and add information. Through concerted and conscientious effort of the DAC Sec. and supportive agencies and organizations, the Resource Manual will develop into valuable and useful tools for users of the Disability Data System, members of the rehabilitation sector and those concerned with disability issues.

## **Chapter 12: THE QUALITATIVE OUTCOMES:**

### **12.1 Capacity building of IEDSOM staff:**

The project enables 26 persons to actively work on a survey in a methodic and scientific manner by achieving all the steps including training, data collection, monitoring/evaluation, data entry/processing/analysis. The project has developed a team spirit among all the participants in a strong willing to attain a common objective that is to build up a reliable, consistent and useful database on the disabled persons.

### **12.2 Toward more awareness and significant ownership:**

Awareness and ownership are induced by improved understanding on the importance and the usefulness of this database to assess, plan and strategize any action for the benefit of the disabled persons.

By providing the stakeholders with this valuable tool, the project was aiming at developing the sense of ownership of the national institutions so that the real beneficiaries are the disabled persons and the services provided are effective and appropriate because they actually address their needs and difficulties.

The IEDSOM Secretariat has the role to continue to sensitize the government side to devote more energy, time and committed human resources to sustaining the database assets.

The Department of Rehabilitation of IEDSOM should make sure that appointed staffs do have sufficient sense of ownership and genuine willing to acquire skills that allow them to maximize and develop these assets at the service of the stakeholders and the disabled persons.

## **Chapter 13: RECOMMENDATIONS**

### **13.1 General Recommendations**

1. Linking Nairobi and Mogadishu office to the district, commune and village administration: The strategy would be to involve the commune leaders in the future surveys, very likely via common program. This involvement would be relevant during the screening and monitoring phases because those steps require strong administrative support to ensure data consistency and reliability.
2. Enabling the project to select field staff according to capacity to fulfil survey duties. Staff appointment by the institutions at all level should be limited and larger room should be made to identify the most talented ones to implement the survey and to train additional surveyors in other regions.
3. Sensitizing the government institutions on the necessity to improve staff wage via various allowances (food, accommodations, transportation,...) with the participation of the project and to require full commitment and sense of ownership from the selected staff.

4. Lobbying in favour of gender equity in the staff recruitment by IEDSOM. Lack of female IEDSOM surveyors limits qualitative communication with female disabled persons and may lead to data bias.
5. Planning appropriate time and adequate transportation means. The field work should be planned during the dry season to access to remote areas.
6. Providing relevant training to build up capacity of the IEDSOM staff especially at the Mogadishu and Nairobi office. Training topics should include the following topics:
  - Survey Tools Design and Development: 1 person as Trainer of Trainers (ToT)
  - Data Collection and Monitoring Techniques: 4-5 persons as ToT
  - Data Entry, Processing and Analysis: Number according to the needs
  - Database Management and Development: 1 person from Mogadishu, 1 person from Nairobi.
  - Budget Planning, Management and Reporting: 1 person
7. Recruiting qualified human resources at the provincial and district levels and providing them with above relevant skills. The most skilful surveyors at the district level who have been identified during the current pilot phase should be used as a pool of ToT so that further number of surveyors will be trained in other provinces.
8. Requiring strong support from affiliated NGOs and organizations to benefit from their insight and secondary data in the remote areas. Survey findings should be disseminated to the affiliated NGOs, organizations and relevant state institutions in order to promote the participatory process.

### **13.2 Specific recommendations:**

- To enable the disabled persons to receive humanitarian assistance and involve in community social life.
- To build up their basic needs such as food, water, shelter, health care services etc
- To reduce poverty through joint implementation project by multiple donors and agencies as well as other NGO's.
- The government must increase its engagement towards disabled persons.

### **PERSPECTIVES**

1. To develop plan to further collect data on Service Providers in Mogadishu and relevant data for the Resource Manual in or outside Somalia.
2. Database Availability and Accessibility:
  - The database should be installed in a stand by computer, which is located at the Nairobi office in Mogadishu.
  - A database program instructor should be made available to the users during working hours at the IEDSOM Secretariat.
  - CD Rom loaded with survey data must be available and find support for diffusion of CD-Roms to all the stakeholders.
  - To propose fee for duplicating other 50 CD-Roms for sale to other interested users and use that income to buy new ones to fill the stock.
  - To update and enrich the database with future findings e.g. tables requested by such and such user. It has to be proposed to the IEDSOM who will assess the pertinence, accuracy and veracity of the findings.

3. To develop year 2008 plan to replicate the survey model to other regions with the agreement of IEDSOM and financial support of various donors.
4. To develop plan for the capacity building to IEDSOM's staff in computer science and tools/methodology of survey design and development.
5. Frequency of data updating: The project intends to update the data collected in Mogadishu every year through additional surveys.
6. Confidentiality issue: The diffused CD-Roms of the database will not provide the name of respondents, which will remain confidential through a password system. Only a limited number of persons will be provided with the password to access to those names. The IEDSOM have the authority to decide who is eligible to be given the password.
7. Software requirement: To download or access to the CD-Roms of survey data, it is required to install SPSS and Microsoft Office program.

## DISCUSSION

The results of the survey and organizational assessments reveal some of the problems people with disabilities experience on a daily basis. Many of these problems go unnoticed by society which leads to further difficulties that could be avoided. The results of this study demonstrate that disability has no bias and can affect any person regardless age, sex, ethnicity, or where they live and it can occur at any point in time. Most disabling conditions are preventable with birth complications, accidents, and inadequate prevention and treatment of diseases contributing to the majority of disabilities. The most prevalent conditions reported in the study were cerebral palsy, developmental delay and strokes and one program that is lacking in the district that could reduce the severity and incidence of these conditions is an adequate disability screening and early intervention program. It makes sense that education along with early identification and intervention could facilitate proper health care, adaptive equipment distribution and therapeutic interventions which in turn would instill hope in the person and the family. The prevention of strokes and other conditions is a very challenging task which will require a lot of organizational and social change and education which is just beginning to be addressed through the ministry of health and other NGOs.

The most prevalent disabilities discovered in the survey assessment involved basic activities of daily living such as bathing and dressing. These activities often provide a person with a sense of dignity and pride. The study also identified functional activities such as walking, standing, squatting and riding a bike to be very prevalent and these activities allow a person the independence to go places and do things when they want or need. Finally, the study showed cognitive issues such as the ability to rationalize, socialize and make decisions to be very prevalent in the district. The cognitive aspect of a person is a primitive component of a person's life and what many people would say define a person. Activities of daily living, functional activities and cognition are vital aspects of a person's life and are often taken for granted by many able-bodied people. They don't realize how important these activities are to a person's pride and life until they are taken away. In many cases, rehabilitation can help restore some level of independence to people with functional and cognitive difficulties thus helping restore some level of dignity, pride and independence.

Not only does a disability affect the individual, it can affect the family and community as well. These people have difficulty caring for themselves, require a lot of social support, and have difficulty contributing to society. An example of this is an elderly man who suffered a stroke and his son. His son has to ride his bike approximately 4-5 miles one way into Martini to get medications for his father and he has to physically assist him with many activities of daily living. This has been very physically and emotionally demanding on the son and he is unsure how much longer he can care for his father in this manner. Without the son's efforts, the father will not be able to receive the proper medicine and exercise for his condition and will live a lower quality of life as a result. Rehabilitation can help change the lives of these people if better access and more interventions were available.

According to the survey assessment, most people go to a health provider when their self care is limited, when they are sick, or when they can not socialize or participate in leisure activities. Fewer people sought out help when they were in an accident or in pain. These findings demonstrate the value people put on independence and social interaction.

The survey and organization assessments showed many gaps in the services that need to be addressed. Issues such as transportation, learning difficulties and social support at home are areas of great need, and more equipment needs to be available to the people. Minimal services are available to the adolescents, middle-aged and elderly and they make up a large percentage of the people with needs. Money, personnel, equipment, space, ideas, and dreams are all vital to an organization's success and the biggest challenges for most organizations in the Mogadishu are often the lack of these resources. Most of the organizations in Mogadishu maximize their resources and they often feel they could do more "if only...". One approach to more effectively maximize resources is to facilitate more collaboration amongst the participating organizations in the districts. The collaboration of resources and ideas would expand a district's ability to reach out to the disabled and minimize the gaps in services.

There seems to be more interest in national statistical services in the field of disability throughout the world. Over the past several decades, national efforts to collect disability statistics have increased significantly, specifically since 1981 which was declared the International Year for Disabled Persons. However, this increase is due mainly to the inclusion in the census of a question or questions on disability which can often be ineffective in collecting data. National registers of persons with disabilities are rare, and the lack of international standards to guide the production and compilation of statistics in the field of disability is a major problem. As a result, the quality, completeness and detail of existing statistical information are usually inadequate for national policy and program needs. The Mogadishu is in great need for data regarding disabilities to help guide policy development, allocate time and resources, and to increase public awareness.

### **Funding Sources**

The project was possible with financial support received from UNDP in the amount of USD 2,450 as well as the technical, moral and logistic support from this potential donor, well-wishers and relevant IEDSOM affiliated members.

**DATABASES ILLUSTRATING DIFFERENT ISSUES NOTED DURING THE SURVEY.**

**Conditions:**

Several conditions were reported. Some of the conditions noted are represented by the table 2:

<b>Condition</b>	<b>Number of People</b>
Visual impaired	925
Stroke	20
Developmental delay	125
Osteoarthritis	450
Amputation	600
General Weakness	84
Shoulder separation	49
Speech difficulty	580
Deafness	387
Jaundice	93
Unknown neuro.	258
Epilepsy	670
Hypothyroidism	723
Foot fracture	1740
Malnutrition	805
Down's Syndrome	450

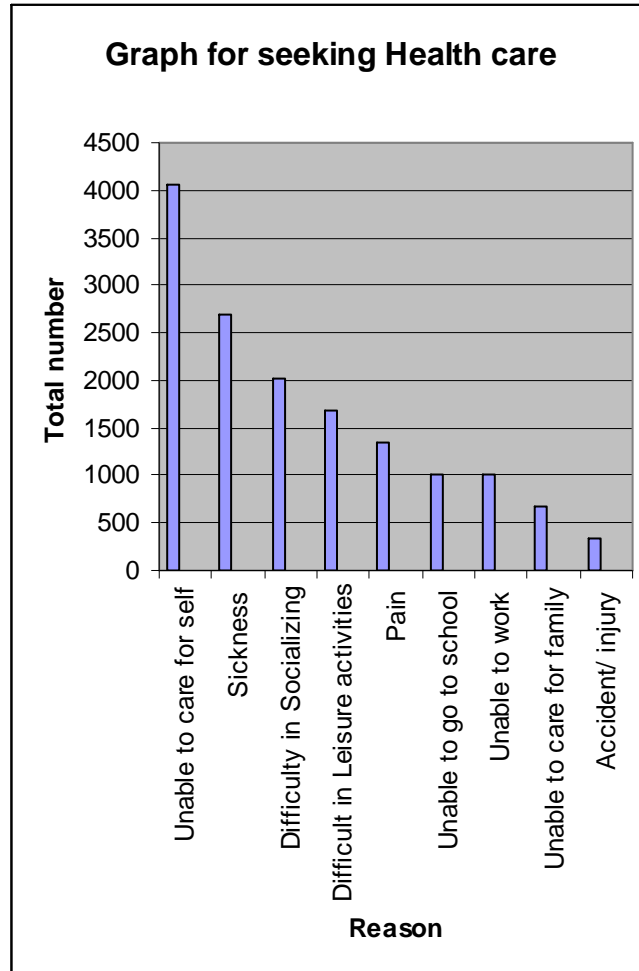
**Table 2. Number of people with functional limitations**

<b>Activity</b>	<b>No difficulty performing</b>	<b>Difficult or unable to perform</b>	<b>Not applicable</b>
Self dressing	2362 (28%)	6073 (72%)	0
Making decisions	3374 (40%)	5062 (60%)	0
Walking/standing	3712 (44%)	4724 (56%)	0
Talking	3712 (44%)	4724 (56%)	0
Squatting	3712 (44%)	4724 (56%)	0
Riding a bike	1350 (16%)	4387 (52%)	2700 (32%)
Self Bathing	4049 (48%)	4387 (52%)	0
Making friends	3712 (44%)	4387 (52%)	337 (4%)
Interact with family	4387 (52%)	4049 (48%)	0
Walk/stand (at all)	4387 (52%)	4049 (48%)	0
Bending	5062 (60%)	3374 (40%)	0
Seeing	518 (56%)	370 (40%)	37 (4%)
Manipulating objects	5062 (60%)	3374 (40%)	0
Self feeding	5737 (68%)	2700 (32%)	0
Riding a bus	5737 (68%)	2700 (32%)	0
Using bathroom	5737 (68%)	2700 (32%)	0
Lifting 10 pounds	5737 (68%)	2700 (32%)	0
Cooking	1350 (16%)	2025 (24%)	5062 (60%)
Sitting	6749 (80%)	1687 (20%)	0
Hearing	150 (80%)	30 (16%)	1 (4%)

**Table 3. Reasons for seeking care:**

<b>Reasons</b>	<b>Number of people</b>
Unable to care for self	4049 (48%)
Sickness	2699 (32%)
Difficulty socializing	2025 (24%)
Difficulty with leisure activities	1687 (20%)
Pain	1350 (16%)
Unable to go to school	1012 (12%)
Unable to work	1012 (12%)
Unable to care for family	675 (8%)
Accident/injury	337 (4%)

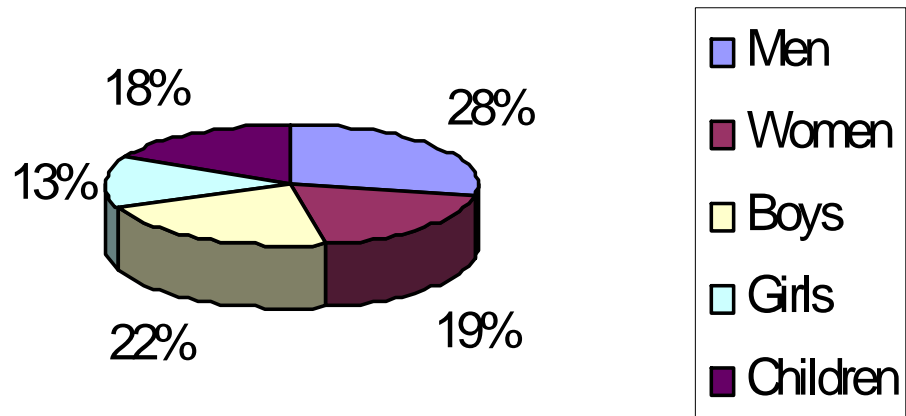
**Graph representation:**



**Distribution of Households Interviewed by District for Men, Women, Boys, Girls and Children.**

*District	Number of Household interviewed				
	Men(adult)	Women(adult)	Boys(youths)	Girls(youths)	Children
Kaara	420	395	320	186	320
C/aziz	286	184	250	150	380
Yaaqshid	402	359	320	147	140
Huriwaa	270	159	200	130	225
War	345	230	280	150	102
Hodan	226	145	180	80	124
Wadajir	106	80	103	67	80
Dharkeanley	93	57	80	65	65
Waabari	80	40	60	48	79
Xanar jajab	85	35	90	60	80
Xanar Weyney	76	40	56	58	66
Shangani	94	50	46	40	59
Boondheere	78	40	40	38	76
Daynute	88	38	80	55	88
Heliwaa	86	36	50	40	77
<b>Total</b>	<b>2735</b>	<b>1850</b>	<b>2115</b>	<b>1314</b>	<b>1748</b>

## Graph representing household interviewed

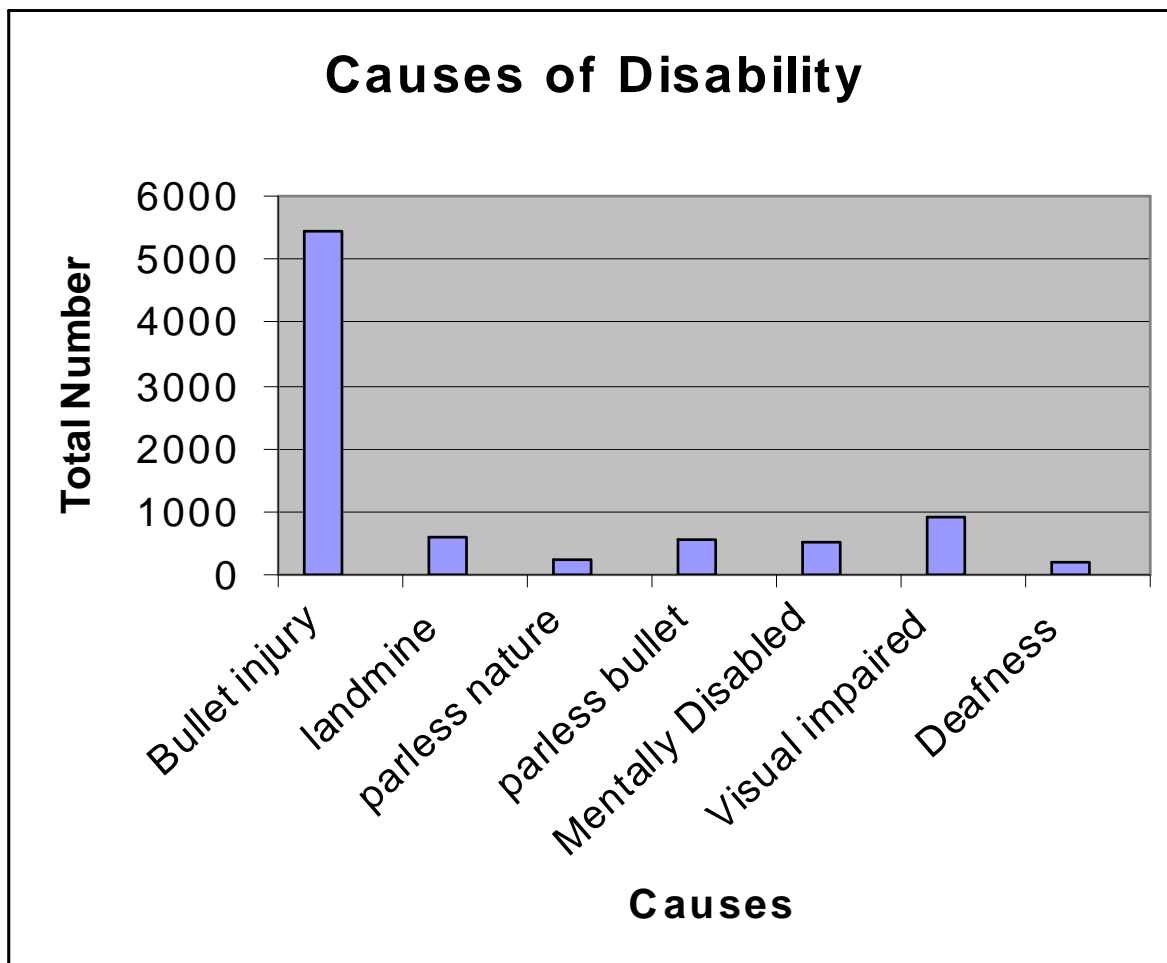


**CAUSES OF DISABILITY:**

The following graph clearly illustrates disability cases reported during the survey. The majority of cases reported shows that injury due to war was the major cause of disability especially among the five districts which is the war zone area.

**Data:**

<b>Cause of Disability</b>	<b>No. of people reported</b>	<b>Percentage representation</b>
Bullet injury	5426	63%
Landmine	615	7%
par less nature	228	3%
par less bullet	557	7%
Mentally Disabled	498	6%
Visual impaired	925	11%
Deafness	187	0.01%



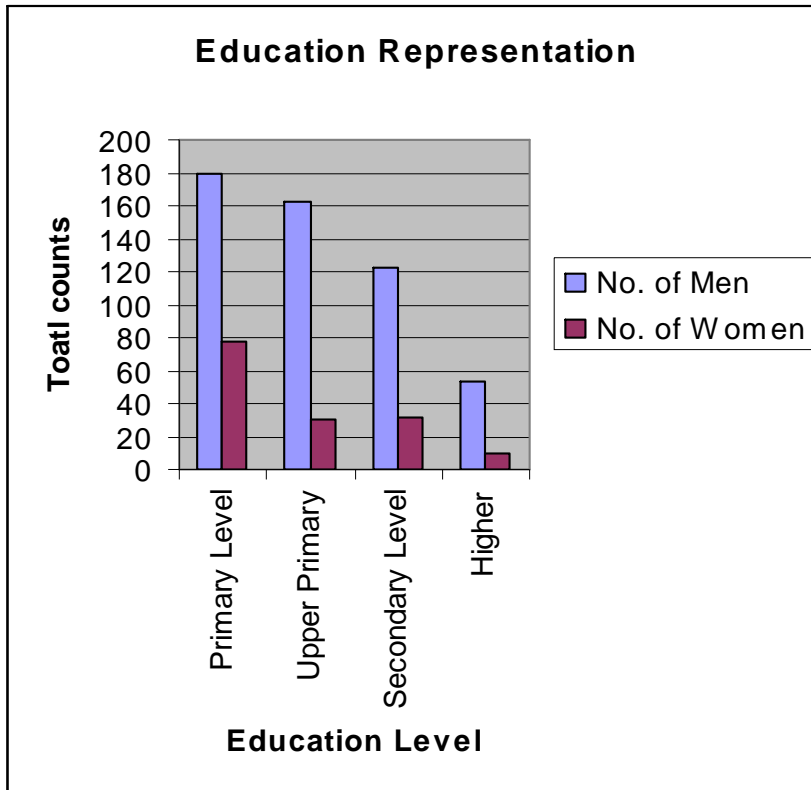
Graph: Representation of causes of Disability among the general participant and reported cases within Mogadishu.

**Education:**

Question 14, 15, and 16 investigate the level of education among the disabled. The study reveals that disabled people are under literate. High number of women are illiterate as compared to men. The table below show a brief illustration of the facts;

**Data:**

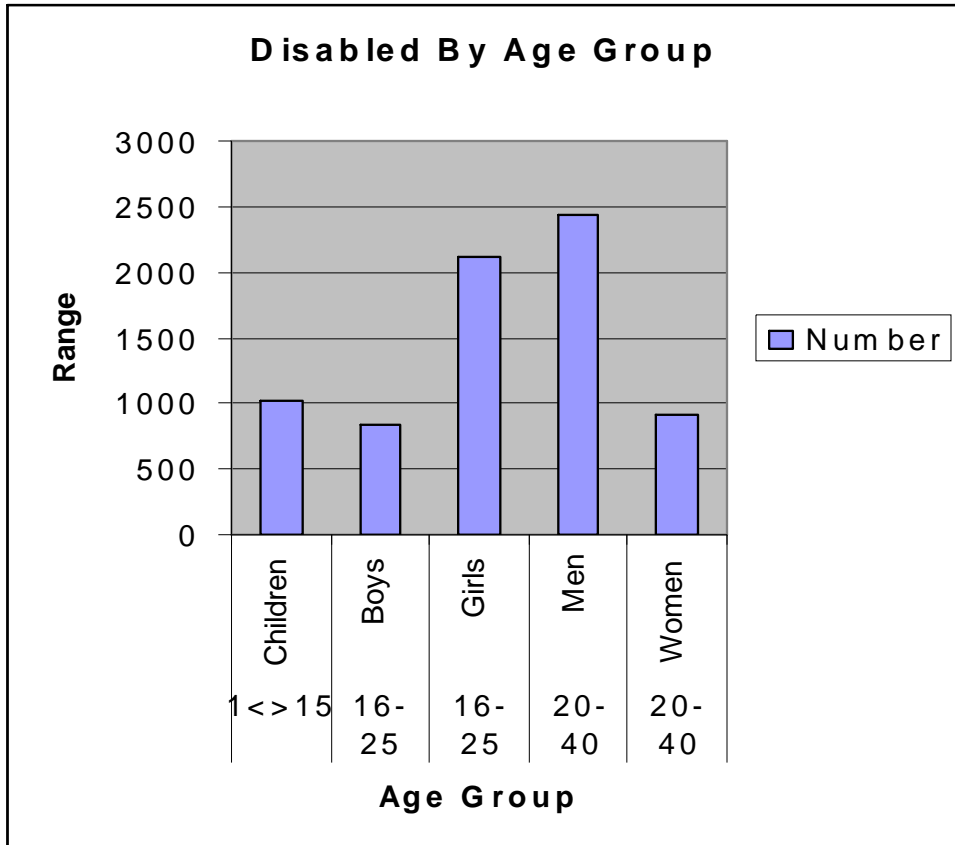
Education Background	No. of Men	No. of Women
Primary Level	180	78
Upper Primary	162	30
Secondary Level	123	32
Higher	53	10
<b>Ability to read and write</b>	518	150



**Age group disability distribution data:**

Age group	Gender	Number
1-15	Children	1013
16-25	Boys	844
16-25	Girls	2115
20-40	Men	2435
20-40	Women	917

**Disability Representation by age group:**



## WORK PLAN:

A work plan is a plan of action and gives details of various tasks that need to be done in the whole of the survey process and gives time frame for each activity undertaken. The following work plan was used during the survey process which aid timely survey and report writing.

<b>Activity</b>	<b>Time</b>	<b>Responsible Party</b>	<b>Expected Outcome</b>	<b>Critical Assumption</b>
Development of Reference	By 12th September	EIDSOM	Terms of Reference	Availability of funds
Appointment of Surveyors	By 14th September	EIDSOM	Contracts Agreement	Surveyors' bid are within available budget
Training and briefing surveyors	By 16th September	EIDSOM and Surveyors	Minutes of the briefing and Training Content	Signed contract between the client and selected surveyors
Development of Indicators	By 17 <sup>th</sup> September	EIDSOM and Surveyors	List of indicators	Final draft questionnaire agreed with Surveyors
Review of the survey Questions	By 18 <sup>th</sup> September	Surveyors	Questionnaire revised as necessary	Sampling frame agreed between surveyors and Organisation
Development of sampling frame	By 19th September	Surveyors	Sampling frame identified	sampled developed
Sampling done and subject identified	By 19th September	Surveyors	Sample	Training of Surveyors conducted
Pre-testing instruments by surveyors	By 20th September	Surveyors	Questionnaire understood	Pre-testing data available and usable
Development of dummy tables using	By 21 <sup>st</sup> September	Surveyors	Dummy tables	Absence of major constraints in the field
Collection of data in the fieldwork	By 16th October	Surveyors and Research coordinators	Raw Data	Data analyzed done on time
Data analysis and interpretation	By 16th October	Project Manager	Draft report	Data analyzed done on time
Writing of Draft Survey Report	By 19 <sup>th</sup> October	Project Manager	Review workshop and list of suggested revision to the Survey report	Report Writing completed
Submitting final Report in Hard copies	By 23rd October	Project Manager	Final Survey Report	Review Workshop held and revision Done