

Senegal



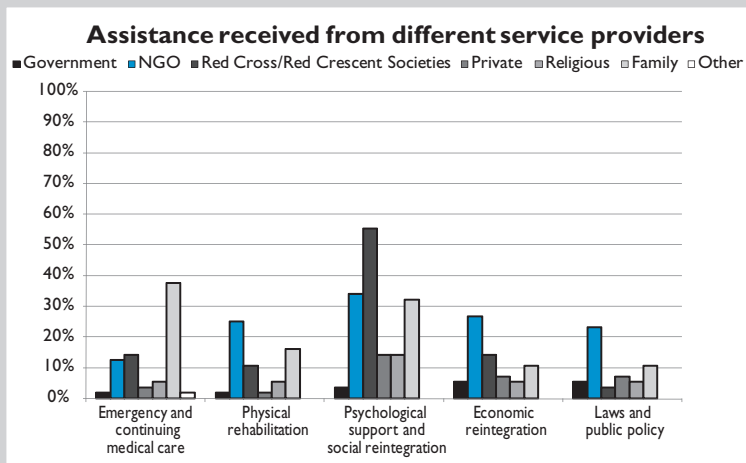
Country indicators

- **Conflict period and mine/ERW use:** Mine/ERW contamination dates back to the conflict around the independence of Guinea-Bissau (1968-1973) and subsequent mining of the border by the Senegalese army. Mines were also used by all parties in the 1982-2004 conflict in Casamance and sporadic use by the armed group Movement of the Democratic Forces of Casamance has been reported since.¹
- **Estimated contamination:** The 2006 Emergency Landmine Impact Survey of Casamance recorded 149 suspected hazardous areas (11km²) and 63km of roads or tracks affecting 93 communities (7% of the population).²
- **Human development index:** 156th of 179 countries, low human development (compared to 157th of 177 in 2004).³
- **Gross national income (Atlas method):** US\$970 – 168th of 210 countries/areas (compared to US\$699 in 2004).⁴
- **Unemployment rate:** 48% (also 48% in 2004).⁵
- **External resources for healthcare as a percentage of total expenditure:** 13.5% (compared to 12.7% in 2004).⁶
- **Number of healthcare professionals:** Four per 10,000 population.⁷
- **UNCRPD status:** Signed the Convention and its Optional Protocol 25 April 2007.⁸
- **Budget spent on disability:** Unknown.
- **Measures of poverty and development:** Senegal is a poor country that relies heavily on foreign assistance. More than 33% of the population lives below the national poverty level and the majority (56%) live on less than US\$2 a day. High unemployment rates resulted in a migration flow to Europe. Ongoing violence in Casamance has isolated the region and prevented economic growth.⁹

VA country summary

Total mine/ERW casualties since 1988: At least 723 ¹⁰			
Year	Total	Killed	Injured
2004	17	0	17
2005	12	4	8
2006	18	8	10
2007	1	0	1
2008	24	1	23
Grand total	72	13	59

- **Estimated number of mine/ERW survivors:** Unknown, but at least 570.¹¹
- **VA coordinating body/focal point:** The National Commission on the Implementation of the Mine Ban Treaty and the Senegal National Mine Action Center (Centre National d'Action Antimines du Sénégal, CNAMS) include VA in their mandate but their role is limited and does not involve implementation.
- **VA plan:** None, nor is there a disability strategy. VA is included in the mine action strategy and disability in the national and regional poverty reduction strategies.
- **VA profile:** Most mine/ERW survivors in Senegal live in the restive Casamance region, where services are much more limited than elsewhere in the country. Throughout 2005-2009, Senegal reported it was committed to VA, but at the same time acknowledged that the needs were not being met due to a lack of resources. The mine action center relied on national and international NGOs and the survivor association to implement activities. Civil society and survivors said that VA was not high on the government's agenda.¹² The only international NGO providing VA services since 1999 ended most of its VA activities in August 2008. Years of conflict and intermittent new outbursts devastated infrastructure and prevented access to services. Throughout 2005-2009, emergency medical care was limited and response times depended on the location of the incident; the army provided assistance. Follow-up medical care was only available in the two regional hospitals, which had sufficient capacity but had intermittent equipment and supply shortages. These two hospitals and their satellite centers also provided physical rehabilitation, which just as follow-up medical care was not free of charge, making services unaffordable for many survivors. Material shortages were noted also here, as well as long waiting lists. Psychosocial support has been provided by international organizations and the Senegalese Association of Mine Victims (Association Sénégalaise des Victimes de Mines, ASVM). The government opened a psychiatric center in 2008 but as of 2009 no mine survivors had been assisted. Throughout



2005-2009 economic reintegration and education opportunities for survivors were inadequate because there were few NGO activities and because survivors had difficulties accessing broader programs for all vulnerable groups. Most survivors were said to be unemployed or self-employed and in need of assistance. Military survivors received separate services, which were mostly free of charge and better, but still had gaps. As of 2009, draft disability legislation had not been approved.¹³

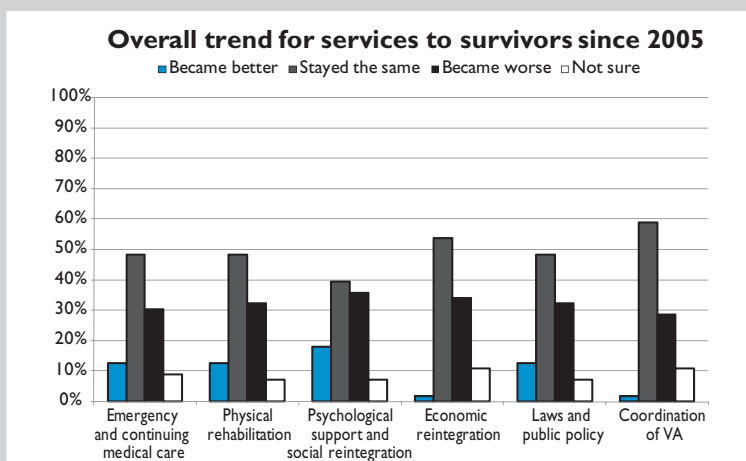
VA progress on the ground

Respondent profile

By July 2009, 56 survivors between 11 and 73 years old responded to a questionnaire about VA progress in Senegal since 2005: 43 men, 11 women, one boy and one girl. Some 64% were heads of households and 14% owned property. Almost half (45%) lived in remote areas without services, 36% in villages with limited services, and 18% in a large city with a variety of services.¹⁴ All were based in the Casamance region where at least 80% of all mine/ERW survivors live.¹⁵ Twenty percent had not received any formal education; 43% had completed primary education or higher; and 23% had attended a few years of primary school.¹⁶ Some 34% of respondents were unemployed after the incident compared to 21% before the incident. More than half (55%) did not feel that their household income was sufficient and the remaining 45% did not respond. This profile corresponds to the casualty profile extrapolated from CNAMS data which indicates that most survivors are men (both civilian and military) injured between 1988 and 2004 in rural areas in Casamance.¹⁷

General findings

The majority of respondents felt that all services had remained the same over the past five years though a significant number also felt that services had declined, particularly economic reintegration. Just 7% of respondents felt that they received more services in 2009 compared to 2005 and 4% thought that the services were better. Some 30% of respondents believed that services for female survivors were “a bit worse” than those available to men; 14% said services for women were “absent”; and 18% said they were “equal”; 30% of male survivors did not respond. Women responded more negatively (42% thought that services were “a bit worse” and 25% said they were “absent”). Nearly two-thirds of people (63%) were not sure if services for child survivors were adapted to their age; 25% felt they were “never” or “almost never” adapted.



The majority (52%) of respondents had not been surveyed by the government or NGOs since 2005 and 29% had been surveyed three times or more. Some 30% felt that this had resulted in being listened to; 18% said they had received more information about services and had fewer problems with bureaucratic procedures. Most (71%)

had never had the opportunity to explain their needs to government representatives. Respondents were all injured prior to 2005 and would only have had their information recorded by the hospital, NGOs or local authorities at the time of the incident. In 2009, ASVM started collecting information on the needs of survivors but lacked the funds to do this systematically – 177 people were interviewed.¹⁸ In May 2009, Senegal stated that identifying the needs of survivors and setting up a surveillance mechanism were among its main challenges.¹⁹

Emergency and continuing medical care

Nearly half (48%) of respondents felt that healthcare had remained the same since 2005 and 13% saw improvements. Also, 50% said that survivors “never” or “almost never” received the medical care they needed. Some 36% found that there were more health centers in their area, but responses depended on where the survivors lived. In cities, 50% saw improvement compared to 28% in remote areas. More than a quarter of respondents (27%) found they could access healthcare closer to home (60% in major cities; 12% in remote areas). Another 38% felt that health center infrastructure had improved and 29% said that staff was better trained. Affordability of services and services by more complete teams were a problem with only 18% of respondents seeing progress; 23% saw more emergency transport.

The survivor responses confirm that medical care was most available in the two regional hospitals in Kolda and Ziguinchor, the latter having more capacity and being better-equipped. Staff capacity has remained the same in the two hospitals throughout 2005-2009. In principle, emergency medical care is free of charge, but continued care is not and medication and supplies always need to be paid for. Military survivors received free treatment but free medication was only available in Dakar. First aid was available at some health centers and army posts, as was some emergency evacuation by the military. However, the timeliness of the response depended on the location of the emergency and the quality of the road. Survivors reported in 2009 that often they needed to be taken to hospital by their families and that ambulances were in bad shape.²⁰ The government also acknowledged that emergency medical vehicles were lacking.²¹

Physical rehabilitation

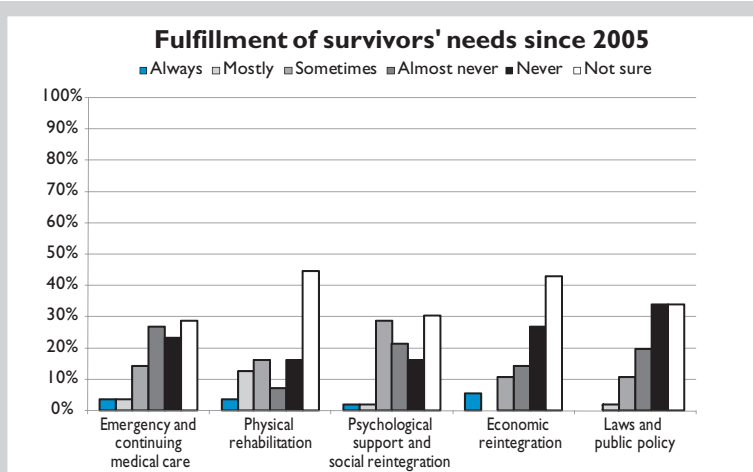
Some 48% of respondents believed that, overall, physical rehabilitation services remained the same since 2005 and 32% thought that services had worsened (40% among respondents in remote areas). The largest group of respondents (45%) was not sure whether survivors received the physical rehabilitation they needed or did not respond; 29% said survivors “sometimes” or “mostly” received these services; and 23% said “never” or “almost never”. When looking at specific progress indicators, responses were largely negative: 27% found that more types of mobility devices were available; 23% said staff was better trained or that infrastructure had improved; and 21% found that the quality of physical therapy and of mobility devices had improved and waiting periods had become shorter. Other indicators registered progress rates of 20% or less: 9% found services more affordable and 4% found that free-of-charge repairs were being increasingly provided.

While considered insufficient by NGOs and survivors, the number of rehabilitation services has not increased since 2005. Services were available in Kolda and Ziguinchor hospitals and in two satellite centers, and all had regular material shortages. But bigger obstacles for survivors were that the services were not free of charge for people without insurance (except for military survivors who receive free services); waiting lists were long; survivors lacked awareness about services and needed help from NGOs or ASVM to be able to access services.²² Particularly since the ASVM fund to cover these costs was discontinued, most survivors were covered by one international NGO working on the issue until the VA program closed in 2008 due to lack of funds.²³ While some respondents saw a decrease in waiting periods, in 2009 the wait for getting a prosthetic limb still averaged 45 days.²⁴ Training for rehabilitation personnel was provided continuously by an international NGO

between 2005 and mid-2008.²⁵ In 2009, the government acknowledged that procedures for obtaining replacement devices needed simplification and that raw materials were lacking.²⁶

Psychological support and social reintegration

Some 36% of survivors thought that overall psychological support and social reintegration services had deteriorated since 2005 and 39% saw no change. Nearly 29% of respondents thought that survivors “sometimes” received the psychosocial assistance they needed; 21% said this was “almost never” the case and just 2% each said the needed services were “always” and “mostly” received. Some 29% of respondents felt more empowered and thought survivors were considered to be “charity cases” less often in 2009 than in 2005. The same percentage was more involved in psychosocial support for other survivors and 25% were more involved in community activities in general or thought that more peer support groups had been created. Almost 18% thought it was easier to get counseling from a psychiatrist and 13% believed that the government was providing more support for psychosocial services.



Formal psychological support in Casamance was only available through a psychiatrist coming from Dakar a few times per year. Peer support groups and informal psychosocial activities have been carried out by ASVM and NGOs throughout the period, but focused more on individuals, and their activities did not translate into a permanent psychosocial support capacity.²⁷ All NGO efforts were dependent on external support, and assistance was often just a small part of broader conflict resolution programs. Basic training was also provided to government staff. In 2008,

the government opened the Kenia Psychiatric Center (Centre Psychiatrique de Kénia) in Ziguinchor. As of April 2009, no mine survivors had been assisted, so respondents would not have perceived a difference.²⁸

Economic reintegration

More than half of the respondents (54%) thought that economic reintegration opportunities had remained unchanged since 2005; 34% saw a decline in services and just 2% saw improvement. While the largest percentage (43%) was not sure, 27% of respondents said survivors “never” received the economic reintegration services they needed; 14% said “almost never”; 11% said “sometimes”; and 5% said “always”. Very few specific improvements were observed. One-fifth of respondents saw more educational and training opportunities, as well as teachers better trained in disability issues. Some 18% felt they could access educational and vocational training opportunities closer to home. Few respondents (10% or less) found that employment opportunities, small business loans or pensions had improved.

Between 2005 and 2009 it was acknowledged that economic reintegration opportunities for mine/ERW survivors were limited. Economic reintegration programs for persons with disabilities were integrated in the national poverty reduction strategy and also in the Casamance regional socio-economic development strategy. Some special schools for children with disabilities existed as did some government vocational training, but this was not free of charge. Other income-generating programs targeted all vulnerable groups, but persons with disabilities found it difficult to access them. Already in 2006, it was noted

that development strategies did not pay sufficient attention to the needs of survivors.²⁹ In May 2009, Senegal acknowledged that one of the main challenges was to facilitate access to employment for survivors. A decree that 15% of those recruited in public offices would be persons with disabilities announced in 2005 did not have implementation legislation to operationalize it as of 2009.³⁰ In 2008, the Ziguinchor hospital records showed that most survivors were unemployed or self-employed but in need of assistance.³¹

Laws and public policy

Nearly half of respondents (48%) said that the protection of their rights had not changed since 2005 and 13% thought that their rights were better protected. Most respondents (54%) thought survivors' rights were "never" or "almost never" respected and 93% of respondents felt that their rights were not a government priority. Some 34% believed that discrimination had decreased and 29% thought that general awareness about the rights of persons with disabilities had increased. However, only 21% thought that legislation and policies relevant to survivors were developed; 16% thought they had more information about their rights; and 13% thought that laws were enforced better.

In 2005, Senegal pointed to pending legislation for persons with disabilities "which should contribute to the improvement of the situation of persons with disabilities."³² However, the draft bill has been stuck in parliament since 2005³³ and in May 2009, the government listed its adoption as a remaining challenge.³⁴

When asked to respond to preliminary findings showing that few survivors saw overall progress, a government representative disagreed. The representative stated that while perhaps not all needs had been met, awareness had been raised. The person added that the responses received would depend on who had participated in the survey as some survivors had been reached but service provision could be hit or miss, depending on the materials available when any given survivor arrived to seek out assistance.

VA process achievements

Year	Form J with VA	ISC VA statement	MSP VA statement	VA expert	Survivor on delegation
2005	NO	NO	YES	NO	NO
2006	YES	NO	YES	NO	NO
2007	YES	YES	NO	YES	NO
2008	YES	YES	YES	YES	NO
2009	NO	YES	N/A	YES	NO

Note: Senegal reported casualty data in its 2009 Article 7 Report but did not provide VA information as in previous years.

Senegal declared in 2005 that "it attaches great importance to assistance to mine survivors."³⁵ VA was included in the mine action strategy and activities, but implementation of activities was delegated to NGOs, DPOs and the regional hospitals. Funding was left almost entirely to the international NGOs, which were dependent on intermittent and decreasing external funding. The international commitment to provide immediate relief has not been matched by long-term capacity building of national authorities or service providers. The government has launched revival plans for Casamance, which to some extent take the needs of persons with disabilities into account. But the region remained the least developed and troubled by conflict thus hampering VA/disability services. According to survivors, the government lacked political will (91%) and it had not increased its involvement (80% saw no progress) or funding (84%).

A government official indicated that the lack of progress was due to coordination challenges and added that, in 2004-2005, VA activities were implemented on an *ad hoc* basis. The representative added that Senegal's expectation when becoming part of the 26 countries with the greatest numbers of survivors and, the greatest responsibility to act, but also the greatest needs and expectations for assistance had been that it would increase

coordination. A second challenge to making progress had been funding, which Senegal had also been expecting as a result of the informal, so-called VA26 process. As of May 2009, the representative did not feel that Senegal had benefited from the VA26 process even though the person felt that the government had demonstrated its commitment to VA and could thus expect international technical and financial assistance.

Already in 2004, NGOs criticized the government for not having a civilian VA program so that international assistance could be sought to supplement Senegal's insufficient national means.³⁶ VA has since 2005 been under the mandate of mine action authorities, but a functioning mine action center (CNAMS) was established only in 2007. CNAMS recognized that the time it took to set up the mine action framework had caused delays in making progress.³⁷ However, since its establishment, CNAMS has directed most of its attention to political issues and clearance. Government responsibilities for disability issues are unclear, but the lead ministry for disability appears to be the Ministry of Family, National Solidarity, Women Entrepreneurship and Micro Finance. There also is a presidential advisor on disability. CNAMS does not liaise with either body and added "each ministry acts independently and there is no coordination."³⁸

Although CNAMS depends on civil society for implementation of VA activities, NGOs and DPOs said that they were not involved in VA coordination. Few survivors (23%) knew who was in charge of coordinating VA; just 14% saw improved coordination with NGOs; and 18% felt there was better coordination with the disability sector. Survivors were not included systematically in coordination, despite the fact that one of the objectives of CNAMS was to provide technical support to ASVM,³⁹ nor did the government provide any financial support to ASVM's activities. While survivors (through the work of ASVM) were more involved in VA implementation (29% thought so), just 11% felt that the needs of survivors were taken into account when VA priorities were set. Another 18% thought that survivors were included in coordination and 14% thought that survivors were involved in making plans. Just 7% believed that they received regular information about VA progress.

In 2005, Senegal presented some objectives for the implementation of the 2005-2009 Nairobi Action Plan, but these were not SMART, as no timelines or specific targets were set. No revised objectives or plans have been presented since then. In 2008, some activities planned under the mine action strategy were outlined. But again, these were not specific and not time-bound, and they did not address all components of comprehensive VA (for example, psychosocial support or laws and public policies were not included). In 2008-2009 it was announced several times that a VA plan would be developed, and that it would be presented at the end of 2009 to cover 2009-2014, thus not the period under review (2005-2009).⁴⁰

Conclusions

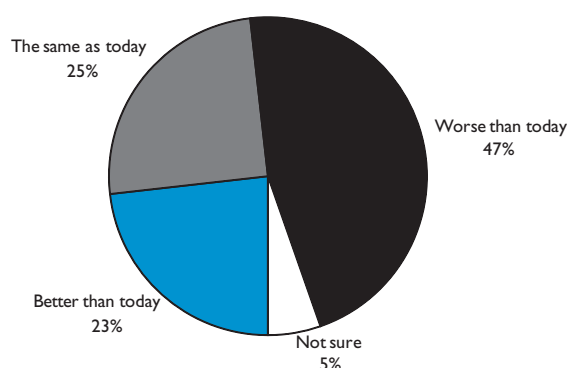
- Senegal remained dependent on the ever-decreasing presence of international organizations to provide VA in Casamance and did not coordinate sufficiently with these organizations.
- Access to services remained problematic, especially for survivors from rural areas due to insecurity, poor road infrastructure, and because of the cost of the services.
- Senegal has not yet developed effective VA/disability coordination mechanisms, and has not linked VA to the disability sector.
- Broader development programs did not take the needs of persons with disabilities sufficiently into account.
- The lack of disability legislation was seen as an obstacle by both the government and survivors.

Suggestions for the way forward

When asked about their expectations for their situation in the next five years, 47% of survivors felt that it would be worse than today; 25% thought it would be the same; and 23% thought it would be better. To assist in a better future ahead the following suggestions may be taken into account:

- Urgently develop, implement and monitor a VA/disability plan with systematic involvement of survivors, NGOs and relevant ministries.
- Ensure that the VA/disability plan complements government development plans and use the VA/disability plan as a tool to guarantee better access by persons with disabilities to the activities under these development plans.
- Identify a clear focal point for VA/disability issues, with a sufficient mandate and capacity to act.
- Ensure that the VA/disability focal point establishes ties between the disability sector (NGOs, DPOs and other service providers) and government bodies in charge of disability issues.
- Ensure that solutions are found to increase national VA capacity, including national funding, while actively seeking continued external funding for the continuation of international NGO activities in the short term.

What do you think your situation will be like in five years?



- Start building the capacity of the government and national NGOs to take on the functions that are now being carried out by international organizations.
- Strengthen ASVM, including by providing financial assistance, and include them as equal partners in VA/disability planning, implementation and monitoring.



Elisabeth Nassalang from lower Casamance
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In her own words: the life experience of Elisabeth Nassalang

In their own words...

The main priority for VA in the next five years is:

- Finance our reintegration.
- Restore our homes.
- Train and support survivors.
- Give us access to bank loans.
- Provide free healthcare.
- Create a direct link with survivors.
- Provide social and medical support.
- Fulfill our basic needs such as food.
- Financial compensation for injuries.
- Improve our living conditions.
- Give training in small business management and provide micro-credit.

In their own words...

If countries really cared about survivors they would:

- Put survivors in charge.
- Finance reintegration projects.
- Improve access to healthcare.
- Help us survive.
- Fund our projects.
- Strengthen or review the support system.
- Respect and apply the Ottawa Treaty.
- Listen.
- Support medical and psychological care.
- Ensure free education for young survivors.
- Make funds available for survivors' associations.
- Give comprehensive support.

In 2000, Elisabeth Nassalang (then 35) went looking for fruit to sell in the fields near her home in Boutoute village, Ziguinchor. She has no memory of actually stepping on the landmine but was later told that this was what caused her to lose her legs. When Elisabeth left the hospital, she went to her father's house since her husband abandoned her and took some of their eight children with him. Elisabeth and her daughters were homeless and had to rely on friends and neighbors. With the help of ASVM, she now has a house and her sons have also come to live with her again.

She started a small shop with micro-credit she received from a Senegalese organization, but the business failed. Again, she has to depend on the charity of her neighbors and occasional help from ASVM. Elisabeth's main concern is for her children and their education, but she also worries about where she will find food from one day to the next.