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Disability

In and Around Urban Areas of Sierra Leone

Jean-Francois Trani
with Osman Bah, Nicki Bailey, Joyce Browne,
Nora Groce and Maria Kett



**Leonard
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Acronyms

DFID	Department for International Development
DPOs	Disabled People's Organisations
MICS	Multiple Indicator Cluster Survey
NGO	Non-Governmental Organisation
UNIOSIL	UN Integrated Office for Sierra Leone
UNICEF	United Nations Children's Fund
UNDP	United Nations Development Programme
WHO	World Health Organization
WHODAS II	World Health Organization Disability Assessment Schedule II

Executive Summary

This is the first in an anticipated series of reports exploring issues related to disability in different countries where Leonard Cheshire Disability works. While each country presents a different context and challenges, this review is intended to present a snapshot of the situation for people with disabilities in and around urban areas of Sierra Leone. It also acts as a point of comparison with the Leonard Cheshire Disability Review, an annual survey and analysis about the lives of persons with disabilities in the UK.

Leonard Cheshire Disability is extending this research series to other countries to get a clear sense of the day-to-day challenges facing disabled people around the world. These reports are intended to provide vital evidence for use by advocates and policy makers alike in their efforts to bring about change. They will also assist development actors and service providers to plan and implement their programmes better based on evidence from the field.

Sierra Leone was chosen as the location for the first report for a number of reasons: Leonard Cheshire Disability has had a strong operational presence in the country for over a decade, and local Leonard Cheshire Disability partner organisations have been active there for over fifty years. Sierra Leone suffered a decade of civil war in the 1990s, and despite numerous international interventions, remains at the bottom of the list of all countries in terms of its development indicators. Our research generated data on the living conditions in Sierra Leone today and compares everyday life for people with and without disabilities. The results from this pilot survey may be used as a benchmark against which future changes in the lives of persons with disabilities in Sierra Leone can be measured and assessed.

This report presents results from a pilot survey undertaken in five selected locations across the country between June and July 2009. 424 respondents were randomly selected in 11 villages in 6 out of 14 districts in the country. These districts were almost all in and around urban areas, and because of this, and the small sample size, these results cannot be extrapolated to the entire country. Nevertheless, the survey identifies interesting trends in a wide range of key areas, including education, employment, health and social participation, and provides a snapshot of the experiences of persons with disabilities.

Finally, the Government of Sierra Leone has now both signed and ratified the United Nations Convention of the Rights of Persons with Disabilities (UNCRPD). This pilot survey can assist them in ensuring that policies are designed to be effective for persons with disabilities in a context of limited resources, as well as highlighting particular gaps in the provision of resources, services and policies.

Methodology

In order to be able to measure and assess the situation of the lives of persons with disabilities, a set of pre-existing methodological tools have been tested which can be further adapted and used in other countries. These tools allow comparison across different geographical and demographic conditions, as well as between persons with disabilities and non-disabled persons over time. They also enable comparison between countries to gain a broader global understanding of the lives of persons with disabilities.

Disability In and Around Urban Areas of Sierra Leone

It is well established that disability is fluid, contextual and is understood differently by different people in different cultures (Groce 2006). Nevertheless, for many people, being identified as 'disabled' can lead to stigma and discrimination for themselves and their families. This has led to debates about how to gather information on disability in an unbiased manner, which can meet the growing calls for more statistical information and disaggregated data about persons with disabilities. This has also led to the challenge of ensuring that the data collected reflects the discrimination and exclusion highlighted above, and that the information collected and analysed is seen from a rights-based perspective and addressed as a human rights issue. These challenges have led to a great deal of work being done on the issue of defining disability, which in turn can support household surveys and data collection. Without such data, there is a real risk that many long-held assumptions and stereotypes will be perpetuated, and that there will be little real change taking place in the lives of persons with disabilities.

Such research goes beyond mere definitions and can bring about greater clarity regarding the many ways in which persons with disabilities are excluded or discriminated against. Without initial identification of disability, however, it is difficult to make quantifiable statements about such exclusion. In light of this, the screening process undertaken in this survey relies on a set of modified questions based on the Washington Group set of questions and the WHODAS II, as well as on the 'limitations of functionings' as considered in the capability approach (Sen, 1999; Trani and Bakhshi, 2008).

The disability screening tool allows for the identification of 'difficulties' in functioning and an assessment of the degree of difficulty experienced. By using the term 'difficulty' the often negative connotations associated with the word 'disability' are avoided. This ensures a wider chance of the inclusion of all persons with difficulties, including those with mental illness, other mental health issues or multiple difficulties that are often excluded from surveys due to stigma and prejudice.

Six dimensions of activity limitation and body functioning difficulties were screened for: physical difficulties or mobility restrictions, sensory difficulties, learning and developmental difficulties, behavioural difficulties, mood and affect difficulties and neurological difficulties. Whilst a few questions could be answered with a direct 'yes' or 'no', most were answered according to a Likert scale scoring from 1-4 ranging from 'no difficulty' (1) to 'yes, always have difficulties' (4). In order to reduce the number of false-negative responses, it was decided to set the screening to identify any person in a household who scored 2 or more as a 'person with difficulties'.

For the analysis, two categories were identified: those persons with mild to moderate difficulties and those with severe to very severe difficulties. The latter includes all respondents who answered that they often have or always had difficulties in response to at least one of the 35 screening questions.

Results show that 83% of the sample respondents had no difficulties at all, 17% of respondents experienced some degree of difficulty, ranging from some to constant. Of these, 2.2% of respondents experience very severe difficulties in terms of functioning or activity limitations. Most of the analysis focuses on the differences in access to services, and participation in livelihood and social activities observed between people without difficulty and those facing severe or very severe difficulties. In fact, as discussed at greater length below, the circumstances of people with mild or moderate difficulties show little difference to those of people without difficulties.

The use of these screening tools allows for a more nuanced identification of both experiences and the potential barriers to full participation in society through the identification of difficulties.

The assessment tool has been developed and tested in previous surveys in Darfur and Afghanistan (Trani and Bakhshi 2008). Moreover, data collection using such tools can be undertaken by enumerators who have undergone training, but do not have to have any specialist skills.

In addition to the screening tool, the survey included a household module which collected basic demographic information on the composition of the household. A household was defined as a group of people living together, sharing resources and income as well as eating together and using a communal kitchen. Data gathered included name, sex, age, marital status, duration of stay in the household and desire to stay permanently, place of origin and reason for moving. Information on employment situations, school attendance, educational achievements and income were also collected for the entire household in this section.

A further set of questionnaires – modules 3-7 were administered to persons who scored 2 and above in the screening module. These modules asked questions on employment, such as type of work, duration of employment and so forth (module 3); education, including questions on numeracy and literacy, access and attitudes (module 4); health, including questions on reproductive health (module 5); livelihoods, including questions on income (module 6) and social participation, including questions on community activities (module 7).

A house to house survey using a disability screening tool was undertaken to ensure that a greater range of respondents with all types of disabilities were reached than might be the case by specifically targeting person with disabilities directly (for example through disabled people's organisations) or by word of mouth. In these types of surveys there is the very real possibility of an over-emphasis on one impairment type (disabled people's organisations are often impairment-specific, particularly in developing countries such as Sierra Leone) or, for example, if the village head deems someone as not suitable for interview.

The survey was carried out in five different districts across Sierra Leone by the Leonard Cheshire Centre for Disability and Inclusive Development at UCL (LCD-UCL), in close collaboration with the Leonard Cheshire Disability West Africa Regional Office (WARO).¹ The data collection was concentrated in and around urban areas because of limitations in funding, time and travel restrictions during the rainy season. Household clusters were selected on the basis of census data (2004). In total, 2,189 respondents completed the household questionnaire (module 1) and screening tool (module 2); and 427 adults (over the age of 18) completed the full set of modules (modules 3-7).

Findings

This section highlights some of the most striking findings from the full report. It is noted at the outset that conclusions presented here are specific to populations in and around urban areas in Sierra Leone. It is hoped that future study will be expanded to collect data from rural areas as well, but for now, these findings are relevant specifically in and around urban areas:

Employment

- Only one third of disabled respondents of working age are in employment.
- Unemployment is significantly higher among people with severe or very severe disabilities.

¹ These were Freetown; Bo; Kono; Kabala and Makeni. Full ethical clearance has been obtained from the UCL Research Ethics Committee for the survey, and all participants were required to sign a consent form.

Disability In and Around Urban Areas of Sierra Leone

- 69% of disabled people of working age report having no income at all.
- 28% of disabled people live in households which report having no income at all. This compares to 20% of non-disabled households.

Education

- The reported level of access to school and literacy rates are similar for persons with disabilities and those without in and around urban areas.
- Of those surveyed, 50% of disabled female respondents and 34% of disabled male respondents have never attended school.
- Only 55% of girls with severe disabilities aged 6-18 years have attended school.
- A higher proportion of respondents with severe or very severe disabilities do not believe education is useful – 11.9% compared with under 3.4% of non-disabled respondents. This reflects assumptions about the value of education, lack of opportunities and prospects for the future for persons with disabilities.
- More than double the number of non-disabled people, compared to disabled people (22.9% and 10.5%) believe that education will improve their chances of getting a job.

Health/Reproductive Health

- Only 14% of disabled respondents have access to improved sanitation.
- One in four respondents with severe or very severe disabilities declared being in poor or very poor health.
- Over twice as many – 16.4% – people with disabilities have no access to health care compared to 7.1% non-disabled people.
- 19.5% of disabled people who are able to access health care are unsatisfied with the health care available to them compared to 6.3% of non-disabled people.
- As an average, persons with severe or very severe disabilities spent 1.3 times more on health expenditure than non-disabled respondents.
- More women with disabilities have never been pregnant (37.3%) compared to non-disabled women (13.5%). Women with disabilities have also had fewer children. However this still means that a majority of women with disabilities, 62.7%, will have one or more pregnancies in their lifetimes.
- There is very limited state provision of assistive devices (wheelchairs, eye glasses, hearing aids and so forth). In almost all cases, even if assistive devices have been provided by a voluntary organisation, there is some cost associated with them that places such devices beyond the means of many of the poorest persons with disabilities.

Livelihoods

- 64.7% of Sierra Leonean families living in and around urban areas own their houses.
- A higher percentage of respondents with severe or very severe disabilities report that they only eat one meal a day.
- There is no significant difference at the household level in livelihood assets and wealth between disabled and non-disabled households in Sierra Leone.

Access to services

- The majority of all respondents interviewed reported being in need of services (82.9%)
- Two thirds of all respondents interviewed consider family and friends to be their main support in life. But more respondents with severe or very severe disabilities also consider religious organisations as an important resource in case of need.

Social participation

- 19% of all Sierra Leoneans interviewed have community responsibilities, and there is no significant difference in community responsibilities according to whether the individual has no disability or a mild, moderate or more severe disability.
- 39% of respondents with disabilities reported that they do not participate in social events because they have been discriminated against or assume that other members of the community would not accept them.
- More respondents with disabilities report being bullied and are 2.7 times more likely to experience physical abuse and/or rape than those with no disabilities.
- All the respondents, whether disabled or non-disabled reported that they believe disabled people should have the same rights as other Sierra Leoneans, which reflects an important positive finding upon which future policies and programs can be built.

Conclusion

This pilot survey presents a snapshot of the current situation in and around urban areas of Sierra Leone for persons with disabilities. It corroborates many of the assumptions held about the lives of persons with disabilities – such as the higher degree of unemployment, limited social participation, difficulty in accessing health care and greater levels of violence and abuse. It also shows low levels of confidence and aspiration among disabled people, such as the many who doubt the value of education for their future.

Presenting a comprehensive profile of Sierra Leoneans with disabilities is a fundamental step towards identifying the challenges that lie ahead for policies and programmes. It is particularly timely as the government of Sierra Leone has recently ratified the United Nations Convention on the Rights of Persons with Disabilities and is in the process of drafting a National Disability Act.

Gathering data on income, employment, education, health, livelihoods, vulnerability, and poverty provides the necessary information to assist with policy formulation and strategic planning. Evidence-based knowledge and the participation of people with disabilities are vital to the design of equitable and inclusive policies and strategies for Sierra Leone. It is hoped that the findings of this report, by highlighting the current status and opinions of persons with disabilities as well as identifying some of the gaps in service provision, provide useful information to all those who campaign for the rights of disabled people in Sierra Leone within both government and civil society.

Chapter 1

Introduction and Methodology

1.1 Study background

This is the first in an anticipated series of reports looking at issues related to persons with disabilities in different countries where Leonard Cheshire Disability works. These reports are intended as a companion to the UK Leonard Cheshire Disability Review, an annual survey and analysis about the lives of persons with disabilities in the UK. Sierra Leone was chosen as the location for the first report for a number of reasons: Leonard Cheshire Disability has had a strong presence in the country for over a decade, and Leonard Cheshire Disability's partner organisations have been active there for over fifty years. Sierra Leone suffered a decade of civil war in the 1990s and, largely due to continued economic instability, is still considered a conflict-affected fragile state. Despite numerous international interventions, Sierra Leone remains at the bottom of all development indicators – it is ranked lowest (179th) in the UNDP Human Development Index (2008).²

This report presents results from a pilot survey undertaken in five selected locations across the country between June and July 2009. The survey focused on a number of key areas, including education, employment, health and social participation, in order to gain a snapshot of the lives of persons with disabilities living in Sierra Leone.

The results are aimed at policy makers, advocates, development actors and service providers to assist them in better planning and implementation of their programmes based on evidence from the field. It is also intended that this survey be a benchmark against which future changes in the lives of persons with disabilities in Sierra Leone can be measured and assessed. Finally, the Government of Sierra Leone has now both signed and ratified the United National Convention of the Rights of Persons with Disabilities (UNCRPD). It is hoped that this survey will assist them in ensuring that policies are designed to be effective for persons with disabilities in a context of limited resources.

The main goals of this study were:

- To gain a broad understanding of the lives, everyday experience and living conditions of persons with disabilities in Sierra Leone
- To develop a set of methodological tools that can be easily adapted and used in other countries in future, allowing an improved tool for accurate data collection that will facilitate better policy development, advocacy and service delivery both in-country, and for comparison between countries.

The present report provides a snapshot view of the situation of disability in Sierra Leone. Some assumptions are made to explain the gap observed between persons with and without disabilities. Additionally, more research is needed to explore the associations between employment, education, social participation, poverty and disability.

² <http://hdr.undp.org/en/statistics/>

1.2 Country Context

Sierra Leone is a West African country bordering Guinea to the northwest and Liberia to the east.



Source: Encyclopædia Britannica

The most recent census was conducted in 2004, and recorded 4,976,871 persons. The population is evenly distributed among the four regions of the North, West, East and South in 14 districts, subdivided into 150 chiefdoms and 12 wards. Whilst the majority of the population lives in rural areas, over 15 per cent of all people live in the Western Urban Area, which includes the capital city, Freetown. The population is almost equally Christian and Muslim; although a number of other religious and traditional beliefs are also practiced. The male/female ratio is 940/1,000. What is perhaps most striking is that almost 45% of the population is aged between 0-14 years, and the median age is 17.5 years.

A decade of civil war officially ended in Sierra Leone in 2002 after the signing of the Lomé Peace Accords. Despite initial early economic recovery, mainly fuelled by foreign aid, mining investments, remittances and investments from the expatriate community, Sierra Leone remains a chronically poor country. Its health and nutrition indicators are among the worst in the world: average life expectancy is 42.2 years and the under-5 mortality rate is 282 per 1,000 live births. Over 70 % of the population lives below the poverty line, and is mostly concentrated in rural, semi-rural and urban areas outside of the capital, Freetown. Unemployment and underemployment rates remain high across the country.³

International development aid to Sierra Leone currently totals around US\$ 244.6 million annually and is distributed among a wide range of projects including rehabilitation of basic educational structures, health sector reconstruction and development, infrastructure development projects and improving power and water supplies. Budget support is provided by several international donors, including the World Bank, UK Department for International Development (DFID) and the

³ World Development Indicators, 2006.

<http://web.worldbank.org/WBSITE/EXTERNAL/COUNTRIES/AFRICAEXT/SIERRALEONEEXTN/0,,menuPK:367849~pagePK:141132~piPK:141109~theSitePK:367809,00.html>.

European Commission. The United Nations is still active in Sierra Leone, through the UN Integrated Office for Sierra Leone (UNIOSIL) and other UN agencies including UNICEF, UNDP and WHO also have a considerable presence. There are also many implementing NGO partners.

One outcome of the peace process was the instigation of the Sierra Leone Truth and Reconciliation Commission. However, many issues are as yet unresolved, including the matter of reparation and compensation for war-wounded and survivors. Possibly as a result of international attention in the post-war period, disability issues have become quite prominent across the country, as it has been well documented that rebels used deliberate amputation of limbs as a method of instilling terror in civilian populations. The government estimates the number of amputees to be anywhere in the region of 1,500 to 3,500 adults and children. Few have received any compensation, though many have been the beneficiaries of international NGO programmes.

1.3 Disability in Sierra Leone

There is little data about persons with disabilities in Sierra Leone. The studies that do exist lack verifiable statistical data and are methodologically weak (Census 2004) or have looked only at children (UNICEF, 2005). The UNICEF Multiple Indicator Cluster Survey (MICS) data for Sierra Leone shows that 24% of children were identified as disabled countrywide, whilst the 2004 census found a prevalence rate of 2.7% (adults and children). Such disparities in measurements raise questions about both the quality of the data collected and, the methodologies adopted (Altman 2001). These studies, however, all indicate that there is a large, under-served population of persons with disabilities, due to war, social, political and cultural barriers and poverty.

In addition to the numbers of people directly affected by the conflict, the general status of persons with disabilities in Sierra Leone is little understood. This includes those who may be psychologically traumatised by their experiences in the war, but who have yet received little, if any, support or services. Finally, little is known about persons with learning disabilities, mental illness and multiple disabilities who, in most countries are less likely to receive social support or services should these exist.

During the years of civil turmoil in Sierra Leone, many people with disabilities lacked support from the government or local and international agencies. Interestingly as a result, they formed their own support groups, many of which later developed into disabled people's organisations. The increased visibility of people with disabilities in the post-conflict phase has prompted growing awareness about disability rights, and in July 2009, the Government of Sierra Leone (GoSL) ratified the UNCRPD and Optional Protocol. Groups such as Leonard Cheshire Disability's Young Voices were instrumental in making this happen.⁴

The disability survey presented here builds a case for making existing poverty reduction strategies and wider development programmes inclusive for all persons with disabilities, and the need to take into account gendered, generational and geographical differences to ensure all inequalities are eliminated.

⁴ www.LCDisability.org/youngvoices

1.4 Methodology

The Disability Survey in Sierra Leone (DSSL) was designed as a pilot programme to develop methodology and tools to better understand the lives of people with disabilities in developing countries. It is intended to be a model upon which to base similar national 'snapshots' to facilitate cross-country comparisons in order to promote inclusive development. The survey is also an attempt to adapt and test additional methodological tools that have already been used in a number of countries (Trani and Bakhshi, 2008).

The data provides a working knowledge on the situation of persons with disabilities in Sierra Leone, based on both qualitative and quantitative data. It gives policy makers, advocates and service providers an overview of what it means to live with a disability in and around urban Sierra Leone today. It is hoped that this survey can also serve as an initial benchmark against which future changes in the lives of persons with disabilities in Sierra Leone can be measured and assessed.

The survey was carried out between June and July 2009 by the Leonard Cheshire Centre for Disability and Inclusive Development at University College London (LCD-UCL) in close collaboration with the Leonard Cheshire Disability West Africa Regional Office (WARO).⁵ It was conducted in five different areas of Sierra Leone: Freetown (Western urban area); Bo (Southern area); Kono (East); Kabala (North) and Makeni (Central area). Clusters in the towns were randomly selected based on the 2004 census Enumeration Areas (EAs). In each area between one and five EAs were visited, which consisted of between 10 – 30 households, according to the area.⁶ In order to facilitate comparison between urban areas and areas around cities, a village near to each of the towns was also selected. Village selection was based on a number of criteria: accessibility (during the rainy seasons some villages are difficult to reach even with a four-wheel-drive vehicle); distance from areas where Leonard Cheshire Disability and its partners are active (risk of bias); and finally villages selected were not within a five-mile radius of a larger town. In each village, permission was obtained from the village chief before starting the survey⁷ and interviews were carried out in 25 randomly selected households.

This particular survey concentrated in and around urban areas because of limitations in funding, time and travel restrictions during the rainy season. Conclusions presented here are therefore specific to populations in and around urban areas in Sierra Leone. It is hoped that future study will be expanded to collect data from rural areas as well.

Data collection was carried out over a four-week period by a team of four data collectors, all of whom received a week-long training on disability issues, data collection, the questionnaire, coding and interview techniques. The questionnaires were checked for errors and inconsistencies in the field to reduce the occurrence of inaccurate and missing data. The data was double-entered by four data entry operatives after a two-day training period, and validated by researchers in Sierra Leone and the United Kingdom.

In each household Modules 1 and 2 (demographic and screening tools) were administered to the head of household, or another member of the household if the head of household was unavailable. Inclusion criteria for module 1 and 2 were whether the person was a member of the household,⁸ and willingness to participate in the survey. Modules 3 to 7 were subsequently

5 A full ethical clearance has been obtained from the UCL Research Ethics Committee for the survey, and all participants were required to sign a consent form.

6 Urban areas being more populous than villages around urban areas.

7 Permission was granted by every chief who was asked.

8 Defined as having lived in the household for at least 6 months.

administered to persons over 18 who were identified as having disabilities based on the screening questions, as well as a control person in each of the households to facilitate comparison. In circumstances when a person was unable to answer questions, a caretaker would answer the questions in the presence of the person. In cases where a person identified via the screening tool was unavailable or not at home at the time of the interview, an appointment was made to return at a later time. However, if on the subsequent visit, the person was again not at home the person was considered 'unavailable for interview' and excluded from the survey. Controls were randomly selected, but availability was considered and only those who were present at the time of the interview or on a recurrent visit were eligible as a control.

In total, 2,189 respondents completed the household questionnaire (Module 1) and screening tool (Module 2); and 427 adult respondents completed Modules 3-7. The entire survey consisted of a total of seven modules:

(1) Household file

The first module – the household file – collected basic demographic information on the composition of the household. A household was defined as a group of people living together, sharing resources and income as well as eating together and using a communal kitchen. Data gathered included name, sex, age, marital status, duration of stay and desire to stay permanently, place of origin and reason for moving. Information on employment situation, school attendance, educational achievements and income was also collected for the entire household in this section.⁹

(2) Disability screening tool

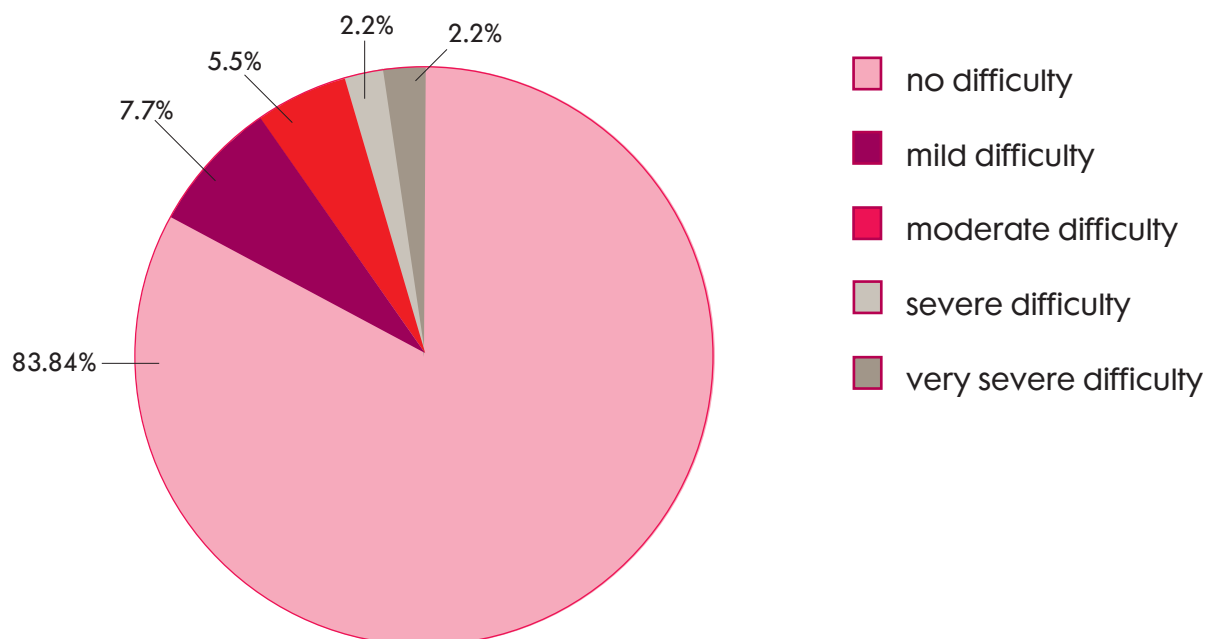
The disability screening tool allows for the identification of disabilities and an assessment of the degree of disability experienced. This ensures a wider chance of inclusion of all persons with disabilities including those with mental illness, other mental disorders or multiple disabilities that are often excluded from surveys due to stigma and prejudice. Six dimensions of activity limitation and body functioning 'difficulty' were screened for: physical difficulties or mobility restrictions, sensory difficulties, learning and developmental difficulties, behavioural difficulties, mood and affect difficulties and neurological difficulties. Such screening allows for a more nuanced identification of experiences and the potential barriers to full participation in society through the identification of disabilities. The assessment tool has been developed and tested in previous surveys in Darfur and Afghanistan (Trani and Bakhshi, 2008).

Figure 1 shows the distribution of the sample according to the level of difficulty as analysed from the 35 answers to the screening tool. Five levels of difficulty were defined based on the four choices given, ranging from 1 = 'No difficulty'; 2 = 'Some difficulty'; 3 = 'A lot of difficulty'; to 4 = 'Unable to do or constant difficulty'. According to the results, 83% of the sample respondents had no difficulties at all, 17% of respondents experienced some degree of difficulty, ranging from some to constant. Of these, 2.2% of respondents experienced very severe difficulties in terms of functioning or activity limitations.

For the purposes of this report, we have categorised those who scored over 2 in any question as having some degree of difficulty which may manifest as a disability. Those who had no difficulties, we have categorised as 'non-disabled'. Most of the analysis focuses on the differences in access to services, livelihood and social participation observed between non-disabled people and those having severe or very severe disabilities. In fact, the circumstances of people with mild or moderate difficulties show little difference with those of people without difficulties.

⁹ All data was anonymised on entry into the database.

Figure 1 Level of difficulty identified within households



(3) Education Module

The education module was comprised of 21 questions to assess literacy and numeracy, type of education facility attended, reasons for lack of education, difficulties around issues of transportation to school, financing education and issues with teachers and other students. It also addresses issues around the perceived usefulness of education for persons with disabilities, whether the person would like to go back to school, and, if so, what he or she would like to learn.

(4) Health Module

This module contained 18 questions around the themes of current health status, access to health care and reproductive health. Questions also included assessments of access to medical care, degree of satisfaction with the available care, health expenses and immunisations. Reproductive health issues covered included questions about sexual activity and behaviour, contraceptive use, access to maternal health services, access to health education and information and forced sexual intercourse.

(5) Labour and employment Module

The labour module asked about current and previous activities, income, difficulties in the workplace and job satisfaction.

(6) Livelihoods Module

This module covered issues such as access to water, shelter, living conditions, assets and land ownership, as well as access to services.

(7) Social participation Module

Questions here include degree of social participation and involvement in community life and social functions, in addition to wider issues of mistreatment and the rights of persons with disabilities.

Findings from these modules are reported in the following chapters.

Chapter 2

Employment & Income

2.1 Context

Unemployment is high in Sierra Leone, especially for youth. Youth unemployment, already high prior to the civil war, was exacerbated by the long years of war and lack of education and job opportunities.¹⁰ There was also specific concern in the immediate post-conflict period for unemployed ex-combatants (often former child soldiers) as it was surmised that poverty and under-employment in this group could fuel a potentially volatile situation.

As observed in other low income countries, employment is seen as an important path to autonomy for persons with disabilities, who are otherwise at a high risk of dependence on others, and have limited capacity to weather economic shocks, such as price increases or crop failure. Within a traditional context where family and community are the most important social groupings, financial contributions to the household are also a means of increasing social value and respect within the family. If employed, persons with disabilities can be regarded as contributors, not as liabilities, challenging many negative perceptions.

Remunerated employment is therefore key to understanding the economic experiences of persons with disabilities and their families. Furthermore, a more general understanding of the living conditions of persons with disabilities and their household helps identify barriers: these include displacement, housing conditions, nutritional status, access to credit, material possessions, inheritance, and participation in community, religious and political life, as well as perception of general living satisfaction.

This chapter assesses the level of income-generating activity in the households of persons with disabilities. Some of the research questions can help determine the degree of vulnerability of persons with disabilities, as well as the households in which they live. Analysis is made of the links between poverty and employment, as well as the impact of an unemployed head of household on the livelihood of a household. The results thus also shed more light on the impact of disability on the living conditions of the entire household unit.

2.2 Results

Figure 2 shows that respondents with severe or very severe disabilities find it more difficult to access the labour market – **just under one third of respondents with severe or very severe disabilities are working, while just over two thirds of respondents with no disabilities are currently employed.** Unemployment is significantly higher among people with severe or very severe disabilities (16.9% compared with fewer than 10.2% of people with mild to moderate or no disabilities).

¹⁰ Youth is defined as from 15 – 35 years old in Sierra Leone in order to reflect the post-conflict situation. Peacebuilding Commission Sierra Leone (2007) Informal Country-Specific Meeting: Discussion on Youth Employment and Empowerment (Summary Note of the Chair). Available on: <http://www.un.org/peace/peacebuilding/Country-Specific%20Configurations/Sierra%20Leone/May%2021%20summary.pdf>

As disability prevalence increases with age, over 13% of respondents who reported any disability fell into the category of 'too young/too old to work', compared with just 3.2% of non-disabled respondents. Figure 2 demonstrates that overall, the level of difficulty in accessing the labour market is higher for disabled than for non-disabled persons. The overall level of unemployment is slightly higher for persons with disabilities (12%) than for non-disabled respondents (9%).

Figure 2 Employment situation for adults (>17)

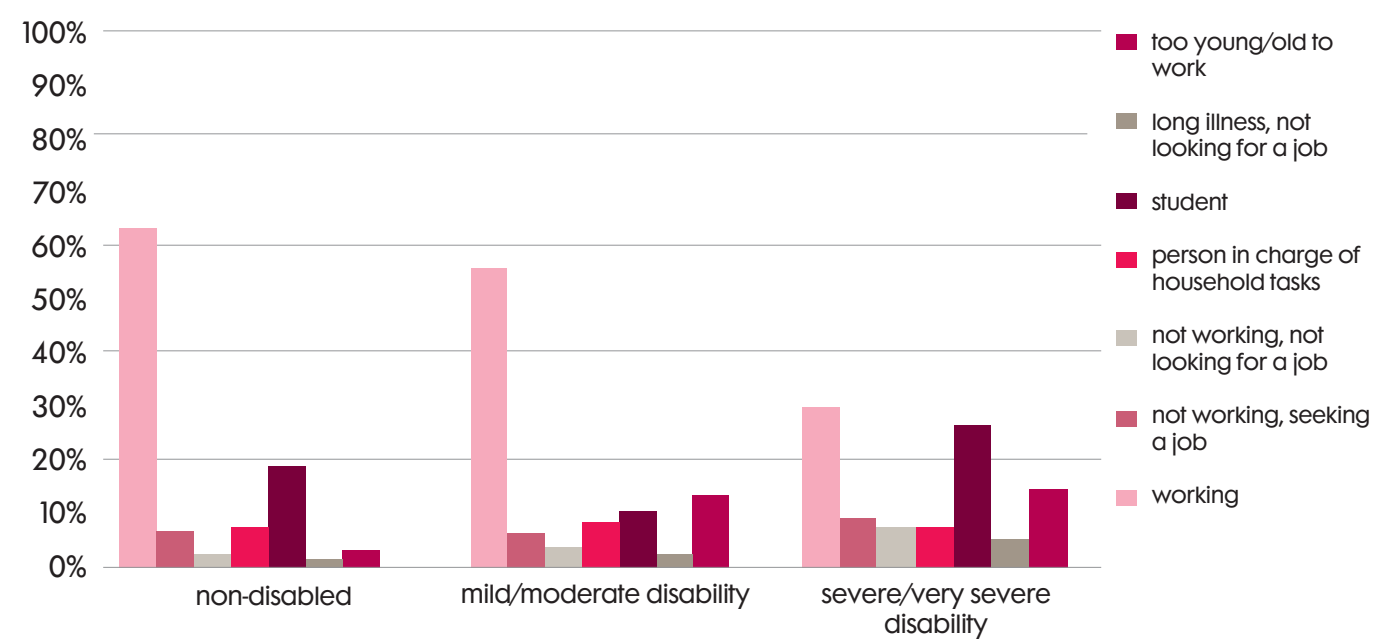
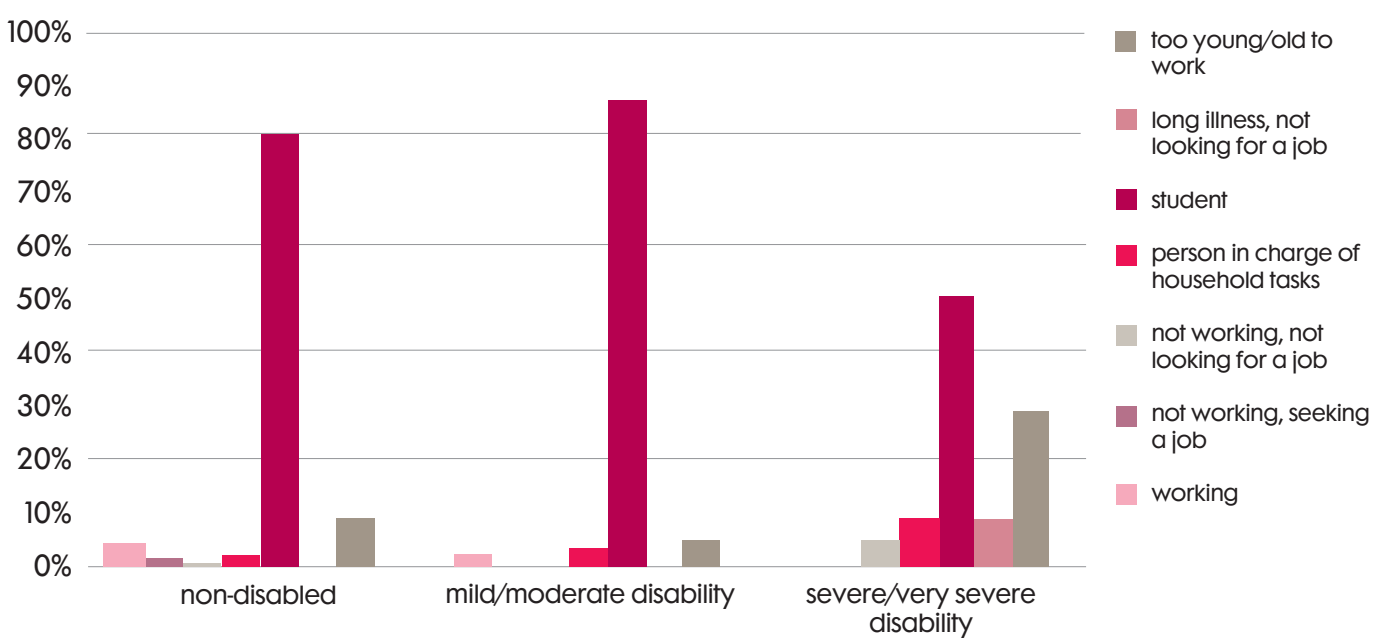


Figure 3 shows that none of the children with severe or very severe disabilities are working, compared with 3.7% of non-disabled children. Some children might be working part time while also going to school, but our data does not show this phenomenon as the pilot study was mainly limited to adults and only a few questions were asked to all members of the household, including children using the family module (see methodology section). Significantly more children with mild to moderate disabilities or no disabilities at all are students, and a higher proportion of children with severe to very severe disabilities are in charge of household tasks (8.3% compared with 2.8% of children with mild to moderate disabilities and 1.8% of non-disabled children). **This suggests that children with**

Figure 3 Children and work (Ages 5-17)



severe or very severe disabilities are more likely to be assigned or undertake household work than their peers, and are less likely to go to school or be employed.

Figure 4 shows that only 15% of working adults with severe or very severe disabilities are employed as farmers, compared with 37.4% of the rest of the respondents. There is very little difference in the percentage of active adults who have their own business – 37% of non-disabled respondents, 34.9% of respondents with mild or moderate disabilities and 35% of respondents with severe or very severe disabilities. The proportion of family helpers is higher among respondents with severe or very severe disabilities, as is the number who are employed by an NGO (5%, compared to 2.4% of non-disabled respondents).

Similarly, Figure 4 shows a significantly higher representation of people with disabilities in government jobs and in companies that are particularly concentrated in towns. The situation is probably very different in rural areas where farming is the main activity.

Figure 4 Employment status for active adults (>17)

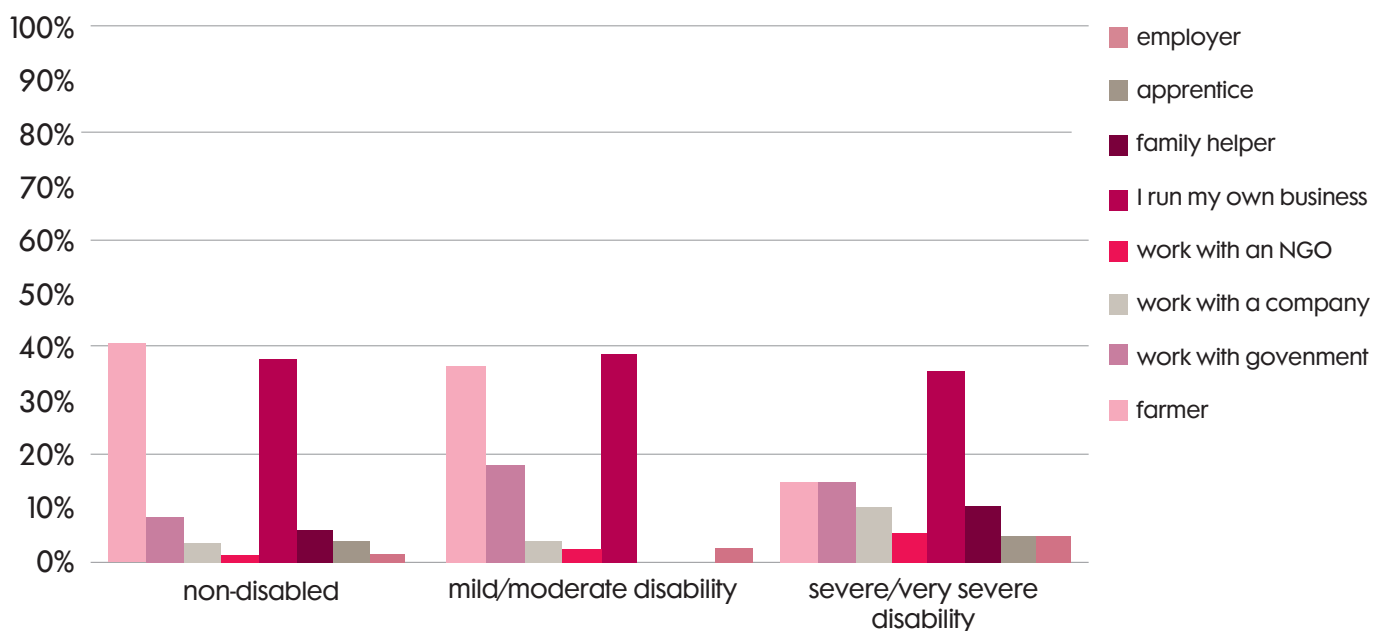


Figure 5 shows that 71.4% of non-disabled children are employed as farmers, compared with 50% of children with mild or moderate disabilities and none with severe or very severe disabilities. A much higher percentage of children with mild to moderate disabilities are employed as apprentices in and around urban areas (50% compared with 9.5% of non-disabled children). This may well be due to the availability and focus of NGO training programmes, or combined skills training, such as weaving or tailoring, and education programmes in towns. However, there were no cases found of children with severe or very severe disabilities who were employed.

Children with severe disabilities are often not included in development programmes in developing countries, especially in post-conflict states. The lack of social visibility of these children, prejudice and lack of knowledge among the population as well as aid agencies, explain this exclusion. Our findings probably are due to the fact that some of those at school are also working at the same time, but our questionnaire does not provide this information. Figure 5 also shows that more non-disabled than disabled children work on farms.

Figure 5 Employment status for active children (5-17)

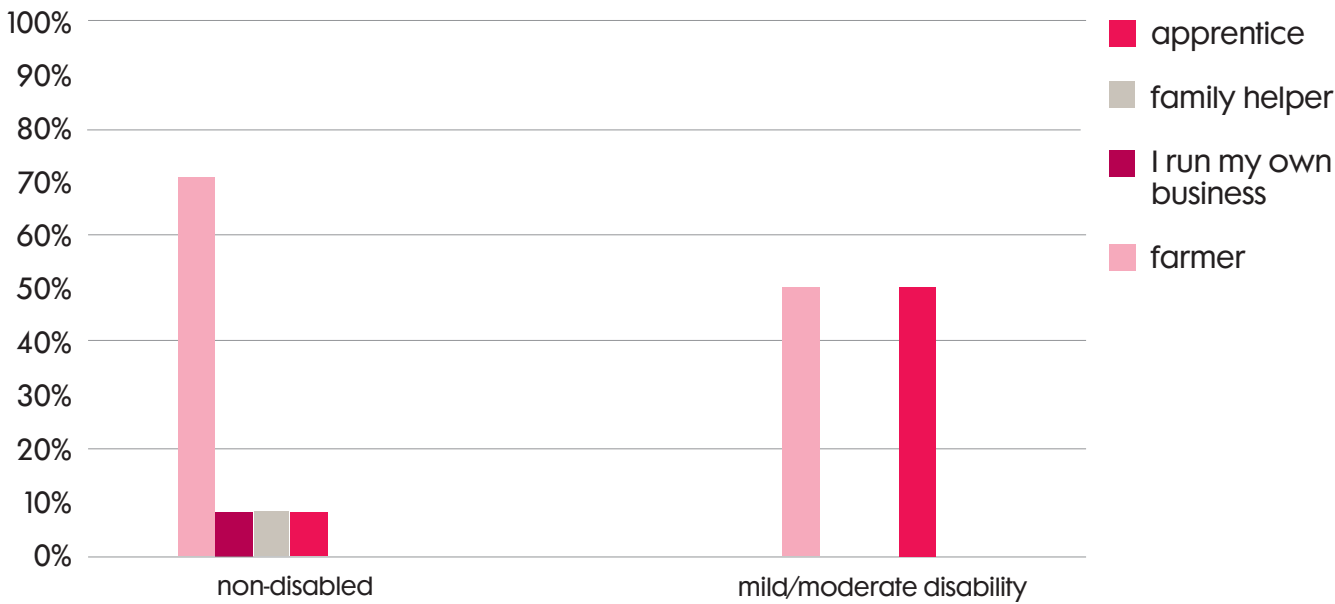


Figure 6 shows that over half of all the active adults interviewed do not experience any difficulty in the workplace, regardless of whether they are disabled or not. The only significant difference is that **a higher proportion of respondents with mild to very severe disabilities found their work overly tiring** (over 13.8% compared with 0.8% of non-disabled respondents). This may indicate that not enough reasonable accommodation or adaptation is being made to workplace environments or in working conditions for persons with disabilities. It could also indicate that those working have no option but to carry on even if they are tired due to lack of any other support mechanisms. Figure 6 demonstrates that adults with disabilities are more likely to face difficulties in their workplace than their non-disabled counterparts.

Figure 6 Difficulty in the workplace for active adults (>17)

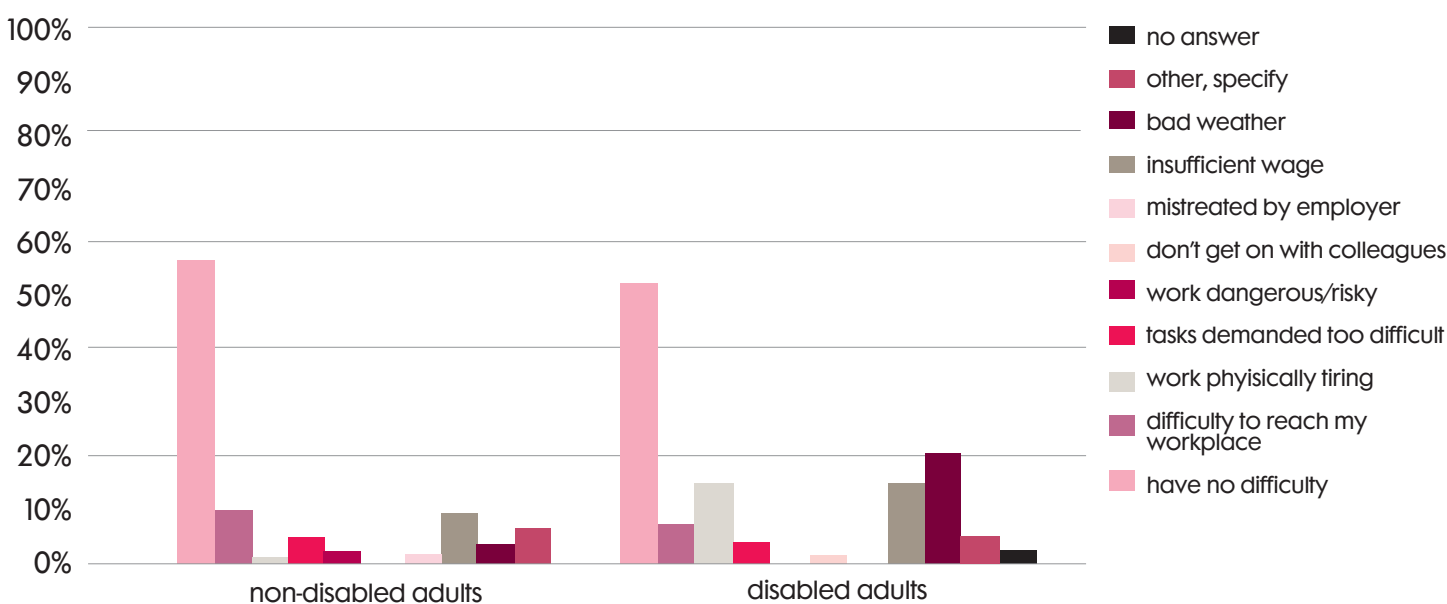


Figure 7 shows that the majority of all adults interviewed consider work to be important, although a higher percentage of adults with severe or very severe disabilities find work to be either unimportant or quite important (28.3% compared with 13% of non-disabled respondents and 9.6% of respondents with mild or moderate disabilities).

Figure 7 Importance of work for adults (>18)

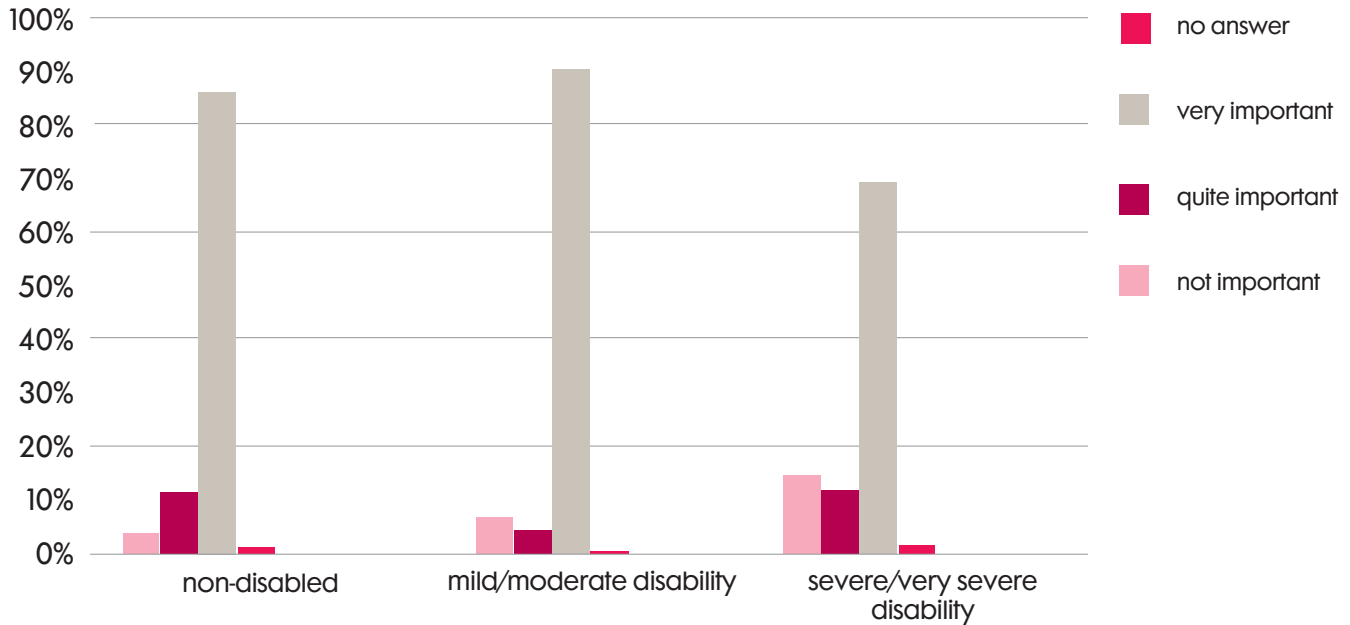
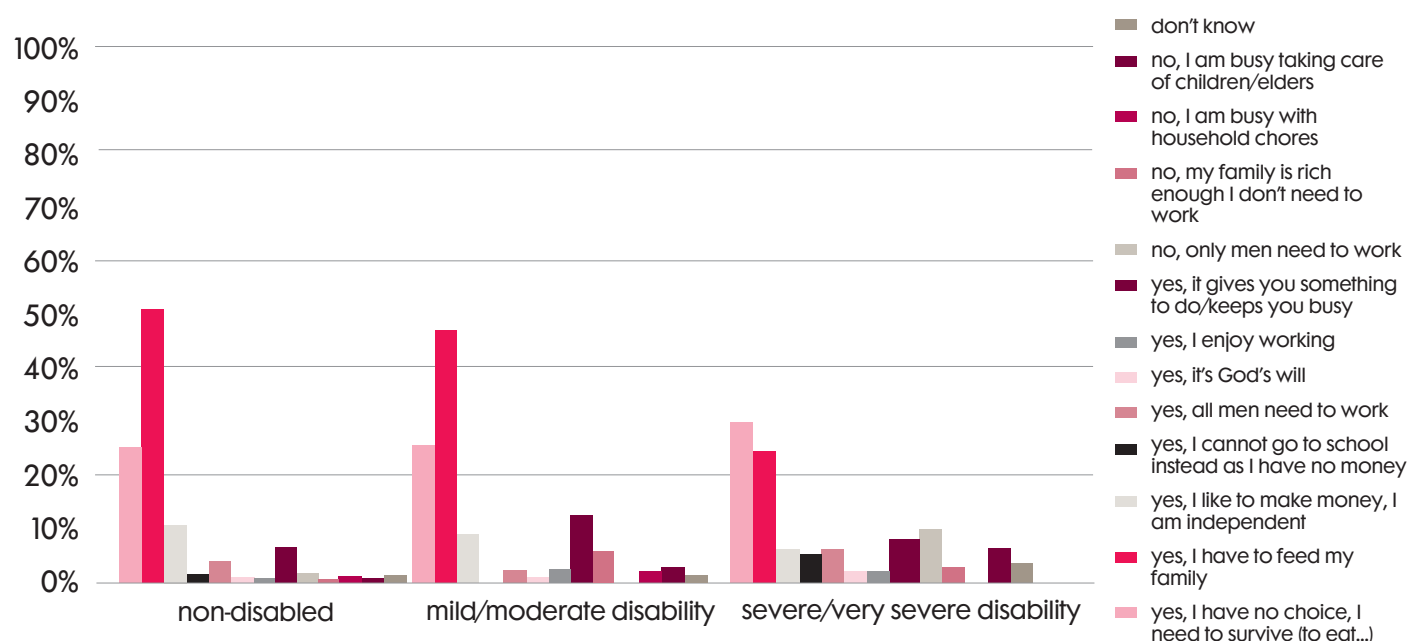


Figure 8 shows that more non-disabled adults and adults with mild to moderate disabilities believe work is important so they can financially support their families, while a slightly higher percentage of adults with severe or very severe disabilities believe work is important for their own survival. **More respondents with mild to very severe disabilities are busy with household chores than non-disabled respondents, which may give an indication as to what persons with disabilities are doing if they are not in remunerated employment.**

According to the survey, over two thirds of respondents with severe or very severe disabilities have no income, while just under one third of non-disabled respondents do not have an income (Table 1). 11% of respondents with severe or very severe disabilities fall within the highest income bracket, while 16% of non-disabled respondents and 31% of respondents with mild/moderate disabilities earn over SLL 150,000 monthly.¹¹

¹¹ One pound Sterling (£1.00) = approximately 5,926.82 Leones (SLL). Therefore SLL 1,800,000 = £307.45

Figure 8 Why is it important or not to work for adults (>18) [Based on 1st answers only]

Table 1 Percentages of respondents in monthly income categories

Respondent monthly income	no disability	mild/moderate disability	severe/very severe disability
No income	32%	36%	69%
under SLL 14,600	3%	3%	0%
SLL 14,601-60,000	26%	18%	8%
SLL 60,001-150,000	23%	13%	11%
SLL 150,001-1,800,000	16%	31%	11%

Table 2 demonstrates the effects of disability on household income. According to the survey:

- 28% of households where one member has a severe or very severe disability have no income.
- 20% of households where none of the members have disabilities have no income.
- 20% of households where members report no disabilities, or where one member has mild or moderate disabilities fall into the highest income bracket (over SLL 5,500,000).
- 18% of households with one member who has severe or very severe disabilities have an income of over SLL 5,500,000.¹²

The differences in income between households having a person with disability and those without are not too pronounced. This is similar to results found in Afghanistan and Zambia,¹³ and shows that **the link between disability and poverty may not be so much about material poverty, but relate more to other forms of deprivation, such as difficulty in accessing education, employment or health care services.**

¹² UK£940.22 at February 2010 exchange rate

¹³ Trani and Loeb (2010)

Table 2 Household monthly income

Household monthly income in quintiles	no disability	mild/moderate disability	severe/very severe disability
under SLL 20,000	20%	18%	28%
SLL 200,001-140,000	21%	19%	18%
SLL 140,001-250,000	20%	17%	17%
SLL 250,001-423,000	19%	26%	18%
SLL 423,001-5,500,000	20%	20%	18%

2.3 Conclusion

This chapter has focused on the employment and income situation of adults and children in Sierra Leone. The survey provides statistical verification of the fact that respondents with severe or very severe disabilities find it more difficult to access employment than respondents with mild, moderate or no disabilities – **only 29.6% of adults with severe or very severe disabilities are working, compared with 56.1% of adults with mild or moderate disabilities and 60.4% of non-disabled adults.**

Of the children included in the interviews, those with severe or very severe disabilities were less likely to go to school and more likely to stay at home and undertake household chores than their peers with mild, moderate or no disabilities. A higher proportion of non-disabled children than children with mild or moderate disabilities reported working on the farm. But a higher proportion of children with mild or moderate disabilities than non-disabled children were in apprenticeships. This may reflect the influence of NGO programmes, as an apprenticeship is one of very few options for a transition to employment for children who do not go to school. No child respondents with severe or very severe disabilities were working or in an apprenticeship. This means that such children were receiving no preparation, either through school or outside school, for being self-sufficient adults.

Similar trends were true for adult respondents with disabilities – a higher proportion were responsible for doing household chores and had no other professional activity (24%), and a lower proportion worked as farmers (15%). There was very little difference between the percentage of disabled and non-disabled respondents who owned their own businesses.

The survey also demonstrates that while over half of all active adults interviewed do not experience any difficulty in the workplace, regardless of whether they are disabled or not, **a higher proportion of respondents with mild to very severe disabilities found their work overly tiring (13.8% compared with 0.8% of non-disabled respondents).** This may indicate that reasonable accommodation or adaptation is not being made within the workplace environment or working conditions for persons with disabilities. It could also reflect the fact that those working have no option but to carry on even if they are tired due to lack of any other support mechanisms, including welfare structures. Clearly, the cost of providing social welfare support is currently difficult for the government of Sierra Leone given limited resources and competing demands, but is an important issue to address in future.

Both individual monthly income and household monthly income were measured by using data from the household file questionnaire and the labour module. **Figure 2 confirms significant urban**

unemployment in Sierra Leone – according to this study, an average of 40% of respondents are not working, while almost 20% are still at school or studying, and approximately 20% are either looking for a job or taking care of household tasks. However, a significant difference can be observed in monthly earnings of individuals. In Table 1, 69% of respondents with severe or very severe disabilities have no income at all, compared to 36% of respondents with mild or moderate disabilities and 32% of non-disabled respondents. The figures in the rest of the table highlight the fact that respondents with severe or very severe disabilities are the lowest earners – only 3% of these respondents are within the highest salary bracket, compared with 15% of respondents with mild or moderate disabilities and 7% of non-disabled respondents.

While disability also affects household monthly income, the differences are not as pronounced as in individual monthly income. **The percentage of households with no income is higher among households where one or more member has a severe or very severe difficulty.** But the difference in income quintiles between disabled and non-disabled households is limited. **This shows that disability has a larger impact on individual income, but a more limited impact on the whole household's income – although this may indicate that other people in the household have to earn an income to supplement this gap.** But it may also indicate that monetary income is not the sole or main factor creating differences between disabled and non-disabled people, unless there is a large difference in living standards within the household. More research is needed to explore this phenomenon.

Chapter 3

Education

3.1 Context

According to UNICEF, there are an estimated 300,000 children who do not attend school in Sierra Leone.¹⁴ Net primary school enrolment/attendance rates between the years 2000-2005 average 41% (UNICEF, MICS 2005). Children with disabilities are often marginalised and excluded within communities, and many of them face stigma and discrimination in school as well as low parental expectations. The present study evaluated the extent and nature of exclusion from school in Sierra Leone for disabled children – both the immediate consequences and the longer-term ramifications of such exclusion, such as lower levels of literacy, social participation and income.

Although an enormous effort has been made to send children to school since the conflict, there is still a long way to go to ensure equitable access between disabled and non-disabled girls and boys. Access to school for all children, including all disabled children in rural areas, is also an issue but our results and conclusions here are limited to urban areas and the areas around them. The difference in access between disabled girls and disabled boys is also of concern.

Surprisingly, in contrast to results found in other countries, our findings show that the **level of access to school and literacy rates are similar for persons with disabilities and those without in and around urban areas**. However it should be strongly noted that access for both groups is low. Figure 9 shows that there is little difference in literacy rates between non-disabled respondents and respondents with mild to very severe disabilities. Over half of all respondents **cannot read, write or count**. Our results also show that a huge effort will be required to bring the new generation of both disabled and non-disabled children to school, as half of the previous generation – those who are adults now – did not access school.

Figure 9 Literacy rates

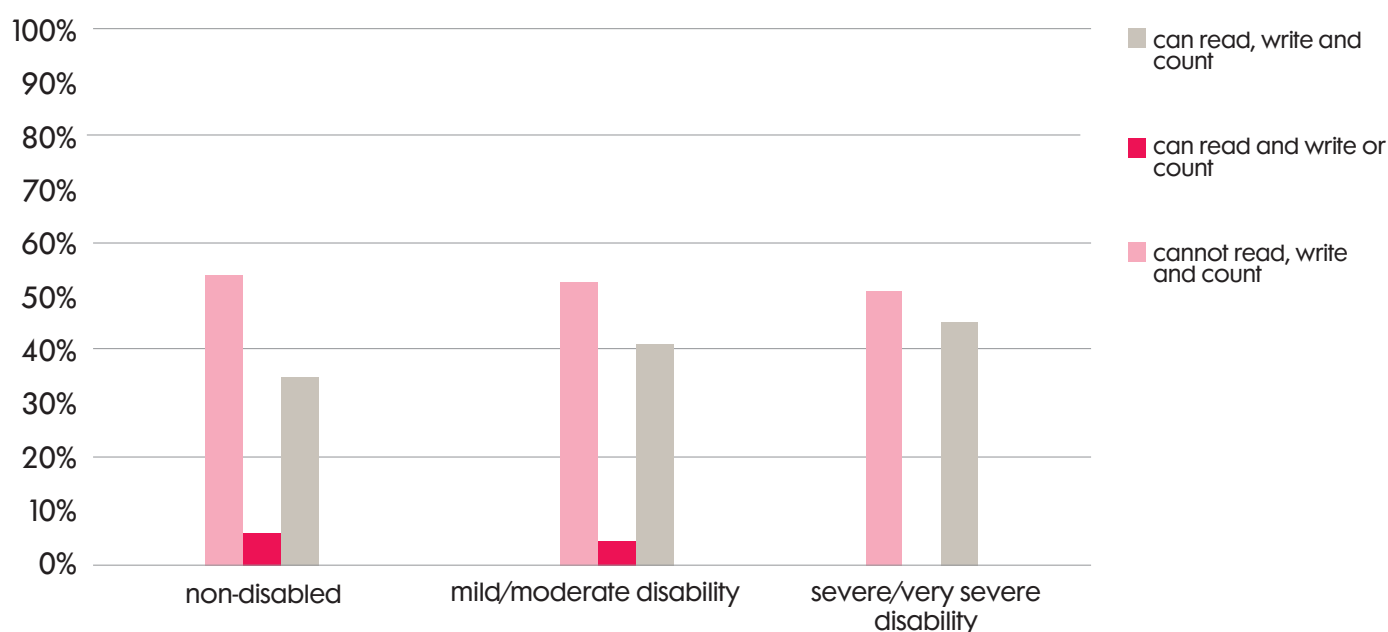
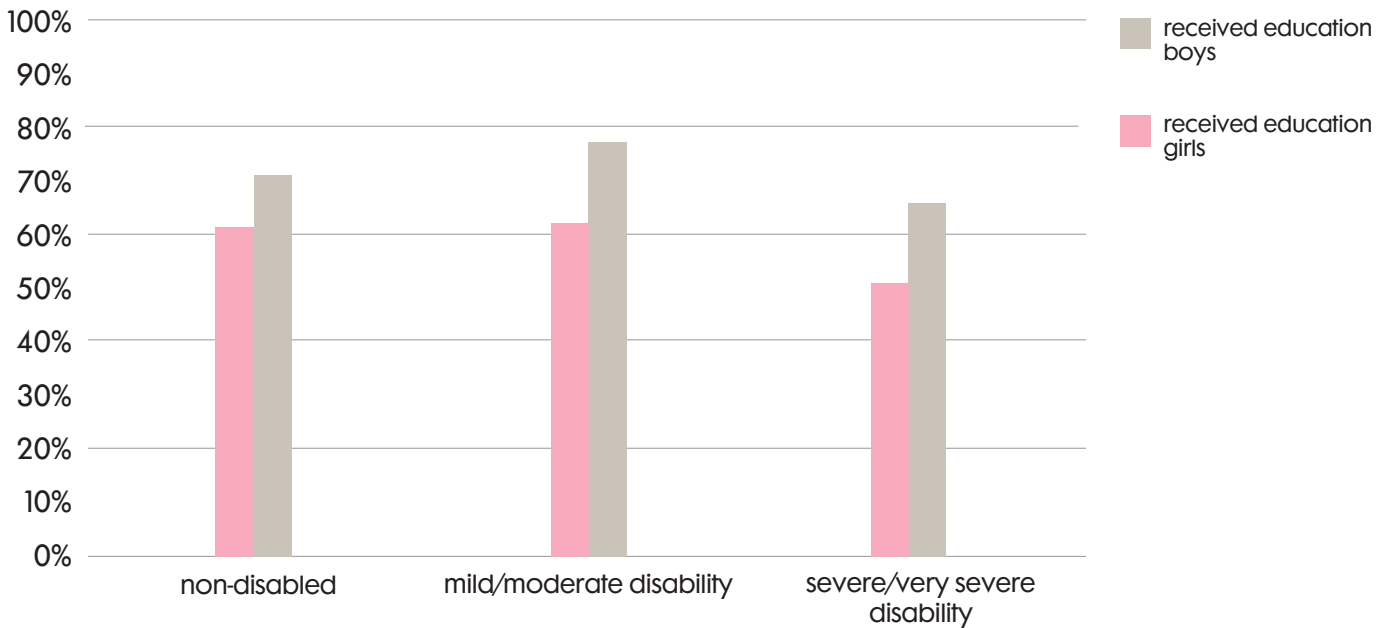


Figure 10 shows very little difference in school attendance whether people have disabilities or not. Overall, more men have received an education than women, and **50% of women of all ages with severe or very severe disabilities have not received any education.**

Figure 10 Access to school according to disability and gender (>6)



Note: Figures 10 and 11 show both differences in attendance between girls and boys with and without disabilities, and the relative percentages of boys and girls attending school.

Figure 11 shows that a significant effort has been made since the end of the conflict to include all children into schools. This effort has also benefited boys with severe disabilities between 6 and 18 years old, as 86% of them have had some access to school in and around urban areas. **Yet only 55% of girls with severe disabilities in the same age group (6-18 years) attend school.**

Figure 11 School attendance according to disability and gender (6-18)

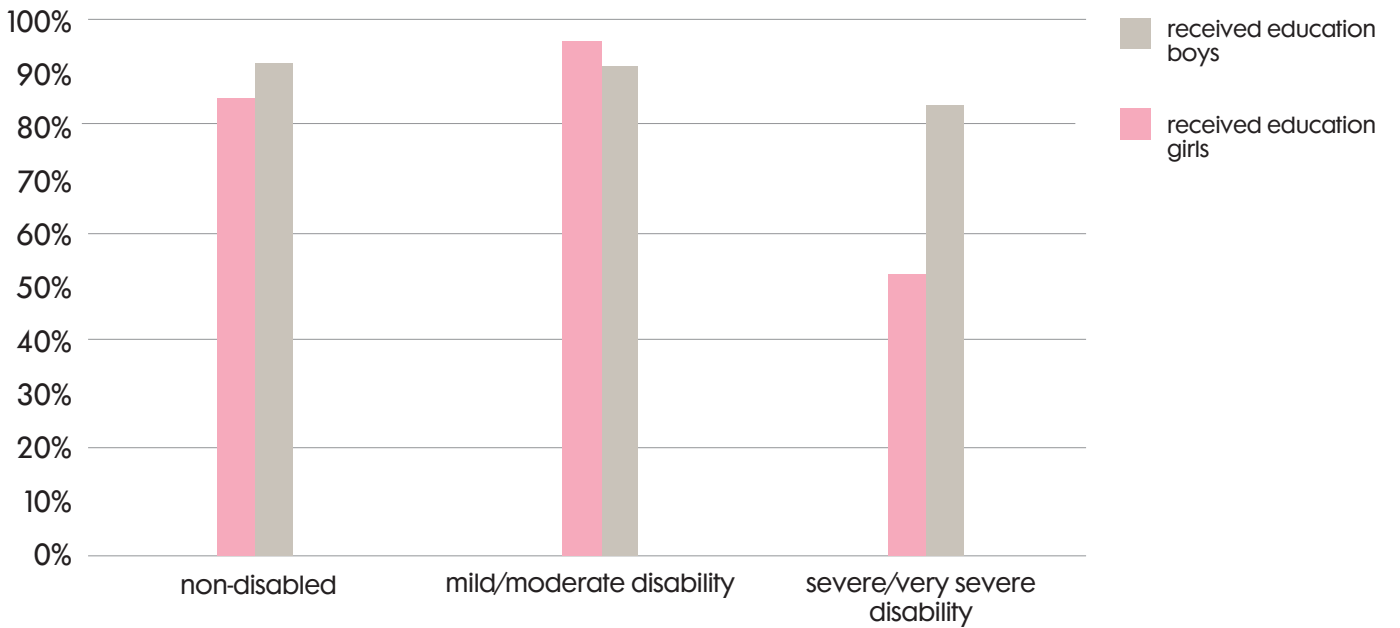


Figure 12 shows very little difference between disabled and non-disabled respondents in the type of school they attended. On average, 45.3% of adult respondents attended government schools, while 46% received no education. **A slightly higher percentage of respondents with severe or very severe disabilities attended religious schools, private schools or professional training centres, compared with other respondents.**

Figure 12 Type of school attended (adults >17)

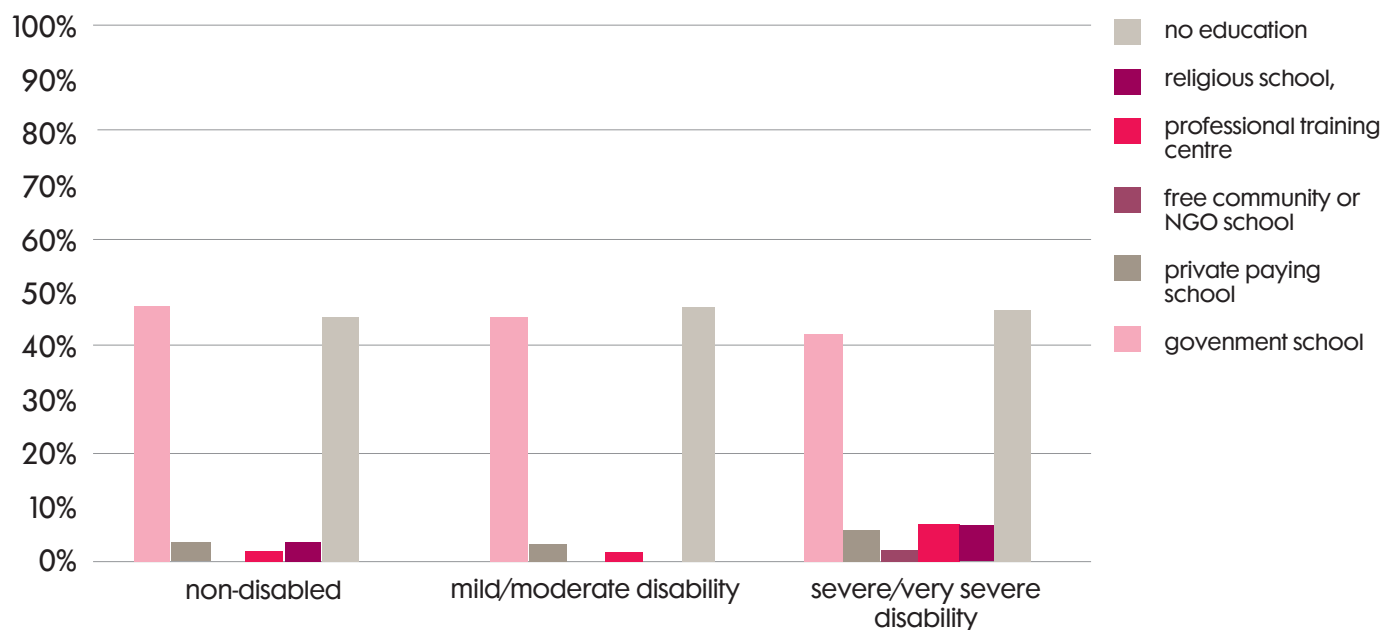


Figure 13 shows that, in general, girls attend school for a shorter time than boys and do not access higher levels of education at comparable rates to boys. In particular, more boys than girls received secondary and tertiary education. This is the case for both non-disabled and disabled children.

Figure 13 Highest educational qualification

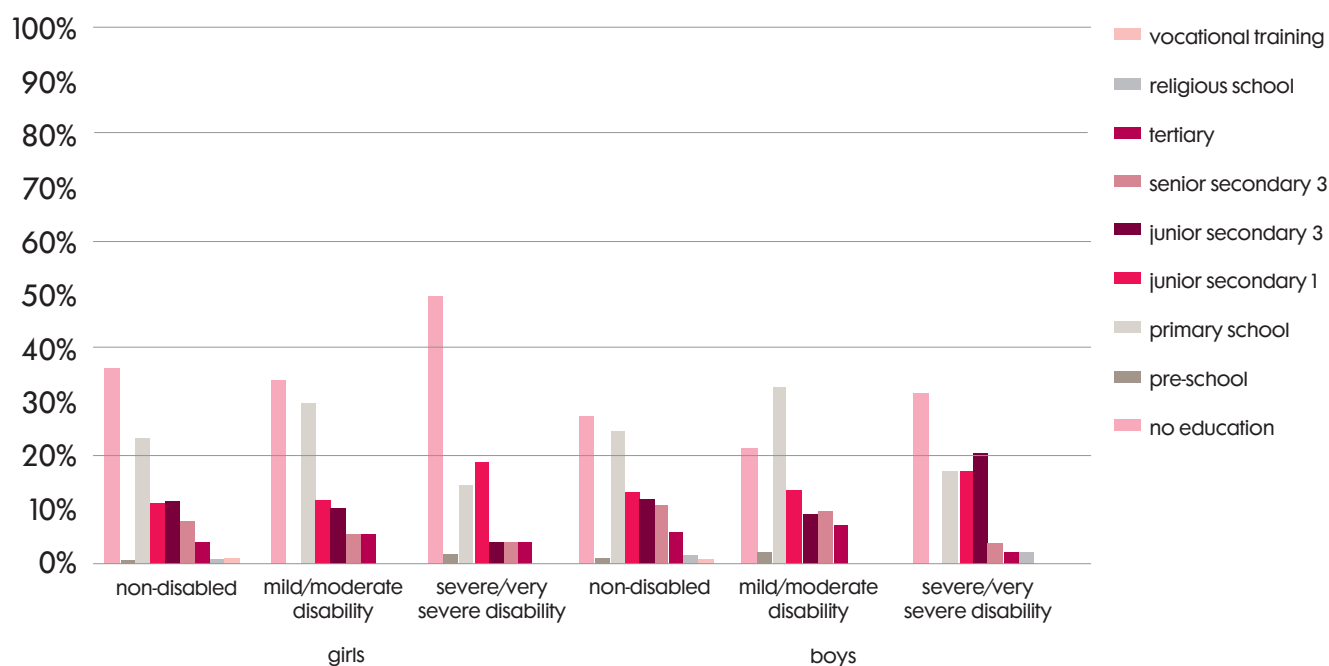
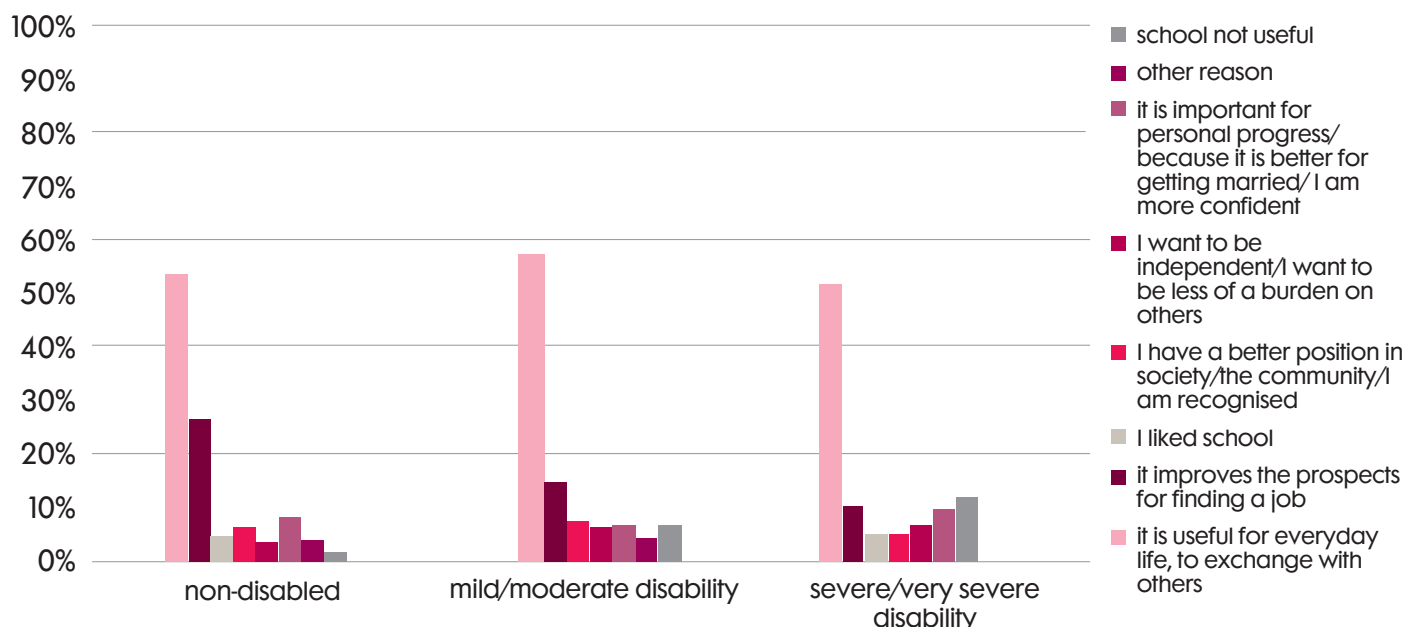


Figure 14 shows that over half of all respondents believe education is important because it is useful for everyday life. A higher proportion of non-disabled respondents believe education will improve their prospects of getting a job (22.9%, compared with 14.3% of respondents with mild or moderate disabilities and 10% of respondents with severe or very severe disabilities). **However, it is notable that a significantly higher percentage of respondents with severe or very severe disabilities believe school is not useful (11.9%, compared with 3.2% of other respondents).**

Figure 14 Attitude to education



3.2 Conclusion

Chapter 3 investigates literacy rates among respondents, as well as access to education and attitudes to education. In some of the results, data has been disaggregated by gender to highlight the differences in access to education for both disabled and non-disabled girls and boys.

Our findings show that over half of all respondents are illiterate, and there is very little difference in literacy rates between those with disabilities and those without. In and around urban areas of Sierra Leone, around 46% of respondents did not go to school at all. **This corresponds to data in Figure 10, which demonstrates that there is little difference in access to education between disabled and non-disabled boys, though overall, boys have better access to education than girls, particularly to secondary and tertiary education.** As UNICEF reports, more concerted effort is still required to improve access to education for all children, in addition to ensuring parents understand the value of education, especially in rural areas where attendance rates are lower (UNICEF, 2005). Furthermore, in this study, we only asked whether children had access to school. The study does not provide information about drop-out rates or on the quality of education received by disabled children who are in school. Clearly, however, the quality of education received once disabled children enter school is an important issue that needs to be further monitored and evaluated.

There is very little difference between disabled and non-disabled respondents in the type of school they attended: 45.3% attended government schools. However, Figure 13 also shows that 50% of girls with severe or very severe disabilities did not attend school, compared with about

37% of girls with mild, moderate or no disabilities, and compared to 34.1% of boys with severe or very severe disabilities.

A higher proportion of respondents with severe or very severe disabilities do not believe education is useful – 11.9% compared with 3.4% of other respondents. This, perhaps, reflects assumptions by people with disabilities about the value of education and their prospects for the future, which may be corroborated by the fact that a higher proportion of non-disabled respondents believe that education will improve their chances of getting a job (22.9%) compared to only 10.5% of respondents with severe or very severe disabilities.

Chapter 4

Health & Reproductive Health

4.1 Context

Health indicators for Sierra Leone are characteristic of a country that has been affected by a decade of war: life expectancy at birth is 39 years old for men and 42 years for women. The probability of a child dying before his or her fifth birthday is 282 per thousand live births – one of the highest rates in the world (WHO, 2006). A major cause of infant mortality is malnutrition, and, according to WHO, 'acute respiratory infections, pneumonia, diarrhoeal diseases, typhoid fever, HIV/AIDS and tuberculosis are the other major causes of morbidity and mortality' (WHO, 2007). Access to safe drinking water, improved sanitation and efficient health care services are the main priorities for the health sector.

4.2 Access to improved sanitation and improved water source

Figure 15 shows that **only 14% of the whole sample population have access to improved sanitation** (less than the figure of 39% used by WHO in 2007). A higher percentage of respondents with mild to very severe disabilities use a private flush toilet facility than non-disabled respondents, though this may be because we surveyed mainly urban areas. Nevertheless, there is not a great deal of difference in the type of toilet facility used between the three groups – on average 80% of respondents use a traditional pit latrine.

Figure 15 Type of toilet facility

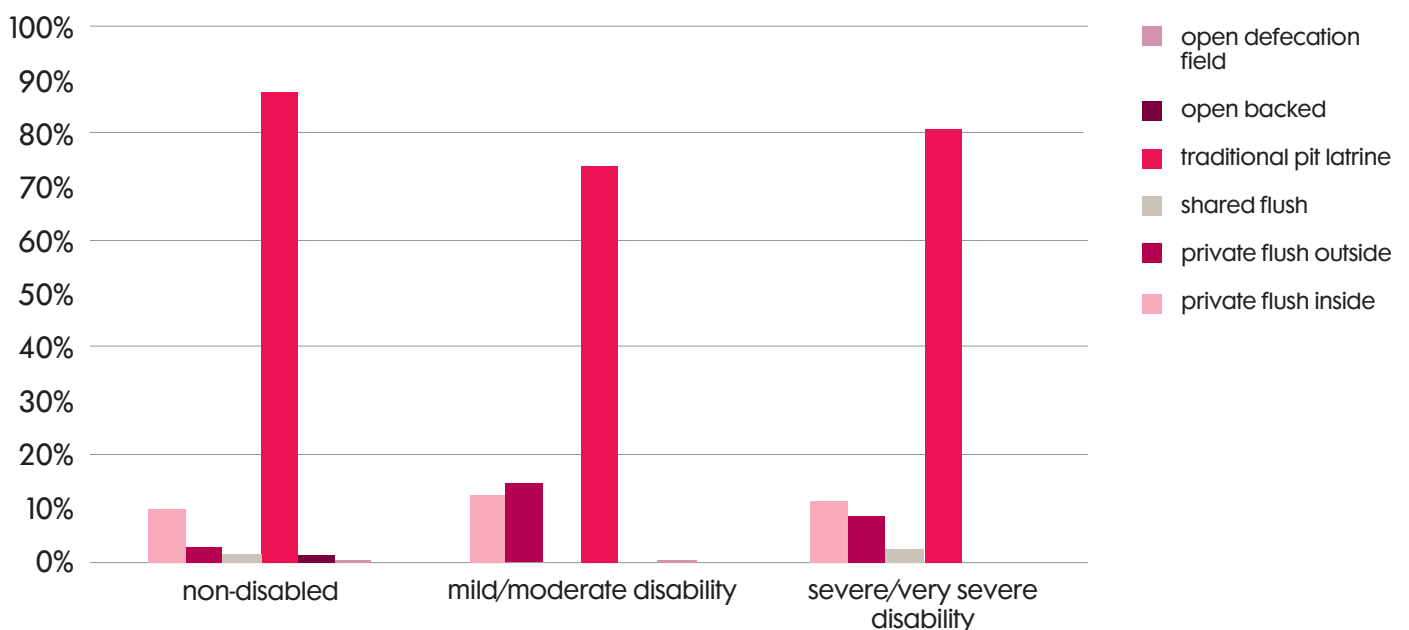


Figure 16 shows **there is almost no difference in access to safe drinking water between the three groups in and around urban areas**. On average, 87.9% of respondents said they had access to safe drinking water. But these figures have to be compared to those in figure 17 showing that access to a water pump or pipe is much more limited: only 58.4% have access to a relatively safe source of drinking water, either pipe or pump (similar to the 57% figure advanced by WHO 2007).

Figure 16 Access to safe drinking water

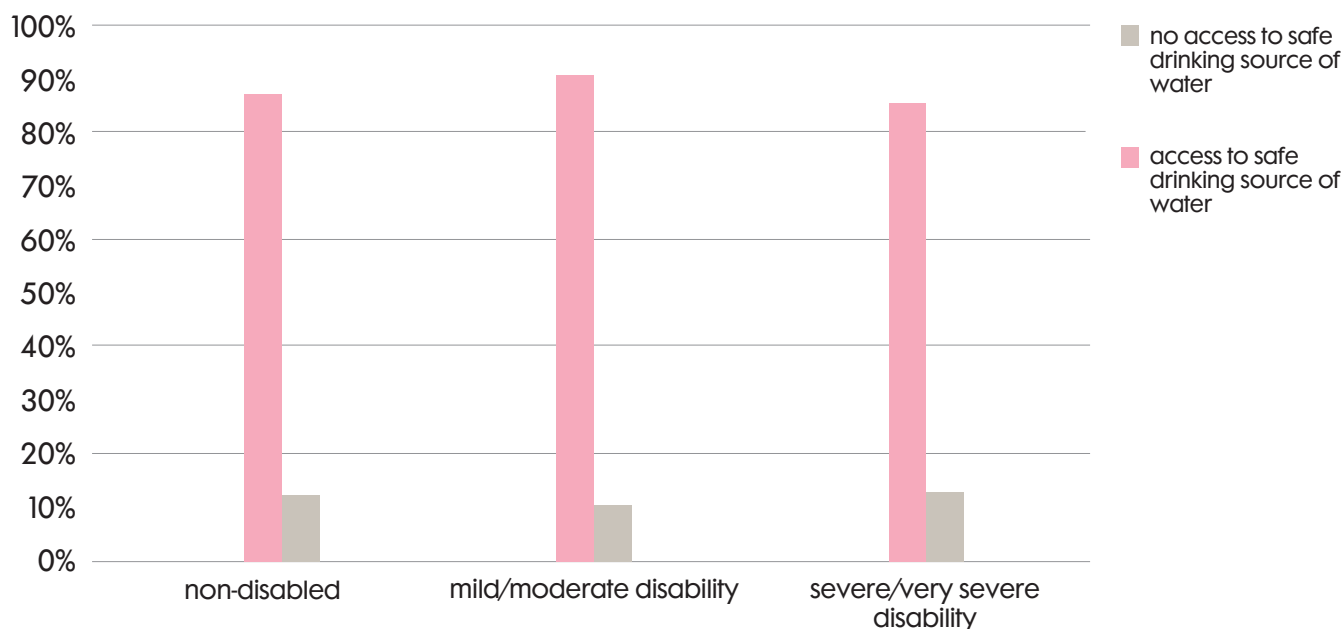


Figure 17 shows that there is little difference in the main source of drinking water between the three groups of respondents. Almost 45% of respondents with severe or very severe disabilities reported that their main water source was within their residence, plot or compound, compared to 38.9% of respondents with mild or moderate disabilities and 28.5% of non-disabled respondents. Non-disabled respondents accessed public sources of drinking water more than respondents with mild to very severe disabilities. In and around urban areas, rain water and river water are not used because wells and pumps are widely available.

Figure 17 Main source of drinking water

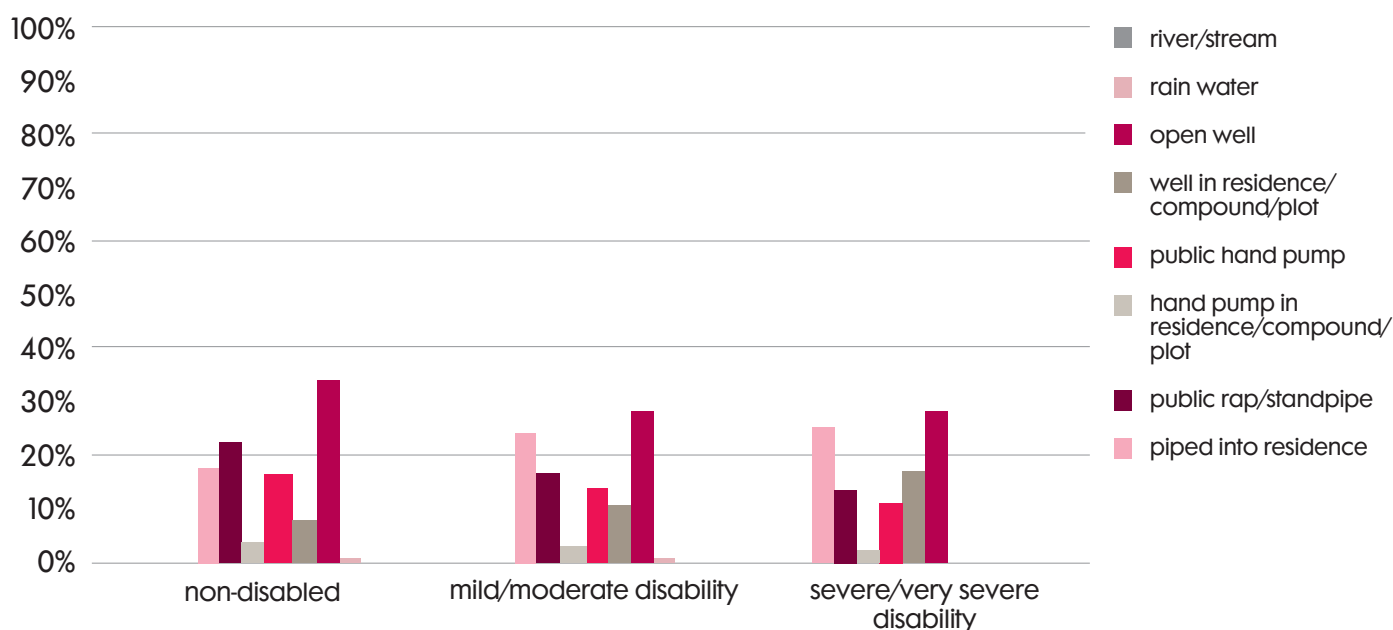
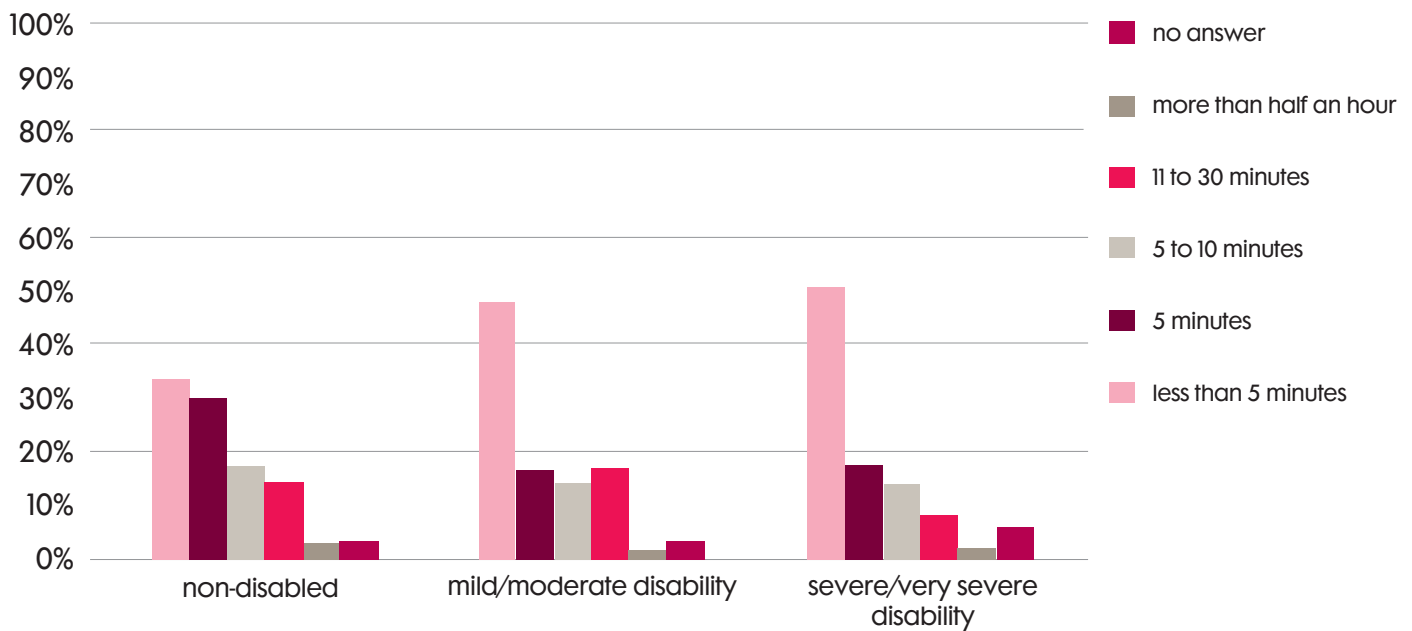


Figure 18 shows that on average, it takes less time for respondents with severe or very severe disabilities to fetch water than non-disabled respondents. This corresponds with the data in Figure 17, showing that more respondents with severe and very severe disabilities have access to a safe water source within their residence, plot or compound. This may reflect the urban setting itself, or the fact that households with more severely disabled members put money into better access to water sources than other households. We assume that, most likely, persons with more severe disabilities are just not expected to fetch water too far away from the house, so the question does not reflect a common activity for them.

Figure 18 Time to fetch water (one way trip)



4.3 Health care access and cost

Figure 19 shows that more respondents with no disabilities describe themselves as being in good health than respondents with mild to very severe disabilities do, and none of the non-disabled respondents describe themselves as being in very poor health. **The highest percentage of respondents who are in very poor health have severe or very severe disabilities.**

Figure 19 Health status

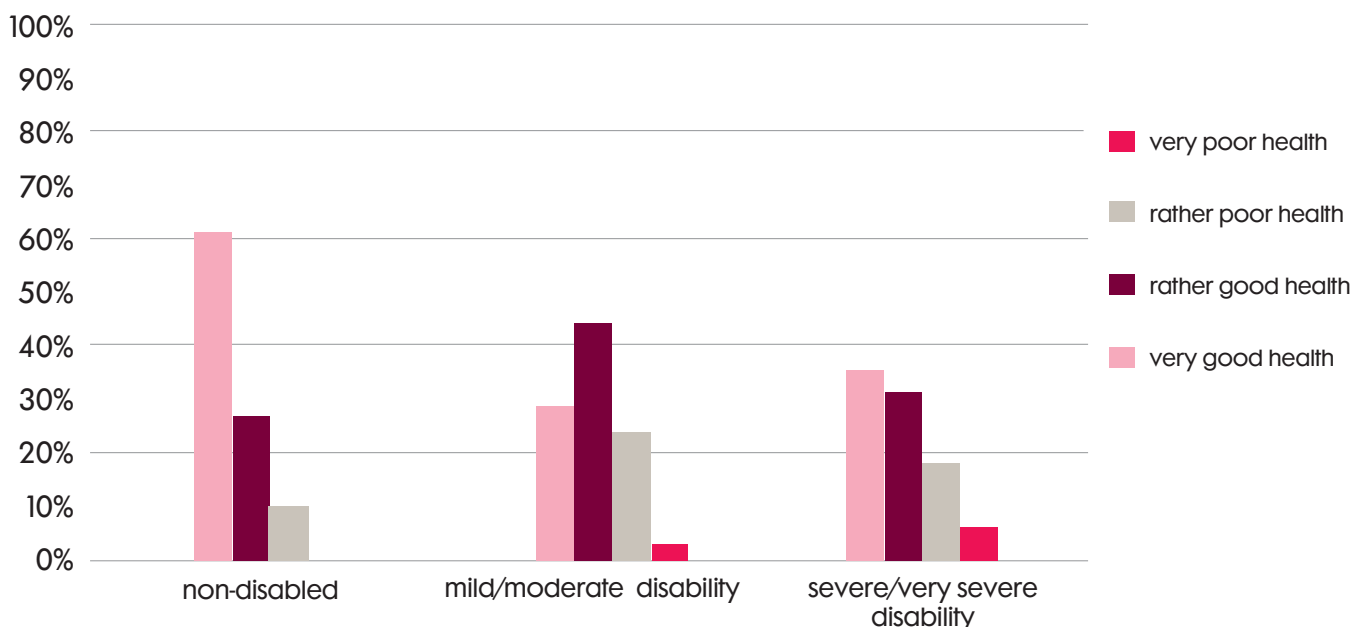


Figure 20 shows that while the majority of respondents have access to some sort of health care, **16.4% of respondents with severe or very severe disabilities said they have no access to health care, compared with only 2.3% of non-disabled respondents and 7.1% of respondents with mild or moderate disabilities.** This may reflect the availability of health care facilities in and around urban areas. It may also reflect lack of accessible transportation to health care facilities for persons with mobility impairments, lack of accessibility to the facilities themselves (including lack of ramps, sign language interpreters and so forth), and/or lack of willingness on the part health care staff to treat persons with disabilities who come to these facilities. It may also reflect the belief on the part of some community members that little or nothing can be done to improve the health of persons with disabilities once they have become disabled.

Figure 20 Access to health care

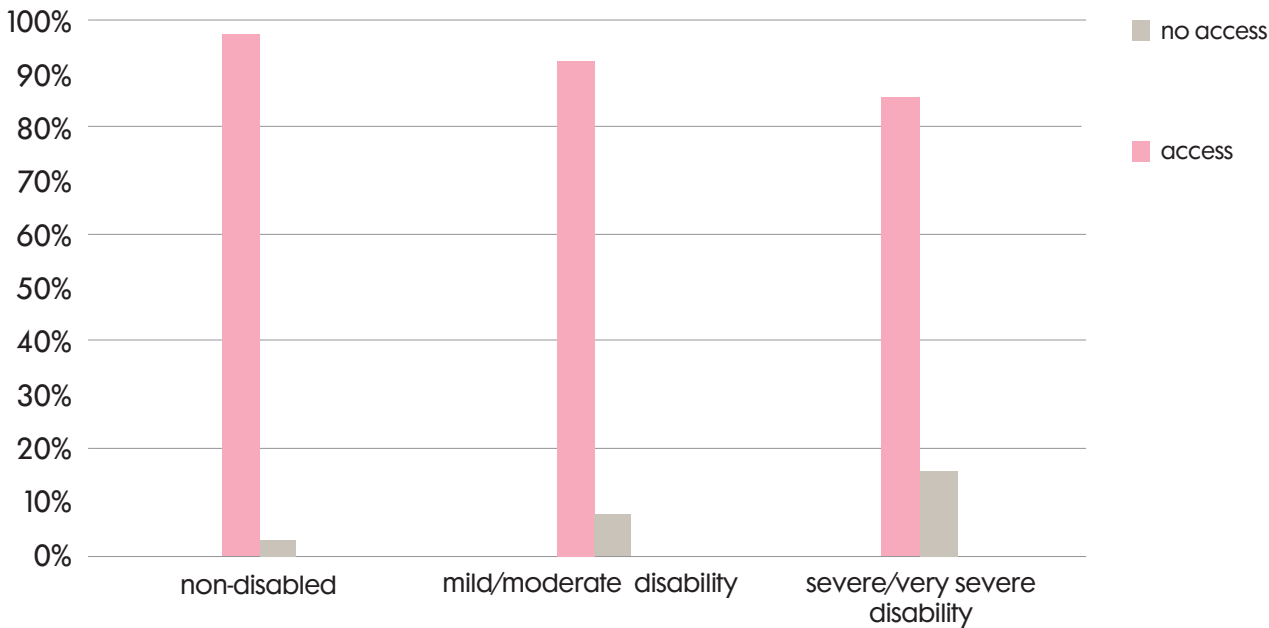


Figure 21 shows that non-disabled respondents were more satisfied with the health care they receive than respondents with mild to very severe disabilities; **19.5% of respondents with severe or very severe disabilities are unsatisfied with the health care they receive, compared with 6.3% of non-disabled respondents.**

Figure 21 Perception of health care

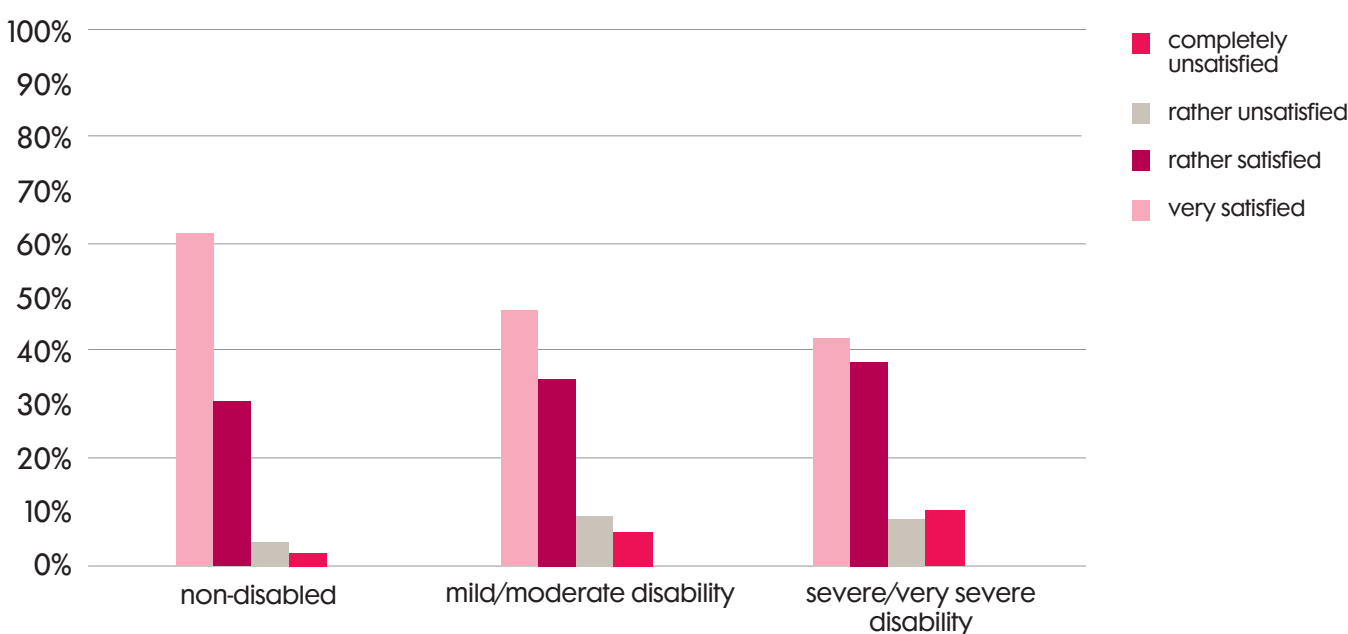
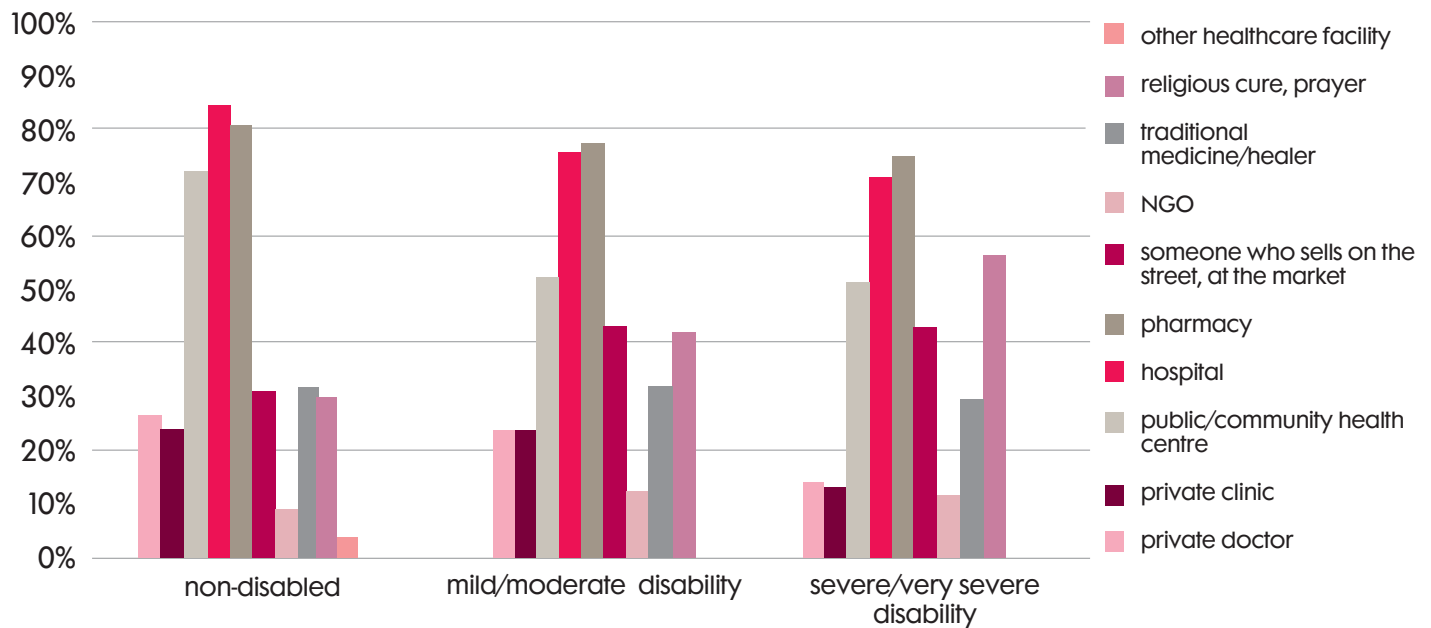


Figure 22 shows that the most widely available health services are hospitals, pharmacies and public/community health centres. More non-disabled respondents find health centres, hospitals, private doctors and clinics to be available (85.1%, 72.9% and 54.2% respectively, compared to 70.2%, 53.7% and 29.8% of respondents with severe or very severe disabilities). There does not seem to be a significant difference around availability of other health care providers. It is interesting to see that a higher percentage of disabled people go to practitioners who offer religious prayer and cure. This probably reflects the lack of awareness about possible benefits for persons with disabilities available through modern medicine. It may also reflect the stigma attached to coming forward with a disability in a public forum, such as a local hospital or clinic.

Figure 22 Health care services available



Note: The figure gives the proportion of respondents who use each type of health care provider.

Figure 23 demonstrates a slight difference between immunisation levels of respondents: 74.6% of respondents with severe or very severe disabilities had been immunised, in comparison to 88.1% of non-disabled respondents.

Figure 23 Level of immunisation

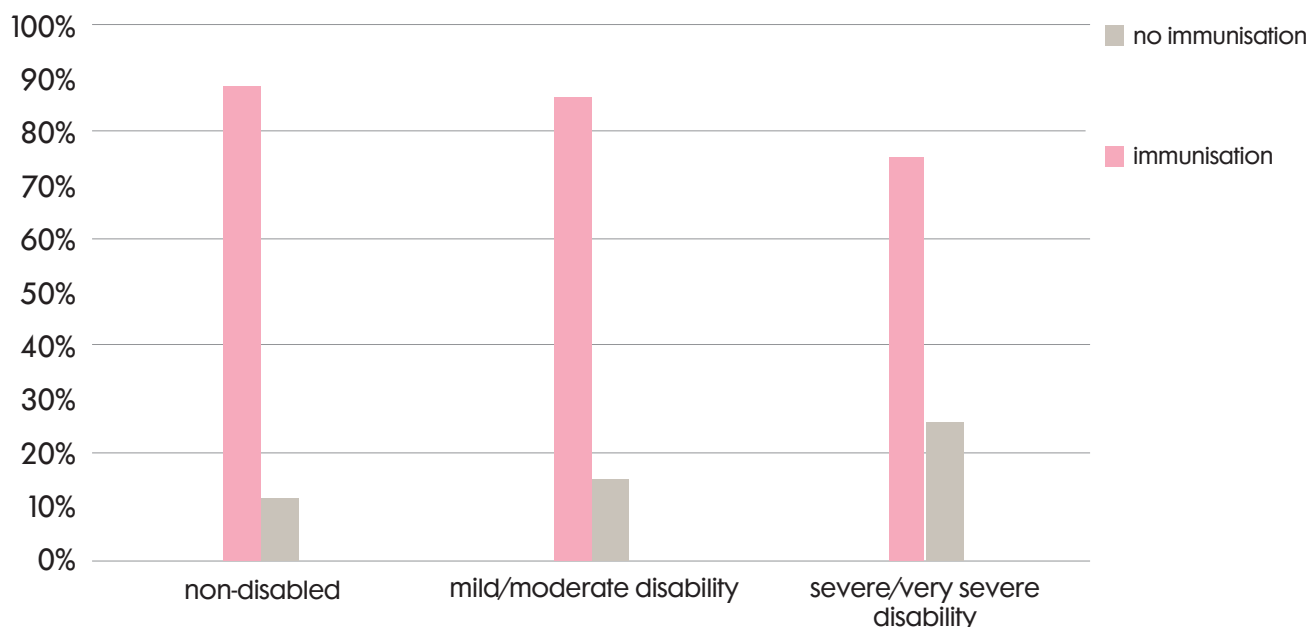


Figure 24 shows that in terms of expenditure linked to health, **85% of respondents spent some money on medication, 61% of them on transportation, 50% on medical tests and 43% on fees.** The only significant difference in terms of type of expenditure between the number of persons with disabilities and the number of non-disabled people is for transportation, and for assistive devices:

- 61.9% of respondents with mild or moderate disabilities and 46.3% of respondents with severe or very severe disabilities spent money on transportation compared with 61.4% of non-disabled respondents. The inaccessibility of transportation probably explains why severely and very severely disabled people spent less on transportation than non-disabled respondents.
- 5.6% and 4.5%, respectively, of respondents with mild or moderate disabilities and with severe or very severe disabilities spent some money on assistive devices (for instance: wheelchairs, crutches, hearing aids, eyeglasses), while none of the non-disabled respondents spent anything on such devices.

Figure 24 Type of Health expenditure during last year

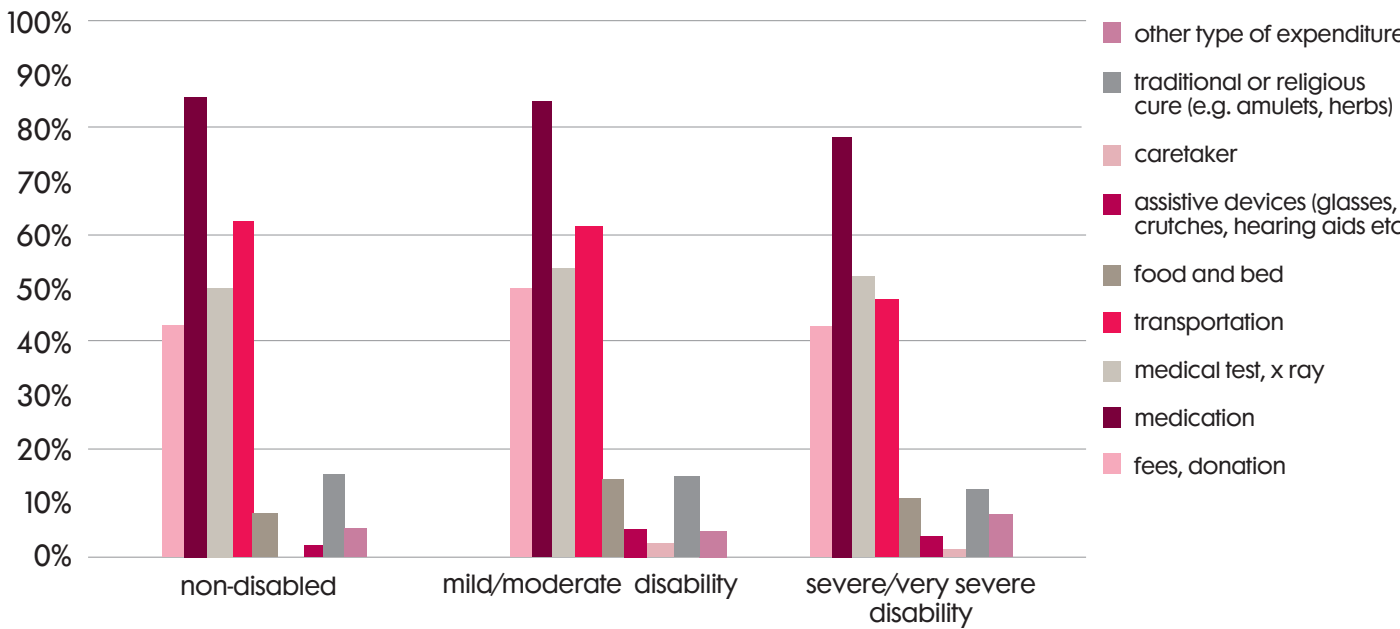


Table 3 shows that **respondents with severe or very severe disabilities spend a great deal more money, on average, for health care.** There are often user fees associated with health care in Sierra Leone, although some NGOs provide free health care services. Interestingly, average expenditure seems to be slightly lower for respondents with mild or moderate disabilities compared to those without any disability. **As an average, persons with severe or very severe disabilities spent 1.3 times more on health care than non-disabled respondents.** The gap is especially important for fees, medications and other expenditure (surgery, long hospitalisation, etc.).

Table 3 Average amount of health expenditure during last year (in SLL)

Average expenditure	no disability	mild/moderate disability	severe/very severe disability	Comparison between disabled and non-disabled (%)
fees	10286	11305	32968	320.5
medication	57049	48431	77742	136.3
medical test	9515	9644	7333	77.1
transportation	13446	6979	6076	45.2
food and accommodation	5974	5861	2692	45.1
assistive devices	0	1480	1045	NA
amulets, herb and other traditional cures	4152	2017	313	7.5
other expenditures	14469	18752	26154	180.8
total average expenditure	14361	13059	19290	134.3

4.4 Reproductive health

There are often a number of assumptions made about persons with disabilities, in particular around issues of sexual and reproductive health. Questions in the survey were designed to gain an understanding of the situation in and around urban areas of Sierra Leone. According to the data presented in Figure 25, 58% of respondents with severe or very severe disabilities have had sexual intercourse within the previous year, compared to 71% of respondents with mild or moderate disabilities and 92% of non-disabled respondents.

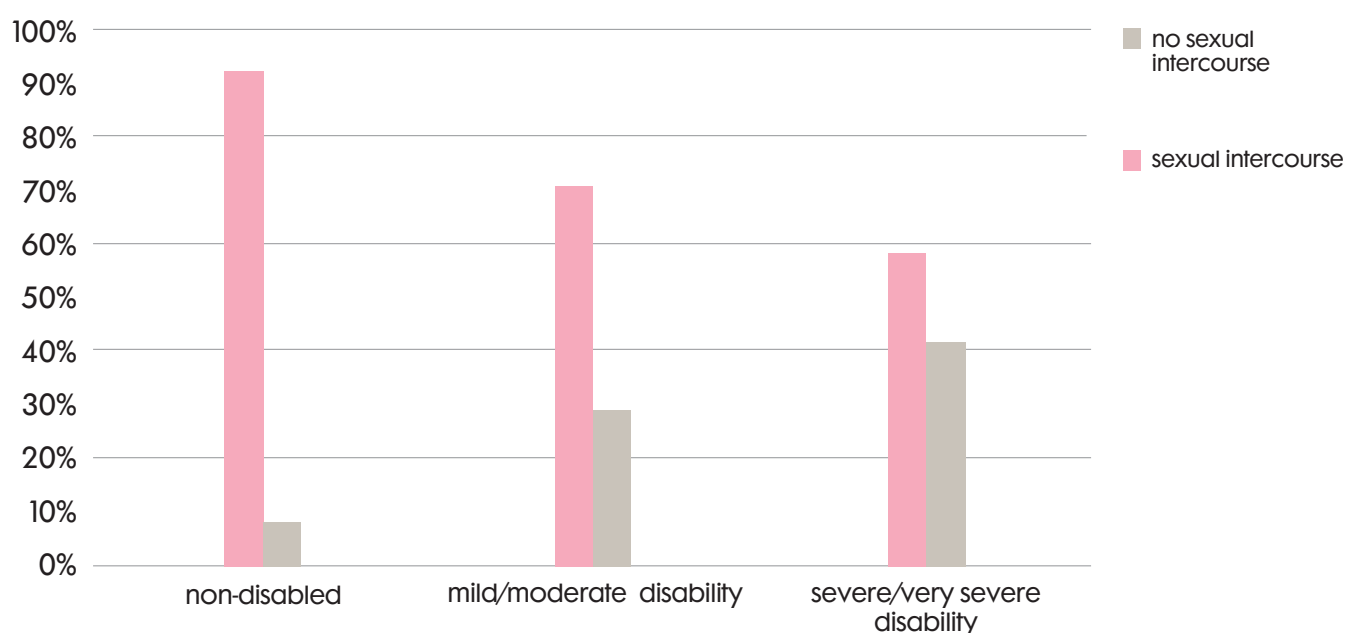
Figure 25 Sexual intercourse during last year

Figure 26 shows that the number of respondents with severe or very severe disabilities who had been forced to have sex is 11.9%, which is slightly higher than respondents with mild or moderate disabilities or no disabilities.

Figure 26 Forced sexual intercourse

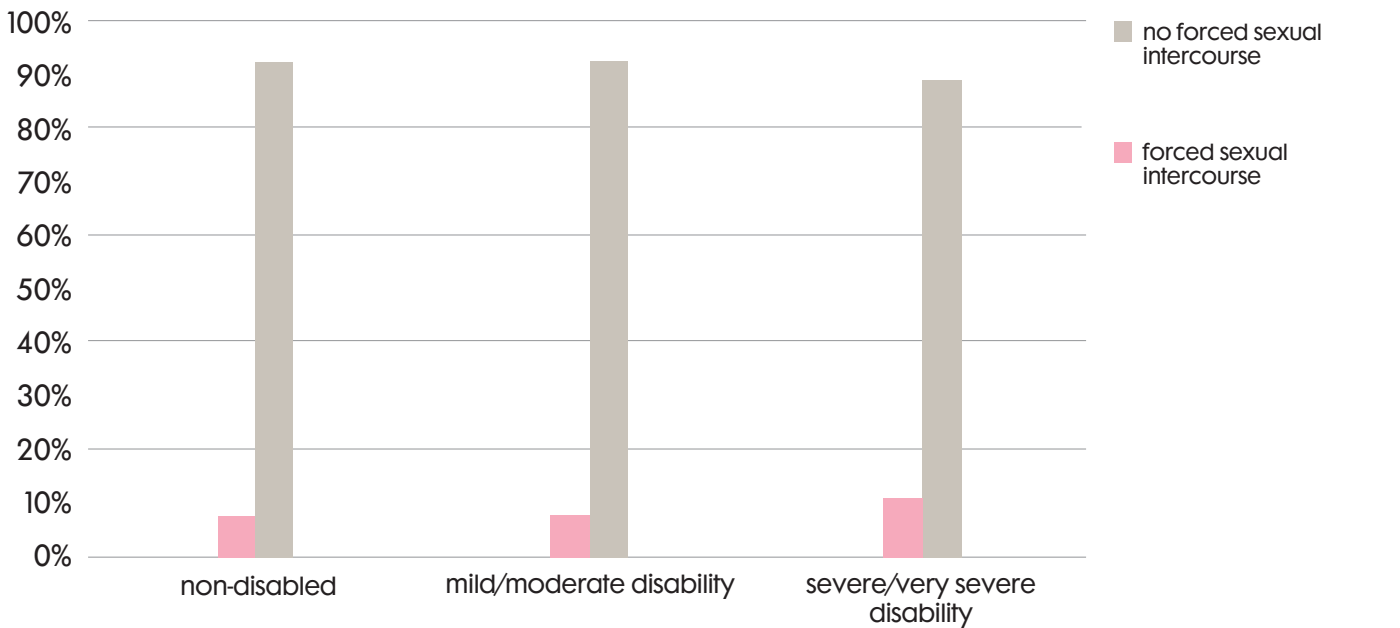
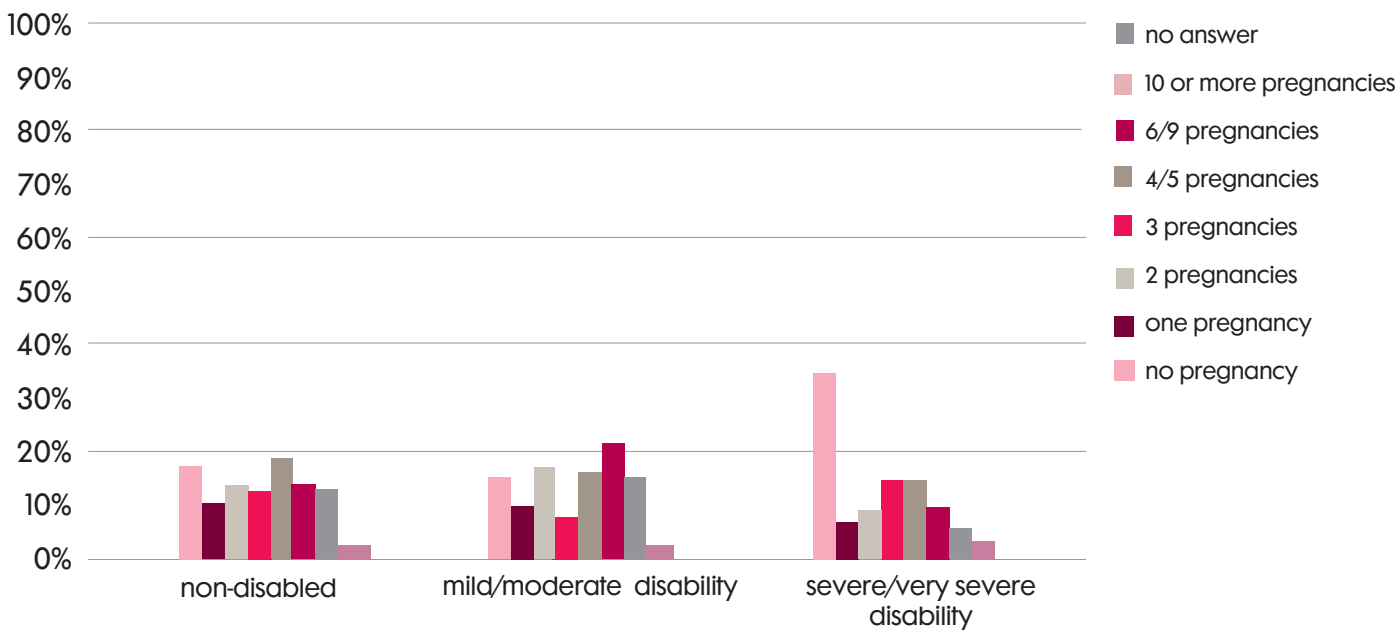


Figure 27 shows that significantly more female respondents with severe or very severe disabilities, or the partners of male respondents with severe or very severe disabilities, have never been pregnant (37.3% compared to 17.3% of non-disabled respondents and 13.5% of respondents with mild or moderate disabilities). Overall respondents with severe or very severe disabilities have had fewer pregnancies than the other respondents. However, it is important to note that while pregnancy rates were lower for those with severe or very severe disabilities, a majority of these couples (59.7%) still had one or more pregnancies.

Figure 27 Number of pregnancies



Despite this, Figure 28 demonstrates that there is not a significant difference in any of the respondents' desire to have a child in the future, regardless of whether or not they have any disabilities.

Figure 28 Desire for a child in the future

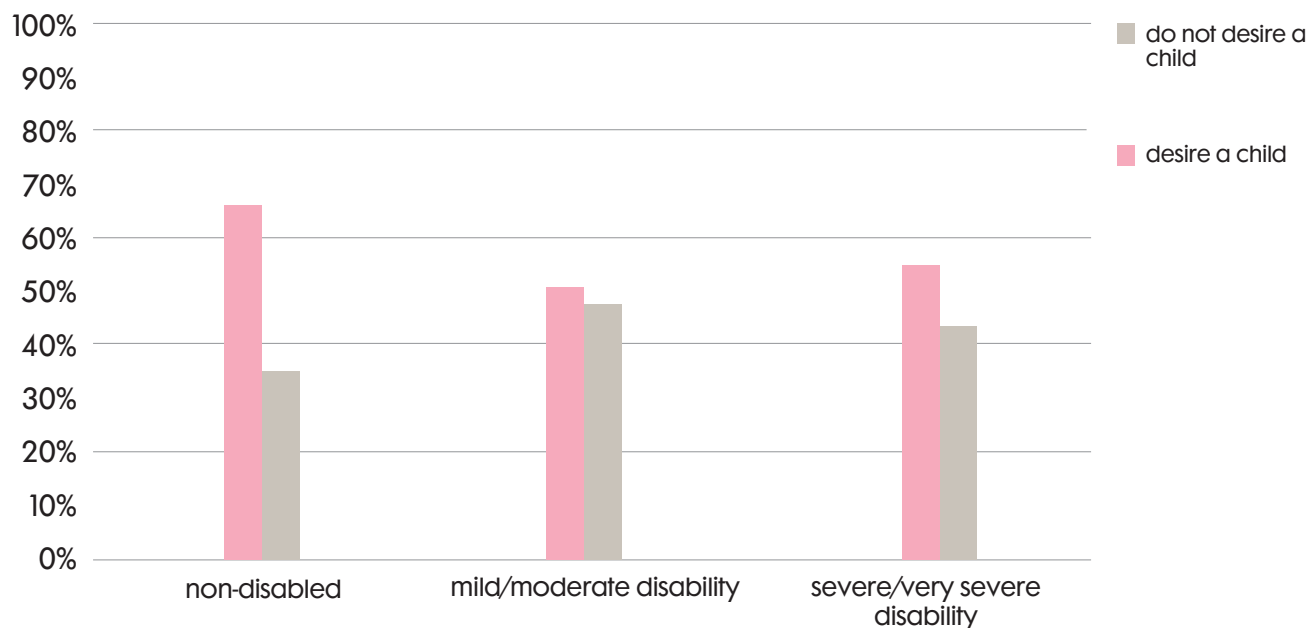
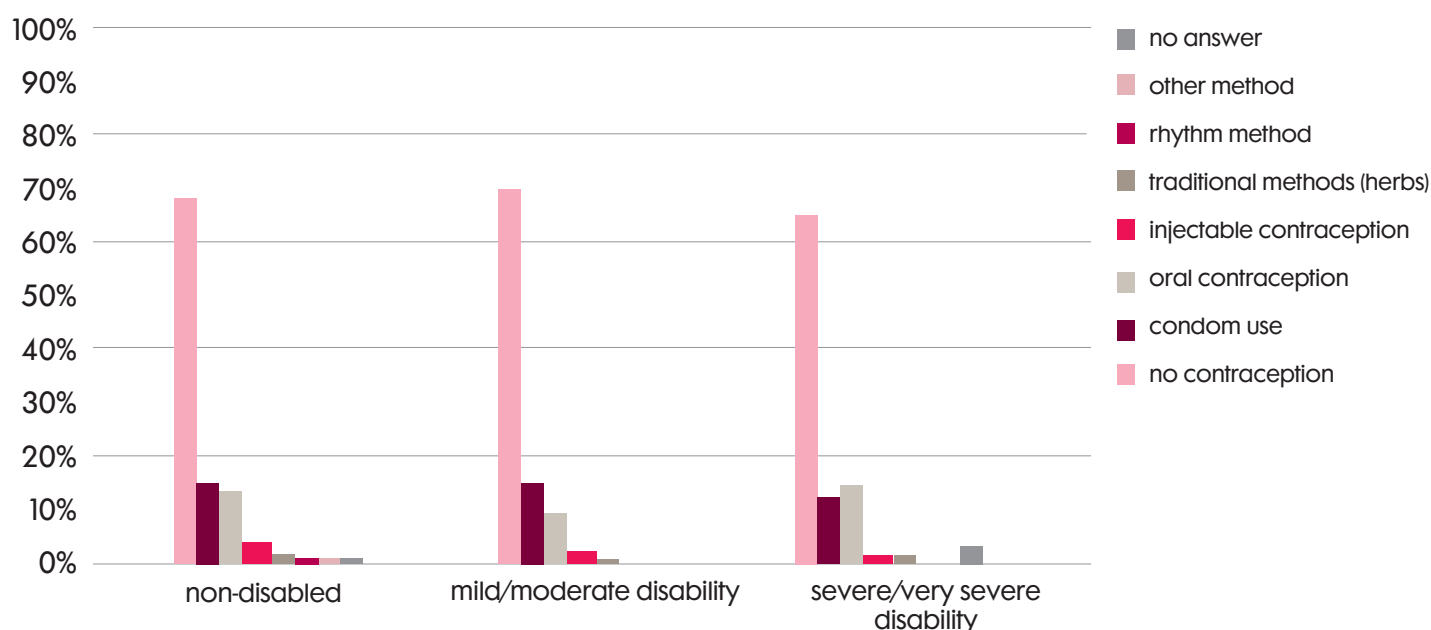


Figure 29 shows that **contraception use is generally low** – an average of 68% of all the respondents do not use contraception. There is not a significant difference between disabled versus non-disabled respondents with regard to contraception use. These results show a higher use than findings from the UNICEF-MICS survey (UNICEF, 2005). More research is needed to explain this gap, which is not solely explained by better access to contraception in urban areas as the gap is also observed in UNICEF data, where 20% of women currently married or in a union in the Western Area reported that they or their partner use a modern or traditional method of contraception (UNICEF, 2005). One can assume that in recent years a major effort has been made to promote the use and provision of contraceptives in all appropriate health services, although the success of such efforts is not known at this time.

Figure 29 Use of contraception



4.5 Conclusion

Many of the results in this chapter corroborate data from other surveys and sources, such as the WHO study of health care and reproductive health in Sierra Leone (WHO, 2007). The majority of respondents have access to some form of health care, although a higher proportion of respondents with severe or very severe disabilities stated having no access. Respondents with severe or very severe disabilities reported being in slightly worse health than other respondents, and were less satisfied overall with the health care they received. The most commonly available health care services were hospitals, pharmacies, and public/community health centres, and those without disabilities reported better access to these, as well as to private doctors and clinics, than respondents with disabilities. More non-disabled respondents had been immunised than respondents with disabilities, which may reflect lack of access to health care centres, lack of awareness about public health campaigns or lack of awareness of the general health care needs of persons with disabilities among health care professionals.

Average total health expenditure was highest for respondents with severe or very severe disabilities, with the highest amounts being spent on fees, medication and assistive devices. Persons with disabilities spent half as much on transportation as non-disabled people, probably due to inaccessibility of buses. There is very limited state provision of assistive devices, (for example: wheelchairs, crutches, hearing aids, eyeglasses) and in almost all cases, even if assistive devices have been provided by an NGO, there is some cost associated with them (such as buying replacements, repairs, etc.), which is reflected in the reported gaps in need and access to such devices.

With regard to reproductive health, fewer respondents with disabilities had had sexual intercourse within the previous year (58% of respondents with severe or very severe disabilities and 71% of respondents with mild or moderate disabilities compared to 92% of respondents with no difficulties). A slightly higher proportion of respondents with severe or very severe disabilities reported that they had been forced to have sexual intercourse within the previous year (11.9%, compared with 9% of other respondents). A higher proportion of respondents with severe or very severe disabilities had never been pregnant, despite a similar desire to have a child (in the future). However, it is still significant to note that the majority of persons with disabilities are sexuality active and will become parents at some point in their adult lives. Contraception use is very low among all respondents (68% do not use any contraception), with very little difference between respondents with disabilities and those without.

Chapter 5

Livelihoods

5.1 Context

As part of the survey, respondents were asked specific questions around livelihoods, including food security and access to food; as well as possession of material resources (durable goods and equipment) by any member of the household or by the household as a whole. These are all indicators of various aspects of livelihoods and of vulnerability, such as the risk of falling into poverty. Durable goods especially can be considered as assets for the household since they can be used to reduce vulnerability of the household, and increase the capacity to overcome unexpected external shocks (such as food price increases). They are commonly divided into different types of goods:

- common goods (usually for consumption or production).
- luxury goods (a sign of social position – for example a large house, expensive animals, TV set, car).
- assets that can be used as protection against vulnerability (such as agricultural equipment or a house).

A greater amount of material possessions is a relative indicator of well being of the household. However, possession of a large amount of land on the one hand, and reliable and extensive social networks on the other, are also invaluable assets that can ameliorate poverty and protect against risks and vulnerability to unexpected shocks.

5.2 Food security

Figure 30 shows that there is very little difference in access to food among those who are not disabled, those with mild disabilities, and those with severe to very severe disabilities. On average, 45.3% of respondents said they always had enough food, and 46.8% of respondents said they sometimes did not have enough food.

Figure 30 Access to food

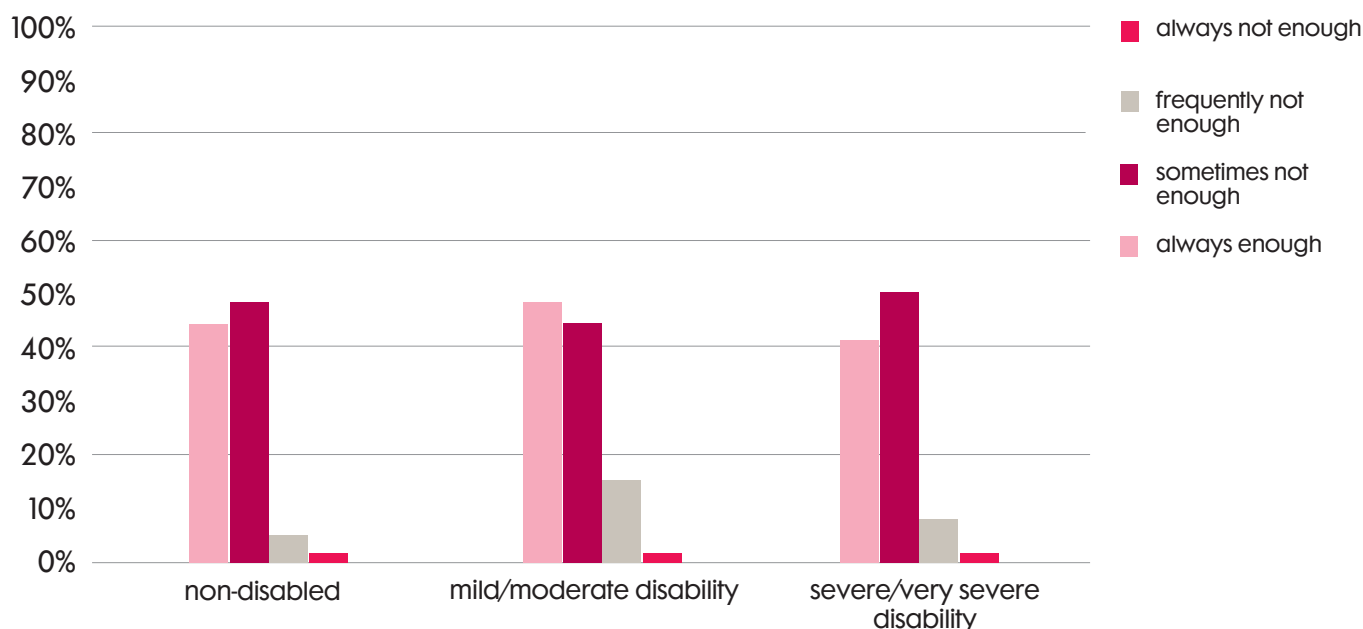
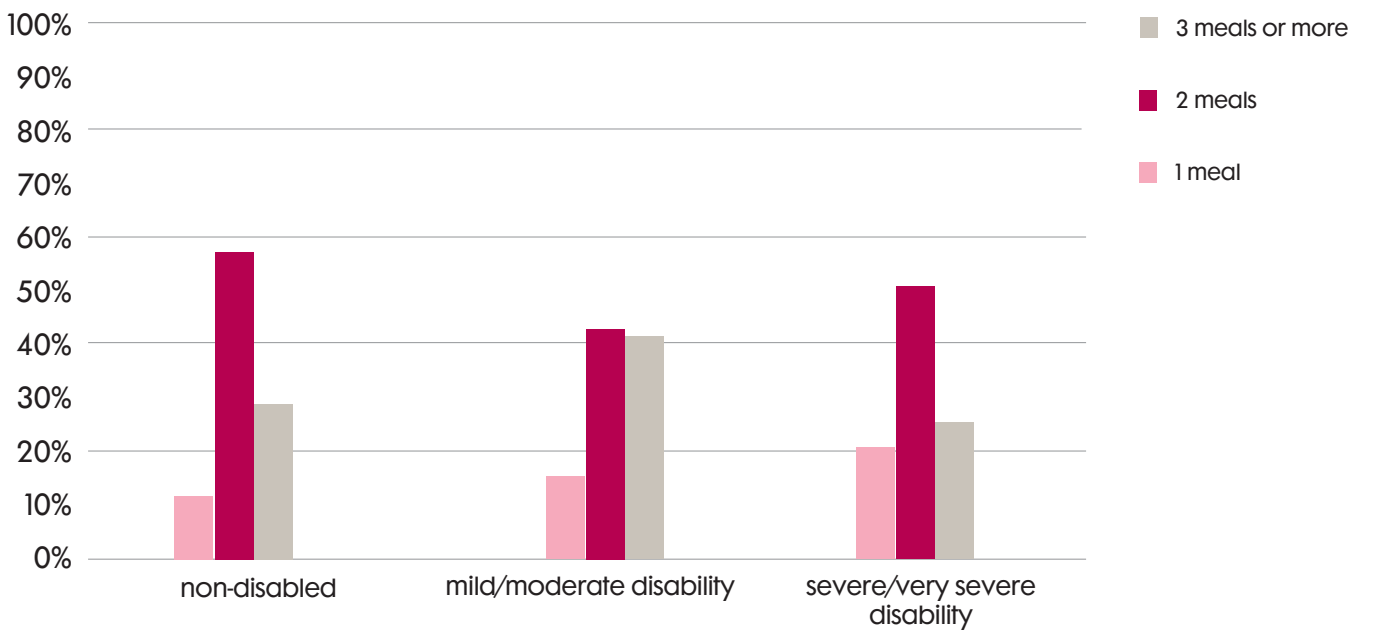


Figure 31 shows that the majority of respondents usually eat two meals a day. However **a higher percentage of respondents with severe or very severe disabilities report they only eat one meal a day** (20.9%, compared with 11.9% of non-disabled respondents). A higher percentage of respondents with mild or moderate disabilities eat three or more meals a day (42.1%, compared with 26.9% of respondents with severe or very severe disabilities). It is unclear why persons with severe or very severe disabilities eat fewer meals per day, but this may reflect their need for assistance in preparing or eating food and limitations on the time or energy of others in the household to assist them. Alternatively it may reflect poverty and related apportionment of food within the household setting or other variables that deserve further exploration. Certainly, the need for good nutrition for people with severe or very severe disabilities makes this finding of great concern.

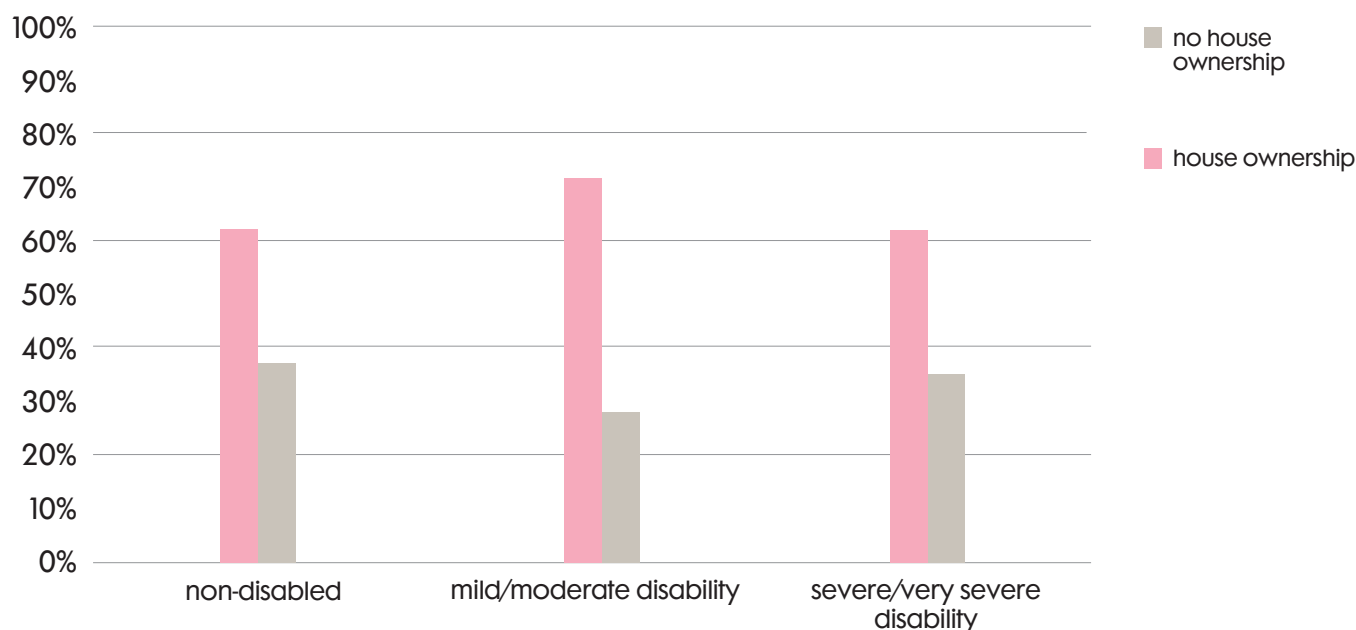
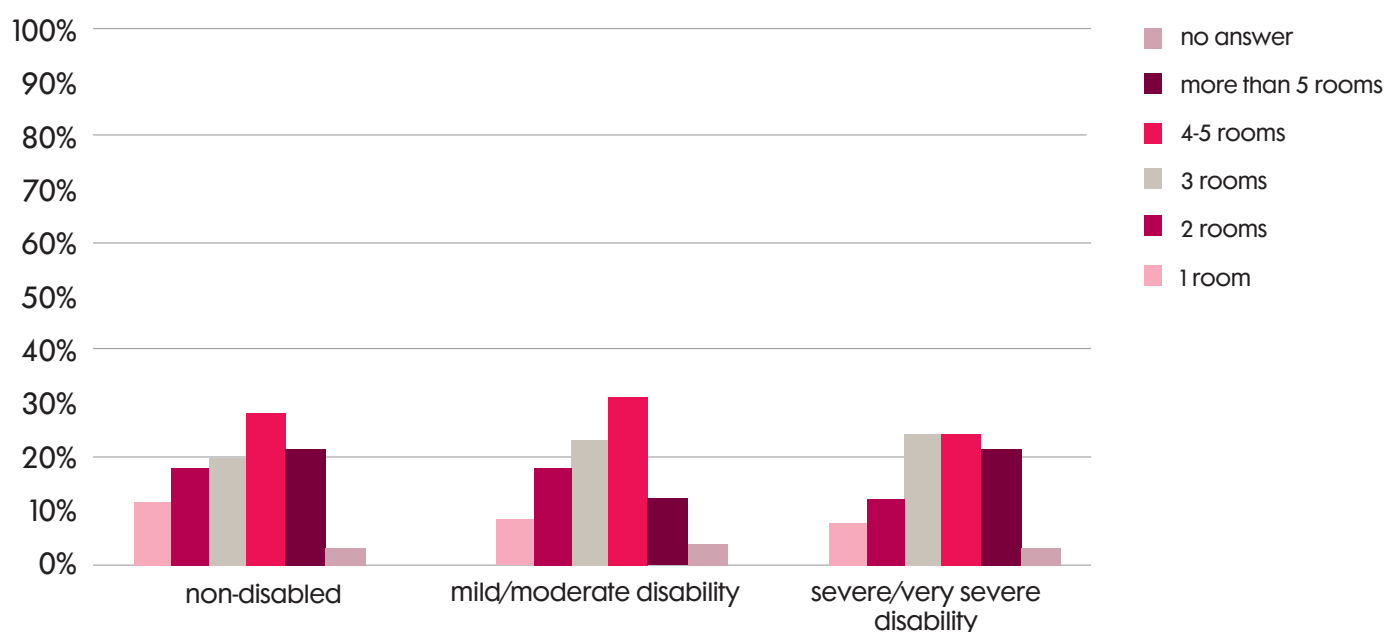
Figure 31 Number of meals a day



5.3 Housing

A striking result is that **64.7% of Sierra Leonean families own their house in and around urban areas**. As already stated, the ownership of a house is an important asset to reduce vulnerability. Figure 32 shows there is little difference in property ownership between families of respondents with disabilities and families with non-disabled respondents.

Figure 33 shows there is not a significant difference between the number of rooms in each group's residences. On average, most households seem to have between 3 and 5 rooms, often required to accommodate large families.

Figure 32 House, farm or flat ownership**Figure 33 Number of rooms**

5.4 Assets of animals and land ownership

Table 4 shows that households with and without a person with disabilities have similar levels of assets. **There is no significant difference in livelihood assets and wealth between disabled and non-disabled households in Sierra Leone.** The same pattern is observed for possession of animals. These results are not surprising considering that the extended family usually lives in the same household, so it is often composed of several breadwinners. Persons with disabilities thus live in households that are on a par with average households.

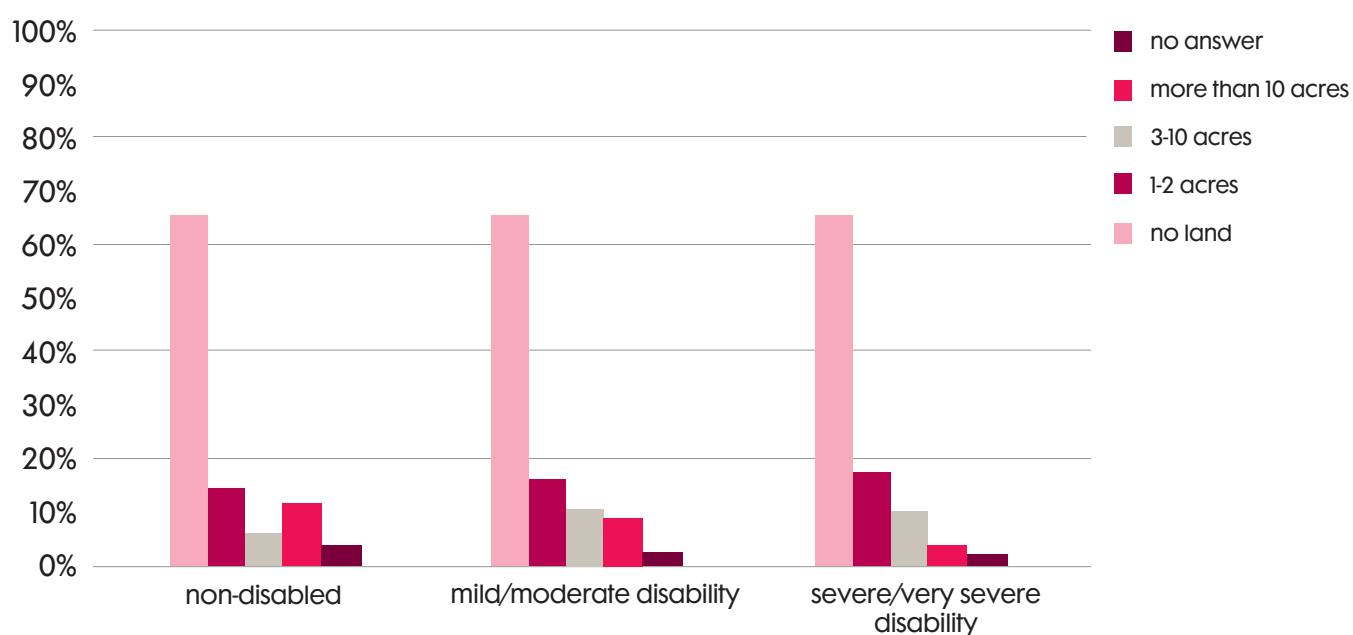
Table 4 Assets ownership (percent of respondents)

Assets	Quantity	no disability difficulty	mild/moderate difficulty	severe/very severe difficulty
radio, music player	none one Several	26% 38% 37%	21% 48% 32%	21% 42% 37%
television	none one several	79% 15% 6%	65% 30% 5%	76% 19% 5%
video	none one several	76% 18% 5%	64% 33% 3%	75% 22% 2%
mobile phone	none one several	33% 19% 48%	25% 26% 48%	28% 22% 48%
pots and pans	none one several	13% 0% 87%	6% 2% 91%	3% 0% 97%
refrigerator	none one several	86% 12% 2%	69% 27% 4%	85% 15% 0%
bed net	none one several	53% 14% 32%	62% 10% 29%	66% 11% 24%
bicycle	none one several	86% 9% 4%	87% 8% 5%	87% 6% 8%
motorbike	none one several	92% 8% 1%	94% 6% 0%	91% 9% 0%
car or truck	none one several	95% 5% 0%	100% 0% 0%	100% 0% 0%
tractor	none one several	98% 1% 0%	98% 2% 0%	100% 0% 0%
generator	none one several	39% 3% 58%	41% 9% 51%	45% 5% 51%
kerosene lamp	none one several	19% 24% 57%	20% 33% 48%	13% 34% 51%
sewing machine	none one several	94% 3% 2%	94% 2% 4%	87% 11% 3%

Table 5 Ownership of animals (percent of respondents)

Animals	Quantity	no difficulty	mild/moderate difficulty	severe/very severe difficulty
sheep	none one several	92% 4% 3%	95% 2% 2%	90% 3% 7%
cows	none one several	98% 0% 2%	100% 0% 0%	97% 0% 3%
goats	none one several	94% 0% 5%	96% 2% 2%	93% 0% 7%
chicken/duck/turkey	none one several	64% 3% 33%	73% 3% 24%	79% 0% 21%
pigs	none one several	99% 0% 1%	98% 0% 0%	99% 0% 1%

Figure 34 shows that an average of 64% of respondents do not own any land. However, a higher percentage of non-disabled respondents own over 10 acres of land – 12% compared with 8.7% of respondents with mild or moderate disabilities and 4.5% of respondents with severe or very severe disabilities.

Figure 34 Size of land

5.5 Conclusion

From the data presented here the difference between households in terms of assets is often not immediately observable; however poverty is widespread in Sierra Leone and is a general leveller. Nevertheless, disability unquestionably affects living conditions, as may be seen from the preceding chapters. They show, for example that when additional expenses are incurred, for health care or other needs, or there is a loss of income through unemployment, families of persons with disabilities are more at risk of remaining in poverty. Households that include a person with a disability as a family member often have to face more difficulties and need more resources in order to maintain or improve their living conditions. Therefore, policies geared towards fighting poverty need to focus on ways to strengthen the capacity and capabilities of such households to reduce vulnerability.

Chapter 6

Access to Services

6.1 Context

Welfare services and infrastructure development are priorities of both the Government of Sierra Leone and the international community in Sierra Leone. In policies designed to support the government to alleviate poverty and develop the country, such as the World Bank Country Assistance Strategy (CAS) for 2006-2009 (WB, 2005), and the Poverty Reduction Strategy Paper (PRSP, 2005), there is a strong focus on economic reform and decentralisation, and development of infrastructure and social sectors. However, as yet there is very little welfare support available in the country, and most of the services available are part of wider social support schemes, such as free basic education.

In addition to various large international organisations, there is a wide network of smaller local, national and international NGOs working in a wide range of sectors including education, health, development, peace and reconciliation, rehabilitation, skills training, capacity building and agriculture. Many were present in the country prior to the conflict, and many others have come to Sierra Leone in more recent years. The present chapter explores the population's need for services and the level of satisfaction in those services currently available.

6.2 Findings

Figure 35 shows **that the majority of respondents reported being in need of services (82.9%)**. There was very little difference between the groups and surprisingly, a slightly higher proportion of respondents without disabilities stated they needed services. This can perhaps be explained by the general situation of the country where employment opportunities are scarce and economic difficulties are widespread among the whole population.

Figure 35 Need of services expressed according to level of disability

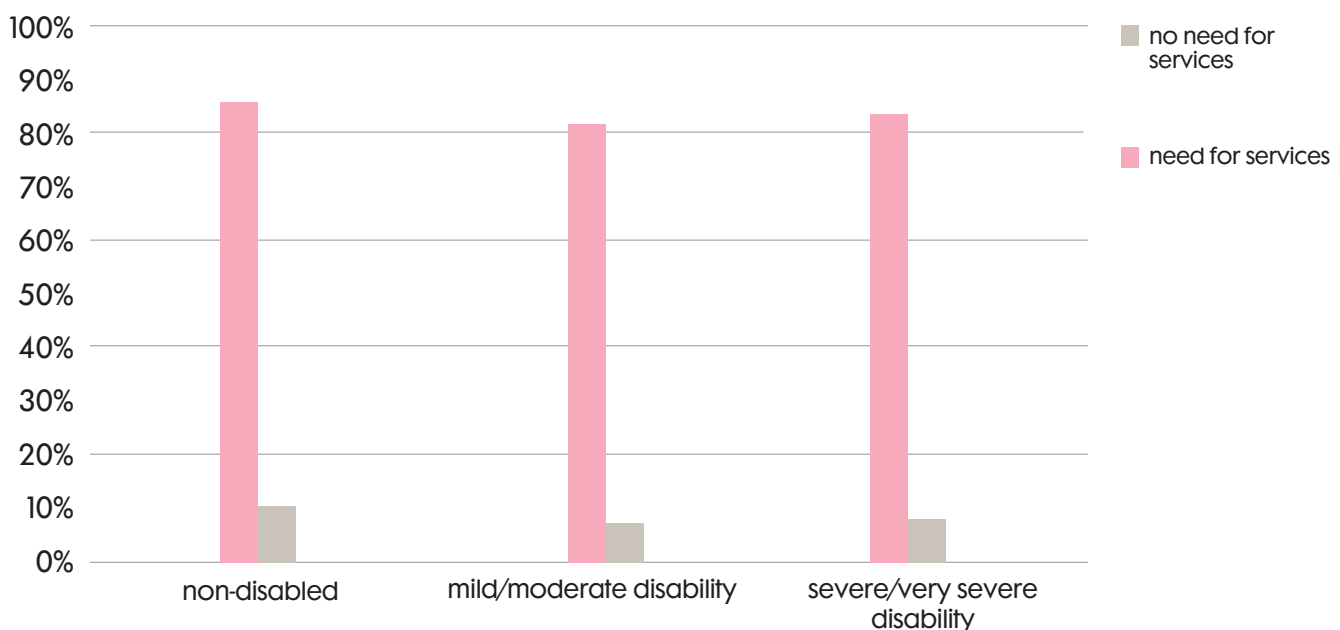


Figure 36 shows that few respondents have access to services, and **significantly fewer respondents with severe or very severe disabilities are accessing social welfare and benefits** (only 1.5% compared with 12.4% of respondents with no disabilities and 14.3% of respondents with mild or moderate disabilities). Somewhat surprisingly, the graph shows that overall more non-disabled respondents are accessing rehabilitation services than respondents with mild to very severe disabilities. Respondents with no reported disabilities are also accessing community based rehabilitation (CBR) and community based services significantly more than respondents with severe or very severe disabilities.

Unsurprisingly, more respondents with disabilities use assistive devices – 8.7% of respondents with mild or moderate disabilities and 4.5% of respondents with severe or very severe disabilities, compared with 0.9% of non-disabled respondents. Respondents with severe or very severe disabilities access support through religious organisations more than any other services, and a higher percentage of them rely on religious organisations than the other respondents (43.3%, compared with 26.3% of respondents with no disabilities and 32.5% of respondents with mild or moderate disabilities).

Figure 36 Access to services

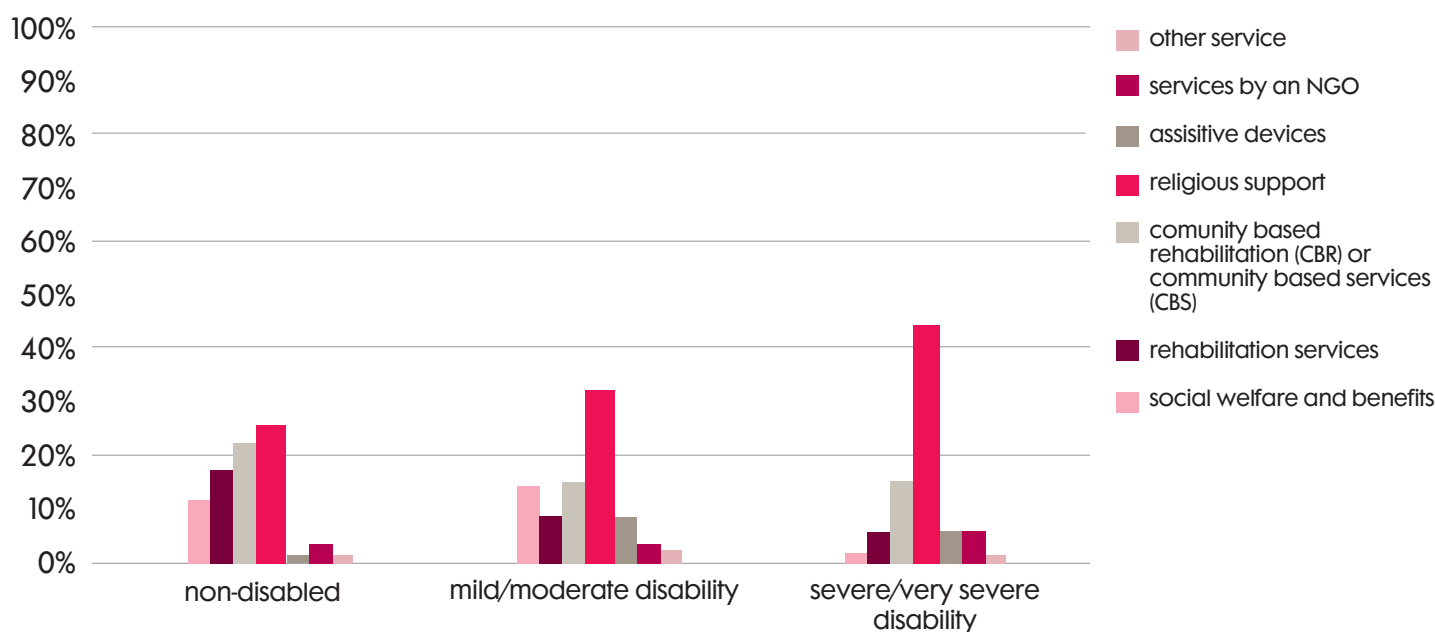
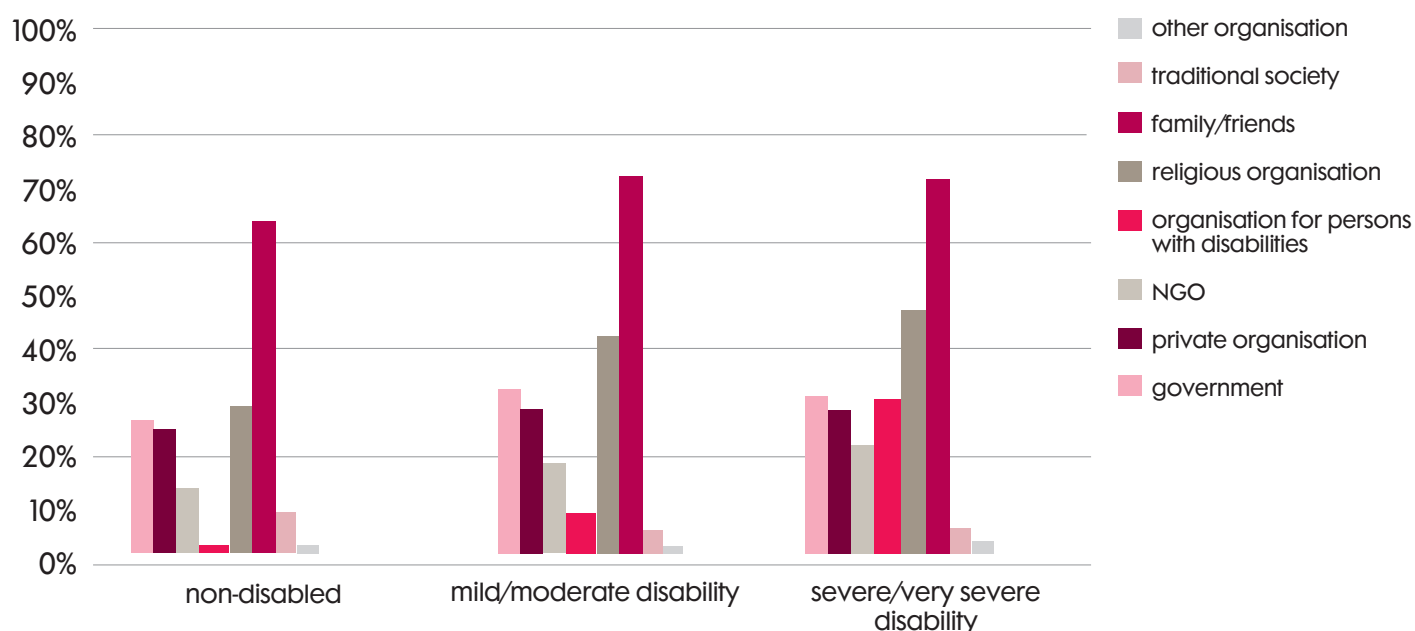


Figure 37 shows that among all three groups, **most respondents believe friends and family will provide the most support**. The extended family in many low income countries is an important source of support and help for members traditionally seen as most vulnerable; this highlights the necessity of ensuring the inclusion of families and communities when designing programmes and policies. Unsurprisingly, a higher percentage of respondents with mild to very severe disabilities believe organisations for persons with disabilities can support them. Also unsurprisingly in Sierra Leone, a large number of respondents with disabilities, alongside some respondents without disabilities, believe religious organisations can or should support them.

Figure 37 Do you think the following different organisations can support you

6.3 Conclusion

The majority of respondents reported being in need of some form of services (82.9%). There was very little difference between the groups and, perhaps surprisingly, a slightly higher proportion of respondents with no reported disabilities stated that they needed services. This may be attributed to the general situation in the country, where employment opportunities are scarce and economic difficulties are widespread among most of the population. Another contributing factor may also be the amount of international aid and development already put into the country, and the potential over-reliance on, and expectation of, such external aid and support.

However, the data indicates that a small proportion of respondents do have access to services. Significantly fewer respondents with severe or very severe disabilities are accessing social welfare and benefits (only 1.5% compared to 12.4% of non-disabled respondents and 14.3% of respondents with mild or moderate disabilities). In addition, unexpectedly, more non-disabled respondents are accessing rehabilitation services than respondents with mild to very severe disabilities. Respondents with no reported disabilities are also accessing community-based rehabilitation (CBR) and community-based services significantly more than respondents with severe or very severe disabilities, though clearly not all community based services are targeted to persons with disabilities. Unsurprisingly, more respondents with disabilities use assistive devices.

However, overall, there are very few services currently available to persons with disabilities in Sierra Leone, despite respondents expressing a high level of need. As a consequence, the majority of respondents do not believe that the Government, NGOs or other organisations are able to provide the support they need. Most believe the family is where they will receive the most assistance. As noted above, the extended family can be an important source of support and help for members traditionally seen as most vulnerable; however, agencies need to be wary of assuming that families will automatically be able or willing to provide support to all members. Religion is an important part of life in Sierra Leone, and more respondents with severe or very severe disabilities rely on support from religious organisations than do other respondents (43.3%, compared to 26.3% of non-disabled respondents, and 32.5% of respondents with mild or moderate disabilities).

Chapter 7

Social Participation

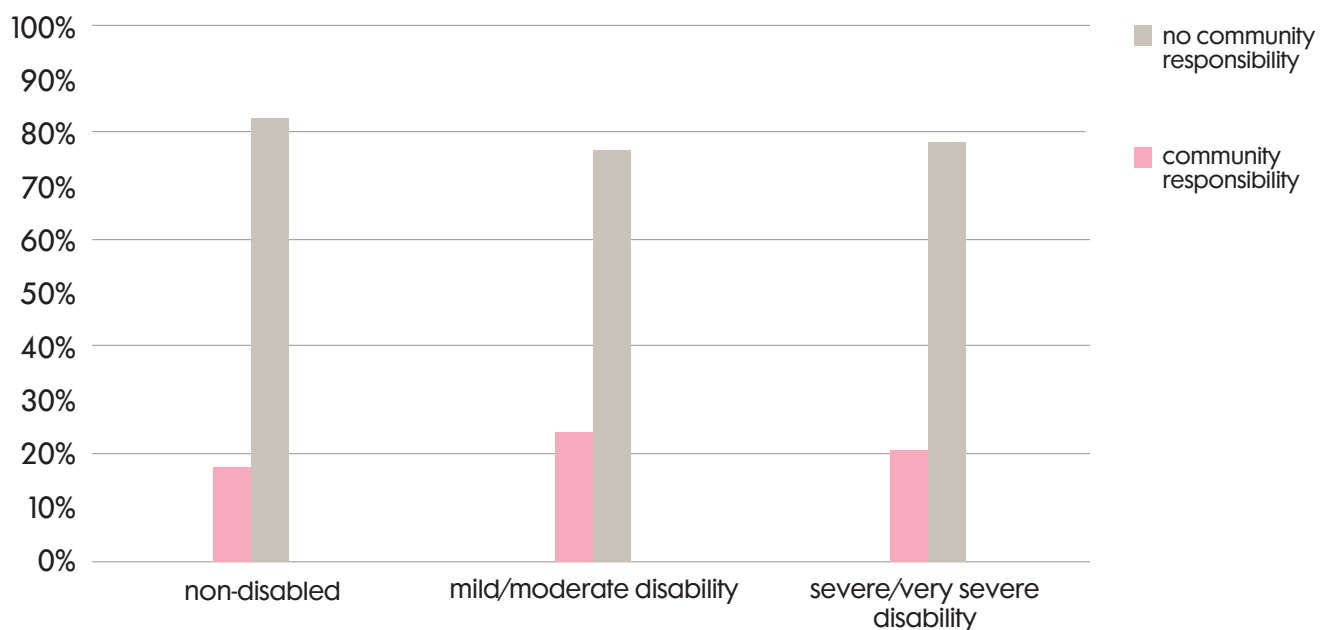
7.1 Context

Persons with disabilities are often excluded from participating in community and social activities, so a key component of this survey was to ascertain whether persons with disabilities have the same opportunities to take part in social and community activities, make friends, and exert their rights as do all other citizens. The results presented in this chapter give a glimpse of the situation in terms of participation in community and social life in and around urban areas of Sierra Leone.

7.2 Findings

An important facet of daily life in Sierra Leone is the extent to which people play an active part in community life within the village or town. Having a leadership role within the community is evidence of a high degree of participation. Figure 38 shows that, overall, **about 19% of Sierra Leoneans interviewed have such responsibilities, and that there is no significant difference according to the level of disability.**

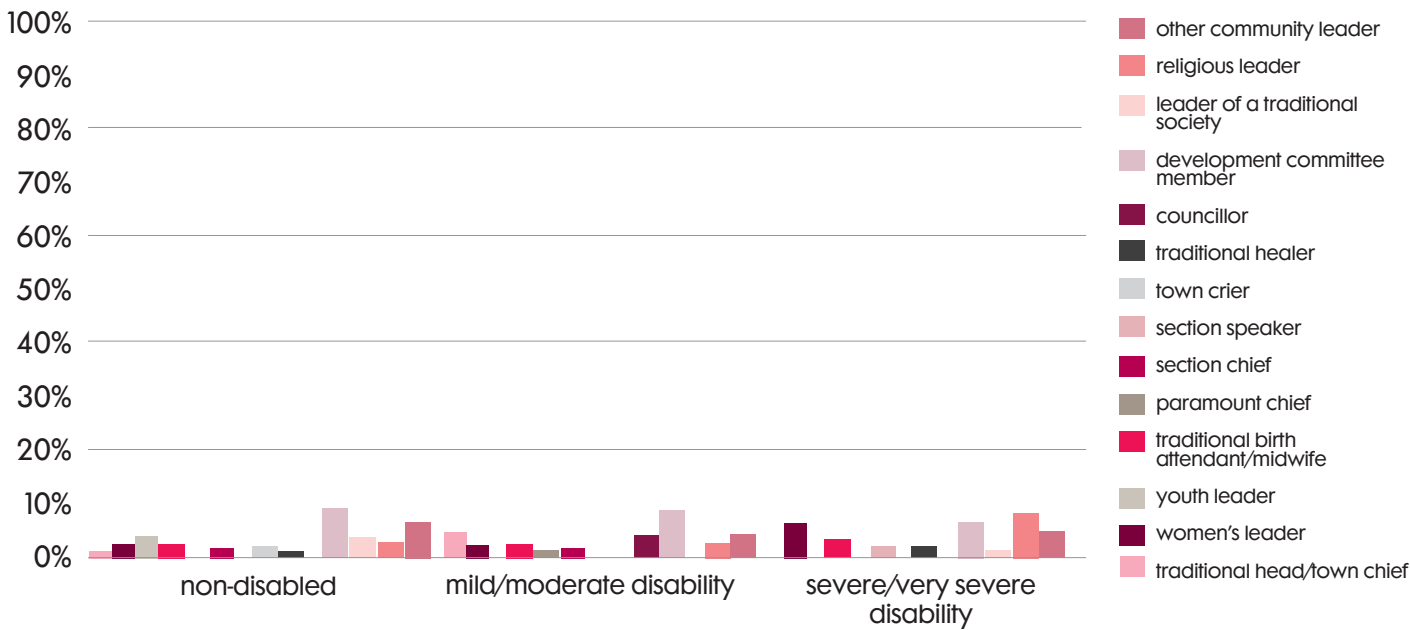
Figure 38 Proportion of Sierra Leoneans in and around urban areas with community responsibility



According to Figure 39 there is a fairly equal distribution in the types of responsibilities held across all three groups; however, there are some notable exceptions. There are no reported traditional village heads (chiefs) or town chiefs with severe disabilities.¹⁵ More respondents with severe disabilities have taken on the role of religious leaders.

¹⁵ However the sample size is small; a larger sample might show that persons with disabilities do hold such roles.

Figure 39 What type of community responsibility



However, according to Figure 40, a higher percentage of respondents with no disabilities (77.6%) did not want to assume any community responsibilities compared to those with severe disabilities (41.5%). Of the respondents with severe disabilities, 7.6% have been refused a position of community responsibility because of their disability, but almost twice the amount (15.1%) were discouraged to apply, or fear they would be rejected if they apply for such a position. We argue that because of the small sample size we cannot make any generalisation in this case, and it may be that some disabled individuals have developed personal attributes that have propelled them forward. Perhaps most likely, leadership comes with age and these older individuals will be more likely to have acquired a disability as part of the aging process.

The survey also asked questions about more general participation in community activities, rather than just questions about holding positions of responsibility or leadership. In this category, there was a significant degree of exclusion of persons with severe disabilities: **less than half of the respondents (46.3%) stated they were participating in community life.**

Figure 40 Reason for not having community responsibility

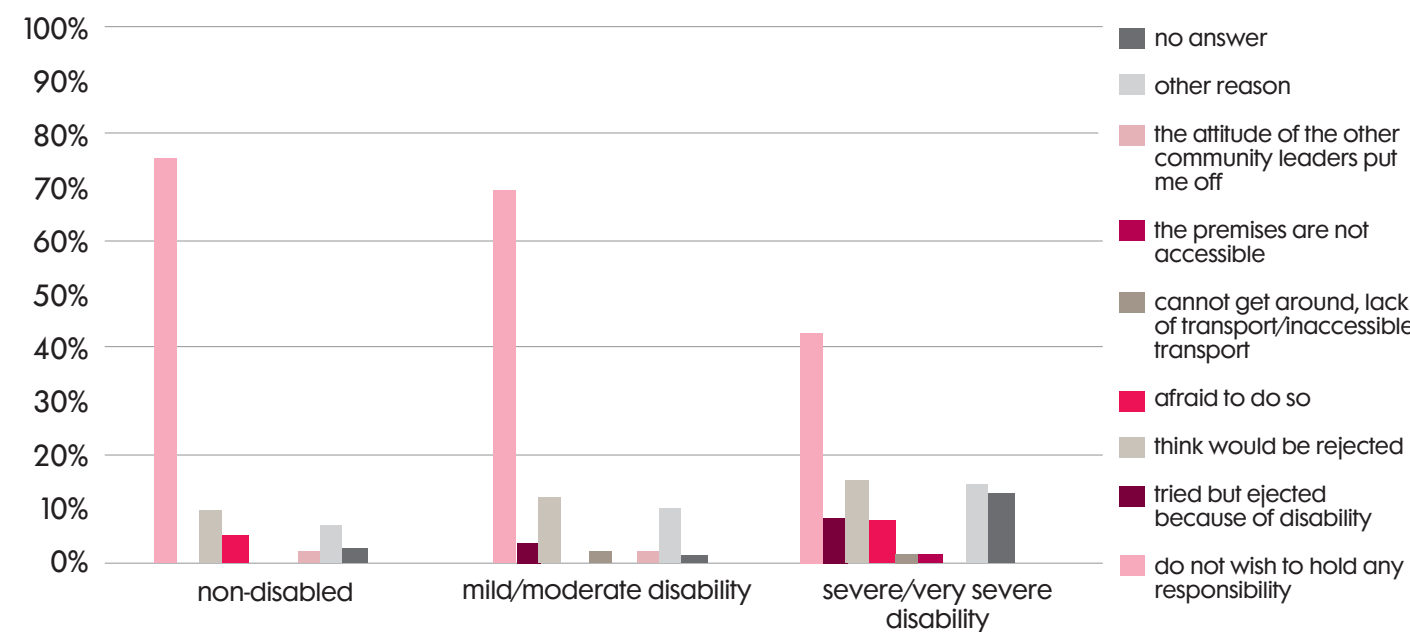
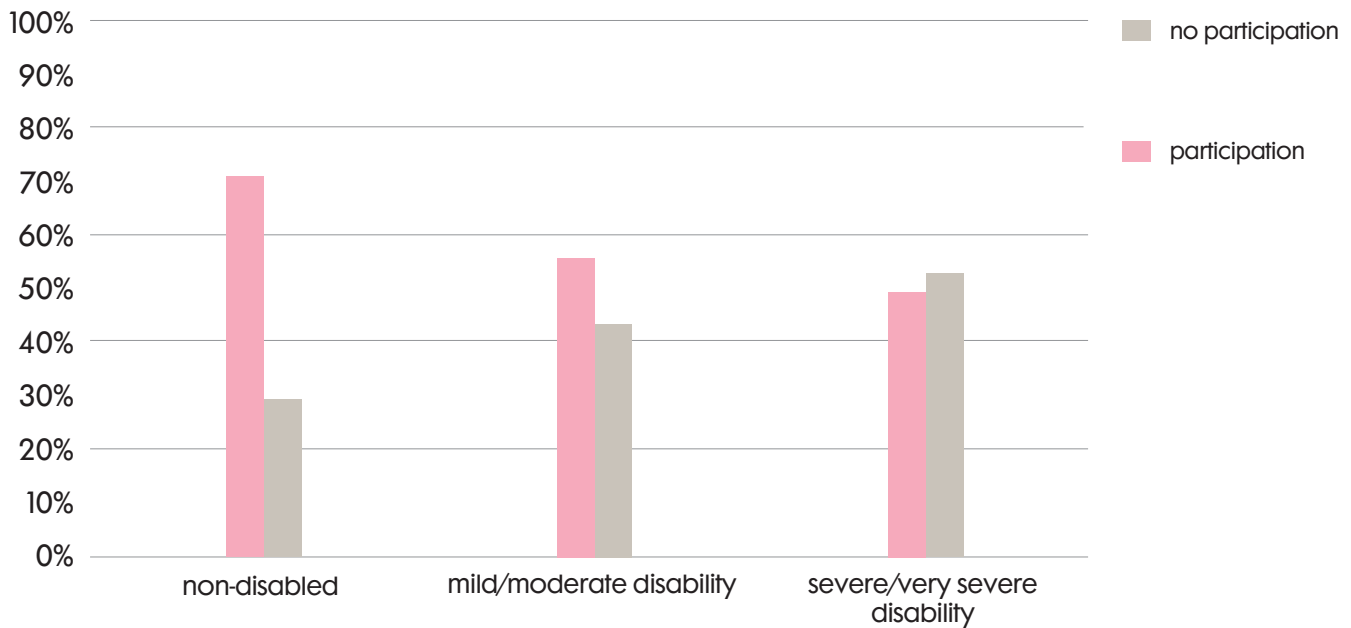
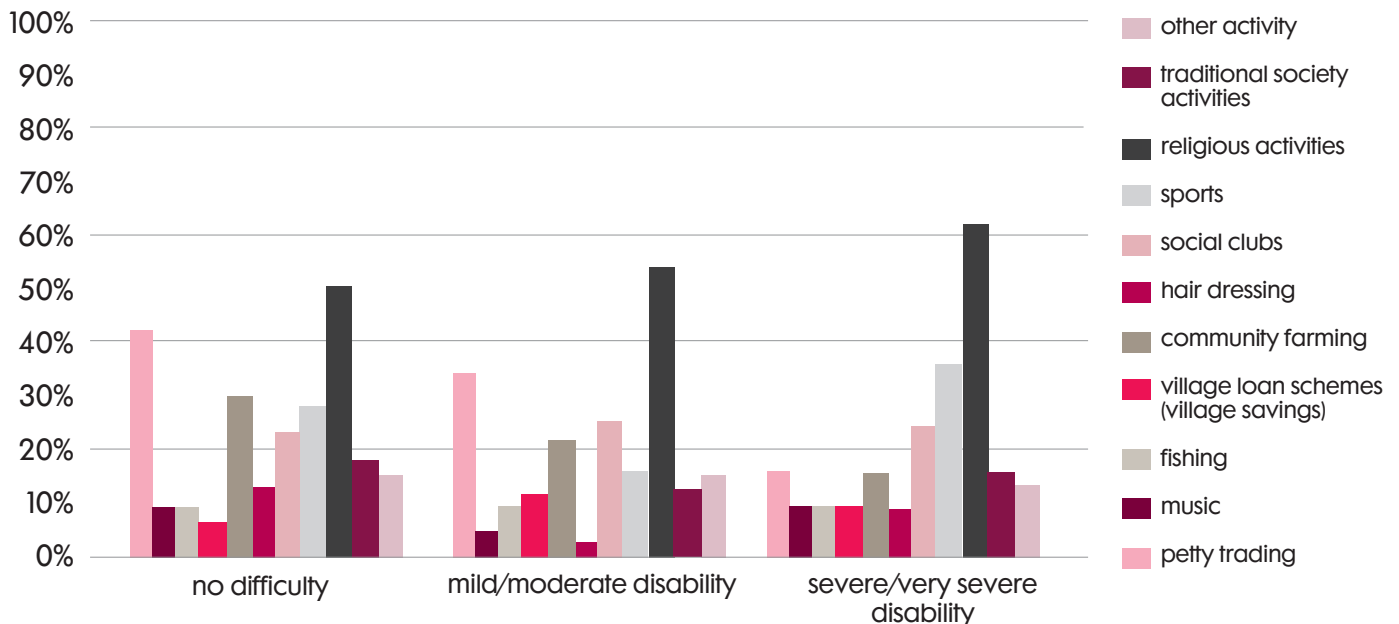


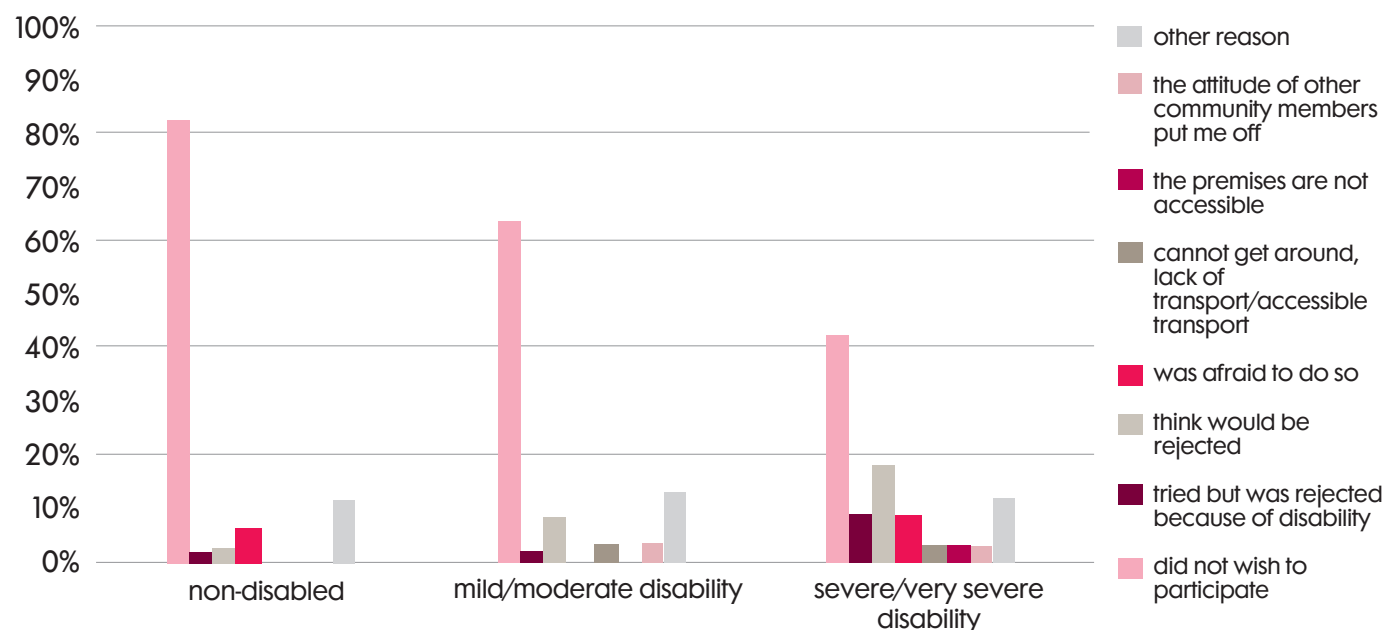
Figure 41 Participation in community activities

Of those who were able to participate, Figure 42 demonstrates that there is not a significant difference between the activities of those with disabilities and those without. The most obvious difference is that respondents with severe disabilities are less involved in community activities linked to work (such as community farming and petty trading), but more involved in religious and sporting activities.

Figure 42 What type of activities you participate in

The lack of participation among persons with severe disabilities is again largely linked to exclusion or fear of exclusion on the basis of disability. Figure 46 shows that the total percentage of all the reasons cited linked directly or indirectly to fear of being excluded is about 40%. **If taken together with exclusion on the basis of inaccessibility, the total percentage increases to 50%.**

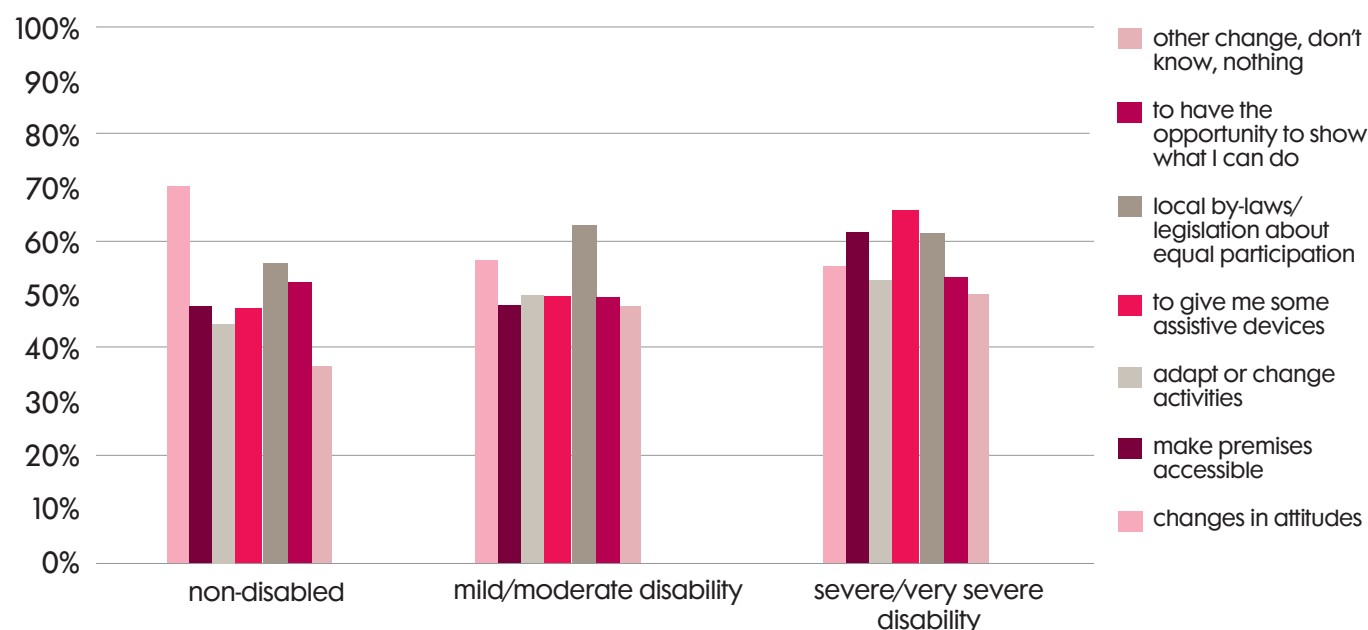
Figure 43 Why you don't participate



In order to understand what respondents perceived were the changes necessary to increase their participation (Figure 47), the survey asked a series of questions around these issues. Two thirds of all respondents believed that good legislation would improve participation. The Government of Sierra Leone is currently in the process of drafting a Disability Act which may go some way towards enhancing inclusion. Perhaps somewhat surprisingly, non-disabled respondents mentioned beliefs as a barrier to inclusion at a higher rate than those with disabilities themselves.

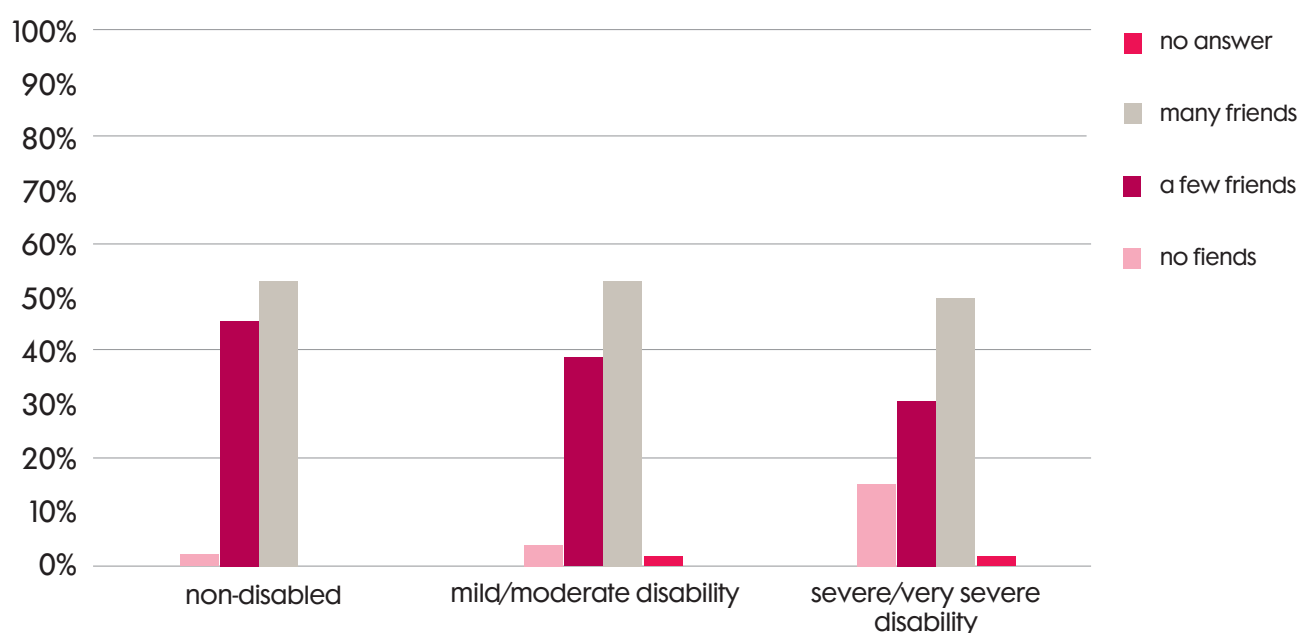
Accessibility is a major concern for two thirds of persons with disabilities, though persons with no disabilities also highlighted accessibility as a barrier. Many reasons can explain this lack of accessibility: distance to facilities, limited time that such facilities were open, or lack of staff on site. These results about changes that could be made for people to participate in community activities need more research to be explained fully.

Figure 44 What changes could be made for you to participate



Another dimension of social inclusion is the ability to make friends. In the survey, while few respondents stated they had no friends, of those who did report having no friends, a significant number were persons with severe disabilities (15%). Nevertheless, 82% declared they had friends. This indicates that while exclusion may manifest itself in a number of significant ways (for example accessibility to public buildings), prejudice is not always manifest at the individual level of social relationships. However, **39% of respondents with disabilities reported that they do not participate in social events because they have been discriminated against or assume that other members of the community would not accept them.**

Figure 45 Have friends



The level of mistreatment and abuse of persons with disabilities appears to be quite high in and around urban areas of Sierra Leone (46%), and is significantly above the level observed among those reporting no disabilities (36%). As shown in Figures 47 and 48, mistreatment can be the result of violence from war (for instance torture or wounds) done by militia, police or gunmen. In this case, there is no significant difference in level of violence reported between respondents with or without disabilities. Highly stressful social conditions such as war can lead to more violent behaviour between people, sometimes as an expression of psychological problems. However, it is difficult to attribute all violence towards persons with disabilities to be a direct result of the war.

Figure 47 shows that **more respondents with disabilities report bullying and are at a higher risk of experiencing physical abuse and rape than those with no disabilities (2.7 times more).**

Children with disabilities are also more likely to complain about mistreatment by their parents. Persons with disabilities face a higher rate of abuse from their in-laws (Figure 48). Overall, comparatively more respondents with disabilities are bullied by their friends. Figure 49 shows that respondents with disabilities are more often unaware of how to react to abuse and violence: **77.4% of them state they did not react for reasons such as they did not know how to react, or they were afraid of further violence and abuse.**

On a more positive note, Figure 50 shows that overall, all respondents agree that persons with disabilities are entitled to the same rights as other citizens. This is an encouraging finding on which to build a change of attitudes and promote anti-discriminatory behaviours.

Figure 46 Mistreatment

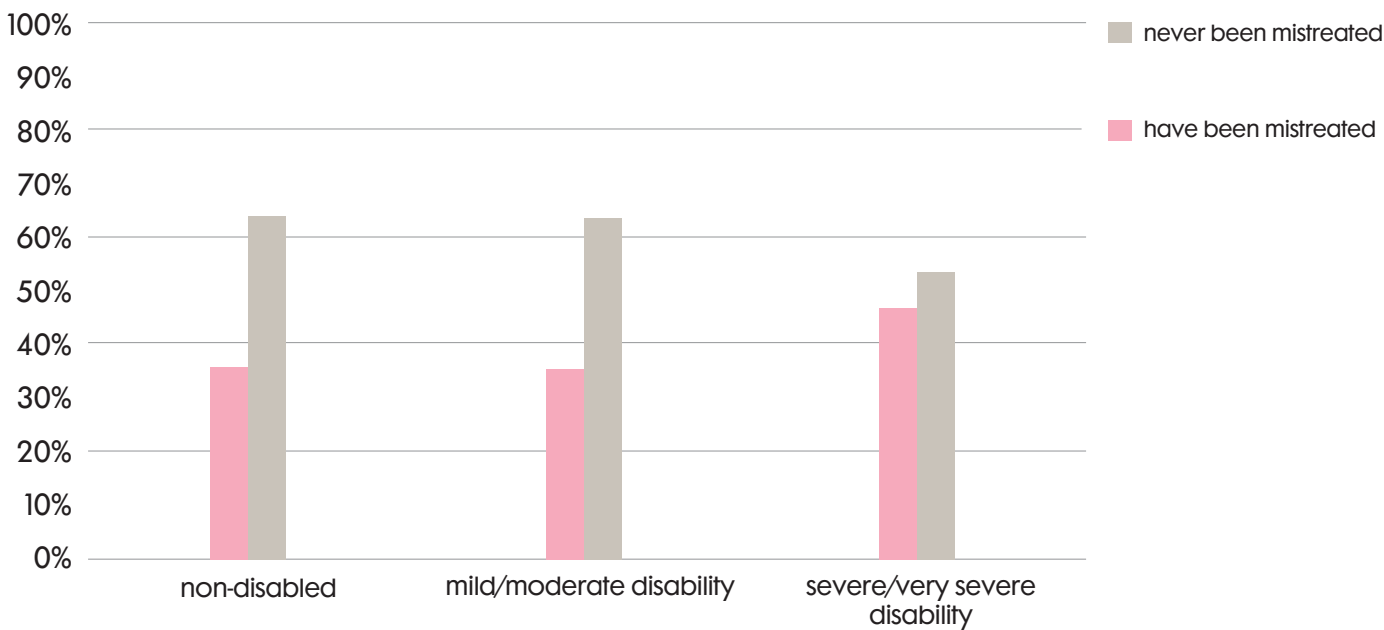
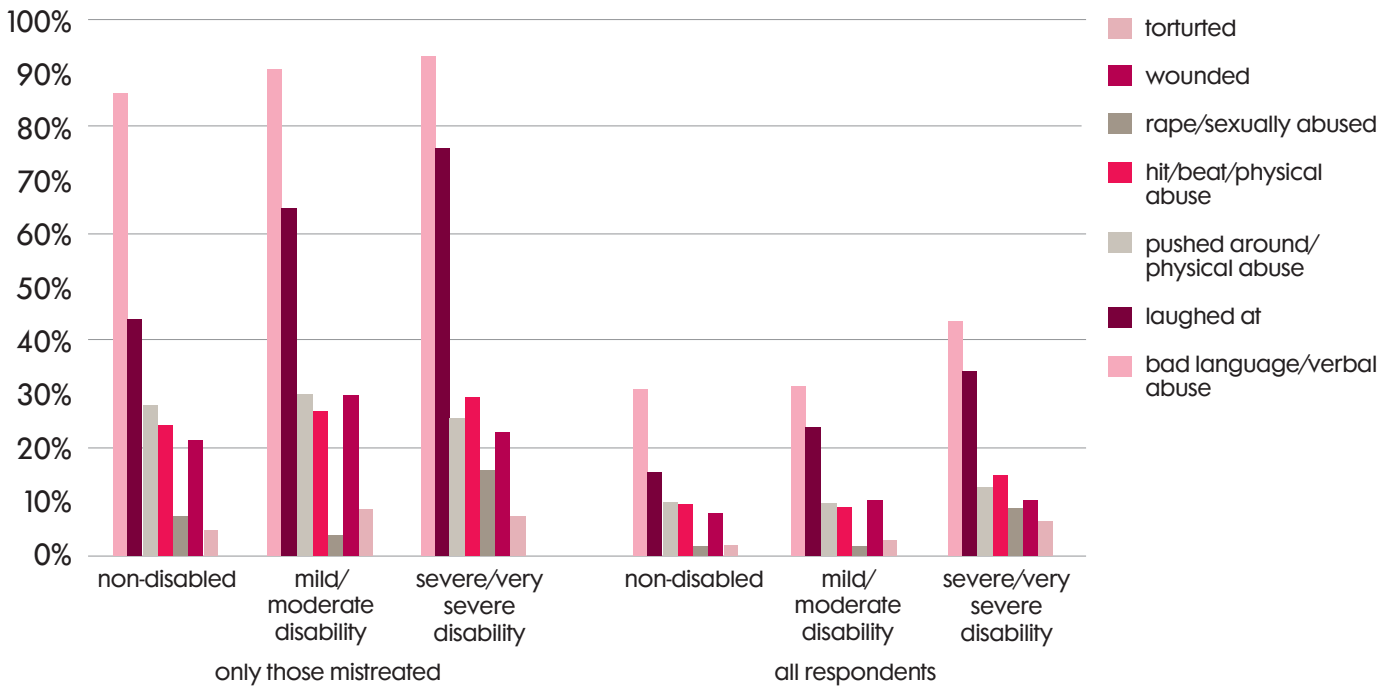


Figure 47 If mistreated, type of mistreatment



Note: calculation (proportion of those who faced each type of mistreatment) is given both for the proportion of the sample which faced mistreatment as well as for the whole sample.

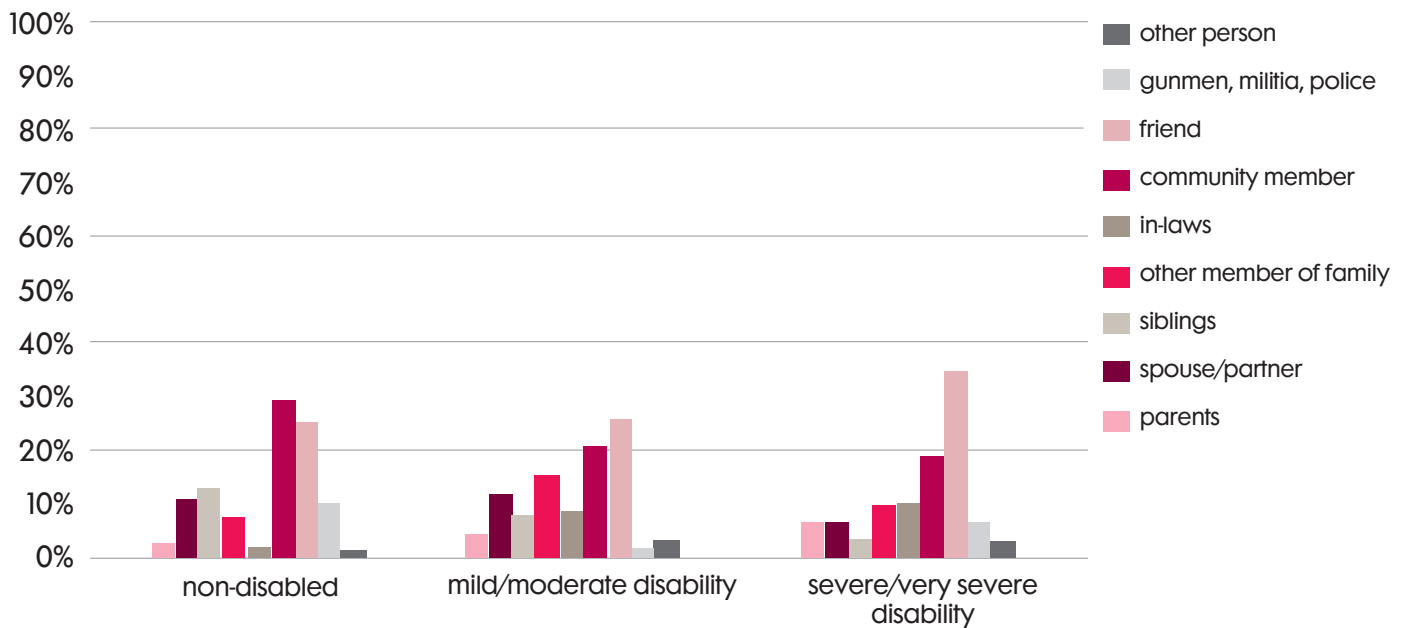
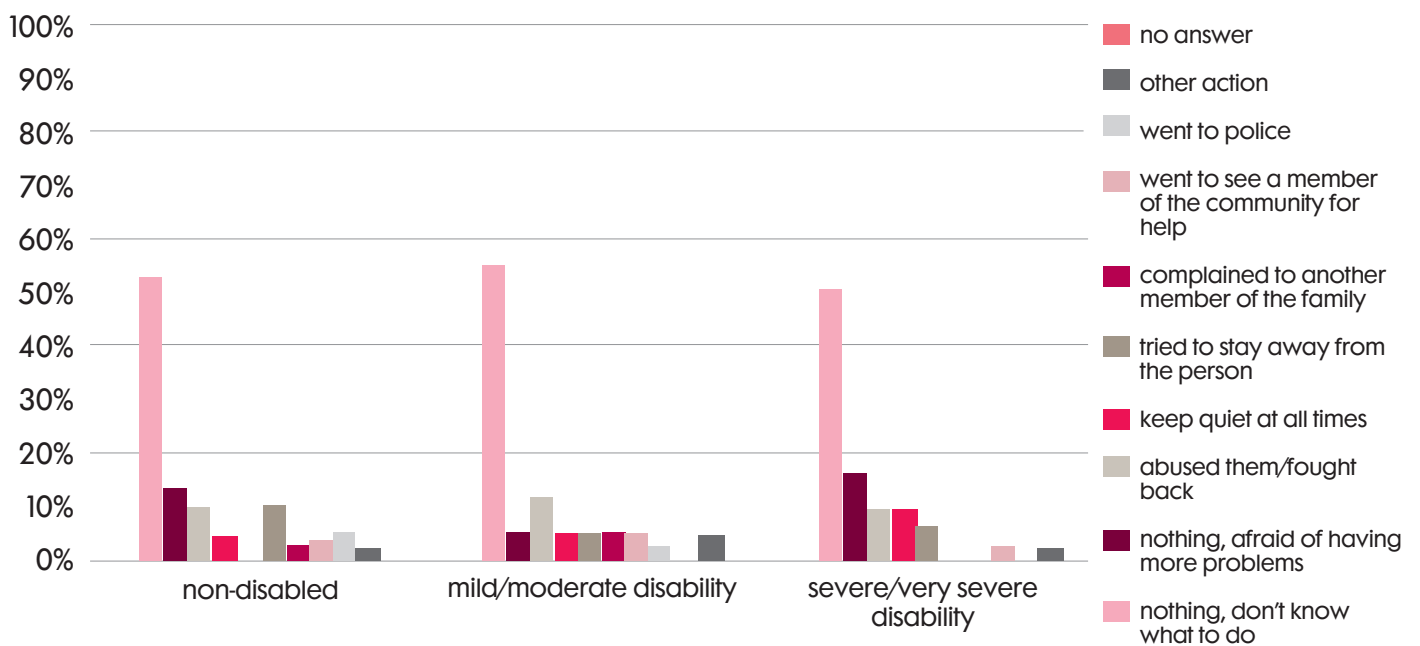
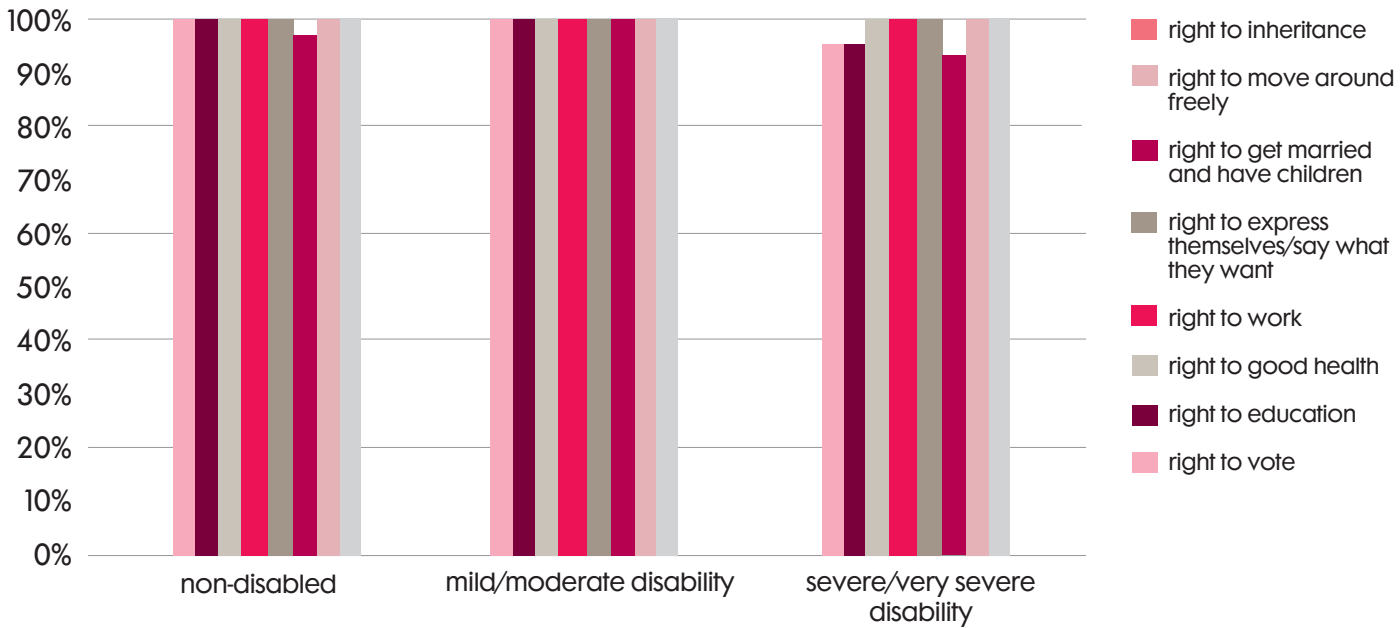
Figure 48 Who mistreated you**Figure 49 What did you do after**

Figure 50 What rights should/do people with disabilities have



7.3 Conclusion

This chapter identifies several encouraging features of social participation for persons with disabilities: similar levels of commitment to leadership roles at community level as for non-disabled persons; the capacity to make friends and the current ability to participate in some, although not all, community activities; and a general consensus that persons with disabilities should have the same rights as everyone else.

However, prejudice and discrimination remain areas of concern and can take various, insidious forms. Firstly, accessibility is a widespread problem: public buildings and transport are often not accessible. Secondly, negative attitudes are not only held by many non-disabled people but also seem to have been instilled in many persons with disabilities themselves. As a result of these attitudes, many persons with disabilities report that they do not risk participating in community social activities.

But perhaps the most shocking aspect of the responses to this survey is the level of violence and mistreatment that respondents with disabilities face. The problem is even more critical if one considers that so many persons with disabilities interviewed report they do not know how to react to violence and abuse, how to confront it, or where to turn for help to stop such situations and prevent further situations developing.

General Conclusion

This pilot survey presents a snapshot of the current situation in and around urban areas of Sierra Leone for persons with disabilities. It corroborates many of the assumptions held about the lives of persons with disabilities – such as the degree of social participation and levels of violence and abuse, but also raises questions about others. For example, it finds that economic poverty related to disability at the household level may be more complex and more nuanced than is often assumed. Presenting a comprehensive profile of Sierra Leoneans with disabilities in and around urban areas is thus a first step towards identifying the challenges that lie ahead for programmes and policies. This is particularly timely in that the Government of Sierra Leone has recently signed and ratified the United Nations Convention on the Rights of Persons with Disabilities. It is also in the process of drafting a National Disability Act.

In light of this new legislation, gathering knowledge on specific barriers to income, employment, education, health, livelihoods, vulnerability, risks and poverty provides necessary understanding, information and insights to assist with policy formulation and strategic planning to ensure equity and inclusion for persons with disabilities.

Designs of policies and strategies have to rely on evidence-based knowledge as well as on the participation of persons with disabilities. More research is needed on a larger scale to fully understand issues linked to disability. Furthermore, this study has specifically concentrated in and around urban areas. Information from rural areas is also needed for a full national picture to emerge. Nevertheless, it is hoped that the findings presented in this report will be useful as a basis for further research and data collection, including in rural areas, as well as to support development of future policies and service provision. It may also help to identify the challenges that lie ahead in changing attitudes and improving the lives of persons with disabilities in Sierra Leone.

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About Leonard Cheshire Disability

Leonard Cheshire Disability works with over 250 disability and development organisations in 54 countries worldwide. Our joint programmes support people with disabilities and raise disability up political and development agendas. All work is underpinned by our research centre run jointly with University College London.

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