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### Armed Violence and Disability: The Untold Story

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PRELIMINARY REPORT -- 2012

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# Armed Violence and Disability: the Untold Story



# About Handicap International

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Established in 1982, Handicap International (HI) started its work at the refugee camps in Cambodia, having witnessed the devastating impact of decades of violent warfare on the population, in particular those who sustained serious injuries as a result of landmines and explosive remnants of war (ERW). Since then the organisation has developed an international reputation in providing assistance to persons with disabilities and prevention of death and impairment, through implementing emergency response missions, development programmes and actions against mines, ERW including cluster bombs in over 60 countries worldwide. The primary focus of the association is to work alongside persons with disabilities and other people in vulnerable situations, to ensure their dignity is preserved and their fundamental rights upheld.

HI leveraged its ground-level expertise to engage in policy dialogue in the early 1990s when it became one of the founding members of the International Campaign to Ban Landmines (ICBL). As such, the organisation participated in the Ottawa Process by advocating for an international treaty to ban landmines. This led in 1997 to the signature of the Convention on the Prohibition of the Use, Stockpiling, Production, Transfer of Anti-Personnel Mines and on their Destruction (MBT). HI became one of the recipient organisations to win the Nobel Peace Prize in the same year for MBT's success. HI went on to co-found the Cluster Munition Coalition (CMC) in 2003, through which extensive advocacy resulted in the signature of the Convention on Cluster Munitions (CCM) in 2008, banning the use, production, stockpiling and transfer of cluster munitions. HI's work with persons with disabilities was integral to these coalitions. The organisation published first-of-their-kind reports on the impact of cluster munitions that helped shape the advocacy messages of the CMC. HI also developed the arguments to recommend victim assistance strategies for the CCM, which later translated into the Convention's Article 5 and action plans for the MBT.

Armed violence is a natural extension of HI Mine Action programmes which now integrate small arms and light weapons (SALW) dimension. On the ground, evidence-based threat/risk reduction and behaviour change programmes are applied at community level to prevent injury, impairment and loss of life (for example, in Libya and the Sahel). Our programmes are also addressing the identification and securing of Ammunitions Storage Areas, stockpiles, caches and armouries; marking, tracing and destruction of mines/ERW/SALW and associate ammunition; Information Management and Exchange, pre-post impact assessments, and perception surveys. At the policy level, HI commenced its advocacy on Armed Violence Prevention & Reduction in relation to initiatives by states, such as the Geneva Declaration of Armed Violence and Development and the Oslo Commitments, and with civil society actors through its involvement in the development of networks and alliances. To support this advocacy, HI has co-established the Global Alliance on Armed Violence (GAHV) with other civil society organisations working on armed violence prevention and reduction.

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## List of Acronyms

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<b>DCP</b>	Disability Creation Process
<b>CCM</b>	Convention on Cluster Munitions
<b>CMC</b>	Cluster Munitions Coalition
<b>CRPD</b>	Convention on the Rights of Persons with Disabilities
<b>CSO</b>	Civil Society Organisations
<b>ERW</b>	Explosive Remnants of War
<b>GAAV</b>	Global Alliance on Armed Violence
<b>GC</b>	Geneva Convention
<b>GD</b>	Geneva Declaration
<b>HI</b>	Handicap International
<b>HNP</b>	Haiti National Police
<b>KII</b>	Key Informant Interviews
<b>KPK</b>	Khyber PashtunKhwa
<b>ICBL</b>	International Campaign to Ban Landmines
<b>NGO</b>	Non-Governmental Organisation
<b>MBT</b>	Convention on the Prohibition of the Use, Stockpiling, Production, Transfer of Anti-Personnel Mines and on their Destruction
<b>MINUSTAH</b>	United Nations Stabilisation Mission in Haiti
<b>OECD</b>	Organisation of Economic Cooperation and Development
<b>PPP</b>	Purchasing Power Parity
<b>SALW</b>	Small Arms and Light Weapons
<b>UDHR</b>	Universal Declaration of Human Rights
<b>UPDF</b>	Uganda People Defence Force
<b>UN</b>	United Nations
<b>UNHCR</b>	United Nations High Commissioner for Refugees
<b>UNDP</b>	United Nations Development Programme
<b>UNOCHA</b>	United Nations Office for the Co-Ordination of Humanitarian Affairs
<b>UNOG</b>	United Nations Office in Geneva
<b>WHO</b>	World Health Organisation

## Structure of the report

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This report is written in a **linear progression** keeping the research project's goals, objectives and approach as its backdrop. Chapter 1 (introduction) gives an overview of armed violence along with the justification of this research and its methods. Chapter 2 presents the findings from the four case study regions in countries, situated within its contextual analysis. Each case study draws on its discussion and summary of findings. Chapter 3 presents the discussion and lessons learned from this research, placing assistance and people at the centre of armed violence initiatives. Finally, a glossary, Annexes and references as endnotes are at the end of the report with notes at the end of every page



# Summary

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For every person who dies,  
several thousand more  
are injured, many of them  
with permanent sequelae<sup>1</sup>

Armed violence has powerful, lasting impacts, inflicting severe injuries and impairments and leaving behind broken families, fearful communities and societies in which violence is the norm. It is a daily fear and fact of life for millions of people, particularly those in low income countries and in the marginalised urban zones of more developed countries.

Violence is one of the world's leading causes of mortality for people between the ages of 15 and 44<sup>2</sup>. An estimated 1.5 million die every year<sup>3</sup>, while many more 'suffer non-fatal injuries and chronic, non-injury health consequences as a result of suicide attempts, interpersonal violence, and collective violence.'<sup>4</sup> 16 million injuries caused by violence require medical attention each year<sup>5</sup>, many of which lead to death and disability<sup>6</sup> and incur considerable direct and indirect costs through treatment, recovery and lost productivity<sup>7</sup>.

Persons with disabilities experience heightened exposure to armed violence as a result of various factors, such as exclusion from education and employment, the need for personal assistance in daily life, social stigma, discrimination and communications barriers for reporting violence<sup>8</sup>. Armed violence injuries and disabilities have far reaching consequences not only at an individual level, but also for society and the wider economy of the country<sup>i</sup>.

Despite a growing body of evidence and knowledge, systematic data on the magnitude, scope, characteristics and impact of armed violence on people is scarce. Data on the demographics of the victims, the types of physical impairments sustained due to armed violence, the socio-economic impact on these individuals post-impairment and the type of assistance available are particularly scarce. This study aims to understand the links between armed violence and impairments that can lead to disabilities. It focuses on individuals who sustain impairments resulting from incidents of armed violence. The Disability Creation Process is adapted to analyse the combination of health problems, discrimination and socio-economic exclusion that can lead to disability for people who have sustained serious injury and/or lasting impairments as a result of armed violence.

This report acknowledges the challenges of data collection in the context of armed violence and includes findings from a pilot research project carried out between May 2011 and April 2012 in Medellin, Colombia; Karamoja, Uganda; Peshawar, Pakistan; and Port-au-Prince, Haiti. These regions of four countries were specifically selected for the diverse contexts of armed violence taking place within them.

<sup>i</sup> See, for example, the case of Honduras and the USA in Yacoub S, Arellano S, Padgett-Moncada D (2006), 'Violence related injuries, deaths and disabilities in the capital of Honduras. Injury.' 37(5):428-34. Epub 2006 Feb 21; and DiScala C and Sege R (2004), 'Outcomes in children and young adults who are hospitalized for firearms-related injuries,' *Pediatrics* 113(5):1306-12.

<sup>ii</sup> Of which one per region was selected for case studies in the country reports. The remaining 8 have been used for quotes and to analyse information.

Research methods included a survey of survivors of armed violence with a sample of 713 respondents across the four countries. Key informant interviews were held with 128 local leaders (security forces, government officials, members of the media, civil society members) and family members of people killed or injured by armed violence. Twelve life histories of survivors of armed violence were recorded<sup>ii</sup>; and data was collected from hospitals and police stations. During data collection a number of challenges were encountered, such as unreliable and irretrievable hospital and police data, difficulties accessing volatile regions and reaching women. The difficulties associated with capturing data on armed violence means that we acknowledge a degree of sampling bias (for example survey samples predominantly concerning younger men).

#### Key findings of the research:

- ✎ Armed violence takes many forms, including organised, individual and collective (e.g. gang violence and armed robbery) and these may overlap. In countries and regions where **multiple types of armed violence** are present, there is often a proliferation of small arms and some abuse of explosive ordnance, leading to further violence. One or two types of armed violence, however, tended to predominate in each country:
  - **MEDELLIN, COLOMBIA:** Organised and collective violence, such as gang and criminal violence (and stray bullets from these types of violence).
  - **KARAMOJA, UGANDA:** Cattle raiding.
  - **PESHAWAR, PAKISTAN:** Violence through the use of explosive ordnance and small arms, and family feuds.
  - **PORT AU PRINCE, HAITI:** Gang violence (and stray bullets from this type of violence).
- ✎ Of the survivors interviewed, many were between the ages of 15 and 35 years at the time of their injury and were predominantly **younger and relatively less educated men** and a disproportionate number from marginalised and poor communities.
- ✎ Of the survivors interviewed, a majority of them sustained lasting impairments (either upper or lower limb loss of function, including spinal cord injuries): 91% in Port Au Prince, Haiti; 90% in Medellin, Colombia; 80% in Karamoja, Uganda and 62% in Peshawar, Pakistan. These lasting impairments resulted in reduced economic opportunities and **subsequent economic and social exclusion**, with survivors

experiencing negative impacts on their household income and livelihood, which are multiplied if they have dependents in their households (children, next of kin and/or spouse) after the armed violence incident.

- ✎ Armed violence frequently diminished the subsistence and educational opportunities available to survivors and their dependents, leading to **difficult changes in social dynamics** for survivors within their families and communities.
- ✎ The services available to the survivors were predominantly immediate health care, however **long term health and rehabilitation and other support** wasn't available. Costs of hospital treatment, inaccessible care and ignorance of available services were major barriers to accessing services.
- ✎ There was **limited government assistance** either available or accessible (including justice systems), even in Colombia where government victim assistance mechanisms exist for survivors of political violence or landmines and Explosive Remnants of War. Follow up health care is also extremely inadequate, so families bear the burden of responsibility for assistance.

Most of the survivors of armed violence we interviewed sustained lasting impairments which left them marginalised, neglected and living in relatively dangerous areas. Weak government institutions and protection services, unemployment or limited alternatives to formal employment have severe economic and psychological impacts on survivors and their families who experience stigmatisation and discrimination.

A number of lessons were learned during the course of this research. Researching armed violence and disability is challenging due to a number of factors. Unsystematic, poor data collection and unreliable, inaccessible data in hospital and police registers also pose a serious impediment to the development of even a snapshot of the problem. Understanding the local political environment is critical and key contacts/approvals need to be made beforehand to enable access to volatile, insecure areas and to ensure that victims are reached. Reaching women can be a particular challenge, not least because of gender and cultural norms.

The links between armed violence and disability are under-researched and under-reported. Building evidence is essential to help foster sound policies, which are grounded in realities. Further research to analyse the impact of armed violence on populations with disabilities, women, and affected families and communities is now needed to deepen our understanding.





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# 1.

**Defining armed violence:** the intentional use of weapons, threatened or actual, to inflict death, injury, lasting impairments, or psychological harm that undermines the safety, security and development of communities.

# Introduction

---

Recent years have seen increasing interest in, and awareness of, the causes and consequences of weapons use and proliferation of attempts to define armed violence. Various organisations have attempted to define ‘armed violence.’ The OECD defines armed violence as ‘use or threatened use of weapons to inflict injury, death or psychological harm, which undermines development.’<sup>9</sup> The Geneva Declaration Secretariat (GD) defines it as, ‘the intentional use of illegitimate force (actual or threatened) with arms or explosives, against a person, group, community, or state that undermines people-centred security and/or sustainable development.’<sup>10</sup> The WHO defines violence as, ‘the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, mal-development or deprivation.’<sup>11</sup>

Key to these definitions are the notions of ‘intentional’ violence, ‘threatened or actual use of physical force,’ and ‘injury, death, psychological harm, security,’ and ‘sustainable development.’ Building on these definitions, armed violence is defined in this report as follows:

**The intentional use of weapons, threatened or actual, to inflict death, injury, lasting impairments, or psychological harm that undermines the safety, security and development of communities**

Armed violence can take place in any contexts, be that in conflict, post conflict, transition or peaceful settings. Armed violence can be categorised into five types<sup>12</sup>:

- ✘ inter-personal (domestic or community/social);
- ✘ collective/organised (social or political violence, pre- or post-conflict);
- ✘ criminal (individual or collective economic violence);
- ✘ conflict (intense political violence);
- ✘ institutional (state violence).

These forms are context-specific and can interact with each other at ‘an individual or collective level and be organised or unorganised in nature.’<sup>13</sup>

Violence is a leading cause of death for people aged 15-44 years<sup>14</sup>. For every person killed directly in armed violence, between 4 and 15 people may also die at a later stage<sup>15</sup>. According to OECD (2009), an estimated 740,000 people are killed every year directly or indirectly by armed violence<sup>16</sup>. A recent study on lethal violence by the Geneva Declaration Secretariat (2011) suggests that 526,000 people are killed

every year, of which 396,000 are intentional homicides (estimated 60% committed by firearms<sup>17</sup>); 55,000 from direct conflict deaths, 54,000 from unintentional homicides and 21,000 killings occur during legal interventions<sup>18</sup>.

While there is extensively documented mortality data, limited information exists on people who are non-fatally injured or who indirectly suffer in the aftermath of armed violence. According to a recent Small Arms Survey (2012), ‘worldwide, at least two million people are living with firearm injuries sustained in non-conflict settings over the past decade. Their injuries generate considerable direct and indirect costs, such as those incurred through treatment, recovery, and lost productivity.’<sup>19</sup> In addition to people living with injuries, there are many who suffer from chronic, non-injury health consequences<sup>20</sup>, such as physical and mental health problems and impaired social and occupational functioning<sup>21</sup>. The burden of armed violence extends to families, friends and communities who bear social and economic costs<sup>22</sup>. In Honduras and the United States of America (USA), for instance, armed violence injuries and disabilities have far reaching consequences not only at an individual level, but also for society and the wider economy of the country<sup>23</sup>.

Persons with disabilities in particular are at increased risk of violence due to various factors such as exclusion from education and employment, needs for personal assistance in daily life, social stigma, discrimination and communications barriers for reporting violence<sup>24</sup>. Individuals with mental health illnesses are particularly vulnerable<sup>25</sup>.

Although available evidence highlights the magnitude of armed violence and its negative effects, study methods and approaches vary, with limited quantitative or qualitative synthesis of these data. Much of the evidence **does not**:

- ✘ systematically differentiate between pre-existing disability and disability as an outcome of armed violence<sup>26</sup>;
- ✘ disaggregate between different types of impairments sustained<sup>27</sup>;
- ✘ focus on lower income countries, but instead concentrate on high income countries such as the United States of America and the United Kingdom<sup>28</sup>.

Collecting complete and reliable information on the aftermath of armed violence is a challenge due to the complexity of these contexts. Lack of access to survivors, lack of standardised norms for survivor identification, negative experiences with health care workers, security constraints, etc.<sup>29</sup>, impede the implementation of more holistic information, management, exchange and research.

# What is Disability?

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An exploratory research project was, thus, implemented in mid-2011 to support and fill gaps in knowledge on the consequences of armed violence and to add to the body of knowledge on armed violence from lower income countries. The research aimed to:

- ❑ identify the **profile of survivors** who sustain lasting impairments as a result of armed violence;
- ❑ assess the **socio-economic impact** on the lives of the survivors and their families;
- ❑ determine the **available assistance**.

The research was conducted in four regions severely affected by violence in four countries: Medellín, Colombia; Karamoja, Uganda; Peshawar, Pakistan and Port-au-Prince, Haiti, between September 2011 and April 2012. These countries were chosen from a series of consultations internally and with experts from a list of predetermined criteria.

This report, while acknowledging the difficulties of data collection in the context of armed violence, presents descriptive analysis of the findings drawn from the primary and secondary research methods of the explorative research (see: methodology) in building evidence on the impact of armed violence, focusing on people who sustained lasting impairments in the four regions. In doing so, it demonstrates that armed violence is a cause of disability.

Like armed violence, **disability** is a complex concept, which is dynamic, evolving, multidimensional and contested<sup>30</sup>. As such, this section of the report does not provide an exhaustive analysis of the concept of disability, but rather an introductory explanation from which it is possible to identify the key linkages with armed violence and to review the findings of this research.

Different models are used to define or explain disability and these shape political decisions as well as social responses

- ❑ The **Charity Model of Disability** was first used to mobilize aid and charity, and relied on the values of solidarity and humanity. This model has been seen as reinforcing negative stereotypes of persons with disabilities, rather than seeing them as people with capacities who are equal members of society.
- ❑ The **Medical or Individual Model of Disability** places emphasis on the medical 'problem' of an individual. This view presupposes that the needs of persons with disabilities can only be addressed by trying to cure or fix their medical problems.
- ❑ The **Social Model of Disability** offers a broader perspective, identifying discrimination **within** society as the major barrier to inclusion and equal rights for persons with disabilities. This can be an empowering conceptual model which challenges the root causes of exclusion by seeing persons with disabilities as agents for development.

Handicap International identifies persons with disabilities as **'persons with lasting physical, mental, intellectual or sensory impairments, which, when combined with certain barriers, prevent them from participating in society on the same basis as other people.'** This definition is in line with the International Convention on the Rights of Persons with Disabilities (CRPD), the International Classification of Functioning, Disability and Health (ICF), and the Disability Creation Process (DCP), all of which broadly define disability not simply as an impairment, injury or illness – but rather as a **complex interaction** between a person's health condition and environmental or contextual factors. As stated in the WHO and World Bank Report on Disability 2011, **'defining disability as an interaction means that 'disability' is not an attribute of the person. Progress on improving social participation can be made by addressing the barriers which hinder persons with disabilities in their everyday lives.'**<sup>31</sup>

The Disability Creation Process (DCP), as detailed in Box I, is Handicap International's preferred model for explaining disability as a relative situation, which varies according to context and environment. For this research, the DCP has been used as a benchmark for understanding the linkages between armed violence and disability. Put simply, the DCP allows us to understand that a combination of **health problems, discrimination and socio-economic exclusion** can lead to a situation of disability for people who have sustained serious injury and/or lasting impairments from armed violence<sup>32</sup>.

<sup>31</sup> This research analyses information on people who become Impaired as a result of Armed Violence and not with existing disabilities.

## BOX 1: THE DISABILITY CREATION PROCESS

(A Global approach endorsed by Handicap International)

Disability is considered a disturbance in a person's **life habits** as a result of **personal factors, impairment, or environmental factors (obstacles)**.

- Impairments: injury or illness that cause loss or limitation of physical and psychological function or alterations in body structure (for example, paralysis or blindness).
- Risk factors: elements that potentially causes disease, trauma or any other disruption to a person's integrity or development.
- Personal factors: characteristics belonging to a person (age, sex...) that are his/her prospective capabilities.

Environmental factor refers to the social and physical dimension which determines the organisation and the context of the society. It includes:

- Facilitators that contribute to achieving life habits (for example, accessible infrastructure);
- Obstacles that hinders the person in achieving life habits (for example, discrimination or inaccessible infrastructure). These obstacles combined with a person's social participation lead to disabling environments.

Life habits are a current activity or social role promoted by the person or his socio-cultural context. A social participation situation means the full achievement of a person's life habits.

Disability is thus a **relative situation**, which varies according to the **context** and the **environment**, but can be modified by reducing the impairment and developing capabilities and also by adapting the environment (see Annex 1 for the DCP model).

Approaches to measuring disability prevalence are diverse and vary across countries<sup>32</sup>. Depending on the purpose, the application of data, the conception or definition of disability, the aspects of disability examined etc<sup>33</sup>. Data collected solely using a medical approach is not an adequate proxy for disability information. 'Without information on how particular health conditions in interaction with environmental barriers and facilities affect people in their everyday lives, it is hard to determine the scope of disability.<sup>34</sup>' In this light, collecting and analysing information on disability is challenging for the variable of analysis has a broad range.

Particularly in an armed violence context, where there are a number of obstacles that impede any data gathering, attempting to measure disability can be a daunting task. It has been reported that the impact of armed violence is significant in

poorer countries with lower ranking Human Development Index (HDI), where there are 'weak public institutions, systematic economic and horizontal inequalities, persistent exclusion of minority groups, highly unequal gender relations, limited educational opportunities, high rates of unemployment, the presence of organized crime and illicit markets, and the availability of illegal firearms and drugs.<sup>35</sup>' In these cases, due to insecurities, the internally displaced, disabled, marginalized, vulnerable and neglected sections of the society are often locked into poverty<sup>36</sup>, with many facing worsening economic conditions.

This report presents analysis of the retrievable information on disability in an armed violence context. It attempts to explain how armed violence survivors sustain lasting impairments and the subsequent socio-economic factors which can lead to disability.

# International Frameworks and Standards on Armed Violence and Disability

Given the global extent of injuries and deaths caused by armed violence, and the impact it has on people's fundamental rights, some international standards have been developed to help address root causes, combat effects, and to advocate for the prevention of armed violence. One of these measures is the non-binding Geneva Declaration on Armed Violence and Development (2006), followed by the Oslo Commitments in 2010. The Geneva Declaration is intended to 'strengthen the efforts of states and civil society organisations to integrate armed violence reduction and conflict prevention programmes into national, regional, and multilateral development frameworks and strategies.<sup>37</sup>' The declaration highlights three components: advocacy, measurability and programming. The Oslo Commitments aim at achieving measurable reductions in armed violence and to realise the existing Millennium Development Goals by 2015<sup>38</sup>.

The Convention on the Rights of Persons with Disabilities (2008), a legally binding instrument and policy commitment, stipulates in Article 11 that in situations of risk and humanitarian emergencies, 'all State Parties shall take, in accordance with their obligations under international law, including international humanitarian law and international human rights law, all necessary measures to ensure the protection and safety, including situations of armed conflict, humanitarian emergencies and the occurrence of natural disasters.<sup>39</sup>' However, the Article

is restricted to protection and safety; there are no measures for assistance or prevention. The article does not incorporate non-conflict settings.

Recent decades have also seen the growing acceptance of a rights-based approach to assistance (CRPD, Convention on Cluster Munitions). A list of existing instruments on this approach for victims is included in Annex 2.

The WHO's 2002 World Report on Violence and Health called for attention to the prevention of violence and unintentional injuries as a key health issue, highlighting the needs of the most vulnerable, including women and children<sup>40</sup>. Urgent need for action was subsequently raised in the UN Secretary-General's 2006 study on all forms of violence against women<sup>41</sup>, and the 2006 UN study on violence against children<sup>42</sup>. In 2009, armed violence victim assistance was included as a programming component of the Guidelines on Armed Violence Reduction published by OECD-DAC<sup>43</sup>. However, apart from the study on violence against children, which includes children with disabilities, none of the above present information on persons with disabilities.

In demonstrating the links between armed violence and disability, this report attempts to understand current governmental actions and obligations in the four countries selected.

## BOX I: THE GOALS AND OBJECTIVES OF THE PILOT RESEARCH PROJECT

This exploratory research set out to fill gaps and support existing knowledge, and was developed **to understand retrospective armed violence experiences that resulted in current health conditions and the consequent impact due to various factors (social and economic) while understanding the existing service structures.**

**Overall goal:** 'To increase the scope and quality of information available on armed violence and disability'

### Objectives:

- ▣ To profile the survivors and those who sustain lasting impairments due to armed violence.
- ▣ To assess the socio-economic impact of armed violence on survivors and their families and communities.
- ▣ To enhance understanding of the needs of victims of armed violence in relation to available services for persons with disabilities.
- ▣ To understand the types of armed violence and contexts where it evolves.

In order to achieve the above goal and objectives, the guiding questions for this research were: **who are the survivors of armed violence, including those who sustain lasting impairments? What is the socio-economic impact on these survivors and their families and communities? And, what kind of assistance did the survivors receive?**



# Methods

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To provide a holistic view on the problematic, a multiple method approach was implemented. These methods were:

- ✎ A **literature review** of existing secondary information from government, non-government, policy and research institutes and organisations in order to present a contextual analysis covering geo-political, social, economic, and historical aspects.
- ✎ **Survey interviews** with 713 survivors of armed violence across the four regions of the four countries, 12 **life histories** and 128 **key informant interviews** (see Annex 4). This was done to assess direct information from concerned people. This report predominantly analyses and presents findings from these responses. The survivor survey has been used as a basis to quantify the facts and the key informant interviews for cross checking and quotes in the report.
- ✎ **Secondary data** from 6 hospitals and 6 police station registries from the regions of the four countries were consulted. This secondary method provided indicators of armed violence in a given area.

To help operationalise the research, a mixture of primary and secondary methods were implemented to: a) generate responses from a representative spectrum within the communities; and b) cross check and triangulate information with different methods for accuracy.

## Primary methods

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Primary methods were implemented over a period of **6 to 7 months in 2011 and 2012**, from September to February in Uganda, September to March in Colombia, October to March in Pakistan and September to April in Haiti (overlapping data entry, verification and analysis). These included:

### Survivor Survey

#### ✎ Sampling

Given the objective of this research to understand armed violence consequences, a **purposive target sampling** technique was applied, where only survivors of armed violence incidents were interviewed. Rigorous mapping was done with existing armed violence prevalence region information from partner organisations. Each of the research regions was selected with a pre developed criteria. One to fourteen areas (see country case studies for names of areas) were selected per region within the countries to ensure the representativeness of areas

of higher levels of armed violence. These areas were chosen with the help of community security mobilisers, in-country researchers and partner organisations. The mapping was done according to the following criteria:

- ✎ Geographically: for key locations to find survivors of armed violence
- ✎ Contextually: to provide an in-depth insight into the unique context of the location and to demonstrate reasons behind its uniqueness.
- ✎ Politically and socio-economically: to understand the conditions of a certain context.

#### ✎ Logistics and field work

The survey was carried out in a mix of urban and rural areas in households, markets, hospitals, and centres: wherever the survivors could be identified. The network of survey locations' key leaders were contacted beforehand to help identify the survivors of armed violence from the existing database of partner organisations.

Due to the lack of information on the existing population of survivors of armed violence, a total of 147-208 interviews were conducted in each country (see Annex 3) to avoid sampling errors and differences in survey sample per country.

In-country researchers were selected by the country team leaders with guidance from partner organisation advisors. To avoid bias in selection, normal job recruitment processes were implemented for the selection of researchers. The job description included criteria for having implemented previous research. The final team selected were a mix of students and researchers, including some persons with disabilities in Colombia.

Two weeks of training were carried out in each of the countries with the in-country researchers. The training included an introduction to the research, use of different methods of the research, practising questions of different methods, role-playing and contextualisation of questions. The trainings ended with area mapping and pre-testing of questions with a small sample of 11 survivors in a different location.

#### ✎ Questionnaire

A standard survey form with mixed open and closed multiple choice questions was contextualised and pre-tested in each country, before translation and implementation. The survey forms were translated into all local languages<sup>iv</sup>.

<sup>iv</sup> The survey forms are available as Annex in the online version of the report.



Five different fields were approached in the questionnaire to provide a standardisation of the fields and questions in all four countries; these questions were later contextualised. These fields were: Part I, developed to generate personal information of the respondents such as age, sex, education, profession, household income etc. Part II, seeking to understand the perception of security within the community such as the major concerns, types of armed violence, and unsafe days and times. The second part was used to re-verify information from survivor's armed violence incident experience with their perception. Part III, focused on the survivor's experience of armed violence incidents. It covered the time, type and the different injuries and impairments sustained. An open-ended question asking survivors to briefly describe the incidents was also included. This part also included open-ended questions on the impact of armed violence within their families and communities. Part IV, touched upon the assistance survivors received after the incidents. It included a number of closed and open-ended questions on different types of assistance the survivors received. This part ended with the survivors' insights on the types of assistance they desired from different actors within their communities such as government, civil society organisations, religious groups, families, etc. Finally, part V examined the survivors' perceptions of weapon usage in their community. This part served to analyse the level and type of weapon proliferation in the countries.

#### ✦ Verification and analysis

The verification process took place in three stages, whereby raw data was tallied against other methods and existing information on the issues. It was further re-verified by the in-country team leader upon entry, the database manager and the country coordinator.

Analysis was done through coding and clustering each of the responses, the codes of which were developed in advance during database creation. The database manager trained each in-country data analyst on coding and data entry. Excel spreadsheets were created for database management of the research and checked. Traditional statistical tool such as pivot tables were used to help provide a descriptive analysis of the key findings.

### Key Informant Interviews (KII)

#### ✦ Sampling

While the survey had a mix of quantitative and qualitative questions, the KII was entirely qualitative. The aim of the key informant interviews was to gain an insight into the situation on the ground and how different key members in the communities responded to the context. The KII also helped in crosschecking and triangulating the survey responses. Key government representatives, political party activists, civil society organisations, government security forces, affected families, and other members of the community such as shopkeepers were target informants. Similar mapping was done to identify these members within the locations of the survey and the regions' headquarters. Existing databases of partner organisations helped in mapping the interviewees.

A total of 18-56 were interviewed in each country, apart from Haiti where there were only 18 respondents (see Annex 4).

#### ✦ Questions

An open-ended guide was developed for this method with all questions having similar standard fields to the survey, except for the survivor experience with armed violence. Role-playing and a number of other exercises were conducted to familiarise the researchers with the questions. Pretesting of these questions was done together with the survey questions. They were all adapted and translated into local languages<sup>v</sup>.

#### ✦ Verification and Analysis

Verification of the data was done in two tiers, one by the in-country team leader and second by the data manager and the country coordinator. All responses were translated into English and entered into Excel spread sheets. Similar to the survey questionnaire, responses were thematically categorised. Each form was then checked against the entered data for accuracy and quotes, these quotes were later transported to a Word file. Much of the KII information has been used in analysis and as quotes in the country case studies to complement the survey findings.

### Life History

Although generally lengthy and involving heavy protocols, the life history method was applied to understand the survivors as people, located within historical, socio-cultural and economic trajectories. Life histories were conducted with 3 survivors per country. The life history samples were chosen from within the survivor representative survey respondents. One life history per case study country was chosen for inclusion in each of the country chapters.

An extensive role-playing exercise was done with the researchers to familiarise them with this method. Some guidelines were given to the respondents in conducting this method.

## Secondary methods

These were applied to complement the findings and provide the necessary analysis. They included:

### Hospital and Police Registry

To develop an account of armed violence data in the regions, hospitals and police registries were examined where available. The research limited data collection for the five year period between 2007 and 2011 to determine recent trends.

Two health care clinics and one hospital in the district headquarters were chosen for the hospital registry. The research extracted information concerning deaths, injuries, treatment, patients' profile and weapons used. Approval from hospital staff in accessing their data, ensuring anonymity of the patients, cross-checking for duplication, etc., guided data collection.

<sup>v</sup> The KII questions are available as Annex on the online version of the report.

Registries at two police posts and one district office were chosen for data collection. The information collected concerned deaths, injuries, victim/perpetrator relation, the use of weapons, and the profile of victims. Prior to approval, building trust and relations were seen as necessary.

Information collection from these two sources proved challenging for the researchers. Different hospitals and clinics had different registry capacities, and some had strict non-disclosure policies. There was also potential duplication of patients who were transferred from health centres to the hospitals. Police were often unwilling to share data from their registries and many police posts did not have organised record keeping procedures. In Colombia, hospitals and police stations were not willing to provide data for the study, though some government data on armed violence was obtained. In Haiti, records from previous years were destroyed in the 2010 earthquake, and the police and hospitals did not wish to share their post-earthquake registries. Hospitals worried about pressure from the state to disclose their records to the police as well.

Given the limited six-month timeline for implementation of the research (September-April, overlapping in some countries), and the difficulties in accessing and reliability of the information, the data from these two sources have not been used or analysed extensively in the report. Where retrievable and verifiable, the information has been recorded.

# Limitations

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A summary of the limitations of the research is given below:

❏ **Pilot research:** With some experience in the field of armed violence and driven by the need to understand armed violence and disability on the ground, this pilot research project was conducted. It does not provide any policy recommendations, but generates analysis of findings with reflections and lessons learned from four specific regions of four countries.

❏ **Representative of the region:** Although sampling was done within each region, the report findings cannot be generalised to the whole country.

❏ **Time and resources:** Given the limited timeframe and resources allocated for this project, a conscious choice was made to choose a small sample of survivors.

❏ **Security:** Due to the nature of the research, there were constant security risks to the in-country researchers. In Haiti, a staff member from one of our partner organisations was shot and killed during research implementation, although the shooting was coincidental and not because of the research. This set back implementation for another month; the final data collection was completed at the end of April. Even with a security protocol that was set in advance, risks evolved and were a constant problem.

❏ **Access to hospital and police registries:** Accessing information due to capacities and disclosure policies of hospital and police registries was challenging.

❏ **Access to women:** Although many reports have identified that men are most often the victims of certain kinds of armed violence, women's victimisation tends to be hidden due the nature of violence they endure (i.e. domestic, sexual). The research endeavoured to provide a sample driven by the use and abuse of weapons, and not the typologies of armed violence, hence most of the violence recorded was crime, gang, militant, and explosives-related. Here, the victims identified were men. The approach in conducting the surveys by contacting key leaders in the community also presented a potential bias in shortlisting survivors the community leaders had easiest access to, most of whom were men.

❏ **Breadth vs. depth:** The research attempted to give a deep understanding of victims of armed violence. In doing so, it was not able to establish a broad global study. This is a limitation as well as an advantage.



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# 2.

## Armed Violence and the links with Disability

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This chapter aims to present in-depth contextual analysis of four regions within four countries with regard to the ways in which armed violence is linked to disability.



# Karamoja, Uganda

Findings discussed from research carried out in: Kotido, Moroto, and Nakapiripirit districts in Karamoja.

## Selected Indicators

❑ **Demographics:** : 35,873,253 population estimated in July 2012<sup>44</sup>. Estimated in 2011: 49.9% under 14 years (8,692,239 male and 8,564,571 female), 48.1% between 15 and 64 (8,383,548 male and 8,255,473 female) and 2.1% over 65 years (291,602 male and 424,817 female).

❑ **UNDP Human Development Index:** 0.446<sup>45</sup> in 2011 (ranked: 161 of 187).

❑ **Gross National Income Per Capita (PPP International \$):** 1,124<sup>46</sup> in 2011.

❑ **Life Expectancy Rate at birth:** 54.1 years<sup>47</sup> in 2011.

❑ **Total Expenditure in Health Care Per Capita (\$):** 115<sup>48</sup> in 2009.

❑ **Health Care Workforce:** 1.2 Physicians and 13.1 Nurses and midwives per 10,000 population<sup>49</sup> (latest year available since 2000).

❑ **Persons with Disabilities data:** Approximately 16% of the total population are living with disabilities as per the population census in 2002<sup>50</sup> (latest available data). This should be seen as an indicative figure, taking into account potential bias in the way disability was considered through the census. For this reason, we do not use the breakdown of figures by type of impairments.

According to the Japan International Corporation and friends report (2008)<sup>51</sup>, the main causes of disability in Uganda are:

- Diseases/illness
- Accident
- Ageing
- Wars
- Congenital and
- Others

❑ **UNCPRD status:** Signatory in 2007 and acceded on the 25th September 2008<sup>52</sup>.

❑ **Progress on Disability:** Set up Department of Disability and Elderly under the Ministry of Gender, Labour and Social Development, National Council of for Disability act 2003, and Persons with Disability Act 2006<sup>53</sup>.



## BOX I: KEY DATES AND EVENTS

- 1971** Unrest in Uganda started with the ousting of president Milton Obote by a military coup led by armed forces commander Idi Amin Dada<sup>54</sup>. Idi Amin's eight year regime was characterised by economic decline, social disintegration and human rights violence on a massive scale.
- 1978** The International Commission of Jurists estimated more than 80,000 Ugandans during Idi Amin's reign<sup>55</sup>.
- 1979** After the removal of Idi Amin, a quasi-parliamentary organ was formed that appointed interim presidency to Godfrey Binaisa<sup>56</sup>.
- 1980** President Obote returned to power. The security forces under Obote had one of the world's worst human rights violation records that manifested in civilian unrest, torture, rape, mass murders, disappearance<sup>57</sup>. This led to fear, anger, mistrust and prejudice among Ugandans along regional and ethnic lines<sup>58</sup>.
- 1980** In response to allegations of rigged elections, the National Resistance Army led by Yuwery Museveni waged a guerrilla warfare popularly known as the 'bush war.' They captured power in 1986.
- 1987** Armed conflict in Northern Uganda was spearheaded by the Lord Resistance Army (LRA) as a response to Museveni's alleged breach of the power-sharing agreement. The 18 year war caused unprecedented suffering to the people of Northern Uganda, leaving hundreds of thousands dead and over 1.4 million displaced<sup>59</sup>.
- 2006** LRA operation is discontinued, leaving the region devastated by the after effects of war

## Brief Background

Armed violence in Uganda since independence has been characterised by regionally focused civil wars<sup>60</sup> driven by fragile government, military and insurgent groups. Millions have been displaced, hundreds of thousands killed and the socio-economic structure of the country has been crippled. Military plays a dominant role in political life and the country still experiences tense periods of violence while transition to multi-party democracy takes place, as evidenced by events around the 2006 elections<sup>61</sup>. There has been protracted violence between ethnic groups of the Karimojong cluster over cattle raids<sup>vi</sup>. Cattle are looted with the use of sticks, machetes, bows and arrows and amatida (locally made Karamoja guns) and is considered a legitimate livelihood. In 1979, the group allegedly acquired modern rifles with the collapse of state law and order and continued raiding cattle with these guns<sup>62</sup>, resulting in loss of lives and livelihood. An estimated 60,000 guns were taken from abandoned stockpiles in Moroto district by the Mateniko clan<sup>63</sup>.

## Karamoja, Uganda

Karamoja region is located in the North-Eastern part of Uganda where an estimated 82% of the population (1,107,308) live in poverty<sup>64</sup>. It is the poorest region in the country<sup>65</sup>. According to a 2008 UNOCHA report, only 46% of the population have access to safe drinking water while 8% access to sanitation. 50% of the population are under 18 years, of which 20% go to school<sup>66</sup>. In 2003, malaria / fever, food insecurity and armed violence led to a drop of 22% in the mortality rate to a level corresponding to that found in humanitarian emergency<sup>67</sup>. Arid conditions and agriculture reliant on intermittent rainfall make pastoralism the livelihood option best suited to the region<sup>68</sup>. Although the Karimojong are mainly known for their pastoral lives, they settle during the short spell rainy seasons to undertake crop production to supplement their animal products<sup>69</sup>. Although statistics are limited, armed violence unquestionably affects the lives of those living in insecure areas. Available statistics are outlined in Box II below:

<sup>vi</sup> The cluster is pastoralist by nature, living and travelling in the borders of Kenya (Turkana and Pokot), Southern Sudan (Toposa), Ethiopia (Merille) and Eastern Uganda (Jie, Dodoth and Karimajong). The Karimojong cluster, one of the major ethnic groups in Uganda, occupies the North Eastern part known as the Karamoja region.

## BOX II: EXISTING STATISTICS ON THE IMPACT OF ARMED VIOLENCE IN KARAMOJA

- ❏ From 1999 to 2003, hospital and clinic records compiled by Mkutu indicated almost 8,000 people killed or injured by small arms related incidents. The wounded-killed ratio was approximately 20:1 (for every 52 deaths and 1054 injured). It was stressed that the records were incomplete<sup>70</sup>.
- ❏ A 2005 Conflict Early Warning and Response Mechanism (CEWARN) regional monitoring reported 545 small arms deaths. Although more robust than Mkutu's, the CEWARN reports are also incomplete and do not record deaths which take place in the bush<sup>71</sup>.
- ❏ According to a UNHCR Report of 29th October 2006, the UPDF killed 48 Karimojong men, women and children, destroyed 166 houses, and arbitrarily arrested, detained and tortured suspects, with evidence of extra judicial killing<sup>72</sup>. Karamoja is considered to have significantly higher levels of small arms deaths and injuries than any other region in Uganda<sup>73</sup>.
- ❏ In 2008, the death rate was recorded to be approaching 60 per 100,000 of the population, making Karamoja one of the world's most affected regions for armed violence<sup>74</sup>.

# Findings of the Research

## Profile of Survivors of Armed Violence

...when there is poverty, they tend to want to steal other people's property and therefore encourage the use of such weapons when they go and steal the property of other people.

Male, 39, Parent of a victim, Kotido

In the three researched districts of Karamoja, police recorded 329 deaths between 2007 and 2011. In the same period hospitals registered 791 patients injured by armed violence of

the total population of 793,000 as per 2002 district census. The age, types of injuries and the nature of the incident were irretrievable. Therefore, the following findings are based solely on primary data collected during this research. One point that could be extracted from the data was the sex of the patients. The hospital data showed 89% male and 11% female registered patients. Corresponding to this, among the 208 respondents of the Survivor Representative Survey, 87% were male and 13% were female, with an average age of 35 years old (see table I below).

**TABLE I: AGE AND GENDER OF INJURED RESPONDENTS**

Age	Male Respondents (% of total respondents)	Female Respondents (% of total respondents)	Row Total (% of total respondents)
0-14	1 (1%)	2 (1%)	3 (1%)
15-35	98 (47%)	7 (3%)	105 (50%)
36-55	61 (29%)	12 (6%)	73 (35%)
56 and older	22 (11%)	5 (2%)	27 (13%)
<b>Total</b>	<b>182 (87%)</b>	<b>26 (13%)</b>	<b>208 (100%)</b>

From our survey sample a majority of those injured were between the age of 15 and 35 years.

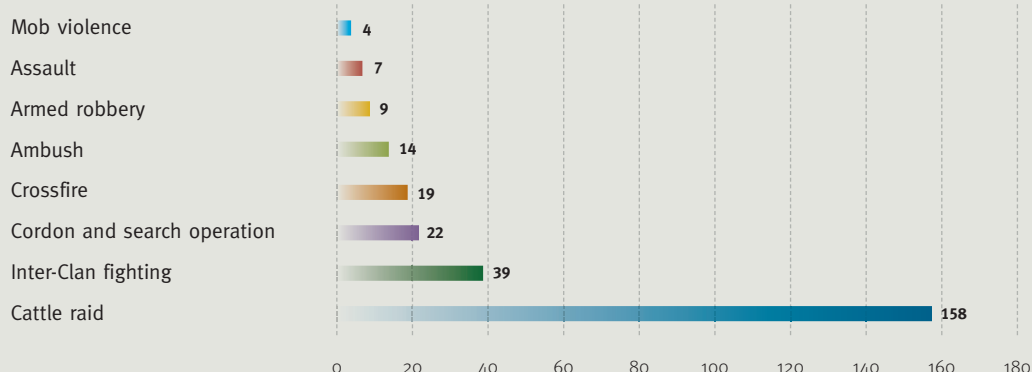
## The Armed Violence Incidents and Lasting Impairments

Although armed violence in Karamoja tends to be related mostly to cattle raids, other incidents reported include cases of inter-clan fighting, cordon and search operation (carried out by Uganda army, Uganda Peoples Defence Forces-UPDF in 2006

to 2007, whereby suspected villages or trading centres or living spaces were surrounded and searched for guns<sup>75</sup>), and road ambush by armed thieves (see Figure I below):

**FIGURE I: INJURING INCIDENT TYPE**

Multiple Responses. Total number of Respondents: 208





Interviews suggest that some of the survivors were involved in armed violence perpetration. The survey identified 38% of respondents as former raiders, some of whom were injured during raids. One respondent recalls, *“we went specifically for the raid in Kenya. We spent 3 days before we reached; we had taken a joint raid with the Jei, Bokora and the Matheniko. We entered into the kraals of the Tukana by 4.am and we fought till 1pm the next day. I was shot by two bullets, my fellow raiders carried me and we were able to escape, but we did not succeed that day.”* – Survey Respondent (Male, 38, amputated leg).

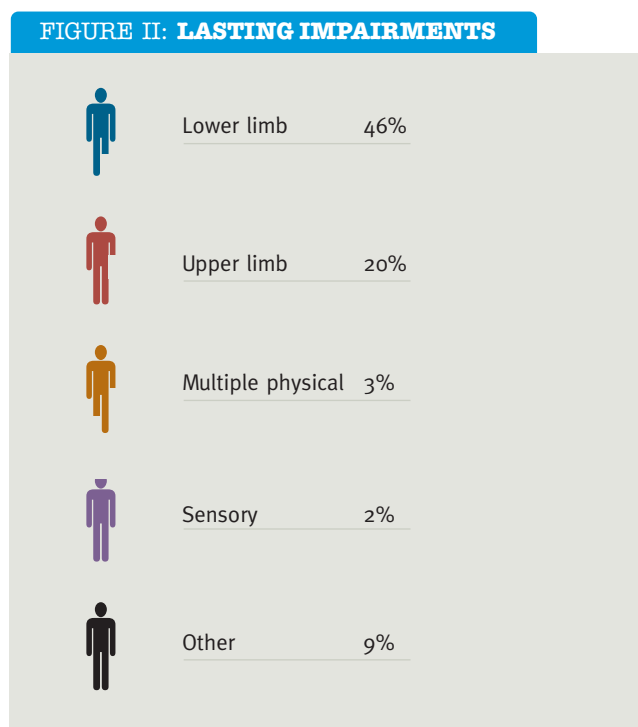
Among the respondents, 21% were injured in the late 1990s, 20% between 2000 and 2004, 52% from 2005 to 2009, and 7% in 2010 and 2011. Early 2000 saw the beginning of the voluntary disarmament process by the Ugandan government, whereby 44% Bokara, 27% Jie and 20% Dodoth clan groups surrendered their weapons, leaving them vulnerable to raids from Kenyan ethnic groups<sup>76</sup>. From 2005 to 2009, guns were allegedly smuggled from South Sudan through other pastoralist groups and the raids intensified with an increase in inter-clan fighting. This was reflected by one of the respondents *“the natives use the guns. From the time of Amin’s takeover, they have acquired those guns and they also get them from Sudan.”* – Political Party member (Female, 42, Moroto). During this period, a forceful disarmament exercise was carried out by the UPDF soldiers (2006-2007), *“it was around 2 am when the UPDF came to my village and told people to get out of their houses. My husband was a cattle rustler and had gone to raid. The army asked us where they were and when we said we didn’t know they shot at us. I was injured and later had one of my legs amputated, but the others ran away on time.”* – Survey Respondent (Female, 24, amputated leg).

Injuries were most commonly caused by small arms: hand-made guns and AK-47 in particular were identified by the respondents. Young men were pointed out as the main actors using these weapons. Other groups were the security forces, unemployed youth, criminal gangs and robbers.

## Lasting Impairments

Among the respondents, 80% have experienced lasting impairments. The most common impairments resulting from the armed violence incidents (see Figure II below) were lower limb impairments (46%) such as amputation, uneven length of legs and paralysis. 20% suffered upper limb impairments (20%) such as loss of hand/arm, motor function; 9% were affected by other impairments such as loss of sexual organs, jaw mobility and chronic pain. Multiple physical impairments such as uneven length of leg and arm were experienced by 3%. Finally sensory impairment such as loss of speech and partial or loss of vision affected 2%. The remaining 20% were injured but did not sustain lasting impairments.

Among the respondents who sustained lasting impairments, the average age was 30 years old at time of injury, of whom 89% were male and 14% were female (see table II below)



**TABLE II: AGE AND GENDER OF 166 RESPONDENTS WHO SUSTAINED LASTING IMPAIRMENTS AT THE TIME OF INJURY**

Age	Male Respondents (% of respondents who sustained Lasting Impairments)	Female Respondents (% of respondents who sustained Lasting Impairments)	Row Total (% of respondents who sustained Lasting Impairments)
0-14	13 (8%)	1(1%)	14(8%)
15-35	83 (50%)	7 (8%)	90 (54%)
36-55	40(24%)	7 (4%)	47(28%)
56 and older	12(7%)	3(2%)	15 (9%)
<b>Total</b>	<b>148 (89%)</b>	<b>18 (14%)</b>	<b>166 (100%)</b>

## Socio-Economic and Psychological Impact of Armed Violence

Exposure to armed violence resulting in loss of physical functioning has a powerful economic and social impact on the lives of survivors, their families and communities, affecting economic well-being and psychosocial interaction. This is further elaborated below.

### ECONOMIC

**After my disability, my family has entered into deep poverty and the community think I am useless.**

Survey Respondent (Male, 30, amputated leg)

Results of the household survey carried out in Northern Uganda in 2004 by the Uganda Bureau of Statistics showed that 72% of persons with disability come from poor households<sup>77</sup>. Among our survey respondents, 42% reported that their current source of income is from agriculture and 42% from informal labour, while 12% were unemployed and the remaining 4% were students or dependents. Cattle keeping and shepherding were an integral part of the culture of the Karamoja region and the main source of income, second to agriculture. Due to their impairments, 43% of the respondents said they changed their profession from cattle keeping to agriculture and charcoal burning. The ones who became unemployed after the armed violence incident (12%) said they resorted to begging and seeking help from family members. Illiteracy was attributed to the limited alternatives for change in employment with 77% of respondents reported being unable to read or write. Given the paucity of formal employment, it is unsurprising that nearly all respondents (95%) said their current household income was insufficient to meet their subsistence and recovery needs. One survey respondent said, *“my family has become so vulnerable. I have become very poor and couldn't take care of the family, so my wife died.”* (Male, 40, loss of vision)

Loss of physical function and poverty have a powerful effect on individual and family well-being. Economic hardship is particularly problematic, with 72% of respondents reported to be heads of households, over half with several dependents, some with more than ten dependents per household. Over one third of respondents explained that after the incident families spiralled into deep poverty, their children having to drop out of school and wives taking responsibility for the family's livelihood. 77% of respondents said armed violence had negatively impacted their economic conditions and increased levels of poverty. One respondent reported that *“my livelihood is based mainly on borrowing money now. I cannot think of a family for I fear I may not be able to provide for them,”* (Male, 23, loss of arm mobility). This change in circumstances has pushed some survivors and their families to resort to violent means to sustain their livelihood: *“people become so poor that they resort to stealing and when you have a gun, you can live a fairly good life”* (Parent of a victim; Male, 75, Nakapiripirit). Others reported suffering from constant stress and trauma.

### SOCIAL

**I am ashamed of limping amidst the others.**

Survey Respondent (27, Male, amputated leg)

The respondent's relations with their families, friends and communities were changed, sometimes negatively, after incidents of armed violence. 12% of respondents reported negative changes in relations with their families, such as neglect and fighting between spouses. One respondent said, *“my family has neglected me”* (Male, 20, amputated hand). 18% of respondents said that relations with community members changed negatively. Some noted that they were discriminated because the community felt they had failed to protect the cattle, others said they were neglected and excluded from community activities. One respondent reported that *“my people laugh at my condition”* (Female, 33, loss of jaw). Another said, *“my family became worried of my security situation, some people and friends stopped talking to me,”* – Survey Respondent (Male, 20, amputated leg).

Furthermore, persons with disability are largely invisible due to the social stigmas surrounding them<sup>78</sup>. In Uganda, regardless of the cause, disabled people are marginalised and considered deserving of their disability. Such barriers lead to long-term socio-economic exclusion and social isolation.

### PSYCHOLOGICAL

71% of all respondents said they experienced negative psychological or emotional effects from the incident or injury, with 40% reporting trauma and stress. 11% said they were in fear, and 20% said they were otherwise negatively affected. Suicide was contemplated by some survivors struggling to adjust to their new condition, *“when I learned of my situation, I was so traumatised that I tried to commit suicide”* – Survey respondent (Male, 19, loss of hearing and partial vision). Another survivor reported, *“I am stressed. I have nightmares of my children who died in the same incident where I was injured”* (Female, 33, no lasting impairment).

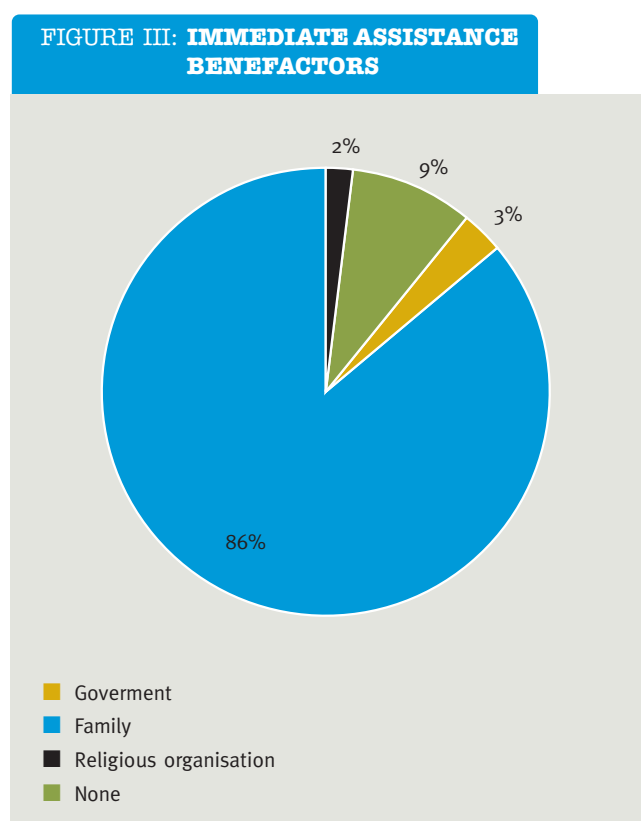
Given the significant social, economic and psychological impact of armed violence on the lives of survivors, their families and communities, it becomes important to understand the type of assistance available for them.

## Survivor Assistance and Lack thereof

I live in abject poverty.  
My children had to drop out of school.  
I have no coping mechanism for this situation

Survey Respondent (Male, 35, amputated leg)

Immediately following the incident, almost all respondents (96%) received medical assistance at a hospital or a local health care centre. Most respondents were helped by their families (86%), who sold their livestock to pay for medical expenses, as described in Figure III below. Although key informant interviews recorded some non-government organisations for rescuing, sensitising and giving provision for food and clothing, the survey did not record the respondents receiving these supports.



Immediate assistance was available to the respondents, with reported services of medication (35%), livelihood support (4%) including economic subsistence, and physical rehabilitation (1%). These hospital services were covered by the families. Taking into account the extended post-incident care needed to fully recover; a majority of respondents (72%) said they were never asked questions about their needs. The survey did not register any long term follow-up health care or economic support to the respondents. This corresponds to the Northern Uganda Baseline Survey (2004) which reported 70% of persons with disabilities had not received any form of physical rehabilitation<sup>79</sup>.

There are currently no provisions for government assistance for survivors of armed violence. In 2010, the Government of Uganda reviewed a Comprehensive Plan of Action on Victim Assistance (CPVA) 2008-2012 to protect and promote rights of landmines survivors and other persons with disabilities<sup>80</sup>. This was not implemented due to lack of funding, limited capacity and awareness among service providers. As per the Cartagena Action Plan (2009), a new CPVA was introduced for 2010-2014. This action plan was developed with the objective of aligning relevant national policies such as the National Development Plan and the National Disability Policy as well as international legislation such as the CRPD, the Cartagena Action Plan and the Convention on Cluster Munitions. For persons with disabilities, the government has adopted a number of laws and policies pertaining to their assistance, protection, prevention and empowerment, including their rights to productive and decent work, basic services and poverty reduction. These laws include<sup>81</sup>:

- ❑ Constitution of Uganda 1995 (Article 21 prohibits discrimination against persons with disabilities);
- ❑ Persons with Disability Act 2006 (elimination of discriminations against persons with disabilities and towards equal opportunities, including 15% tax reduction to private employers to employ persons with disabilities);
- ❑ National Policy on Disabilities 2006 (human rights based framework for responding to the needs of persons with disabilities);
- ❑ Uganda Vision 2025 and the Poverty Eradication Action Program (long-term development framework and initiatives aimed at sustaining rapid economic growth and poverty) etc.

Survivors of armed violence are currently afforded no special protections, with survivors with disabilities falling under the general laws covering persons with disabilities. As one interviewee said, *“nothing has been put in place to help those who have been injured or those who lost their relatives and even property”*- Chairperson I – Local Council I (Male, 41, Moroto), another respondent said, *“the government focus is on sponsoring of other things and not giving assistance to victims of armed violence,”* – Vice Chairperson-Local Council I, (Male, Moroto).

In the Karamoja region, the government has made efforts to provide public healthcare services in different parishes, sub-counties and districts. The national security forces engage in recovery of victims' property, facilitation of justice and protection from further threats. Access to these services, however, is limited, as one respondent said, *“I don't know where to find them,”* – Survey Respondent (Male, 23, Loss of arm). Due to an inadequate supply of medication in the hospitals and poor maintenance of healthcare centres, many respondents to the survey (96%) reported having delayed accessing public services or opted for treatment in private hospitals with their family's support. As one respondent said, *“many people are referred to the hospital for treatment, government has not done anything for the survivors,”* – Medical staff (Male, 39, Moroto). Private hospitals are expensive, exacerbating the economic insecurity of more than a third of respondents. Security forces have not been able to reduce cattle raiding, in spite of forced disarmament. Many cases are not reported to the police due to mistrust and fear of arrest. One interviewee said, *“no service provision has been put in place by the government because some of the survivors are perpetrators and the government is not bothered”* – Social worker (27, Male, Moroto).

A wide range of civil society organisations (CSOs) have worked to tackle the issue of armed violence in Karamoja, from partnering with the government in sensitisation campaigns on small arms and light weapons to direct implementation of programmes, such as food distribution and security and skills training. Advocacy groups have been active in urging the government to develop appropriate policies to address armed violence in line with international standards. According to the respondents, however, none of the survivors were aware of these advocacy groups.

Survivors of armed violence struggle in a challenging environment. Like ordinary people, they seek to live in a safe, secure neighbourhood with employment opportunities. A majority of respondents asked for employment opportunities, access to vocational training and income generating activities, scholastic materials, and particularly appealed to CSOs to build the capacity of survivors and deliver services. There was an evident need for trained clinical staff and proper medication in the hospitals and clinics, trained mental health counsellors, free or reduced health and rehabilitation charges and availability of physical rehabilitation centres and trained therapists. Demands for the protection of victim's rights were put to the government, but with the difficulties in access to services, survivors were sceptical of their needs being met. One responded *“why are you asking me such questions? Are you going to take these forms and bring back the reply? Provide me with assistance that has been neglected for so long!”* – (Male, 44, lower limb impairment).

## Discussion

**The government has to play a bigger role by contributing to funding projects that are directed to the welfare of these people and not leave everything to the donors.**

Political party member (Male, 54, Moroto)

Despite the reduction in armed violence, the implementation of legislation and a range of support projects, those with impairments are unable to sustain their daily lives. The government is progressing towards assisting survivors of landmines and ERW, and addressing the needs of persons with disabilities, but those who have experienced armed violence remain marginalised. Changes in long-standing pastoralist cultures, the open transfer of arms, weak government security structures and an abundance of unemployed young men are some of the factors which contributed to the escalation of armed violence. These challenges must be addressed in holistic and multifaceted care and assistance programmes. The **lack of social safety nets, negative cultural practices, weak legislative enforcement and insecurity** need to be addressed in programming to support survivors. Below is a summary of main findings as presented in the text:

### BOX III: SUMMARY OF MAIN FINDINGS

- ❑ Cattle raid, inter-clan fighting and ambushes are the most common form of armed violence in Karamoja. The common weapons identified were small arms.
- ❑ The arid landscape with heavy agriculture-based income dependency, poverty, pastoralist culture and inadequate service outreach characterises Karamoja as the poorest region in Uganda
- ❑ A majority of respondents were between the age of 15 and 35. They were predominantly men and likely to be involved in cattle raid, inter-clan fighting and ambushes themselves.
- ❑ 80% of the survivors (166 of 208 respondents) of armed violence sustained lasting impairments, most commonly upper and lower limb loss of function and amputation. The average age of these individuals during the time of injury was 30 years old. Those who sustain lasting impairments experience severe economic consequences, due to change or loss of employment and illiteracy exacerbates economic exclusion. Impacts on social relations with families, friends and communities are often negative, with many respondents reporting psychosocial distress, trauma, stress and fear.
- ❑ Generalised, negative perceptions of persons with disabilities, socio-economic exclusion and psychological trauma makes respondents vulnerable to further risks.
- ❑ Survivors receive informal assistance from their families for hospital expenses, covering medication and treatment, but very little by way of physical rehabilitation services. Long term health follow-up and economic support are non-existent.
- ❑ Although government has made some progress in providing assistance to victims of landmines and explosive remnants of war and other persons with disabilities, there is no specific government provision for victims of armed violence. A majority of the survivors and those who sustained lasting impairments in Karamoja have not received government support.
- ❑ The service providers are focussed on community and food security, peace-building and material support. Accessible assistance for victims of armed violence was not found.
- ❑ A majority of respondents (72%) have never been approached or asked questions about their needs.

## Maria (alias) in first person narrative

My family comes from Pokot in Kenya. My great grandparents moved to Nakapiripirit in Uganda because another tribe burnt their homestead. Even in Uganda, my family migrated to two other places when many of my tribe people (Itimarino clan) started dying. My grandfather was a well-known raider. He passed his wealth to my father and taught him how to raid. He also made sure that my grandmother was married traditionally with cows to showcase his status to the other clan. Following my grandfather's steps, my father also became a raider. He had three wives; my mother was the eldest with five children. I am the first born from my mother. To support the family, my mother used to sell firewood. My mother was the initiator of women into marriage. Her duty as an initiator was to cast out evil spirits; she was also allowed to curse. She was the women's leader because she was the eldest wife of the eldest son. My father had many roles: he was a herbal doctor and a cattle raider. At that time, cattle raiding was different- they used to steal cattle and disappear ensuring no one was left injured.

As a child, I used to go to collect firewood, fetch water and look after my siblings. I went to school but did not know what class I was in because I only went there to eat the porridge that the school provided. When I stopped school, I was made a shepherd. I looked after the cows for three years. As I grew older, I danced the Karimojong traditional dance in the evenings. These dances were performed as celebration dances when the raid was successful, as well as for potential engagements when men would search for their future bride. That is where I met my husband. He was also a raider.

One day, my parents and I had gone to collect charcoal and we met a group of warriors. The warriors demanded us to tell them where the cattle were. We said we didn't have cattle then and that we were there to pick up some charcoal. They asked for charcoal from us, we gave it to them and they left. But after a few minutes, two of the warriors came back and showered bullets on us. My parents died instantly. I was shot on the elbow, shoulder and pelvis. I was taken to the Matany Hospital where community members paid for the treatment. Post healing, I am unable to cut trees for charcoal because of a lot of pain in my shoulders.

During the time of disarmament, my husband was captured and tortured by the UPDF. Now, my husband cannot do anything, he is suffering chronic pain. I sell firewood; carry water for people in town and some casual labour to sustain my family. I still cry myself to sleep every day thinking of how I lost my parents and the dire conditions that my family live in right now.



# Medellín, Colombia

Findings discussed from research carried out in: Popular, 12 de Octubre, Villa Hermosa, and San Javier comunas of Medellín

## Selected Indicators

❑ **Demographics:** 45,508,205 population in 2010 in 10,570,899 households. 34,387,230 in urban areas and 11,120,975 in rural areas in 2005. 49% male and 51% female<sup>82</sup>. Breakdown by age (2010): 29% age 14 and under, 34% age 15-34, 24% age 35-54, 13% age 55 and up<sup>83</sup>.

❑ **UNDP Human Development Index:** 0.710 in 2011 (ranked 87<sup>th</sup> of 187).<sup>84</sup>

❑ **GNI per capita by Atlas method:** US\$5,510<sup>85</sup> in 2010.

❑ **Life Expectancy Rate at birth:** 70.4 years for men and 77.6 years for women<sup>86</sup> in 2011.

❑ **Total Expenditure in Health Care Per Capita (\$):** US\$472 in 2010<sup>87</sup>.

❑ **Health Care Workforce:** Average number of inhabitants per physician (2008): 802. Hospital beds per 1,000 inhabitants (2008): 1.1.<sup>88</sup>

❑ **Persons with Disabilities data:**<sup>89</sup> 6.3% of the population is classified as persons with disabilities in 2005 (latest available data). This should be seen as an indicative figure, taking into account potential bias in the way disability was considered through the census. For this reason, we do not use the breakdown of figures by type of impairments.

The main causes of disabilities in Colombia, as outlined by the government in 2010<sup>90</sup>, are:

- Congenital or related to pregnancy or birth complications
- Accidents
- Occupational hazards
- Drug use
- Natural disasters
- Non-conflict violence
- Armed conflict
- Difficulties accessing medical services
- Others

❑ **UNCRPD status:** Signed UNCRPD in March 2007, ratified 10 May 2011<sup>91</sup>.

❑ **Progress on Disability:** Signed Inter-American Convention on the Elimination of all Forms of Discrimination against Persons with Disabilities in June 1999, ratified 4 December 2003<sup>92</sup>. Development since 2007 of the National System for Disabilities under the auspices of the Ministry of Health and Social Protection, which integrates national, departmental, and municipal committees on disability, consolidated under Law 1145 of 2007<sup>93</sup>.





## BOX I: KEY DATES AND EVENTS

**1930s and 1940s:** Regional violence due to political competition between the Liberal and Conservative parties.

**1946 to 1958: La Violencia** ('The Violence'), a period of violence with two peaks, from 1948 to 1953 and from 1954 to 1958; claimed the lives of hundreds of thousands of Colombians and included the use of especially brutal forms of killing and torture<sup>94</sup>.

**1958:** Liberal and Conservative leaders agree to end fighting and form a coalition, the National Front, featuring a rotational system of government between the two parties, lasting until 1978. The National Front circumscribed access to the political system for other actors, sparking great discontent, especially among leftists, and leading to the formation of revolutionary guerrilla groups, most prominently the Revolutionary Armed Forces of Colombia (FARC), the National Liberation Army (ELN), the Popular Liberation Army (EPL), the 19th of April Movement (M-19), and the indigenous Quintín Lame movement.

**1980s:** Growing violence by revolutionary groups spreading into fast-growing cities, combined with urban terrorism of M-19 and rapidly increasing violence by drug trafficking syndicates; state weakness leads to development of private security sector and the formation of anti-guerrilla paramilitary groups and death squads dedicated to 'social cleansing.'

**1990s:** Guerrilla groups weaken, but paramilitary violence increases and narcotrafficking violence continues.

**2000s:** Gradual process of demilitarisation of guerrilla and paramilitary groups and the homicide rate begins to fall after having been the highest in the world in the 1980s and much of the 1990s<sup>95</sup>.

## Brief Background

Armed violence in Colombia continues to take place at a high level, with paramilitary, guerrilla and drug trafficking violence all occurring. Many former paramilitary members have established organised criminal gangs known as BACRIM (**Bandas Criminales**), who, along with ordinary street gangs, terrorise communities. Criminal gangs are highly territorial, creating **fronteras invisibles** (invisible frontiers) at the edges of their territory; civilians crossing these invisible borders may be attacked. Given Colombia's long history of violence, some argue that a 'culture of violence' exists in which the use of violence is normalized and accepted<sup>96</sup>. Civilians in Colombia were estimated in 2007 to have approximately 3.1 million small arms, ranking Colombia 25<sup>th</sup> internationally by this metric, a rate of about seven small arms per 100 persons<sup>97</sup>; approximately 23% of these small arms are registered with the state<sup>98</sup>.

## Medellin, Colombia

Medellín is Colombia's second largest city, with an estimated population of 2,343,049 in 2010<sup>99</sup>. It is the capital of the department of Antioquia. The city has long been characterized by social exclusion and inequality, but this situation has begun to improve thanks to a series of redevelopment and infrastructure initiatives undertaken since the 1990s, such as the MetroCable system of aerial trams providing safe access to the **comunas**, the poor, marginalised neighbourhoods in the city's hills. In the **comunas**, people have experienced all varieties of violence, from common crime and state-guerrilla confrontations, to political assassinations, youth gang violence and paramilitary and narcotrafficking violence. Local gangs were incorporated in the 1980s into broader drug-related violence during the war of the Medellín Cartel, Pablo Escobar's drug trafficking syndicate, with the Cali Cartel. This complex web of violent actors has left Medellín with high levels of violent organized crime and extortion, as well as a large stock of SALW and heavier weapons taken advantage of by the BACRIM. The long duration of violence in Medellín and Colombia as a whole means that robust statistics are available. The findings of existing studies on Medellín outlined in Box II below.

## BOX II: EXISTING STATISTICS ON THE IMPACT OF ARMED VIOLENCE IN MEDELLIN

- ❑ A 2003 Oxfam study of the impact of small arms in Medellín found that 61% of all deaths in the city were caused by homicide, with men aged 15 to 44 suffering the highest casualty rate and 90% of homicides committed with small arms<sup>100</sup>.
- ❑ From 2008 to 2011, there were 6,910 violent deaths in Medellín (6,429 men and 481 women), with 1,650 homicides in 2011; the majority of people killed are adults between the ages of 18 and 35<sup>101</sup>. Violence has been increasing, with 5,253 homicides between 2008 and 2010, an 89% increase over the previous three year period; 33% of these homicides were committed with SALW, the most common cause of death<sup>102</sup>.
- ❑ In 2011, the Medellín region was also the site of the highest number of small arms seizures by the investigative arm of the **Fiscalía**, the national prosecutorial service, which seized 194 pistols and 73 revolvers in its operations against criminal organisations, 26% of its total national small arms seizures<sup>103</sup>.

# Findings of the Research

## Profile of Survivors of Armed Violence

It was not possible to collect police and hospital data in Medellín, but according to data obtained from the government of Medellín's Information System on Security and Cooperation (SISC), there were 5,859 homicides between from 2009 through 2011. 94% of people killed were male and 6% were female. Most of those killed were young, with 40% between the ages of 18 and 26, and 21% between the ages of 27 and 32. Over this time period, 5,066 recorded homicides (86%) were committed with small arms, while only 5 were committed with explosive ordnance. 69% of homicides took place in the streets. The National Police in Medellín also reported confiscating a total of 6,804 arms from 2009 through 2011, 12% of which were homemade.

The problem in Comuna 13 is that we have over 16 years of occupation, first of the guerrillas and then of the paramilitaries, which has generated the creation of armed groups and gangs that are part of the territory and the social fabric, so the youths are already permeated not only by the problem of violence, but also by drugs, narcotrafficking and drug dealing. This is a latent problem in society.

Civil society member (Male, 26)

The 198 survey respondents, 87% of whom were male and 13% of whom were female (corresponding to the gender breakdown in the homicide data in Table I below).

**TABLE I: AGE AND GENDER OF INJURED RESPONDENTS**

Age	Male Respondents (% of total respondents)	Female Respondents (% of total respondents)	Row Total (% of total respondents)
0-14	1 (1%)	0 (1%)	1 (1%)
15-35	94 (47%)	13 (7%)	107 (54%)
36-55	71 (36%)	11 (6%)	82 (41%)
56 and older	6 (3%)	2 (1%)	8 (4%)
<b>Total</b>	<b>172 (87%)</b>	<b>26 (13%)</b>	<b>198 (100%)</b>

As in the government homicide data, the majority of those injured by armed violence in our sample were between the ages of 15 and 35.

## The Armed Violence Incidents and Lasting Impairments

Violence in Medellín today tends to be related to gang disputes or common crime, a fact confirmed by data reported by respondents on the types of armed violence incidents in which they were injured (see Figure I on page 28).

Interviewees suggest that some survivors of gang violence were involved in perpetration, for *"Violence in Medellín is characterised by the victim's association with people involved in illicit activities... the perpetrator and victim are often confused and victims many times do not want others to know that they have been a victim"* (NGO worker, male, 57). According to one respondent, the injuring incident occurred while *"I was waiting outside on a motorbike for my partner to exit with stolen money from a bank. When he came out, I turned on the motorbike to escape, but a man leaving a parking lot shot me, hitting me in the head, and after that I remember nothing"* – (Survey respondent, male, age unreported, upper and lower limb impairments). Another survivor was wounded in a fight between his gang and another gang: *"Several friends and I had met up in the neighbourhood; we knew that a neighbouring gang was heading our way so we went to wait in ambush for them. During the*

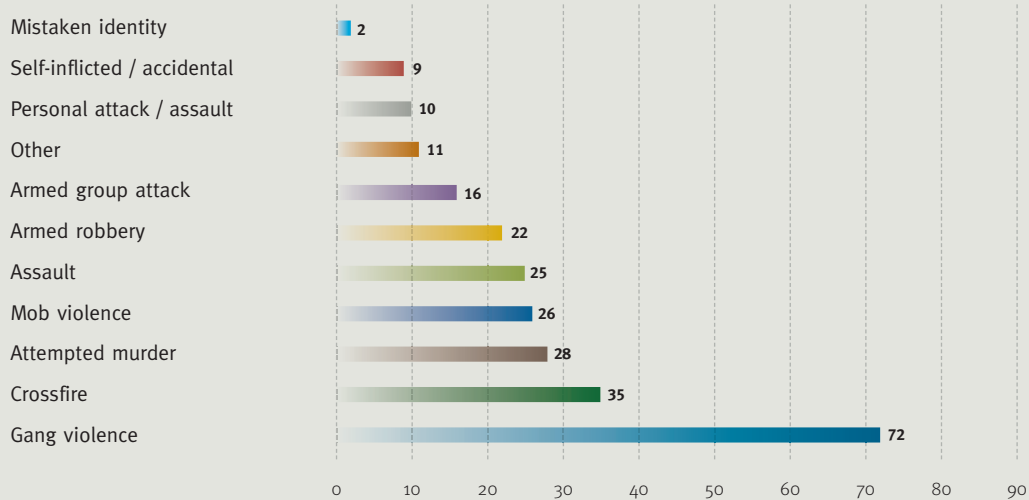
*attack, I felt a shiver in my leg. A fellow gang member told me I was spurting blood and ran with me to escape, later getting a taxi to go to the hospital"* – (Survey respondent, male, 21, lower limb impairment).

Among the respondents, 9% were injured in the 1980s, 37% in the 1990s, 39% between 2000 and 2009, and 13% in 2010 and 2011. The year was not specified for 5 of the respondents. The early 1990s were a peak period for narcotrafficking violence, while the late 1990s and early 2000s saw high levels of paramilitary violence. Since the mid-2000s, criminal gang violence has predominated in Medellín, especially in poorer areas.

Injuries were most commonly caused by small arms, and especially handguns, rather than explosive ordnance. Among all of the injuries, half were caused by revolvers and one-quarter were caused by pistols, the weapon was an unspecified gun in 7% of cases, a rifle in 6% of cases, and an assortment of other guns in the remainder of the cases. Bombs were the cause of injury for only 3% of respondents, while only one respondent was injured by a grenade.

**FIGURE I: INJURING INCIDENT TYPE**

Multiple Responses. Total number of Respondents: 198

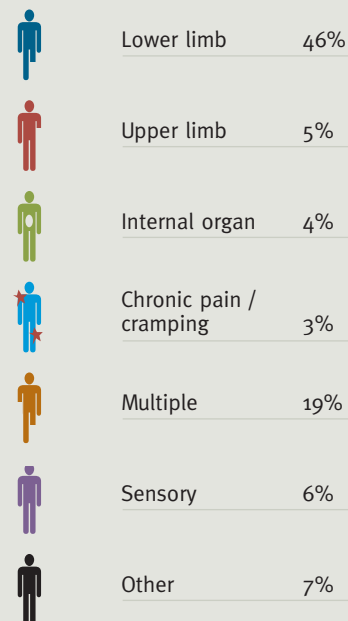


## Lasting Impairments

Among the survey respondents, 90% have experienced lasting physical impairments. The most common impairments resulting from the armed violence incident (see Figure II) were lower limb impairments such as amputation or paralysis (46% of respondents), followed by multiple impairments (19%), no lasting impairments (10%), other physical impairments such as loss of teeth or jaw mobility or damage to sexual organs (7%), sensory impairment entailing a full or partial loss of vision or hearing (6%), upper limb impairments such as loss of hand motor function or loss of arm mobility (5%), damaged internal organ function leading, for instance, to a need for a colostomy bag or an oxygen tank (4%), and chronic pain or muscle cramping (3%). A total of 85 respondents (43%) suffered spinal cord injuries that left them with lower limb or multiple (lower and upper limb) impairments due to resulting paraplegia, quadriplegia, or hemiplegia. A total of 58% of respondents reported long-term reduced mobility.

Among the respondents who sustained lasting impairments at the time of the incident (178 in total), 86% were male and 14% were female, with an average age of 29 years old (see Table II below).

**FIGURE II: LASTING IMPAIRMENTS**



**TABLE II: AGE AND GENDER OF 178 RESPONDENTS WHO SUSTAINED LASTING IMPAIRMENTS AT THE TIME OF INJURY**

Age	Male Respondents (% of respondents who sustained Lasting Impairments)	Female Respondents (% of respondents who sustained Lasting Impairments)	Row Total (% of respondents who sustained Lasting Impairments)
0-14	5 (3%)	0 (0%)	5 (3%)
15-35	90 (51%)	11 (6%)	101 (57%)
36-55	52 (29%)	10 (6%)	62 (35%)
56 and older	6 (3%)	4 (2%)	10 (6%)
<b>Total</b>	<b>153 (86%)</b>	<b>25 (14%)</b>	<b>178 (100%)</b>

## Socio-Economic and Psychological Impact of Armed Violence

Armed violence has had a powerful, extended impact on the economic and social lives of survivors and their families and communities. These impacts are exacerbated by the psychological harm and reduced mobility experienced by most survivors after the armed violence incidents, as described below.

### ECONOMIC

**Economic assistance is needed because in many cases those killed were heads of households, and here this has left many single mothers.**

Affected family member (Female, 31)

Formal employment was relatively rare among respondents, with 35% of respondents reportedly unemployed and 28% informally employed; the most prominent sectors for formal employment were service (14%) and labour (11%). Many other respondents were not working, with 8% describing themselves as retired, 5% as homemakers, 5% as dependent on charity or living on the streets, and 4% as students, meaning that only 30% of respondents were formally employed at the time of the interview. The incident and resulting injuries and impairments led to a reported loss of household income for 66% of respondents due to costs or a change in employment type or status. Given this paucity of formal employment and the loss of household income, it is unsurprising that household income was reported to be insufficient for 85% of respondents to meet their subsistence and recovery needs.

Impairments as a result of armed incidents caused many respondents to change to less physically demanding jobs or to stop working altogether. Of the 94 respondents who said they have changed professions since the incident, 66 (70%) said they did so due to the incident or the resulting impairment. Of the 90 respondents who said they became unemployed after the incident, 37 (41%) explicitly stated that it was due to the impact of the incident or the resulting impairment. One survey respondent said, *“I suffered from depression such that I could not return to work”* – (Survey respondent, female, 37, foot amputated), while another respondent stated, *“I could not work because I do not have mobility”* – (Survey respondent, male, 25, upper and lower limb impairments).

Loss of income and difficulty meeting household needs (18%) were also reported by respondents as the second most common impact of the incidents on their families due to the costs of rehabilitation and frequently the loss of the respondent's income, on which the household had previously depended. 32% of respondents reported being heads of households, with up to 13 dependents who were affected. Not being able to work or find work was a source of psychological stress for some respondents, with one survivor saying, *“I was greatly affected, because in my family they depended on me”* – (Survey respondent, male, 33, lower limb impairment). Family members might also stop working, as one respondent said *“My mother had to leave her job to take care of me”* – (Survey respondent, male, 38, upper and lower limb impairments).

### SOCIAL

**...[my family] did not know how to treat a person with a disability.**

Survey respondent (Male, 35, paraplegic)

Respondents' relationships with their families, friends, and communities were changed, sometimes negatively, after the armed violence incidents. 7% of respondents reported negative changes in relations with their families, including being abandoned by their families or spouses and increased fighting and disputes within the family, with one respondent saying that after the incident, *“I started to see greater disunity and conflict”* (Survey respondent, male, 55, quadriplegic). 8% of respondents said their relationship with their communities has changed negatively since the incident; one respondent said, for instance, *“My buddies often mock me now”* – (Survey respondent, male, 33, damage to sexual organs). A lack of mobility due to impairments has also affected several respondents' social interactions as they are now unable to play sports or visit friends. Families and communities, however, were more often supportive of and empathetic towards survivors, with 49% of respondents saying this of their families. A further 49% said their communities had experienced negative psychological and emotional effects due to the incident, with one respondent saying, *“It was very difficult for my friends to see me [injured]”* – (Survey respondent, male, 28, visual impairment).

Persons with disabilities in Colombia face stigma and social exclusion due to their condition and the failure of their surrounding communities to recognise and adapt to their needs<sup>104</sup>.

### PSYCHOLOGICAL

68% of all respondents said they were negatively psychologically or emotionally affected by the incident and injury, with 16% reporting fear or stress, 11% depression, 5% trauma, 3% loss of self-esteem, and 33% saying they were otherwise negatively affected. Survivors of armed violence may also be more vulnerable to attacks in the future because mobility and mental impairment limits their ability to escape: *“...people who suffer from mental disabilities are highly vulnerable in moments of armed conflict, as well as those with limited physical mobility, who must be in wheelchairs; in these moments of emergency or violent incidents there is an implied message that people need to get away quickly to hide and protect themselves, but these disabled persons are vulnerable and at a great disadvantage to those who can easily escape”* – Civil society member (Male, 60).

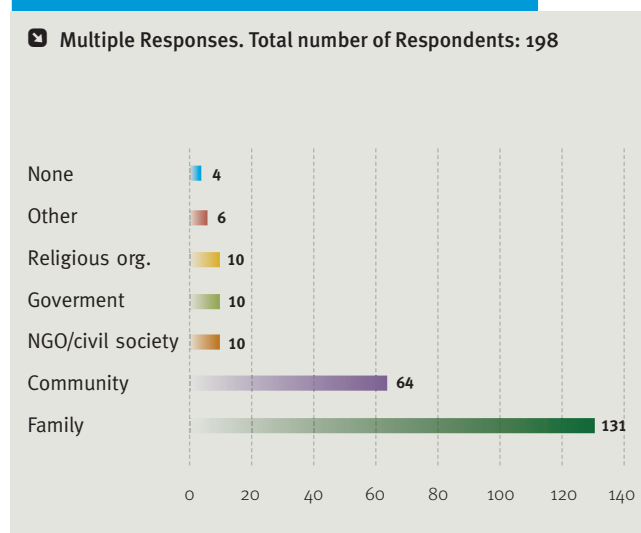
# Survivor Assistance and Lack thereof

Locally there are problems because the program of victim assistance discriminates against some conflict victims. Things are done, but we need a series of programs in accordance with the realities of society, with more attention paid within armed group and gang territories.

Civil society member (Male, 52)

Immediately following the incident, almost all respondents (91%) received medical assistance at a hospital. Most respondents were helped by their family (66%) and community members (32%) immediately after the incident, as described in the chart of immediate assistance benefactors (see Figure III below).

FIGURE III: IMMEDIATE ASSISTANCE BENEFACTORS



Hospital care was generally paid for by survivors' families or through an insurance program. The majority of immediate assistance received was medical assistance, with 81% of respondents receiving medication and 45% receiving assistance with physical rehabilitation, while 38% reported receiving psychological support, 32% received subsistence support, and only 19% received economic support. Taking into account the extended post-incident period, two-thirds of respondents had previously been asked questions about their situation as survivors of armed violence. The survey did not register any long term health and rehabilitation care or economic support to the respondents.

There are currently no provisions for specific government assistance for survivors of non-political armed violence. Programs are in place for assistance to landmine survivors, and

the Law of Victims and Land Restitution (Law 1448 of 2011) set up institutions to protect and aid survivors of violence and forced displacement from organized political conflict involving the government, guerrillas, and paramilitaries. The National Policy of Integrated Action against Antipersonnel Mines, Unexploded Ordnance, and Improvised Explosive Devices (2009) supports national and regional institutional capacity for interventions to reduce the proliferation of explosive ordnance, to educate communities about risks, and to promote the rehabilitation and socio-economic inclusion of survivors<sup>104</sup>. Survivors of urban violence, however, are currently afforded no special protections, with survivors with impairments falling under the general laws covering persons with disabilities and receiving assistance under these auspices from the government and NGOs. As one interviewee said, *"In Medellin, the victim assistance program needs to be told that there are war victims and violence victims and the local government can have its own policies beyond the national ones, policies that do not discriminate between victims of armed conflict and victims of armed violence"* – (Civil society member, male, 52). Limited mobility may also impede survivors in receiving assistance, as service providers are often unwilling to enter the *comunas*. Some respondents reported receiving a government subsidy of COP120.000 (approximately US\$66), but many also said they were unaware of available government assistance or how to access it, with an aid worker likewise suggesting that *"there is a lack of knowledge of where to ask for help and where help is given"* – (NGO worker, female, 40).

Informally, Civil Society Organisations (CSO) in Colombia have provided psychosocial assistance through peer group support, income-generating projects and have sought the inclusion of survivors of landmines and ERW. Local government has also provided psychosocial assistance and worked toward socio-economic inclusion; and developed an information management system to track survivors and their needs, supported rehabilitation centres, helped survivors and their families access care, and has paid for services for survivors ineligible for government assistance<sup>107</sup>. Similar assistance mechanisms do not exist for survivors of non-conflict related armed violence and their families. This is extremely important, since in our survey only 7% of respondents were injured in political armed violence (such as being shot while on a patrol as a member of the military, hit with shrapnel in a terrorist bomb attack, or caught in the crossfire of a battle between security forces and guerrillas). The vast majority of survivors interviewed were injured by gang or criminal violence, or by stray bullets from these activities.

Like ordinary people, survivors want to live in safe, secure neighbourhoods with job opportunities and readily available assistance. A majority of respondents said they wanted economic assistance and employment opportunities from the government. Many requested more psychosocial and rehabilitative care, more integrative follow up health and rehabilitation care and house visits by medical and other service providers for people with limited mobility. Demands were made for safety patrols, opportunities for youth to be able to advocacy and advice persons with disabilities to protect their rights. One survey respondent summarises, *"I want...help and collaboration to gain a better quality of life, economically and morally, to allow me to come out ahead with my family and give them a better future."* – (Male, 44, paraplegic)



## Discussion

Adequate victim assistance is that which is not just assistance, but which teaches and trains, which opens doors and does not keep the person the same, being a victim all the time and staying a victim...

Government official (Male, 41)

Medellín continues to experience high levels of non-conflict related armed violence, while a low-intensity internal conflict continues to simmer in the country. Gang violence and criminal violence are everyday facts of life in urban areas, constraining residents' lives with fear and 'invisible frontiers'. Violence has become normalised in Colombia, seen as an acceptable form

of resolving disagreements which permeates society. The government is making strides toward the reduction of violence and the assistance of survivors of conflict-related violence, but non-conflict armed violence remains a neglected area even through many victims of 'collective and organised, criminal violence' may be linked with the conflict through networks rooted in economic and power dynamics. Yet 'organised and collective violence' is one of the primary causes of physical impairments in Medellín. One cannot ignore that victims of armed violence sustain lasting impairments in Medellín, face economic and social exclusion, and are affected psychologically. **Challenging discriminatory social norms, providing better economic and employment opportunities for poor youths and survivors, improving access to and reducing costs of medical care, and expanding the scope of current policies to cover non-political armed violence** should be the focus of armed violence-sensitive initiatives for assistance. Below is the summary of main findings presented in the text.

### BOX III: SUMMARY OF MAIN FINDINGS

- ❑ Organised, collective and criminal violence (gang violence, common criminal violence, and drug violence) and collateral damage from such violence is the cause of most armed violence-related impairments in Medellín. This finding may be biased by the fact that some activities of gangs and aspects drug violence are related to internal conflict. The most common weapons are small arms
- ❑ The normalisation of violence as a means of resolving disagreements and illegal possession of arms in civilian hands has exacerbated Medellín's economic, social and political instability. Mobility of arms is often restricted by both gangs' territorial frontiers and inaccessible public spaces.
- ❑ A majority of survivors fell between the age of 15 and 35 years at the time of their injury.
- ❑ 90% (178 of 198 respondents) of armed violence survivors sustained lasting impairments. Spinal injuries and paralysis and injuries to limbs or extremities are the most common disabling injuries due to armed violence, leading to a great need for accessibility and adaptive services
- ❑ The people who sustained lasting impairments often experience economic impacts, with a loss of formal employment that has led to economic exclusion. Secondary to economic impacts are the negative consequences in family relations. All of this has resulted in depression, fear, stress and trauma for many respondents.
- ❑ Persons with disabilities are generally stigmatised; policies that do exist are slow to change social norms. Given socio-economic exclusion and the challenges of adjusting to new conditions, persons with disabilities are vulnerable to potential risks.
- ❑ Survivors most often receive assistance from hospitals, their families, their communities, and non-governmental organisations. However, respondents had difficulties finding long term health and rehabilitation follow-up services and support.
- ❑ Government assistance is limited because there are no legal or institutional provisions specifically for survivors of non-political armed violence and affected families and communities.
- ❑ Survivors suggest there is a need for free clinics or house visits in the comunas offering a full range of follow-up, psychosocial, and rehabilitative care in addition to more general medical assistance.



## Jorge (alias) in first person narrative

I worked hard as a teenager, starting out as a bus attendant, and quickly learning to drive buses on my own, by the age of 15. One day, when I was 17, I was driving a minibus and there was an accident, a collision with another vehicle. Since in our culture he who yells the most is considered right, the other driver and I got out after the collision and began to argue angrily. The other man went back to his car and pulled out a .38 calibre pistol. When he got the gun, I turned and began to run and then I collapsed, hit by two bullets.

The P3 vertebra in my spine had been hit and I could no longer feel or move anything from my stomach down—my legs, my toes, my genitals... I had not expected to be shot, because it is normal in the city to have those types of arguments if you run a stoplight or stop sign or do not use your turn signal. But I never expected that someone would have a gun and simply use it without thinking as the other man did after the accident. The man drove away after shooting, but I didn't want to hunt the perpetrator, but instead simply to focus on recovery. I especially focused on the physical recovery, without realizing that emotional recovery is more important, because of that moment of shock, of realizing that I no longer had all my abilities, could not drive or ride a motorcycle or go where I wanted, that I could not live on the second floor of a building, that I could not feel my extremities, I felt like part of me had been chopped off.

The people on the bus called the authorities and an ambulance arrived to give me first aid and take me to the hospital. There I received emergency treatment and then responsibility for my care was turned over to a Social Security facility. The care was not very good, because there was a strike and I was left alone on a gurney for three days with only pain medication and no one attending to me or telling me what was happening, despite having fractured my arm, clavicle, and jaw while falling, in addition to the spinal injury. After the three days of lack of care, I also developed an ulcer on my back, which did not fully heal for eight and a half years. After those three days, I received the surgeries I needed, but the ulcer remained, causing pain and damaging my self-esteem. It hurts me to think that the neglect that happened to me, which was so unnecessary, might happen to other people as well.

Through group therapy and talking with a psychologist, I have come to terms with the emotional impacts of the incident and have learned how to overcome my situation. I have now lived as long with a disability as I did without one and I feel that I have continued to mature. My relationship with my mother has become much closer now, whereas we were distant before the incident, and I have a very active social life now, including having had long term girlfriends.

I still consider myself poor, but my economic situation has been improving. I mostly travel now on the Metro, since I live about 900 meters from a Metro Cable station that I can get to in my wheelchair. I generally feel safe, but sometimes it is difficult being in a wheelchair in my area, because you may be sharing the road with large vehicles, and not all drivers pay attention.

Ten years after the incident in which I was injured, I went back to school, refocused, with a new vision for my life. I began working on the issue of disabilities, working as an instructor and facilitator on processes of rehabilitation. I now participate in activism around disabilities and also lead workshops, becoming more social and feeling like a leader once again.

# Peshawar, Pakistan

Findings discussed from research carried out in: Urban (Hayatabad Township, University Town, Kohat Road, Nishterabad, Gulbahar, Tehkal, Momin Town) and Rural (Kacha Garai, Achanai, Palosai, Sofaid Darai, Pushtakhara, Mattani, Bada Ber) areas of Peshawar

## Selected Indicators

❑ **Demographics:** : 190,291,129 population, estimated in July 2012<sup>107</sup>. Estimated in 2011: 35.9% under 14 years (34,093,853 male and 32,278,462 female), 60.4% between 15 and 64 (58,401,016 male and 54,671,873 female) and 4.2% over 65 years (3,739,647 male and 4,157,870 female).

❑ **UNDP Human Development Index:** 0.504<sup>108</sup> in 2011 (ranked: 145th of 187).

❑ **GNI per capita (PPP International \$):** 2550<sup>109</sup> in 2011.

❑ **Life Expectancy Rate at birth:** 65.4 years<sup>110</sup> in 2011.

❑ **Total Expenditure in Health Care Per Capita (\$):** 63<sup>111</sup> in 2009.

❑ **Health Care Workforce:** Physicians and 5.6 Nurses and midwives per 10,000 population<sup>112</sup> (latest year available since 2000).

❑ **Persons with Disabilities data:** Approximately 2.49% of the total population are living with disabilities (2.48% in Punjab, 3.05% in Sind, 2.23% in Balouchistan and 2.12% in Khyber Pashtunkhwa Province) as per the last population census in 1998 (latest data available)<sup>113</sup>. However, given the unreliability of the data, WHO estimates the total population of persons with disabilities to be more, at 13.4%<sup>114</sup>. This should be seen as an indicative figure, taking into account potential bias in the way disability was considered through the census. For this reason, we do not use the breakdown of figures by type of impairments.

According to Pakistan's National Institute of Populations Studies 2011<sup>115</sup>, the main causes of disabilities are:

- Epidemics and diseases
- Congenital and heredity
- Accidents - road and train accidents, aerial firing, buildings collapsed, protests and processions, tortures in detention cells

- Natural disasters – earth quake and floods, sliding, avalanches
- Lack of education and awareness
- Health services - Poor services, accessibility, affordability
- Conflicts – arms conflicts and disputes, land mine victims, bomb blasts
- Poverty – poor education, lack of awareness, inaccessibility of quality services

❑ **UNCRPD status:** Signatory in 2008 and ratified on the 5<sup>th</sup> July 2011<sup>116</sup>.

❑ **Progress on Disability<sup>117</sup>:** Set up Disabled Persons (Employment and Rehabilitation) Ordinance, 1981, National Policy for Persons with Disabilities, 2002, under Ministry of Social Welfare and Special Education, National Action Plan for Persons with Disabilities, 2006 and Special Citizens Act, 2008.



## BOX I: KEY DATES AND EVENTS

**1947:** Pakistan gained its independence from British India through partition in 1947 along Hindu-Muslim divides<sup>118</sup>. During this split, millions of people were displaced and thousands killed in communal violence.

**1948 and 1965:** Since the split, India and Pakistan have had turbulent relations leading to two wars. Between the wars, the country witnessed exceptional growth, but after has experienced economic decline and internal instability<sup>119</sup>.

**1958-1971, 1977-1988, 1999-2001 AND 2001-2008:** Four military regimes ruled for a total of 31 years<sup>120</sup>.

**1971:** War between East and West Pakistan intensified leading to the creation of Bangladesh (formerly East Pakistan)<sup>121</sup>. An estimated 10 million civilians fled to India and more than 90,000 Pakistan army became India's prisoners of war, with many more unaccounted-for deaths during this period<sup>122</sup>.

**1977-1988:** Military coup by General Zia-ul Haq, is recorded to have Islamised the country backed by right wing political parties, which opened doors to religious extremist groups to make political gains and mobilise local communities in the name of Islam<sup>123</sup>. The regime was characterised by widespread poverty, low literacy rate, growth in militant madrasas, and the recruitment of young people in the name of jihad<sup>124</sup>. As a result, the social fabric changed<sup>125</sup> in the Federally Administered Tribal Areas (FATA<sup>vii</sup>). An influx of extremist and religious groups spread from the tribal areas to parts of Khyber PashtunKhwa (KPK), Punjab, Baluchistan and Sindh<sup>126</sup>.

**1980:** At the Soviet invasion of Afghanistan (1979), Pakistan played a key role in the creation and patronage of Islamist extremist groups for the United States of America (USA), supporting anti-Soviet Jihad in Afghanistan and the Afghan Taliban in 1990, aiding them to seize control<sup>127</sup>.

**1979-1989:** US government allegedly gave \$2 billion in arms aid to Afghanistan through Pakistan<sup>128</sup>. During peaks of crises, approximately 50-60 trucks of weapons crossed Pakistan's border every day, with an estimate of 70% being diverted and finding its way to black markets and covert weapons deals in South Asia<sup>129</sup>.

**1989-1999:** Armed resistance to Indian rule began in the Kashmir valley. It is reported that at the height of conflict, thousands of shells were used daily. The Red Cross recorded that at least 30,000 people had been forced to flee their homes<sup>130</sup>.

**2001:** Following the attacks in the USA, the country joined the USA-led 'war on terror', ostensibly reversing its support to the Taliban regime in Afghanistan<sup>131</sup> and altering the country's approach towards armed conflict against the militants<sup>132</sup>. Relations with Afghanistan deteriorated, with various bombardments in major provinces from both Afghan as well as Pakistani militants. This saw unprecedented numbers of civilians killed and injured.

**2011 onwards:** With the assassination of Osama bin Laden in Pakistan, the relations with USA have become strained. Pakistan continues to be attacked by militant groups<sup>133</sup>.

## Brief Background

Armed Violence in Pakistan continues to occur at a high level, with militant, drug trafficking and political violence all prevalent, with widespread availability of weapons. Civilians in Pakistan were estimated in 2007 to have approximately 18 million small arms, or around 9 small arms per 100 persons, ranking the country 6<sup>th</sup> internationally in terms of possession<sup>134</sup>. These weapons are said to have been a) leaked from the Afghanistan arms pipeline, b) Soviet stocks captured during the Afghan war, c) locally produced replica Soviet guns as well as from army production, d) legal and illegal transfers between cities and from other routes such as Middle East and Southeast Asia<sup>135</sup>. It is also argued that in the male-dominant tribes of Khyber PashtunKhwa a culture of guns and violence exists, in which their use demonstrates social standing and physical power<sup>136</sup>.

## Khyber PashtunKhwa (KPK) and Peshawar, Pakistan

KPK is a province in Pakistan located in the north west of the country. Its provincial capital is Peshawar. According to the UNDP Pakistan National Human Development Report 2003, KPK's Human Development Index stands at (\$) 0.510 ranking it 3rd among the four provinces in Pakistan<sup>137</sup>. 29% of people are estimated to live in poverty, of which 37.5% live in rural areas, 28% in the provincial capital and 41% in small cities<sup>138</sup>. 88% of all districts in KPK are food insecure<sup>139</sup>. Over the years, KPK has become a hot spot for various bombardments and suicide attacks which impacted on the daily lives of those that live there. In 2009, approximately, 1,363 civilians were killed in fighting; and 1,403 people were killed and 3,351 injured in militant attacks in FATA and KPK<sup>140</sup>. However, with the prevailing insecurity, exact loss of lives, casualties and livelihoods cannot be determined and there are no official data or accurate records.

<sup>vii</sup> FATA was recognised as a semi-autonomous state since Pakistan's independence and is included as one of the territories in Pakistan since the 1973 constitution. The FATA falls in the North of Pakistan bordering Afghanistan and settled areas of Khyber PashtunKhwa (KPK) with a majority of Pashtun time. This territory was formed during British India. Post 1973 recognition of FATA as within Pakistan, is administered by the Government of KPK in Peshawar and governed by the Frontier Crimes Regulation 1901. [Shinwari, N (2010), 'Understanding FATA: Attitudes Towards Governance, Religion and Society in Pakistan's Federally Administered Tribal Areas,' Community Appraisal and Motivation Programme (CAMP), pg: 3-7 and International Crisis Group (2009), 'Pakistan: Countering the Militancy in FATA,' pg: 1-8]

# Findings of the Research

## Profile of Survivors of Armed Violence

In the 14 towns and villages of urban and rural Peshawar, the police recorded 776 deaths due to armed violence between 2007 and 2011. In the same period, hospitals registered 10,820 injured patients of armed violence. The age and sex of the injured and the nature of the incidents were unobtainable from police records, and the nature of incidents unobtainable from the hospital records. Therefore, the following presentation and analysis is solely based on primary data collected during this research. Hospital data did show the sex of the patients, with

93% male and 7% female registered. Corresponding to this, among the 147 respondents of the Survivor Representative Survey, 95% were male and 5% were female, with an average age of 33 (see table I below).

**When there is poverty, lack of education, active militant groups, of course there is violence.**

NGO worker (35, Male, Peshawar).

**TABLE I: AGE AND GENDER OF INJURED RESPONDENTS**

Age	Male Respondents (% of total respondents)	Female Respondents (% of total respondents)	Row Total (% of total respondents)
0-14	2 (1%)	0 (0%)	2 (1%)
15-35	89 (61%)	4 (3%)	93 (64%)
36-55	43 (29%)	3 (2%)	46 (31%)
56 and older	6 (4%)	0 (0%)	6 (4%)
<b>Total</b>	<b>140 (95%)</b>	<b>7 (5%)</b>	<b>147 (100%)</b>

From our survey sample, a majority of those injured were between the age of 15 and 35 years.

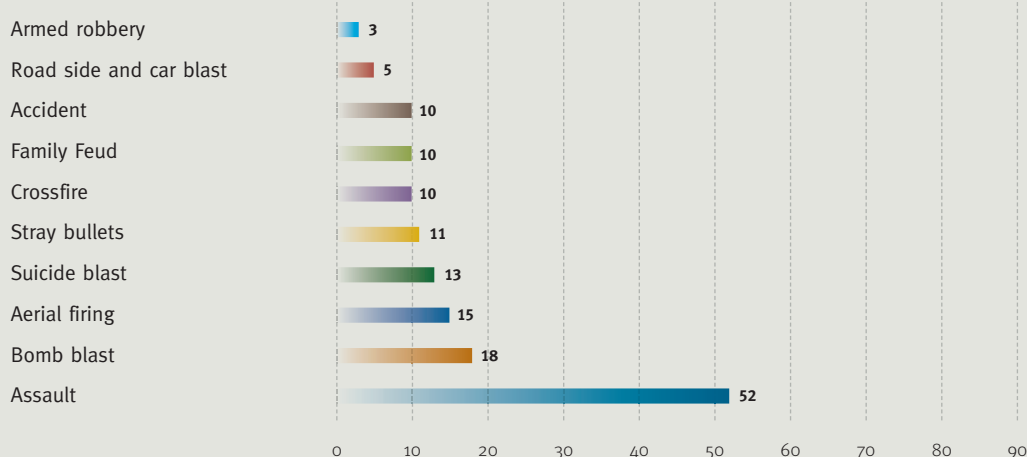
## The Armed Violence Incidents and Lasting Impairments

Armed violence in Peshawar tends to be related to explosive violence or victims experiencing assault, caught in cross fire

and stray bullets, a fact confirmed by data reported by respondents on the types of incidents in which they were injured (see Figure I below).

**FIGURE I: INJURING INCIDENT TYPE**

Multiple Responses. Total number of Respondents: 147



The survey identified 34% of respondents were related to perpetrators and 66% had no relation to the perpetrators. One respondent recalls, “My cousin and I were talking, when our enemies came and started firing at us. My cousin died on the spot and I was injured,” – Survey Respondent (Male, 19, upper limb impairment).

Among the respondents, 15% were injured in the 1990s, 11% between 2000 and 2004, 48% from 2005 to 2009, 22% in 2010 and 2011. The year was not specified for two of the respondents. In response to various bombardments by insurgent groups, the government under new president Asif Ali Zardari launched an offensive against militants within the provinces in 2008-09<sup>141</sup>. The militants responded with a string of attacks targeting civilians. This included a suicide bombing in Peshawar market that left more than 100 dead. KPK is said to be the largest province to house small arms in Pakistan<sup>142</sup>. One respondent recalls, “Early in the morning I came out from my house going to

school with my brother and cousin. I sat in vehicle with my uncle and my aunty. My uncle and my aunty were also there, going to work. When we reached Bara check-post, the suicide bomber came. He wanted to attack an army convoy but the convoy escaped. As a result of the explosion, my brother, my uncle and my cousin died on the spot,” – Survey Respondent (Male, 14, loss of vision and inoperable wound from bomb blast).

Injuries were most commonly caused by small arms (67%). Out of the 67%, 36% identified the small arm as an AK-47, 27% claimed to have been injured by pistols, 1% identified a G3 assault rifle and 3% couldn’t identify the type of small arm. The remaining 33% of the respondents were injured by explosive ordnance, including: suicide bombs (15%), bombs (12%), mortar shells (3%) and grenades (3%). Various different groups, including unemployed and illiterate young men were cited as using weapons. One respondent said, “everyone uses weapons, it has become our tradition” – Police officer (Male, 58, Peshawar).

## Lasting Impairments

118 of the 147 respondents answered to the questions related to impairments. Among the 118 responses, 62% have experienced lasting impairments. The most common impairments resulting from armed violence incidents (see Figure II) were lower limb such as amputation and paralysis due to spinal cord injuries (24%), followed by upper limb (15%) such as amputation and loss of function, chronic pain (11%) with some cases of inoperable wounds from bomb blasts, multiple impairments (7%) such as loss of hand, leg or triple amputee and loss of sight and arm or leg, and sensory (5%) loss of sight, partial vision and loss of hearing. The remaining 38% were injured but did not sustain lasting impairments.

Among the respondents who sustained lasting impairments (72 in total) at the time of the injury/incident, the average age was 28 years old, of whom 94% were male and 6% female (see Table II below)

FIGURE II: LASTING IMPAIRMENTS

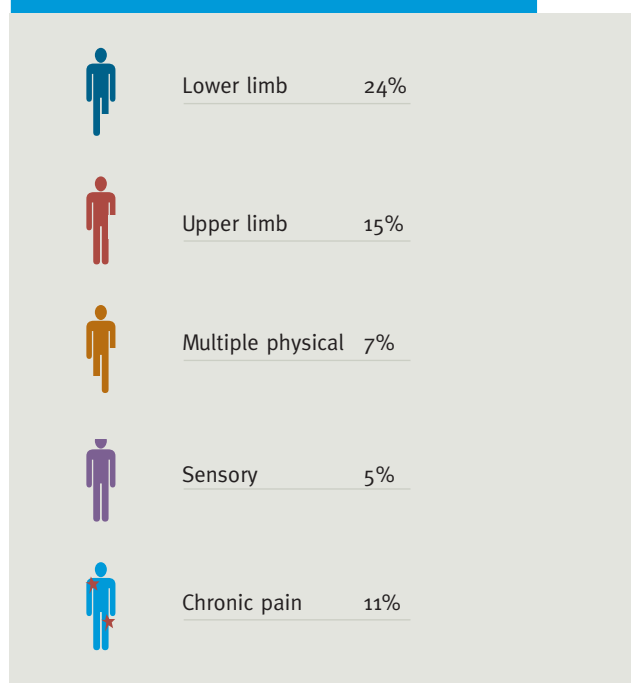


TABLE II: AGE AND GENDER OF 72 RESPONDENTS WHO SUSTAINED LASTING IMPAIRMENTS AT THE TIME OF INJURY

Age	Male Respondents (% of respondents who sustained Lasting Impairments)	Female Respondents (% of respondents who sustained Lasting Impairments)	Row Total (% of respondents who sustained Lasting Impairments)
0-14	1(1%)	0(0%)	1(1%)
15-35	13 (18%)	2(3%)	15 (21%)
36-55	51(71%)	1(1%)	52 (72%)
56 and older	3(4%)	1(1%)	4(6%)
<b>Total</b>	<b>68 (94%)</b>	<b>4(6%)</b>	<b>72(100%)</b>



## Socio-Economic and Psychological Impact of Armed Violence

Exposure to armed violence and the lasting impairments that are sustained as a result has intense impacts on the lives of survivors, their families and communities, affecting economic and psychosocial well-being. This is further elaborated below.

### ECONOMIC

*I was in the market doing business and there was a bomb blast nearby, I was injured severely and up to 50 people were killed with others injured too. Later we learned that it was a suicide attack. I am now disabled and cannot provide for my family.*

Survey Respondent (Male, 27, amputated left arm)

According to the Economic Survey of Pakistan (2008-2009), the vast majority of Pakistanis struggle every day with poverty, high unemployment and inadequate healthcare<sup>143</sup>. The challenges of finding formal employment are exacerbated by injuries and lasting impairments. While respondents were previously engaged in teaching and labouring work, after the experience with armed violence, 31% of the respondents said they had turned to agriculture as their primary source of income, followed by 23% choosing lightweight labour, 21% business such as mobile phone stores. 18% were involved in the service sector and the remaining 10% were unemployed and depending on the joint family income. Although respondents in Peshawar were relatively literate or had some informal education (compared to our samples from Haiti, Uganda and Colombia), lack of savings, social safety nets and underdevelopment put limitations on the alternative employment that could be sought. Among our respondents, 33% were illiterate, 24% had some schooling, 24% had completed secondary schooling, 12% completed 1st university degrees and 5% had obtained 2nd university degrees. One respondent confirmed, “*when there is rampant poverty, unemployment and government neglect...people not only pick up arms but suffer long term effects,*” – NGO worker (Female, 31, Peshawar). Given the paucity of formal employment, it is unsurprising that 63% of respondents said that their current household income is insufficient to meet their subsistence and recovery needs. One survey respondent stated, “*I wasn’t able to work after the accident. My father is now supporting me.*” – (Male, 33, upper limb impairment)

Economic hardship was considered particularly problematic since 54% of respondents were heads of households, who had several dependents, 40% of whom were sons over 18 years, 3% were spouses and 3% were children under 18. 63% of respondents reported that their families have suffered particularly due to loss of income, with one saying “*I am a farmer and this was a big incident for me, the whole family was in the hospital and no one could earn.*” – (Male, 42, loss of hearing) A spouse who lost her husband said, “*it is very difficult for us, I lost my husband and I am not able to work,*” – (Female, 42, Chronic pain and inoperable wound from bomb blast).

Heightened levels of armed violence, lack of government security measures and unemployment have created fear of sustaining further impairments in further incidents. Some (10%) have migrated to safer locations, with one saying, “*you know, it was this mad guy who opened fire, I was so fearful of what would happen to my family, so we moved to another village.*” – (Male, 40, no lasting impairment)

### SOCIAL

Changes in economic circumstances also affect family social dynamics, creating frustration and conflict. One respondent noted that “*my family now see me as a burden*” – (Male, 27, lower limb impairment). While most respondents said their families had taken care of them, 11% said that they had been neglected, abandoned and even kicked out of the house. One respondent said, “*my family thinks I am dead,*” – (Male, 33, chronic pain), another said, “*my family kicked me out of the house. But I had my friends to help me out.*” – (Male, 30, loss of function of right arm). Some others said that their relations with their communities changed for the worse (6%), with some noting that they left the community for a while due to changes in social relations. One expressed, “*I left my community for some time, after the incident my social life totally changed,*” – (Male, 35, loss of leg mobility). These negative relations sometimes served as reason for some families to take up violence in an environment where violence to resolve violence has become normalised, driven by codes of honour and access to weapons.

### PSYCHOLOGICAL

The negative economic and social impacts of armed violence incidents can have a powerful effect on the survivors’ mental health. A total of 90% of respondents stated that they had been traumatised or otherwise negatively affected psychologically. Of the respondents, 39% reported to be psychologically affected due to loss of livelihood, 22% reported being fearful, 16% said they were terrified, 13% suffered from anxiety, stress and trauma. One respondent said, “*6 bullets hit me on my shoulder and back. I lived in fear thinking that the people might attack me again, for a long time*” – (Male, 42, spinal cord injury).

## Survivor Assistance and Lack thereof

...these explanations are of no use. No one has contacted me before and no one pays attention to my needs.

Survey Respondent (Male, 30, upper limb impairment)

Immediately following the incident, a majority (99%) of the survivors receive medical assistance at a hospital. These survivors received support only from their families (99%), the remaining 1% did not answer.

Immediate assistance was available to the respondents, including medication (99%), economic support (47%) and psychological counselling (35%). The costs of these services were covered by the families or survivors themselves. In spite of the extended post-incident care needed to fully recover, a majority of respondents (70%) said they were never asked questions about their needs. The survey did not register any long term health and rehabilitation care or economic support for the respondents.

There are currently limited provisions for government assistance to survivors of armed violence. The government of KPK provides Rs. 300,000 (approx. 3,500 USD) for each civilian death, Rs. 100,000 (approx. 1,200 USD) for each serious injury<sup>144</sup>. Both victims of terrorism and militant-related incidents are eligible for this compensation. However, the nature of this compensation is on an *ad hoc* basis with no proper data collection mechanisms and vague implementation. In addition, there is no clear policy for the support of war victims, leaving many without assistance<sup>145</sup>. The vast majority of our respondents had not received any government compensation. Three of them attempted to contact the government but were not acknowledged. One respondent confirmed, *"I tried to get some assistance from the government, but was in vain. I paid for all my hospital treatments, it has hampered my family income since I supported them through my shop, but had to shut it down while I was hospitalised."* – (Male, 70, lower limb impairment and with seven dependents). For persons with disabilities, the government has adopted policies such as the Employment and Rehabilitation of Disabled Ordinance 1981, the National Policy for Persons with Disabilities 2002, National Policy on Education 2009, Child Protection Law-Khyber Pashtunkhwa 2010 and the National Plan of Action 2006-2025. The government also allocated Rs. 6,282,283 million in the 10 year Perspective Development plan 2001-2011 for education, training and rehabilitation of persons with disabilities<sup>146</sup>. While these policies have helped in identifying and realising the rights of Persons with Disabilities, the progress of implementation is questionable. The Ministry of Social Welfare and Special Education and its national Council for Rehabilitation for Disabled Persons, responsible for the protection of the rights of the Persons with Disabilities, was abolished in 2011 and provinces were asked to take charge in their respective areas. Ad hoc practices, lack of management, no centralised structure for policy implementation, no standard policy for war victims and persons with disabilities, failure to identify victims, nepotism and delays in compensation hamper implementation of the existing policies<sup>147</sup>. One respondent reflected, *"government takes too much time to get anything processed, even if they help*

*they do not help poor people, they only give attention to people they know"* – (Male, 33, amputated arm). Mistrust of the government was repeated by many respondents as major reason for the lack of support.

Ongoing violence in Peshawar and KPK, and greater use of weapons in these areas, has meant that several international and national organisations have made services available (including emergency medical services, physical rehabilitation centres)<sup>148</sup>. However, the deteriorating security situation and closed access roads has restricted access to services, with many survivors and civil society organisations being prevented from traveling to services and hospitals. This was exacerbated by severe flooding in 2010 in violence-affected areas, where bridges and roads were washed away and increasing numbers of people required medical attention<sup>149</sup>. The limited number of hospitals and rehabilitation centres in Peshawar that work to provide basic medication and physical rehabilitation services are privately owned. All patients have to pay for their treatments and are unable to cover the costs of long term health and rehabilitation follow-up. A recurrent complaint from survey respondents was that *"the hospitals are unaffordable."* The health facilities outside of Peshawar, on the other hand, have meagre resources and expertise required to treat victims of bomb blasts, mortars, artillery, gunshots, landmines or explosive remnants of war (ERW) that require multiple complicated surgeries and longer care<sup>150</sup>. Pakistan's per capita spending on healthcare is among the lowest in the world<sup>151</sup>.

Access to justice is also constricted in Peshawar. In cases of family feuds or assault by known enemies, the respondents tend to avoid in reported cases for the fear of their family's safety. One respondent confided, *"this was a family dispute; I cannot go to register to the police. Besides, the government doesn't really care for us."* – (Male, 30, upper limb impairment)

Furthermore, the social stigma surrounding persons with disabilities contributes to the problem of access. Many persons with disabilities are seen to diminish the family status in society, due to which they may not seek long-term support. In Pakistan, persons with disabilities are often largely invisible, unheard of or unaccounted for<sup>152</sup>. These people are often marginalized, facing overwhelming barriers in daily life, particularly with regards to accessing basic services, education and skills development<sup>153</sup>. There is a high level of stigmatization and persons with disabilities are perceived as a social burden, and not as people with aspirations or abilities<sup>154</sup>.

In a challenging environment, the survivors of armed violence aspire to live in a safe, secure neighbourhood with employment opportunities. A majority of respondents said they wanted quotas for job opportunities for persons with disabilities, provision for income generating activities and financial support for affected families and communities. There is an evident need for physical rehabilitation centres with trained physiotherapists, availability of prosthetics, follow up services and peer counselling groups. Clear demands for these facilities at no or low-cost were made. However, the survivors also recognised that their needs could not be met without community security, neighbourhood watches, protection of their rights and greater access to public services. One respondent summarises, *"these life threatening attacks should stop for god's sake, no more! How can we live in peace if there is no security, how can we access care, if it is inaccessible..."* – (Male, 25, multiple amputees by a suicide attack).

## Discussion

Peshawar continues to experience high levels of violence and family feuds. Armed violence is an everyday fact of life in urban areas. Arms culture created by civilian possession of guns and weapons, as well as government's forceful military operations contribute to high incidence of armed violence. People face myriad barriers to achieving decent livelihoods, particularly those who have lasting impairments. Victims of armed violence sustain lasting psychological and physical impairments in Peshawar and face economic and social exclusion. They rely solely on strong family ties for support. **Normalised violence, justice, security, challenging community perceptions of disability, inclusive services, available and accessible quality health care** should be the focus of initiatives for assistance. Below is the summary of main findings presented in the text.

### BOX III: SUMMARY OF MAIN FINDINGS

- ❑ Violence driven by use of explosive ordnance and small arms, and family feuds are the most common causes of armed violence-related impairments in Peshawar. The most common weapons are small arms and explosive ordnances (bombs).
- ❑ Deteriorating security situation, natural disasters and illegal possession of arms in civilian hands has exacerbated Peshawar and KPK's economic, social and political instability. Mobility is often restricted by militant groups, constant curfews, weak transportation and the continuous threats of attacks.
- ❑ The average age of survivors of armed violence is 33 with a majority falling between the age of 15 and 35 years.
- ❑ 62% (72 of 118 responses) of armed violence sustained lasting impairments, most commonly upper limb and lower limb loss of function and amputation. The average age of these individuals at the time of the incident and injury was 28 years with a majority falling between the age of 15 and 35 years
- ❑ The people who sustained lasting impairments experience severe economic impacts, with changes to and loss of formal employment that has led to economic exclusion. Secondary to economic exclusion is the impact on social interaction with families and communities, and migration due to prevailing insecurities. All of the above have had psychological impacts, creating fear, trauma, anxiety and worry for respondents.
- ❑ In addition, persons with disabilities are generally stigmatised in Pakistan with very few existing policies in place for their protection. Given socio-economic exclusion, psychological impacts and negative perceptions of disabilities there is potential for respondents to be vulnerable to further risks.
- ❑ Survivors have received informal assistance from their families, mainly for hospital expenses. These hospitals have provided medical treatment with little physical rehabilitation. Long term health and rehabilitation follow up and economic support is non-existent.
- ❑ Although there is government policy in place to provide assistance to civilian victims of war, implementation is questionable and there is no real protection for victims. Although service providers have attempted to address basic health needs, accessing the victims in insecure regions remains challenging.
- ❑ Survivors struggle to support their families in abject poverty, but readily express their needs and suggest ways for assistance. They are rarely asked about their needs, however.
- ❑ There is a lack of data on the impact of armed violence, or the record of assistance given to the survivors (including persons with disabilities) and their affected families.

## Ahmed (alias) in first person narrative

Ninety years ago, my grandfather murdered someone in his neighbourhood. The aggrieved family was very powerful and eager to take revenge. My grandfather became a fugitive and left his home. The elders in the community tried to settle the dispute by asking my family to give my sister's hand in marriage to the affected family, which we did. My grandfather also served fourteen years in Kala Pani under the British government. When he was released, he believed that he was forgiven after keeping his side of the deal. However, this wasn't the case. He was murdered and his sister left her husband with their three kids. Later one of the boys had to be returned, but she was able to keep her daughter. The sons and his side of the family always hated us for the past mistake of my grandfather.

One day during Ramazan, my brother and I were shopping in the bazaar. Ijaz, my great aunt's (grandfather's sister) son was also there. Ijaz started beating my cousin. Seeing this, I went to settle the dispute but Ijaz got really angry and abused me. We got into a fight and at one point he ran to his car, pulled out a machine gun and started indiscriminately firing. A bullet hit my collarbone but my cousin got multiple injuries. Three innocent bystanders were killed. Just a few months later, in another city my brothers and cousins were fired upon. This made us realise that the deep-rooted family history would never get resolved.

Our children dropped out of their schools, people who worked resigned to ensure our security. Our economic conditions are declining day by day, and there was a time when we had to sell our land for survival. It hasn't been easy for us living in fear that any day we might be shot or killed. We do not have any protection from the government, so we are doing what we can with the little we have from the land we sold

# Port-au-Prince, Haiti

Findings discussed from research carried out in: Bel Air.

## Selected Indicators

- ✕ **Demographics:** : 10,123,800 population in 2011<sup>155</sup>. 50% urban and 50% rural (2010)<sup>156</sup>. Breakdown by age (2010): 36% age 14 and under, 37% age 15-34, 18% age 35-54, 9% age 55 and up<sup>157</sup>.
- ✕ **UNDP Human Development Index:** 0.454 in 2011 (ranked 158th of 187)<sup>158</sup>.
- ✕ **GNI per capita by Atlas method:** 1,123<sup>159</sup> in 2011.
- ✕ **Life Expectancy Rate at birth:** 60.7 years for men and 64.3 years for women<sup>160</sup> in 2011.
- ✕ **Total Expenditure in Health Care Per Capita (\$):** US\$71<sup>161</sup>.
- ✕ **Health Care Workforce:** No data available.
- ✕ **Persons with Disabilities data:** Estimated at 800,000 people (8% of the population)<sup>162</sup>, 200,000 of whom are children<sup>163</sup>. This should be seen as an indicative figure, taking into account potential bias in the way disability was considered through the census. For this reason, we do not use the breakdown of figures by type of impairments.
- ✕ **UNCRPD status:** Acceded to UNCRPD on 23 July 2009<sup>165</sup>.
- ✕ **Progress on Disability:** Signed Inter-American Convention on the Elimination of all Forms of Discrimination against Persons with Disabilities in June 1999, ratified 29 May 2009<sup>166</sup>. Created Secretariat of State for the Integration of Persons with Disabilities by Presidential decree in May 2007. Act on the Integration of Disabled Persons passed by Parliament 13 March 2012.

In addition to those disabilities caused by the 2010 earthquake, a 2003 survey of amputees in Haiti<sup>164</sup> revealed the following causes of disability:

- Infections
- Congenital or caused by birth or pregnancy complications
- Accidents
- Occupational hazards
- Hit by object
- Gunshot wound
- Diabetes
- Other





## BOX I: KEY DATES AND EVENTS

- 1957** François ‘Papa Doc’ Duvalier elected president, beginning a violent dictatorship and creating the Tonton Macoutes paramilitary force with youths from the “zones populaires” (popular zones)<sup>viii</sup> of Port-au-Prince<sup>167</sup> such as Bel Air, Martissant, and Cité Soleil.
- 1971** Papa Doc dies, but violent rule continues under his son, Jean-Claude ‘Baby Doc’ Duvalier.
- 1986** Baby Doc is overthrown in a popular revolt, leading to several years of instability.
- 1990** Former priest Jean-Bertrand Aristide elected president.
- 1991** Aristide driven from office and a campaign of murder and intimidation begun against his supporters<sup>168</sup>.
- 1994** Aristide returned to office under auspices of a UN-authorized, US-led multinational security force.
- 1995** Aristide succeeded by René Préval and the old army demobilized and its weapons decommissioned, though many veterans “either fled to exile or melted away into private security forces or criminal organizations.<sup>169</sup>” Aristide creates own Fanmi Lavalas political party.
- 2000** In lead-up to elections, Aristide deploys gangs of unemployed youths from the popular zones of Port-au-Prince to intimidate his opponents and also contributes to the politicization of the Haitian National Police (HNP)<sup>170</sup>; Aristide succeeds in winning back the presidency.
- 2004** Rebellion by a coalition of anti-Aristide forces drives Aristide to resignation and exile on 29 February, leading to the deployment of the United Nations Stabilisation Mission in Haiti (MINUSTAH).
- 2006** HNP and MINUSTAH undertake raids to disrupt and destroy criminal gangs in Cité Soleil, resulting in some civilian casualties, but largely viewed by local residents as justified<sup>171</sup>.
- 2010** An earthquake on 12 January kills an estimated 158,679 people in the Port-au-Prince area<sup>172</sup>, and the subsequent escape of thousands of prisoners from the National Penitentiary sparks fears of an upsurge in gang violence; in December, violent demonstrations erupt around the presidential election.
- 2011** In July, MINUSTAH again deploys 2,100 peacekeepers into the popular zones of Cité Soleil, Bel Air and Martissant ‘to disrupt criminal activity’<sup>173</sup>

## Brief Background

Armed violence in Haiti since the turn of the millennium has continued at high levels, driven by formerly politicized criminal gangs and leading to ‘a situation akin to urban warfare’<sup>174</sup> that is augmented by ordinary criminality and violence used by MINUSTAH and the HNP in their efforts to combat gangs and crime. Haiti also has a significant stock of small arms due to past upheaval and present gang activity, with Haitian civilians possessing an estimated 190,000 small arms, a rate of 0.6 privately owned small arms per 100 people. Only around 11% of these small arms are registered with the government<sup>175</sup>.

## Port-au-Prince, Haiti

Port-au-Prince, the capital and home to an estimated 20% of Haiti’s population<sup>176</sup>, has been the centre of both political and gang activity in the country. The Bel-Air popular zone, where research for this study was conducted, is home to the city’s port, its largest market, and, as of 2007, at least 135,000 people<sup>177</sup>. There are minimal public services available in Bel Air, and since 2006 MINUSTAH has provided security, though the HNP is gradually gaining more responsibility in the area. In 2006, the homicide rate in Bel Air was 32 per 100,000 inhabitants, which by 2009 was halved to 16 per 100,000, which is relatively low by Latin American and Caribbean standards<sup>178</sup>. Violence increased again, however, in 2010, with the homicide rate rising to 49 per 100,000, and local observers have noted the rise of a new generation of criminals who are less likely to pay attention to traditional community leaders<sup>179</sup> and are thus less subject to informal accountability. Haiti’s instability and the earthquake have limited the statistics available on violence in the country, but the findings of existing studies on Port-au-Prince are outlined in Box II.

<sup>viii</sup> ‘Popular zones’ are poor, densely populated urban areas, or slums in layman’s terms. They are the equivalent of barrios populares or favelas in Latin America

## BOX II: EXISTING STATISTICS ON THE IMPACT OF ARMED VIOLENCE IN MEDELLIN

- A 2010 study in Port-au-Prince found that only 2.3% of households reported owning firearms, but half of all respondents said that there are too many guns in society<sup>180</sup>.
- In Port-au-Prince in 2004 and 2005, a study found that approximately 65% of homicides were caused by gunfire<sup>181</sup>.
- Rates of murder, physical assault, and sexual assault all fell sharply in Cité Soleil, Bel Air, and Martissant from 2004-2009<sup>182</sup>, though violence has escalated again recently, with surveys recording a dramatic increase in urban homicide between August 2011 and February 2012<sup>183</sup>.
- In Bel Air, in 2006 the homicide rate was 32 per 100,000 inhabitants, which by 2009 was halved to 16 per 100,000, which is relatively low by Latin American and Caribbean standards; violence increased again, however, in 2010, with the homicide rate rising to 49 per 100,000<sup>184</sup>.
- In Cité Soleil and Martissant, a 2006 study found that violent deaths were most common among men ages 15-39, with gunshot wound fatality rates of 13% and 10% in the respective areas<sup>185</sup>.

## Findings of the Research

### Profile of Survivors of Armed Violence

It was not possible to collect secondary police and hospital data in Port-au-Prince. Therefore, the following presentation and analysis is solely based on primary data collected during this research. Of the 160 respondents of the Survivor Representative Survey in Bel Air, 74% were male and 26% were female, with an average age of 33 years (see Table I below).

I was at a party where there was an escaped prisoner and a policeman. The policeman called the police to arrest the fugitive, but at that moment the policeman drew his gun, as did the fugitive, and they began to shoot. I received a bullet in the ankle.

Survey respondent (Male, 30)

TABLE I: AGE AND GENDER OF INJURED RESPONDENTS

Age	Male Respondents (% of total respondents)	Female Respondents (% of total respondents)	Row Total (% of total respondents)
0-14	1 (1%)	1 (1%)	2 (1%)
15-35	80 (50%)	24 (15%)	104 (65%)
36-55	30 (19%)	16 (10%)	46 (29%)
56 and older	8 (5%)	0 (0%)	8 (5%)
<b>Total</b>	<b>119 (74%)</b>	<b>41 (26%)</b>	<b>160 (100%)</b>

### The Armed Violence Incidents and Lasting Impairments

The majority of respondents were injured by crossfire (56%), generally in fights between gangs or in battles between security forces and gangs, as demonstrated by the breakdown of the types of injuring incidents shown in Figure II.

54% of respondents said they were injured in the streets and 23% said they were injured in their homes, while 7% were injured while working and 2.5% were injured during demonstrations. Those people injured by armed violence may also be involved

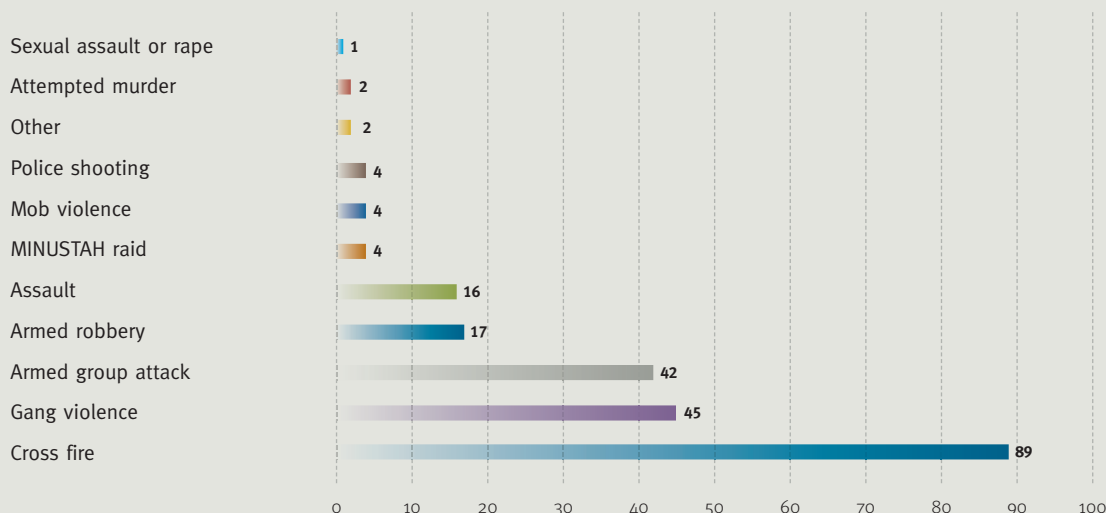
in armed violence as perpetrators, with a number of respondents (8%) also reporting involvement in gangs or perpetrating violence. One survivor told how he was injured in a chase with police: "I was coming from Rue Alexandre on a motorbike and on the way back to my house we noticed that a police car was following us. Very close to my house, they hit us with the bumper of the car, and then the police shot at us. My friend died and I was hit by four bullets, three around my head and the other in my right wrist" – (Survey respondent, male, 30, chronic head injury).

The majority of our respondents (61%) were injured between 2004 and 2006 during the period of the coup and great political instability, with another spike of violence in 2010 and 2011 after the earthquake.

All respondents were injured by guns, rather than by explosive weapons, and the most common guns used in the incidents were pistols (26%), revolvers (15%), and submachine guns or assault rifles, e.g. T-65s and M-14s (13%), though nearly half of respondents (48%) did not know the type of gun with which they were injured.

FIGURE I: **INJURING INCIDENT TYPE**

Multiple Responses. Total number of Respondents: 160

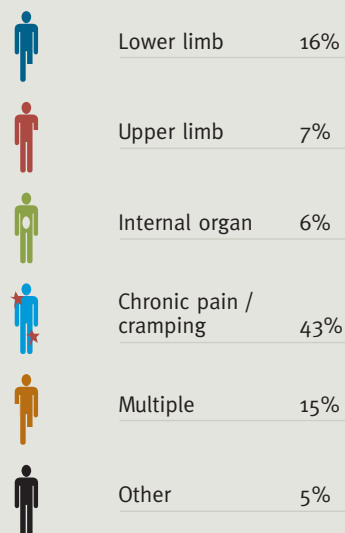


## Lasting Impairments

Among our respondents, 91% reported lasting physical impairments from being injured by armed violence, as described in Figure II. The most common physical impairments reported were chronic pain or muscle cramping (43%), lower limb impairments like limping or amputation (16%), and multiple impairments, for instance upper and lower limb impairments due to spinal cord injuries and vision or hearing loss combined with tooth loss or permanent jaw damage (15%). The remainder of the impairments included upper limb impairments such as loss of shoulder mobility or paralysis of the arm or hand (7%), internal organ damage leading to chronic digestion or respiratory problems (6%), and other impairments (5%). Six survivors had their leg or foot amputated, while one survivor's arm was amputated.

Among the respondents who sustained lasting impairments at the time of the incident and injuries (146 in total), 74% were male and 26% were female, the same as in the total sample, with an average age of 30 years old (see Table II).

FIGURE II: **LASTING IMPAIRMENTS**



**TABLE II: AGE AND GENDER OF 146 RESPONDENTS WHO SUSTAINED LASTING IMPAIRMENTS AT THE TIME OF INJURY**

Age	Male Respondents (% of respondents who sustained Lasting Impairments)	Female Respondents (% of respondents who sustained Lasting Impairments)	Row Total (% of respondents who sustained Lasting Impairments)
0-14	1 (1%)	1 (1%)	2 (1%)
15-35	69 (47%)	21 (14%)	90 (62%)
36-55	30 (21%)	16 (11%)	46 (32%)
56 and older	8 (5%)	0 (0%)	8 (5%)
<b>Total</b>	<b>108 (74%)</b>	<b>38 (26%)</b>	<b>146 (100%)</b>

## Socio-Economic and Psychological Impact of Armed Violence

Exposure to armed violence and being disabled by armed violence have intense, lasting impacts on the lives of survivors, their families, and their communities, especially affecting their economic well-being, social interactions and psychological impact. These long term impacts are detailed below.

### ECONOMIC

Poverty and unemployment are widespread in Haiti, and many of our respondents wound up in even more dire socio-economic situations after being injured. Over half (53%) of respondents were unemployed, while others received earned income from business (14%), service (10%), labour (9%), and transfers or remittances (8%). Nearly all respondents (98%) said their current household income was insufficient. The general difficulty of finding employment in Haiti is compounded by injury and impairments. Of the 18 respondents who said they changed occupations since the incident of armed violence, 6 (33%) said they did so due to the incident or the resulting impairment. Of the 99 respondents who said they became unemployed since the incident, 15 (15%) said they had no employment due to the incident or the resulting impairment. 37% of respondents said their income had diminished due to the incident or resulting impairments increasing expenses and preventing survivors from working. One respondent said her income is “*greatly diminished, because I can no longer [go out] selling*” – (Survey respondent, female, 40, upper limb impairment and chronic pain). Another who had previously worked as a seamstress said she had to become a merchant after being shot in the foot because “*I can no longer pedal [a sewing machine]*” – (Survey respondent, female, 50, lower limb impairment and hearing loss).

This economic hardship is particularly problematic since 69% of respondents were heads of households (18% were children, and 7% were spouses) and the heads of households reported having as many as 17 dependents. 7% of respondents mentioned that their families have suffered specifically due to the loss of their income, with one saying “*I cannot work to feed my family*” – (Survey respondent, female, 39, lower limb impairment), while two respondents said they are now unable to send their children to school due to the loss of income or costs of healthcare.

### SOCIAL

These economic changes may also affect family social dynamics. One respondent said “*I live depending on my family, but before they depended on me*” – (Survey respondent, male, 28, quadriplegic), creating potential frustration and conflicts. While most respondents said their families had taken care of them, three said that they had been abandoned or neglected by their families, with one saying, “*they have treated me with negligence*” – (Survey respondent, male 66, chronic pain). Several respondents also mentioned no longer being able to participate in community activities in which they were formerly active. Only 4 respondents mentioned negative experiences with their communities after the incident, such as being excluded or derided, with one survivor saying that his community “*has not been very sensitive to me*” – (Survey respondent, male, 38, leg amputated).

Persons with disabilities have historically been stigmatized in Haiti, with their physical or mental impairments often seen as ‘mysterious and dangerous.’<sup>186</sup> However, since the earthquake, the large number of new persons with disabilities has made disabilities more accepted.

### PSYCHOLOGICAL

67% of all respondents stated that they had been traumatised or otherwise negatively affected psychologically by their victimisation, with 21% reporting depression, 16% reporting fear or stress, 11% reporting psychological trauma, and 19% reporting other negative mental health effects. A previous study among survivors of violence in other popular zones of Port-au-Prince found that 25% of respondents in Cité Soleil and 38% in Martissant reported suffering psychological distress<sup>187</sup>. Few mental health services are available or accessible to survivors and their families, a problem that exists across the spectrum of survivor assistance.

Given the significant social, economic and psychological impact of armed violence on survivors, their families and communities, it becomes important to understand that type of assistance available for them.

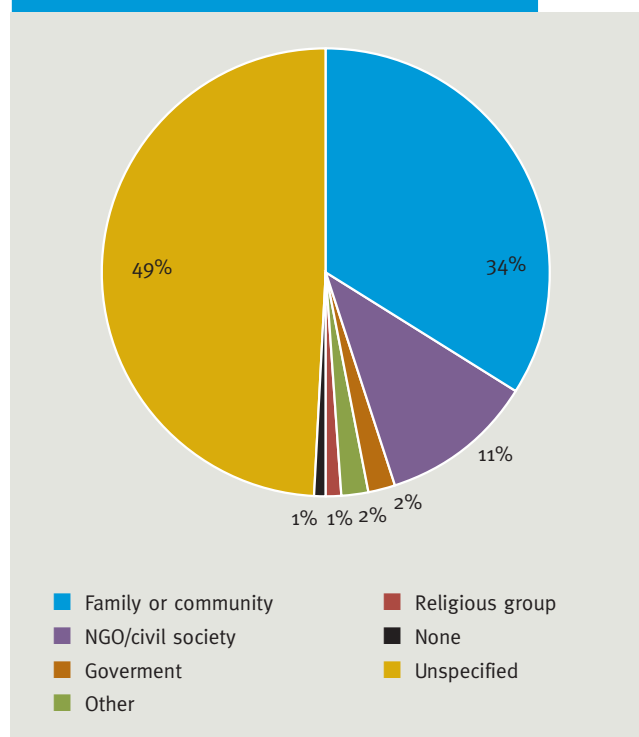
## Survivor Assistance and Lack thereof

Only NGO knows how to provide medical assistance, but it is up to us to travel to where they are; they never enter into this area.

Affected family member (Female, 40)

Immediately following the incident, 73% of survivors received medical assistance at a hospital, while 8% received medical assistance from private doctors or nurses. Immediate assistance in the aftermath of the incident was generally provided by respondents' family or community members, as outlined in Figure III below, although nearly half of all respondents did not specify who attended to them or transported them to the hospital immediately after the incident.

**FIGURE III: IMMEDIATE ASSISTANCE BENEFACTORS**



Prior to the earthquake, many of the survivors were treated at the Hospital of the State University of Haiti, though now most are treated at NGO clinics or St. Joseph Hospital. The most common types of assistance received were medication (44%), subsistence support (21%), psychosocial support (17%), and physical rehabilitation assistance. Only 9% of respondents reported receiving any economic aid. The survey did not register any long term health and rehabilitation care or economic support to the respondents.

Assistance may be difficult to come by, with economic and availability obstacles creating a disabling environment. In a previous study among survivors of violence, 11% in Cité Soleil

and 23% in Martissant were unable to access healthcare due to insecurity or costs, with 40% of survivors in both areas seeking informal care, such as that provided by traditional healers<sup>188</sup>. Prior to the earthquake, a 2001 study found that there were only three full-time and two part-time prosthetics shops, all very limited, serving an estimated amputee population of 8,000-16,000, with only 25% of amputees having ever received prosthetics and others not receiving prosthetics because they could not pay for them<sup>189</sup>.

Access to justice is also constricted, for Haiti's police capacity remains one of the lowest in the world, with only one police officer for every 1,000 people at the end of 2009<sup>190</sup>. Courts also offer limited protection for citizens, with a conviction rate after arrest in Port-au-Prince of only 2.1% in 2009<sup>191</sup>. This is a particular problem for survivors, as nearly half (47%) say they have reduced mobility since the incident, and this can leave them more vulnerable to future victimisation, with 48% of respondents saying they felt afraid or less secure following the incident. In the words of one respondent, *"the fact that I can no longer walk normally [means] I am in greater danger"* – (Survey respondent, male, 25, lower limb impairment).

Most survivor assistance provision falls to international and local non-governmental organisations. In addition to MINUSTAH, there are a number of international organisations working to analyse and address armed violence in Haiti and in Port-au-Prince specifically.

Provision of medical, rehabilitation and other assistance to survivors of armed violence has generally taken place under the auspices of the more general disabilities and health programs of organisations, though interviewees say that there are few services directly available in the poorest neighbourhoods. Assistance for disabled persons has greatly improved due to increased international attention to the issue after the 2010 earthquake. The earthquake led to an estimated 3,000-4,000 more persons undergoing amputations, but because many international assistance programs have a remit only to serve people injured by the earthquake, persons who became disabled before or after the earthquake due to armed violence have either been unable to receive services or have had to present themselves as earthquake victims<sup>192</sup>.

The Haitian government is beginning to take more responsibility for disability issues, as the parliament on 12 March 2012 passed the Act on the Integration of Disabled Persons, giving the government greater legal obligations toward the protection and integration of persons with disabilities. Specifically, the law emphasizes the need to meet the basic necessities of persons with disabilities (i.e. education, healthcare, and lodging), institutes obligations for accessibility of public buildings and modes of transport, prohibits discrimination in employment, and creates a quota of hiring 2% persons with disabilities for any public or private employer with over 20 employees<sup>193</sup>.

However, like ordinary people, those with disabilities seek to live in an environment with employment opportunities, schooling for children and social protection against violence. Many respondents reiterated that they wanted non-government organisations to create soup kitchens or food banks to ensure that survivors and their families have food, financial assistance from the government and health centre access that is free of charge. There was evident demand for trainings and micro-



credit opportunities. Safety and security is also a top priority for the survivors, who ask for more police posts in Bel Air and for the police force to receive better pay and resources. They also talked of ensuring protection of rights of persons with disabilities. In summary, one respondent said, *“victims must be supported so that we can feel comfortable in our own skin, because we are people, too”* – (Female, 25, chronic pain and lower limb-impairment).

## Discussion

**Doctors, social workers, and psychologists should work together in a multidimensional team to allow victims to regain a zeal for life.**

Security forces officer (Female, age unreported)

Haiti has been afflicted by armed violence for decades, with people living through political and non-political armed violence, along with surviving natural disasters. Politically and criminally motivated gang violence continues to disrupt everyday life, especially in the popular zones of Port-au-Prince and other cities. A general lack of government capacity and infrastructure impedes both law enforcement and the access to services and reintegration of survivors of armed violence. These survivors are constantly faced with challenges, particularly in seeking subsistence opportunities. Those who are impaired are economically and socially excluded. **Security, justice, access to care and rehabilitative services and the creation of economic opportunities** should be the focus of armed violence sensitive initiatives for assistance. Below is the summary of main findings presented in the text.

### BOX III: SUMMARY OF MAIN FINDINGS

- ❑ Criminal gang violence (i.e. confrontations between gangs and confrontations between gangs and security forces) stray bullets from such violence are the most common cause of armed violence-related disabilities in Bel Air. The most common weapons are small arms.
- ❑ The changing political context alongside devastating natural disasters, active gangs and illegal possession of arms among civilians has undermined Bel Air's economic and social stability.
- ❑ The average age of survivors of armed violence is 33 years, with a majority falling between the age of 15 and 35. They are predominantly young men.
- ❑ 91% (146 of 160 respondents) of armed violence survivors sustained lasting impairments, most commonly chronic pain, lower limb mobility and multiple impairments due to spinal cord injuries. The average age of these individuals at the time of the incident/injury was 30 years.
- ❑ Over one-third of survivors experienced a loss of household income after the incident, compounding already difficult economic situations, leading to increased demand for employment opportunities and financial assistance in order to meet basic household needs.
- ❑ Survivors, their families, and their communities may be psychologically scarred by incidents of armed violence, but little psychological support and counselling capacity exists.
- ❑ In addition, persons with disabilities are generally stigmatised, with very few existing policies for their protection. Given the adjustments to new physical conditions, socio-economic exclusion, psychological impact and existing perception of disabilities, respondents are potentially vulnerable to further risks.
- ❑ Non-governmental organisations provide the vast majority of survivor assistance due to low government capacity and survivors expressed a desire for greater access to free medical, therapeutic, and rehabilitative care within Bel Air and other popular zones.

## Jeanne (alias) in third person narrative

(Interview conducted with Jeanne, her mother, and her grandfather.)

Jeanne was born 1 September 2001. On the evening of 9 August 2005, around 9 p.m., Jeanne left her grandfather's house with her two aunts. Just as they had closed the gate, they heard shots, and then cries that Annette one of Jeanne's aunts, was dead. All three lay on the ground. Annette was killed instantly and she had been pregnant. Jeanne and the other aunt had been hit by bullets in the legs. Jeanne's grandfather came outside and seeing his children on the ground began to cry. People in the area were afraid, but two or three people arrived to help transport Jeanne and her wounded aunt on a door through the back lanes to avoid being seen. They were carried to Rue St. Martin where there were soldiers from MINUSTAH to transport the wounded to the Médecins sans Frontières hospital.

With regard to the police, one cannot speak of any aid because the zone had been left to itself, and it turns out that the gangsters were far better armed than the police. Annette, Jeanne's aunt, was left on the floor for the night and the next day she was transported to the morgue. Jeanne's mother had to undertake the funeral arrangements alone.

From 2004 to 2006, life was very difficult in the area; there was no life after dark. Many people had access to arms and it was because of this that times were so bad in Bel Air. Supposedly it was a gangster named Shaba who had shot Jeanne and her aunts. He was killed the next day after confrontations with other armed groups from Bel Air. According to Jeanne's mother, the incident was a hard blow for the family, and they worried Jeanne would lose her right leg, but thanks to God and the care she received from MSF, Jeanne survived. She attended therapy sessions and was given a crutch to help her walk. Now she can walk without crutches, but her right leg is shorter in comparison to her left leg. In addition, during the same period, someone robbed the store of Jeanne's father, and thus far they have been unable to recover.

Jeanne's family wanted to leave the area, but they lacked the means to do so. Jeanne lost nearly two years of schooling, since she had been four years old when the incident occurred. She always asks her mother to explain this when the children at her school tease her.

Jeanne says she initially felt different from other children, but her mother helped her to overcome all this. Jeanne says that, "In my school, children frequently ask me why my leg is how it is and I have never been afraid to explain what happened to me. I hope that children no longer suffer from this situation and I also pray that everyone can one day live in peace."





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# 3.

## Discussion and Lessons Learned

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Findings generated, analysed and presented throughout this report from the four regions in Uganda, Colombia, Pakistan and Haiti have demonstrated a clear link between armed violence and disability.



## Discussion

Findings generated, analysed and presented throughout this report from the four regions in Uganda, Colombia, Pakistan and Haiti have demonstrated a **clear link between armed violence and disability**. Interviewed survivors of armed violence who sustain lasting impairments face many barriers in sustaining their daily lives, especially those who live in marginalised, neglected and relatively dangerous areas with weak government institutions, inequalities, harsh environments and unemployment or limited alternatives to formal employment. These individuals are confronted everyday with the brutal realities created by their new conditions, including impacts on the economic conditions of themselves and their families, on their social interactions and psychological well-being. Limited assistance for long-term health and rehabilitation, a lack of economic support and social participation further exacerbates exclusion. Highlighted below are the main issues raised in the report:

❏ In areas where there are a number of risk factors such as cattle raids in Karamoja, organised and collective violence in Medellin, violence driven by explosive ordnance and small arms and family feuds in Peshawar, and gang violence in Port-au-Prince, populations are vulnerable to attacks and accidents. The situation is made worse by weak or non-existent social protection mechanisms, a lack of security safety nets, a deteriorating security situation and illegal possession of arms in the hand of civilians. In these situations, a clear cut victim-perpetrator relation cannot be established and the variety of contexts in which armed violence operates, its root causes and representation, need to be understood.

❏ Of the survivors of armed violence in the four regions, the majority sustained lasting impairments. Survivors were mostly between the age of 15 and 35 at the time of the incident/injury that led to lasting impairments. Findings confirm that not only are members of this age group prone to deaths and injuries, but also to long term impairments. Survivors who sustain lasting impairments experience severe socio-economic impacts, which are multiplied if they have dependents in their households (children, next of kin and/or spouse). In areas of serious poverty and endemic unemployment, (Bel Air, Haiti), families often spiral deeper into poverty and exclusion. Heightened insecurity (Peshawar, Pakistan) forces families to migrate to safer communities.

❏ In all four countries, people with injuries and impairments caused by armed violence experienced significant stigma and discrimination. Although it was beyond the scope of the research to examine social relations in depth, it was able to show some negative consequences of the incidents as reported by the survivors, including neglect by family (Karamoja), mocking by friends (Medellin), ejection from the family home (Peshawar) and conflicts with family (Port-au-Prince).

❏ Inaccessible and unavailable long-term health and rehabilitation services and socio-economic support are major challenges. Despite the availability of hospitals, the cost of the treatment was too high for many survivors, which meant they opted out of long term care. Constant curfews, restricted mobility in gang or militant-controlled areas (Peshawar, Pakistan and Medellin, Colombia), weak transport systems (Karamoja, Uganda) and inaccessible justice (Port-au-Prince, Haiti) are some of the barriers to available services. The quality of care delivered at the available services can also be insufficient.

❏ Government policies and provisions are often at odds. In Uganda a number of policies exist, but outreach and implementation are piecemeal and uneven; Colombia, the most developed of the four countries, has policies for victims of various weapons, but no provisions for victims of organised and collective criminal or gang violence; the policies that existed in Pakistan are currently under review, with more focus now on decentralisation; and in Haiti a history of violence and natural disaster has prevented the government from fully forming and implementing policies. Thus, while implementing programs and policies on armed violence the varied contexts must be taken into account.

❏ Where government policies are weak, some non-governmental organisations have provided services to the survivors. However, these have often been limited to hospital care and rehabilitation and the majority of survivors have subsequently relied on informal support.

❏ People who sustain disabilities caused by armed violence are highly vulnerable and at an increased risk of violence. There is a need to recognise, acknowledge, adapt and implement the Convention on the Rights of Persons with Disabilities with special emphasis on Article 4 (general obligations of States towards Persons with Disabilities), Article 16 (Persons with Disabilities' right to live with freedom of exploitation, violence and abuse), Article 19 (Persons with Disabilities' right to live independently and included communities they live in), Article 25 (Persons with Disabilities' right to access to available health care) and Article 28 (Persons with Disabilities' right to adequate living and social protection).

## Lessons Learned

Along with the ability to demonstrate the links between armed violence and disability, a number of lessons have been learned in the process of this research. While some limitations were related to access, representation of the region, time and resources and security (see Limitations) other important reflections can be made on collecting data, and essential next steps. These are given below:

### DATA COLLECTION

The links between armed violence and disability are, without doubt under-researched and under-reported. Building evidence in this area is essential to help develop sound policies. However, armed violence and disabilities are dynamic, complex and therefore difficult to measure. Conceptualising and implementing this kind of research can thus be challenging. The registers in police stations and hospitals would be the natural first step in understanding the extent of the problem. However, unsystematic and poor data collection or unreliable and inaccessible data in places where the information is available at local level poses serious impediments. Creativity is needed to design and implement research of this kind. Hospital clerks could be trained, for example, on proper registrations and their work monitored for a year to review patterns of patients. Other lessons learned are:

- ❑ Rigorous training and precision in the implementation of qualitative and quantitative research is essential.
- ❑ The sensitivity of the topic may pose risks to the respondents as well as the researchers. It is important to understand the local political environment beforehand; one may need to get approval for research and build good relations with local officials and groups. In Colombia for instance, some of the in-country researchers were unable to enter certain neighbourhoods.
- ❑ The process of developing a usable data entry template for different countries is necessary, though time consuming, and proper training sessions and follow-up are essential at the preparatory stage. While cleaning and verifying data many mistakes were revealed which had to be corrected by referring back to the original forms, making this final verification process essential.
- ❑ As difficult as it may be to measure disabilities within an armed violence setting, some tools do exist to help researchers undertake a systematic analysis, such as the International Classification of Functioning, Disability and Health<sup>ix</sup> and the Disability Creation Process.

<sup>ix</sup> For more information see World Health Organisation, International Classification of Functioning, Disability and Health (ICF). Available at: <http://www.who.int/classifications/icf/en/>

### ESSENTIAL FUTURE RESEARCH

This report was able to add important evidence to existing knowledge on armed violence and disabilities. This represents, however, only the tip of the iceberg, for it was the goal to simply explore the armed violence-disability link. Having completed this step opens up a range of new issues for exploration, including:

- ❑ The impact of armed violence on populations with existing disabilities, to understand vulnerabilities and risks;
- ❑ An understanding of the impact of armed violence on affected families and communities and their livelihood conditions;
- ❑ A deeper assessment of service providers, health care, accessibility and the challenges in making services available and accessible for persons with disabilities;
- ❑ Psychosocial research on the people who experience armed violence;
- ❑ Disability rights, policies and implementation in various countries with disabilities resulting from armed violence;
- ❑ Gender-based and domestic violence that cause disabilities amongst both women and men;
- ❑ Research in heavily armed violence-affected countries to understand the extent of the damage to lives, livelihoods and creation of disabilities;
- ❑ And finally, understand the threat of armed violence, particularly the use and abuse of small arms and light weapons in all contexts (emergency, armed conflict, transition).





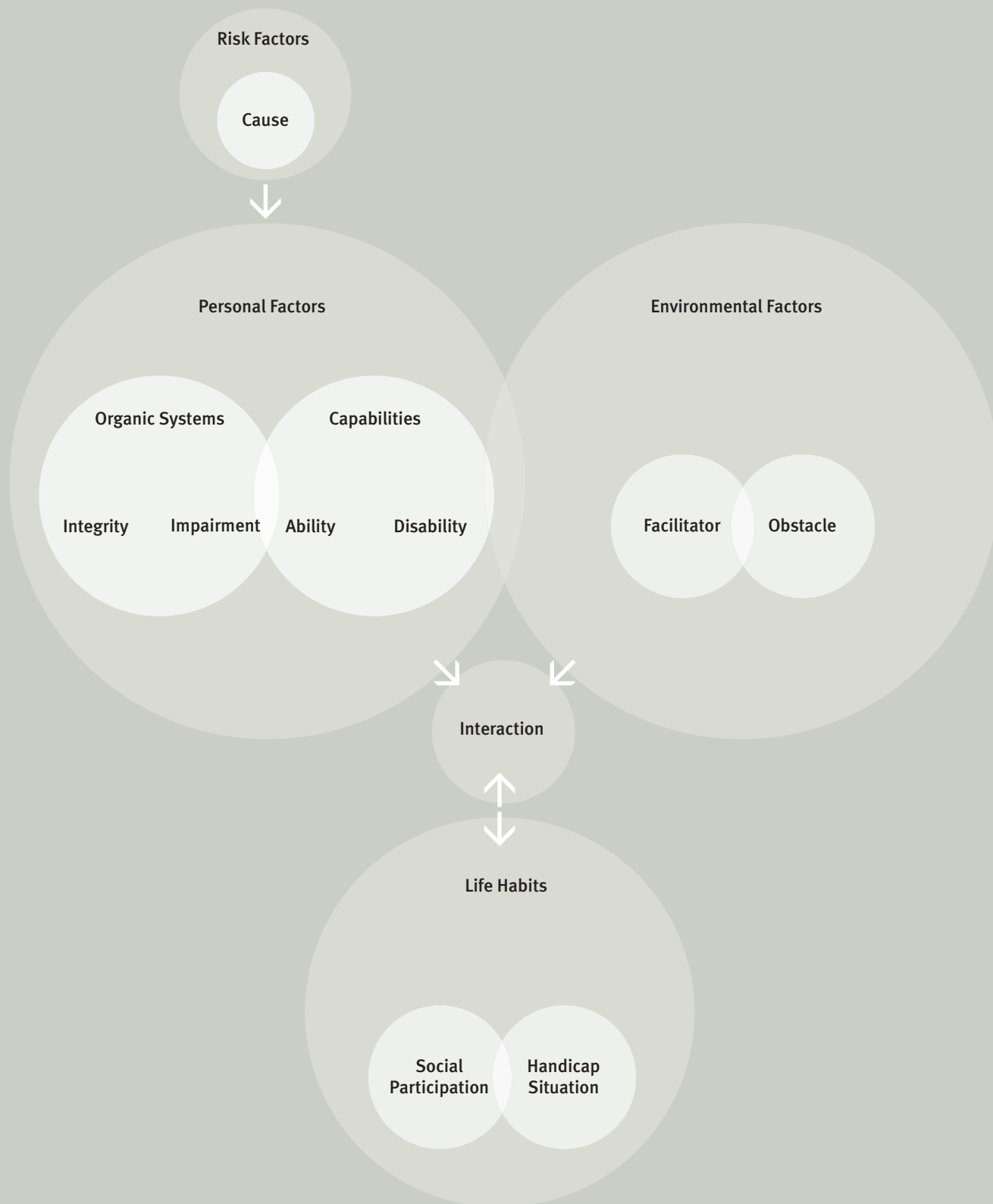
# Glossary (Only lists concepts that are not explained in the text but used frequently)

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Access to services <sup>194</sup>	Delivery of services to persons with disabilities. These range from health, education, housing, rehabilitation, employment, leisure, vocation education and so on. However, different barriers exist to services which can also be named as 'disabling environments,' such as poverty, violence.
Affected families and communities <sup>195</sup>	Families and communities of survivors and people killed by armed violence.
Civilians	Anyone who is not a member of armed forces, militia or armed groups. Civilians are fundamentally distinct from combatants under International Humanitarian Law.
Explosive ordnance <sup>196</sup>	Munitions containing explosives. NOTE: Includes bombs and warheads; guided and ballistic missiles; artillery, mortar, rocket and small arms and light weapons ammunition; all mines, torpedoes and depth charges; pyrotechnics; clusters and dispensers; cartridge and propellant actuated devices; electro-explosive devices; clandestine and improvised explosive devices; and all similar or related items or components that are explosive in nature.
Explosive remnants of war (ERW) <sup>197</sup>	Unexploded ordnance and abandoned explosive ordnance.
Incident <sup>198</sup>	A generic term that includes all accidents, performance failures, faults involving ammunition or where ammunition is present.
Injury	Any physical or mental harm done to the body as a result of violence, accident.
Light weapon <sup>199</sup>	Any man-portable lethal weapon for use by two or three persons serving as crew (although some may be carried and used by a single person) that expels or launches, is designed to expel or launch, or may be readily converted to expel or launch a shot, bullet or projectile by the action of an explosive. NOTE: includes, inter alia, heavy machine guns, hand-held under-barrel and mounted grenade launchers, portable anti-aircraft guns, portable anti-tank guns, recoilless rifles, portable launchers of anti-aircraft missile systems, and mortars of a calibre of less than 100 millimetres, as well as their parts, components and ammunition.
Policies <sup>200</sup>	The rules, regulation and standards established by local, regional, national and international government or other recognised authorities, which govern or regulate systems that control services, programmes and other infrastructural activities in various sectors of the society.
Perpetrators	Perpetrators as actors in armed conflict or armed violence are often referred to as being actively involved in disrupting communities, fostering failure of socio-economic and political infrastructures, promoting antagonistic behaviour and so on.
Safety <sup>201</sup>	The reduction of risk to a tolerable level.
Services <sup>202</sup>	The provision of benefits, structural programmes and operations, which may be public, private, or voluntary, and established at a local, community, regional, state, provincial, national or international level by employers, associations, organisations, agencies or government in order to meet the needs of individuals (including the persons who provide these services). The goods provided by a service may be either general or adapted and specifically designed.
Small arm <sup>203</sup>	Any man portable lethal weapon designed for individual use that expels or launches, is designed to expel or launch, or may be readily converted to expel or launch a shot, bullet or projectile by the action of an explosive. NOTE 1: includes inter alia, revolvers and self-loading pistols, rifles and carbines, sub-machine guns, assault rifles and light machine guns, as well as their parts, components and ammunition. NOTE 2: Excludes antique small arms and their replicas.
Survivors <sup>204</sup>	Persons injured as a direct consequence of armed violence.
Victims <sup>205</sup>	Are 'all persons who have been killed or suffered physical or psychological injury, economic loss, social marginalization or substantial impairment of the realization of their rights' caused by the use of weapons i) Direct victims are persons injured or killed as a direct consequence of armed violence; ii) Indirect victims include families and communities of those killed or injured as a direct consequence of armed violence.
Violence <sup>206</sup>	The intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, mal development or deprivation.
Weapon <sup>207</sup>	Small arm or light weapon.

# Annex 1: The Disability Creation Process

An explanatory model of the causes and consequences of disease, trauma and disruptions to a person's integrity or development  
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## Annex 2:

# Selected International Mechanisms on Protecting Rights and Assistance to Victims

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### **1. International Humanitarian Law- IHL (the Geneva Conventions, 1949)**

- Recognises certain legal obligations towards victims of armed conflict
- Special responsibilities for treating victims who have been combatants
- Protocols I, II, IV and the Additional Protocols of 1977

### **2. The Universal Declaration of Human Rights (1948) - UDHR**

- Fundamental human rights as human beings are equal in dignity and rights
- Especially right to life, liberty and security; protection of these rights; non-discrimination and equal social participation

### **3. Convention on the Rights of Persons with Disabilities (2006) - CRPD**

- Inclusion of Persons with Disabilities (including as a result of armed violence) in commitments to ensure fundamental rights

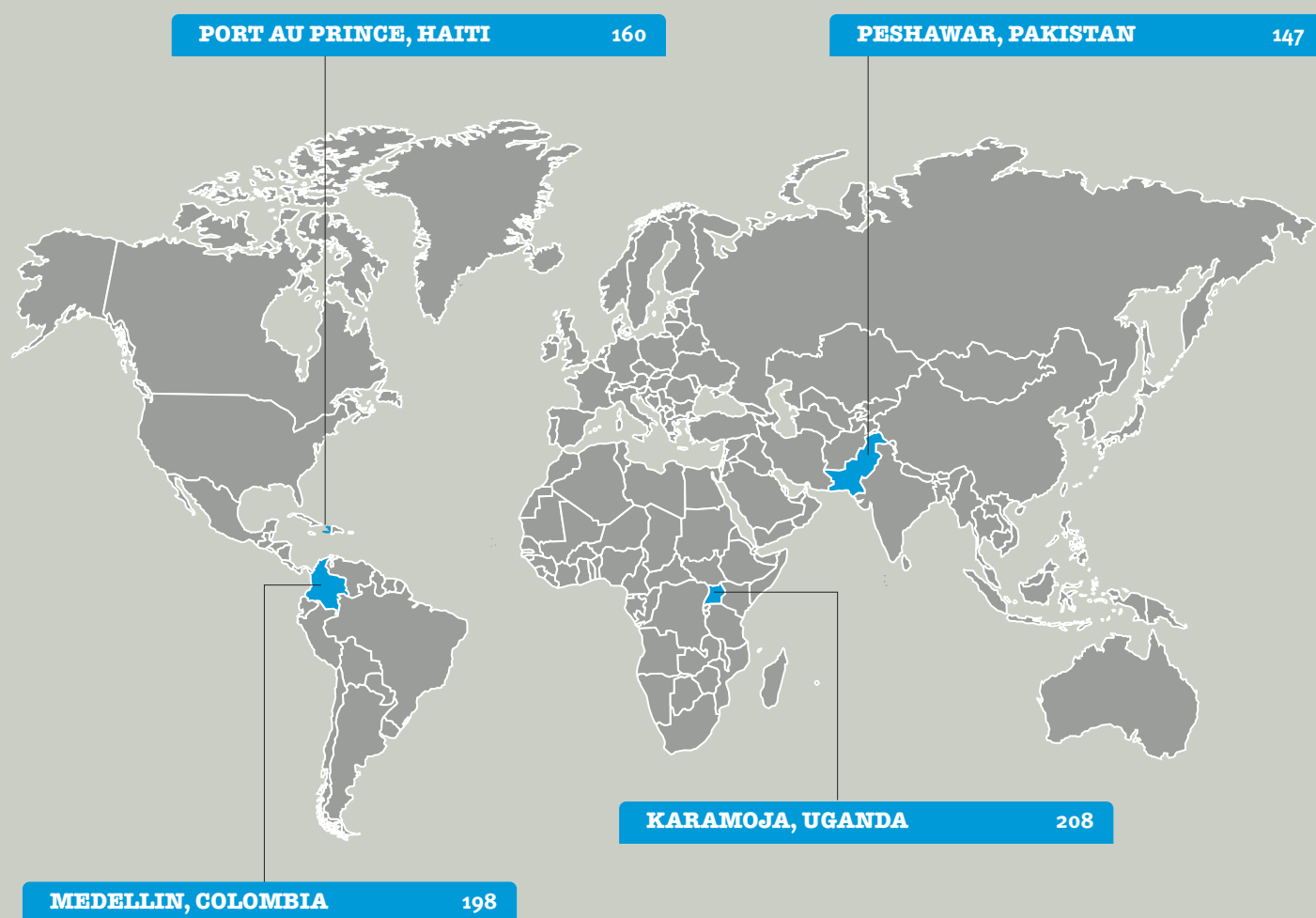
### **4. Article 5 Convention on Cluster Munitions (2008) - CCM**

- Assistance to victims of the above weapons falls under six components: i) data collection, ii) emergency and on-going medical care, iii) physical and functional rehabilitation, iv) psychological and psychosocial support, v) social and economic inclusion, vi) law and public policies



## Annex 3: Sample per region

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## Annex 4: Key Informant Interview Respondents

### UGANDA

Profession/Relation to Survivor	Age	Sex
Deputy DISO	29	Male
Dist. Police Cmdr	56	Male
LC I chairperson	32	Male
LCIII vice-chair		Female
LC V sec. of security	41	Male
Medical staff		Male
Parent of victim	35	Male
Parent of victim	39	Male
Parent of victim	72	Female
Civil society	27	Male
Deputy DISO	30	Male
Dist. Police Commissioner		Male
Family of victim	23	Male
LC I chair	41	Male
LC I vice chair		Male
LC I chair	37	Male
LC III vice chair	41	Female
LC III finance secretary		Male
LC V chair		Male
Media practitioner	27	Male
Medical record assistant	39	Male
Parent of victim	66	Male
Parent of victim	70	Male
Parent of victim	78	Male
Parent of victim	60	Female
NRM vice chair	42	Female
UPC district chair	54	Male
Deputy DISO	37	Male
Dist. Police Commissioner	55	Male
LC I chair	55	Male
LC III chair	28	Male
LC III chair	57	Male
LC III chairperson	30	Male
LC V chairperson	55	Male
Medical staff		Male
Parent of victim	26	Male
Parent of victim	75	Male

### COLOMBIA

Profession/Relation to Survivor	Age	Sex
Doctor	44	Female
Family member	31	Female
Sociologist	52	Male
Teacher	48	Female
Family member	31	Female
NGO Administrator	46	Male
Civil society	26	Male
Family member	30	Female
Family member	36	Male
NGO	40	Female
Family member	65	Female
Family member	37	Male
Medical staff	53	Male
Civil society	51	Male

Government official	57	Male
NGO	26	Female
NGO	57	Male
Civil society	30	Male
Government official	41	Male
Civil society	38	Male
Medical staff	48	Female
Media	40	Male
Civil society	60	Female
Civil society	60	Female
Government official	25	Male
Government official	55	Female
NGO	30	Male
Government official	29	Male
Civil society	44	Male
Government official	31	Female
Civil society	33	Male
Civil society	35	Female
Civil society	60	Male
Civil society	46	Male
Civil society	44	Female
Family member	54	Female

## PAKISTAN

Profession/Relation to Survivor	Age	Sex
Public health professional	26	Female
Food department official	47	Male
NGO worker	31	Female
Security personnel	53	Male
Parent of a victim	45	Male
Medical Staff	37	Male
Community member	25	Male
Community member	25	Male
Security personnel	42	Male
Parent of a victim	43	Male
Community member	30	Male
Local councillor	45	Male
Policeman	58	Male
Community member	18	Male
Government official	58	Male
Media	33	Male
Media	30	Male
Media		
University worker	31	Male
Family of victim		
Family of victim	31	Male
Family of victim	34	Male
Family of victim	21	Male
Family of victim	26	Male
Family of victim	35	Male
Medical staff	27	Male
Community member	34	Male
Security personnel	30	Male
Security personnel	27	Male
Political party	48	Male
Political party	70	Male
Political party	45	Male
Government official	33	Male
Community member	18	Male
Community member	33	Male
Community member	23	Male
Community member	43	Male

# References

- <sup>1</sup> C. Mock, J. Lormand, J. Goosen, M. Joshipura, and M. Peden (2004), 'Guidelines for essential trauma care,' WHO; pg:5
- <sup>2</sup> Krug, EG et al., eds (2002), 'World Report on Violence and Health,' Geneva, WHO; and WHO and Liverpool John Moores University (2012), 'Violence Prevention: The Evidence.'
- <sup>3</sup> WHO and Liverpool John Moores University (2012), 'Violence Prevention: The Evidence,' pg:13
- <sup>4</sup> Ibid:13
- <sup>5</sup> World Health Organisation, (2008), 'Preventing violence and reducing its impact: how development agencies can help,' Geneva, WHO
- <sup>6</sup> Mock, C et el (2004), 'Guidelines for essential trauma care,' Geneva, World Health Organisation
- <sup>7</sup> The Graduate Institute of International and Development Studies, Small Arms Survey (2012), 'Authorised Small Arms Trade Revised up-to USD 8.5 Billion per year: More than double previous estimate,' Geneva
- <sup>8</sup> Hughes, K et el (2012) 'Prevalence and risk of violence against adults with disabilities: a systematic review and meta-analysis of observational studies,' Lancet 2012, pg: 3
- <sup>9</sup> Organisation for Economic Co-operation and Development-OECD (2009), 'Armed Violence Reduction Enabling Development,' OECD, pg: 28.
- <sup>10</sup> Geneva Declaration Secretariat (2008) 'Global Burden of Armed Violence,' Cambridge: Cambridge University Press, pg:2
- <sup>11</sup> WHO (2002), 'World Report on Violence and Health,' pg:5
- <sup>12</sup> Krause, K and Muggah, R (2011), 'Background Note 1: Measuring the Scale and Distribution of Armed Violence,' Geneva Declaration on Armed Violence and Development, pg:2
- <sup>13</sup> Ibid
- <sup>14</sup> Krug, EG et el (2002), 'World Report on Violence and Health,' WHO
- <sup>15</sup> Geneva Declaration Secretariat (2008), 'Global burden of Armed Violence 2011,' and World Health Organisation (2002), 'World Report on Violence and Health,' Table 8.2
- <sup>16</sup> OECD (2009), 'Armed Violence Reduction: Enabling Development'
- <sup>17</sup> Geneva Declaration Secretariat (2008), 'Global burden of Armed Violence 2011, Lethal Encounters,' Cambridge: Cambridge University Press, pg:75
- <sup>18</sup> Geneva Declaration Secretariat (2011), 'Global burden of Armed Violence 2011: Lethal Encounters,' Cambridge: Cambridge University Press, pg:4
- <sup>19</sup> The Graduate Institute of International and Development Studies, Small Arms Survey (2012), 'Authorised Small Arms Trade Revised up-to USD 8.5 Billion per year: More than double previous estimate,' Geneva. Available at: <http://www.smallarmssurvey.org/fileadmin/docs/A-Yearbook/2012/eng/Small-Arms-Survey-2012-About-3-Press-Release-EN.pdf>
- <sup>20</sup> JMU and WHO (2012), 'Violence Prevention: The Evidence,' Liverpool John Moores University and World Health Organisation, Geneva, pg:3
- <sup>21</sup> JMU and WHO (2012), 'Reducing violence through victim identification, care and support programmes,' in 'Violence Prevention : The evidence,' Liverpool John Moores University and World Health Organisation, Geneva, pg: 3
- <sup>22</sup> Geneva Declaration on Armed Violence and Development (2010), 'Background Paper: Oslo Conference on Armed Violence: Achieving the Millennium Development Goals,' pg: 4 and Action on Armed Violence (2010) 'Victims and Survivors of Armed Violence: Responding to Rights and Needs.'
- <sup>23</sup> Yacoub S, Arellano S, Padgett-Moncada D (2006), 'Violence related injuries, deaths and disabilities in the capital of Honduras,' Injury. 37(5):428-34. Epub 2006 Feb 21; and DiScala C and Sege R (2004), 'Outcomes in children and young adults who are hospitalized for firearms-related injuries,' Pediatrics 113(5):1306-12
- <sup>24</sup> Hughes, K et el (2012) 'Prevalence and risk of violence against adults with disabilities: a systematic review and meta-analysis of observational studies,' Lancet 2012, pg: 3
- <sup>25</sup> Ibid:2
- <sup>26</sup> Ibid:8
- <sup>27</sup> Ibid
- <sup>28</sup> Ibid, and JMU and WHO (2012), 'Reducing violence through victim identification, care and support programmes,' in 'Violence Prevention : The evidence,' Liverpool John Moores University and World Health Organisation, Geneva, pg: 3
- <sup>29</sup> Ronnberg AK, Hammerstrom, A (2000), 'Barriers within the health care system to dealing with sexualized violence: a literature review,' Scandinavian Journal of Public Health, 28:222-229; and Stinson CK and Robinson, R (2006), 'Intimate partner violence: continuing education for registered nurses,' Journal of Continuing Education in Nursing, 37:58-62
- <sup>30</sup> WHO and WB (2011), 'World Report on Disability,' World Health Organisation and World Bank, Geneva; pg:3
- <sup>31</sup> Guy, M (2011), 'Disability Terminology Guidelines,' unpublished, Handicap International
- <sup>32</sup> WHO and WB (2011), 'World Report on Disability,' World Health Organisation and World Bank, Geneva; pg:21
- <sup>33</sup> Ibid
- <sup>34</sup> Ibid:22
- <sup>35</sup> Ibid
- <sup>36</sup> Kett, M and Van Ommeren, M (2008), 'Disability, conflict and emergencies,' in Lancet, Vol. 374, pg: 1801-2
- <sup>37</sup> The Geneva Declaration on Armed Violence 2006 and followed by Oslo Conference and Commitments 2010. Available at <http://www.genevadeclaration.org/home.html>
- <sup>38</sup> <http://www.osloconferencearmedviolence.no/>
- <sup>39</sup> United Nations, Convention on the Rights of Persons with Disabilities, 2008, Article 11. Available at: <http://www2.ohchr.org/english/law/pdf/disabilities-convention.pdf>
- <sup>40</sup> Krug EG (2004), 'Injury surveillance is key to preventing injuries,' Lancet 364(1563)
- <sup>41</sup> United Nations Secretary General (2006, July), A/61/122/add.1, In-depth study on all forms of violence against women: Report of the Secretary-General.
- <sup>42</sup> United Nations Secretary General (2006, August), Report of the independent expert for the United Nations study on violence against children
- <sup>43</sup> OECD (2009), 'Armed Violence Reduction: Enabling Development,' Annex C
- <sup>44</sup> Central Intelligence Agency, the World Factbook: Uganda, Available at <https://www.cia.gov/library/publications/the-world-factbook/geos/ug.html> Accessed: 25th April 2012
- <sup>45</sup> UNDP (2011), Human Development Report 2011 Table 1- Human Development Index and its Components, Available at: [http://hdr.undp.org/en/media/HDR\\_2011\\_EN\\_Table1.pdf](http://hdr.undp.org/en/media/HDR_2011_EN_Table1.pdf) Accessed: 25th April 2012
- <sup>46</sup> Ibid
- <sup>47</sup> UNDP (2011), Human Development Report 2011 Table 1- Human Development Index and its Components, Available at: [http://hdr.undp.org/en/media/HDR\\_2011\\_EN\\_Table1.pdf](http://hdr.undp.org/en/media/HDR_2011_EN_Table1.pdf) Accessed: 25th April 2012
- <sup>48</sup> WHO, Country Statistics : Uganda, Available at <http://www.who.int/countries/uga/en/> Accessed: 25th April 2012
- <sup>49</sup> WHO, Uganda : Health Profile, Available at <http://www.who.int/gho/countries/uga.pdf> Accessed: 25th April 2012
- <sup>50</sup> Uganda Bureau of Statistics (2002), 'Population and Housing Census,' Uganda
- <sup>51</sup> Japan International Corporation and friends (2008), 'A presentation on the status of persons with disability in Uganda', Available at: <http://www.jicafriends.jp/leaders/pdf/l2008personaluganda01.pdf> Accessed: 25th April 2012
- <sup>52</sup> UN Treaty Collection, Status as at: 25-04-2012: Convention on the Rights of Persons with Disabilities, Available at [http://treaties.un.org/pages/ViewDetails.aspx?src=TREATY&mtdsg\\_no=IV-15&chapter=4&lang=en](http://treaties.un.org/pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-15&chapter=4&lang=en) Accessed: 25th April 2012
- <sup>53</sup> Government of Uganda, Ministry of Gender, Labour and Social Development, Persons with Disability Act 2006, Available at: <http://www.mglsd.go.ug/wp-content/uploads/2010/04/PWD%20Act%202006%201.pdf> and Department of Disability and Elderly, Available at: <http://www.mglsd.go.ug/> Accessed: 25th April 2012
- <sup>54</sup> US Department of State, Background Note: Uganda. Available at: <http://www.state.gov/r/pa/ei/bgn/2963.htm>
- <sup>55</sup> Keatley, Patrick (18 August 2003), 'Obituary: Idi Amin', The Guardian, London
- <sup>56</sup> Acheson-Brown, D (2001), 'The Tanzanian Invasion of Uganda: A Just war?,' in International Third World Studies Journal and Review, Vol. XII. A
- <sup>57</sup> Lomo, Z and Hovil, L (n.d), 'Chapter 2: Root Causes of the Conflict in Uganda,' in Institute of Security Studies. Available at: <http://www.iss.co.za/pubs/Monographs/N099/Chap2.pdf>

- <sup>58</sup> Faculty of Law, Makerere University, Uganda (2004), 'Behind Violence: Causes, Consequences and the Search for Solutions to the War in Northern Uganda,' Refugee Law Project Working Paper 11, pg:8
- <sup>59</sup> Ibid:5
- <sup>60</sup> Tanga, O (2009), 'Politics, Ethnicity and Conflict in Post Independent Achililand,' Uganda 1962-2006, DPhil thesis, University of Pretoria, Pretoria
- <sup>61</sup> Bayne, S (2007), 'Aid and conflict in Uganda,' Safer world, London, pg:17
- <sup>62</sup> Mkutu, K (2001) 'Pastoralism and conflict in the Horn of Africa,' Africa Peace Forum, Saferworld and University of Bradford, pg: 8-17
- <sup>63</sup> Beven, J (2008) 'Crisis in Karamoja: Armed Violence and the Failure of Disarmament in Uganda's Most Deprived Region,' Small Arms Survey, pg: 26
- <sup>64</sup> OCHA (2008a), 'Joint Factsheet on Karamoja : Humanitarian and Development Realities in the Region'
- <sup>65</sup> Chapman, C and Kagaha (2009), A, 'Resolving conflicts using traditional mechanisms in the Karamoja and Teso regions of Uganda,' Minority Rights Group International, pg: 2
- <sup>66</sup> BBC (2007), 'Surviving Uganda's cattle wars,' in Matthysen et al (2010), The Karamoja Cluster of Eastern Africa: Arms Transfers and their repercussions on communal security perceptions, IPIIS, pg: 6
- <sup>67</sup> Powell, J (2010) 'Karamoja : A literature review,' Saferworld, London, pg:3
- <sup>68</sup> Powell, J (2010) 'Karamoja : A literature review,' Saferworld, pg : 4
- <sup>69</sup> Matthysen et al (2010), 'The Karamoja Cluster of Eastern Africa : Arms Transfers and their repercussions on communal security perceptions,' IPIIS, pg: 6
- <sup>70</sup> Mkutu, K (2003), 'Pastoral Conflict and Small Arms: The Kenya-Uganda Border Region,' Saferworld, London, pg:42
- <sup>71</sup> Beven, J (2008) 'Crisis in Karamoja: Armed Violence and the Failure of Disarmament in Uganda's Most Deprived Region,' Small Arms Survey, pg: 41
- <sup>72</sup> Powell, J (2010) 'Karamoja : A literature review,' Saferworld, pg : 13
- <sup>73</sup> Beven, J (2008) 'Crisis in Karamoja: Armed Violence and the Failure of Disarmament in Uganda's Most Deprived Region,' Small Arms Survey, pg: 16
- <sup>74</sup> Ibid
- <sup>75</sup> Longole, R (2007), 'The history of Disarmament in Karamoja,' Paper presented at the 'Disarmament of Pastoral Communities Workshop,' Kotido Peace Institute, Entebbe, 28-30 May
- <sup>76</sup> Powell, J (2010) 'Karamoja : A literature review,' Saferworld, London, pg :11
- <sup>77</sup> Ibid:75
- <sup>78</sup> Lang, R and Murangiri, A (2009), 'Disability Scoping Study,' Department for International Development, Government of United Kingdom
- <sup>79</sup> Uganda Bureau of Statistics (2004), 'The Northern Uganda Baseline Survey,' Uganda, pg:80
- <sup>80</sup> Landmine and Cluster Munition Monitor (2011), 'Uganda: Casualties and Victim Assistance,' Available at: [http://www.the-monitor.org/index.php/cp/display/region\\_profiles/theme/2271](http://www.the-monitor.org/index.php/cp/display/region_profiles/theme/2271) Accessed: 25th April 2012
- <sup>81</sup> ILO and Irish Aid (2009), 'Decent Work for Persons with Disabilities: Inclusion of Persons with Disabilities in Uganda,' International Labour Organisation and Irish Aid, Kampala
- <sup>82</sup> Departamento Administrativo Nacional de Estadística (DANE), (2010a), 'Boletín Censo General 2005,' Available at [http://www.dane.gov.co/files/censo2005/PERFIL\\_PDF\\_CG2005/00000T7Tooo.PDF](http://www.dane.gov.co/files/censo2005/PERFIL_PDF_CG2005/00000T7Tooo.PDF), Accessed: 23rd April 2012
- <sup>83</sup> UN Economic Commission of for Latin America and the Caribbean (UN ECLAC), (2012), 'CEPALSTAT: Databases and Statistical Publications,' Available at <http://websie.eclac.cl/infest/ajax/cepalstat.asp?carpeta=estadisticas&idioma=i>, Accessed: 24th April 2012
- <sup>84</sup> UNDP (2011), 'Colombia,' International Human Development Indicators,' Available at <http://hdrstats.undp.org/en/countries/profiles/COL.html>, Accessed: 23 April 2012
- <sup>85</sup> World Bank (2012), 'Colombia at a glance,' Available at [http://devdata.worldbank.org/AAG/col\\_aag.pdf](http://devdata.worldbank.org/AAG/col_aag.pdf), Accessed: 23rd April 2012
- <sup>86</sup> UN Economic Commission of for Latin America and the Caribbean (UN ECLAC), (2012), 'CEPALSTAT: Databases and Statistical Publications,' Available at <http://websie.eclac.cl/infest/ajax/cepalstat.asp?carpeta=estadisticas&idioma=i>, Accessed: 24th April 2012
- <sup>87</sup> World Bank (2012), 'Health expenditure per capita (US\$),' Available at <http://data.worldbank.org/indicator/SH.XPD.PCAP>, Accessed 9th September 2012
- <sup>88</sup> UN Economic Commission of for Latin America and the Caribbean (UN ECLAC), (2012), 'CEPALSTAT: Databases and Statistical Publications,' Available at <http://websie.eclac.cl/infest/ajax/cepalstat.asp?carpeta=estadisticas&idioma=i>, Accessed: 24th April 2012
- <sup>89</sup> DANE (2006), 'Boletín Censo General 2005, Discapacidad-Colombia: Actualización,' 30 November 2006, Available at <http://www.dane.gov.co/censo/files/boletines/discapacidad.pdf>, Accessed: 24th April 2012
- <sup>90</sup> DANE (2010b), 'Formulario: Registro para la Localización y Caracterización de Personas con Discapacidad,' Available at <http://www.dane.gov.co/files/investigaciones/discapacidad/formulario.pdf>, Accessed: 28th May 2012
- <sup>91</sup> United Nations Treaty Collection (2012), 'Status as at 25-04-2012: Convention on the Rights of Persons with Disabilities,' Available at [http://treaties.un.org/pages/ViewDetails.aspx?src=TREATY&mtsg\\_no=IV-15&chapter=4&lang=en](http://treaties.un.org/pages/ViewDetails.aspx?src=TREATY&mtsg_no=IV-15&chapter=4&lang=en), Accessed: 25 April 2012
- <sup>92</sup> Organization of American States (2012), 'Signatories and Ratifications: A-65: Inter-American Convention on the Elimination of all Forms of Discrimination against Persons with Disabilities,' Available at <http://www.oas.org/juridico/english/sigs/a-65.html>, Accessed: 1 May 2012
- <sup>93</sup> Ministerio de Salud y Protección Social (2012), 'Sistema Nacional de Discapacidad,' Available at <http://www.minproteccionsocial.gov.co/asistenciaSocial/Paginas/Sistema%20de%20Discapacidad.aspx>, Accessed: 25th April 2012
- <sup>94</sup> Bailey, A (1967), 'La Violencia in Colombia,' in Journal of Inter-American Studies 9(4), pg: 561-75
- <sup>95</sup> UNODC (2011), '2011 Global Study on Homicide: Trends, Context, Data' Vienna: United Nations Office on Drugs and Crime
- <sup>96</sup> On a Colombian 'culture of violence,' see Sánchez, G (2003), Guerras, Memoria e Historia, Bogotá: ICANH, and Waldmann, P (2007), 'Is There a Culture of Violence in Colombia?' in Terrorism and Political Violence 19(4) pg: 593-609
- <sup>97</sup> Graduate Institute of International Studies, Small Arms Survey (2007), 'Guns and the City,' Geneva: Small Arms Survey, pg: 47
- <sup>98</sup> Ibid: 67
- <sup>99</sup> Departamento Administrativo Nacional de Estadística (DANE), (2010a), 'Boletín Censo General 2005,' Available at [http://www.dane.gov.co/files/censo2005/PERFIL\\_PDF\\_CG2005/00000T7Tooo.PDF](http://www.dane.gov.co/files/censo2005/PERFIL_PDF_CG2005/00000T7Tooo.PDF), Accessed 23rd April 2012
- <sup>100</sup> Oxfam (2003), 'The Impact of Small Arms on Health, Human Rights and Development in Medellín,' Boston: Oxfam
- <sup>101</sup> Personería de Medellín (2012), 'Los derechos humanos en Medellín 2004-2011, Tomo 2 (2008-2011),' pg: 260, Available at [www.personeriamedellin.gov.co/libro/libro2/index.html#/personeriaMedellin/1](http://www.personeriamedellin.gov.co/libro/libro2/index.html#/personeriaMedellin/1).
- <sup>102</sup> Ibid: 111-115
- <sup>103</sup> UN PoA (2012), 'Modelo de informe sobre la aplicación del Programa de Acción para prevenir, combatir y eliminar el tráfico ilícito de armas pequeñas y ligeras en todos sus aspectos,' Available at <http://www.poa-iss.org/CASACountryProfile/PoANationalReports/2012@43@Colombia-PoAwithAnnex-2012-S.pdf>, Accessed: 29th May 2012, pg: 18
- <sup>104</sup> Janeth Hernández Jaramillo and Israel Cruz Velandia (2006), 'Exclusión social y discapacidad,' Bogotá: Universidad del Rosario
- <sup>105</sup> See Consejo Nacional de Política Económica y Social (2009), 'Documento Conpes 3567,' pg: 44-50, Available at <http://www.dnp.gov.co/Portals/o/archivos/documentos/Subdireccion/Conpes/3567.pdf>, Accessed: 26th April 2012
- <sup>106</sup> Landmine and Cluster Munition Monitor (2011), 'Colombia: Casualties and Victim Assistance,' Available at [http://www.the-monitor.org/index.php/cp/display/region\\_profiles/theme/1695](http://www.the-monitor.org/index.php/cp/display/region_profiles/theme/1695), Accessed: 17th May 2012
- <sup>107</sup> Central Intelligence Agency, the World Factbook: Pakistan, Available at <https://www.cia.gov/library/publications/the-world-factbook/geos/pk.html> Accessed: 30th April 2012
- <sup>108</sup> UNDP (2011), Human Development Report 2011 Table 1- Human Development Index and its Components, Available at: [http://hdr.undp.org/en/media/HDR\\_2011\\_EN\\_Table1.pdf](http://hdr.undp.org/en/media/HDR_2011_EN_Table1.pdf) Accessed: 30th April 2012
- <sup>109</sup> Ibid
- <sup>110</sup> UNDP (2011), Human Development Report 2011 Table 1- Human Development Index and its Components, Available at: [http://hdr.undp.org/en/media/HDR\\_2011\\_EN\\_Table1.pdf](http://hdr.undp.org/en/media/HDR_2011_EN_Table1.pdf) Accessed: 30th April 2012
- <sup>111</sup> WHO, Country Statistics: Pakistan, Available at <http://www.who.int/countries/pak/en/> Accessed: 30th April 2012

- <sup>112</sup> WHO, Pakistan: Health Profile, Available at <http://www.who.int/gho/countries/pak.pdf> Accessed: 30th April 2012
- <sup>113</sup> Population Census Organisation, The Government of Pakistan (1998), 'Disabled Population by Nature of Disability,' Islamabad, Pakistan. Available at: <http://www.census.gov.pk/Statistics.php>
- <sup>114</sup> World Health Organization (2005), 'Pakistan World Health Survey 2003-2004,' Geneva, Switzerland and WHO and WB (2011), 'World Report on Disability,' World Health Organisation and World Bank, Geneva; pg:274
- <sup>115</sup> Ahmed, T n.d. 'The population of Persons with Disabilities in Pakistan,' Pakistan National Institute of Populations Studies
- <sup>116</sup> UN Treaty Collection, Status as at: 30-04-2012: Convention on the Rights of Persons with Disabilities, Available at [http://treaties.un.org/pages/ViewDetails.aspx?src=TREATY&mtldsg\\_no=IV-15&chapter=4&lang=en](http://treaties.un.org/pages/ViewDetails.aspx?src=TREATY&mtldsg_no=IV-15&chapter=4&lang=en) Accessed: 30th April 2012
- <sup>117</sup> Ministry of Social Welfare and Special Education, Pakistan Available at: <http://www.moswse.gov.pk/> and Ahmed et al (2011), 'Policies for Special Persons in Pakistan: Analysis of Policy Implementation,' Berkeley Journal of Social Sciences 1(2)
- <sup>118</sup> International Crisis Group (2011), 'Pakistan Conflict History,' pg: 1
- <sup>119</sup> Chowdhary, A and Wahidunnin, M (2008), 'Handbook on the South Asian Economies,' Edward Elgar Publishing, pg: 72-75
- <sup>120</sup> Ali, T (2008), 'The dual: Pakistan on the flight path of American power,' London: Pocket Books
- <sup>121</sup> Ibid.
- <sup>122</sup> BBC, 'India-Pakistan: Troubled Relations,' Available at: [http://news.bbc.co.uk/hi/english/static/in\\_depth/south\\_asia/2002/india\\_pakistan/timeline/1971.stm](http://news.bbc.co.uk/hi/english/static/in_depth/south_asia/2002/india_pakistan/timeline/1971.stm) Accessed: 1St August 2012
- <sup>123</sup> Ali, T (2008), 'The dual: Pakistan on the flight path of American power,' London: Pocket Books
- <sup>124</sup> Khan, R (2009) 'The crisis in Pakistan: Facing serious threats to human security,' NGO Committee on Disarmament, Peace & Security. Available at: [http://disarm.igc.org/index.php?option=com\\_content&view=article&id=298%3Athe-crisis-in-pakistan-facing-serious-threats-to-human-security&catid=139%3Adisarmament-times-summer-2009&Itemid=2](http://disarm.igc.org/index.php?option=com_content&view=article&id=298%3Athe-crisis-in-pakistan-facing-serious-threats-to-human-security&catid=139%3Adisarmament-times-summer-2009&Itemid=2) Accessed: 30th April 2012
- <sup>125</sup> Ibid
- <sup>126</sup> Khan, R (2009) 'The crisis in Pakistan: Facing serious threats to human security,' NGO Committee on Disarmament, Peace & Security. Available at: [http://disarm.igc.org/index.php?option=com\\_content&view=article&id=298%3Athe-crisis-in-pakistan-facing-serious-threats-to-human-security&catid=139%3Adisarmament-times-summer-2009&Itemid=2](http://disarm.igc.org/index.php?option=com_content&view=article&id=298%3Athe-crisis-in-pakistan-facing-serious-threats-to-human-security&catid=139%3Adisarmament-times-summer-2009&Itemid=2) Accessed: 30th April 2012
- <sup>127</sup> International Crisis Group (2011), 'Pakistan Conflict History,' pg: 1 and Khan, R (2009), 'The crisis in Pakistan: Facing serious threats to human security,' NGO Committee on Disarmament, Peace & Security. Available at: [http://disarm.igc.org/index.php?option=com\\_content&view=article&id=298%3Athe-crisis-in-pakistan-facing-serious-threats-to-human-security&catid=139%3Adisarmament-times-summer-2009&Itemid=2](http://disarm.igc.org/index.php?option=com_content&view=article&id=298%3Athe-crisis-in-pakistan-facing-serious-threats-to-human-security&catid=139%3Adisarmament-times-summer-2009&Itemid=2) Accessed: 30th April 2012
- <sup>128</sup> Agha, A (2001), 'Dealing with the problem of Small Arms,' The Dawn, Pakistan
- <sup>129</sup> Graduate Institute of International Studies, Small Arms Survey (2001), 'Profiling the Problem', Oxford: Oxford University Press, pg: 180-181
- <sup>130</sup> BBC, 'India-Pakistan: Troubled Relations,' Available at: [http://news.bbc.co.uk/hi/english/static/in\\_depth/south\\_asia/2002/india\\_pakistan/timeline/1971.stm](http://news.bbc.co.uk/hi/english/static/in_depth/south_asia/2002/india_pakistan/timeline/1971.stm) Accessed: 1St August 2012
- <sup>131</sup> International Crisis Group (2011), 'Pakistan Conflict History,' pg: 1 and Khan, R (2009), 'The crisis in Pakistan: Facing serious threats to human security,' NGO Committee on Disarmament, Peace & Security. Available at: [http://disarm.igc.org/index.php?option=com\\_content&view=article&id=298%3Athe-crisis-in-pakistan-facing-serious-threats-to-human-security&catid=139%3Adisarmament-times-summer-2009&Itemid=2](http://disarm.igc.org/index.php?option=com_content&view=article&id=298%3Athe-crisis-in-pakistan-facing-serious-threats-to-human-security&catid=139%3Adisarmament-times-summer-2009&Itemid=2) Accessed: 30th April 2012
- <sup>132</sup> Ibid
- <sup>133</sup> Times of India (2011), 'Pakistan-US relations in jeopardy after Osama bin Laden death,' Available at: [http://articles.timesofindia.indiatimes.com/2011-05-02/pakistan/29495607\\_1\\_bin-osama-yusuf-raza-gilani](http://articles.timesofindia.indiatimes.com/2011-05-02/pakistan/29495607_1_bin-osama-yusuf-raza-gilani) Accessed: 15th August 2012
- <sup>134</sup> Graduate Institute of International Studies, Small Arms Survey (2007), 'Guns and the City,' Geneva: Small Arms Survey, pg: 47
- <sup>135</sup> Khan, R (2004), 'The prevalence and impacts of small arms and light weapons in NWFP and Federally Administered Tribal Areas (FATA) of Pakistan,' Graduate Institute of International Studies, Small Arms Survey, pg:19-31
- <sup>136</sup> Ibid:5
- <sup>137</sup> Hussain, A et al (2003), 'Pakistan: National Human Development Report – Poverty, Growth and Governance,' UNDP
- <sup>138</sup> According to the Social Policy Development Centre (SPDC), based on poverty incidence by province for 2001-2002 data, SPDC (2004), 'Combating Poverty: Is Growth Sufficient?,' Annual Report, 2004 in Aftab, S (2008), Poverty and Militancy, 'Pips Journal of Conflict and Peace Studies,' 1(1), pg: 70
- <sup>139</sup> World Food Programme and Sustainable Development Policy Institute (2003), 'Food and Insecurity in Rural Pakistan,' in Aftab, S (2008), 'Poverty and Militancy,' Pips Journal of Conflict and Peace Studies, 1(1), pg: 73; and Government of Pakistan, Poverty Reduction Strategy Papers- II
- <sup>140</sup> Data from Amnesty International and Pakistan Institute of Peace Studies on estimated Civilian Casualties in CIVIC (2010), 'Civilians in Armed Conflict: Civilian Harm and Conflict in Northwest Pakistan,' pg: 11
- <sup>141</sup> International Crisis Group (2011), 'Pakistan Conflict History,' pg: 1
- <sup>142</sup> Ibid
- <sup>143</sup> Pro-Pakistan (2009), 'Economic Survey of Pakistan: 2008-2009,' Islamabad.
- <sup>144</sup> CIVIC (2010), 'Civilians in Armed Conflict: Civilian Harm and Conflict in Northwest Pakistan,' pg: 47
- <sup>145</sup> Ibid:51-52
- <sup>146</sup> The Government of Pakistan (2002), 'National Policy for Persons with Disabilities,' Islamabad, pg:11
- <sup>147</sup> CIVIC (2010), 'Civilians in Armed Conflict: Civilian Harm and Conflict in Northwest Pakistan,' pg: 57
- <sup>148</sup> Landmine and Cluster Munition Monitor (2011), 'Pakistan Casualties and Victim Assistance,' Available at: [http://www.the-monitor.org/index.php/cp/display/region\\_profiles/theme/1260](http://www.the-monitor.org/index.php/cp/display/region_profiles/theme/1260) Accessed: 22nd March 2012
- <sup>149</sup> Ibid
- <sup>150</sup> CIVIC (2010), 'Civilians in Armed Conflict: Civilian Harm and Conflict in Northwest Pakistan,' pg: 29
- <sup>151</sup> United Nations Development Programme (2009), 'Human Development Report 2009: Health and Education,' New York
- <sup>152</sup> World Bank and Japan International Cooperation Agency (2002), 'Country Profile on Disability: Islamic Republic of Pakistan,' pg:5-6
- <sup>153</sup> Ibid
- <sup>154</sup> Ibid
- <sup>155</sup> UNDP (2011), 'Haiti,' International Human Development Indicators, Available at <http://hdrstats.undp.org/en/countries/profiles/HTI.html>, Accessed: 29th April 2012
- <sup>156</sup> World Bank (2012), 'Haiti at a glance,' 29 March 2012, Available at [http://devdata.worldbank.org/AAG/hti\\_aag.pdf](http://devdata.worldbank.org/AAG/hti_aag.pdf), Accessed: 29th April 2012
- <sup>157</sup> UN Economic Commission of for Latin America and the Caribbean (UN ECLAC) (2012), 'CEPALSTAT: Databases and Statistical Publications,' Available at <http://websie.eclac.cl/infest/ajax/cepalstat.asp?carpeta=estadisticas&idioma=i>, Accessed: 24th April 2012
- <sup>158</sup> UNDP (2011), 'Haiti,' International Human Development Indicators, Available at <http://hdrstats.undp.org/en/countries/profiles/HTI.html>, Accessed: 29th April 2012
- <sup>159</sup> Ibid
- <sup>160</sup> UN Economic Commission of for Latin America and the Caribbean (2012), 'CEPALSTAT: Databases and Statistical Publications,' Available at <http://websie.eclac.cl/infest/ajax/cepalstat.asp?carpeta=estadisticas&idioma=i>, Accessed: 24th April 2012
- <sup>161</sup> World Health Organization (2012), 'Haiti,' Available at <http://www.who.int/countries/hti/en/index.html>, Accessed: 29th April 2012
- <sup>162</sup> IRIN (2010), 'Haiti: Emergency sheds light on needs of pre-quake disabled,' 15 September 2010, Available at <http://www.irinnews.org/Report/90484/HAITI-Emergency-sheds-light-on-needs-of-pre-quake-disabled>, Accessed: 29 April 2012



- <sup>163</sup> BBC (2009), 'Haiti: After the storm,' 4 December 2009, Available at [http://news.bbc.co.uk/today/hi/today/newsid\\_8393000/8393135.stm](http://news.bbc.co.uk/today/hi/today/newsid_8393000/8393135.stm), Accessed: 29th April 2012
- <sup>164</sup> Bigelow, J et al., (2004), 'A picture of amputees and the prosthetic situation in Haiti,' in *Disability and Rehabilitation* 26(4), pg:246-252
- <sup>165</sup> United Nations Treaty Collection (2012), 'Status as at 25-04-2012: Convention on the Rights of Persons with Disabilities' Available at [http://treaties.un.org/pages/ViewDetails.aspx?src=TREATY&mtdsg\\_no=IV-15&chapter=4&lang=en](http://treaties.un.org/pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-15&chapter=4&lang=en) Accessed: 25th April 2012
- <sup>166</sup> Organization of American States (2012), 'Signatories and Ratifications: A-65: Inter-American Convention on the Elimination of all Forms of Discrimination against Persons with Disabilities,' Available at <http://www.oas.org/juridico/english/sigs/a-65.html>, Accessed: 1st May 2012
- <sup>167</sup> Council on Hemispheric Affairs (2010), 'The Tonton Macoutes: The Central Nervous System of Haiti's Reign of Terror,' 11 March 2010, Available at <http://www.coha.org/tonton-macoutes/>, Accessed: 30th April 2012
- <sup>168</sup> Amnesty International (2004), 'Haiti: Perpetrators of Past Abuses Threaten Human Rights and the Reestablishment of the Rule of Law,' London: Amnesty International.
- <sup>170</sup> International Crisis Group (2004), 'A new chance for Haiti?' in ICG Latin America/Caribbean Report No. 10, 18 November 2004, pg:5
- <sup>171</sup> Ibid:7
- <sup>172</sup> Dziedzic, M and Robert, P (2008), 'Haiti: Confronting the Gangs of Port-au-Prince,' in United States Institute of Peace Special Report 208, September 2008
- <sup>173</sup> Kolbe, R et al (2010), 'Mortality, crime and access to basic needs before and after the Haiti earthquake: a random survey of Port-au-Prince households,' in *Medicine, Conflict and Survival* 26(4), pg: 281-297
- <sup>174</sup> MINUSTAH (2011), 'Launching of 'Operation Phoenix' to secure Port-au-Prince key neighborhoods,' 14 July 2011, Available at <http://minustah.org/?p=31133>, Accessed 30rd April 2012
- <sup>175</sup> Muggah, R (2005), 'Securing Haiti's Transition,' Small Arms Survey Occasional Paper 14, October 2005, pg:14
- <sup>176</sup> Alpers, P and Wilson, M (2012), 'Guns in Haiti: Facts, Figures and Firearm Law,' Sydney School of Public Health, The University of Sydney, 29 January 2012, Available at <http://gunpolicy.org/firearms/region/haiti>, Accessed: 2nd May 2012
- <sup>177</sup> Central Intelligence Agency (CIA), 2012, 'The World Factbook: Haiti,' 12 April 2012, Available from <https://www.cia.gov/library/publications/the-world-factbook/geos/ha.html>, Accessed: 29th April 2012
- <sup>178</sup> Viva Rio (2007), 'Recensement démographique Bel Air, Available at <http://www.comunidadessegura.org/en/node/42433> Accessed: 29th April 2012
- <sup>179</sup> Viva Rio (2011), 'Recovery, Security and Development at Local Level, PID 330097, Mid-Year Report April/Sept 30, 2011,' September 2011, Available at [http://www.comunidadessegura.org/files/mid\\_year\\_narrative\\_report\\_sept\\_2011.pdf](http://www.comunidadessegura.org/files/mid_year_narrative_report_sept_2011.pdf), Accessed: 30th April 2012, pg:24
- <sup>180</sup> Ibid, p.24
- <sup>181</sup> Kolbe, A and Muggah, R (2011), 'Securing the State: Haiti Before and After the Earthquake,' in ch.8 in Graduate Institute of International Studies, Small Arms Survey (2011), *States of Security*, Geneva: Small Arms Survey
- <sup>182</sup> Kolbe, R and Hutson, RA (2006), 'Human rights abuse and other criminal violations in Port-au-Prince, Haiti: a random survey of households,' in *The Lancet* 368(9538), pg: 864-873
- <sup>183</sup> Muggah, R (2010), 'The effects of stabilization on humanitarian action in Haiti, in *Disasters* 34(S3), pg:S444-S463
- <sup>184</sup> Kolbe, R and Muggah, R (2012), 'Haiti's Urban Crime Wave? Results from Household Surveys, August 2011 – February 2012,' Strategic Brief, March 2012, Instituto Igarapé
- <sup>185</sup> Viva Rio (2011), 'Recovery, Security and Development at Local Level, PID 330097, Mid-Year Report April/Sept 30, 2011,' September 2011, Available at [http://www.comunidadessegura.org/files/mid\\_year\\_narrative\\_report\\_sept\\_2011.pdf](http://www.comunidadessegura.org/files/mid_year_narrative_report_sept_2011.pdf), Accessed: 30th April 2012, pg:24
- <sup>186</sup> Ponsar, F, et al (2009), 'Mortality, violence and access to care in two districts of Port-au-Prince, Haiti,' in *Conflict and Health* 3(4), pg: 6
- <sup>187</sup> Erik Johnson (2003), 'An Introduction to Haitian Culture for Rehabilitation Service Providers,' Buffalo, NY: Centre for International Rehabilitation Research Information and Exchange (CIRRIE)
- <sup>188</sup> Ponsar, F, et al (2009), 'Mortality, violence and access to care in two districts of Port-au-Prince, Haiti,' in *Conflict and Health* 3(4), pg: 6. Differences in survey structure or question phrasing may have resulted in the higher percentage found in Bel Air.
- <sup>189</sup> Ponsar, F, et al (2009), 'Mortality, violence and access to care in two districts of Port-au-Prince, Haiti,' in *Conflict and Health* 3(4), pg: 6
- <sup>190</sup> Bigelow, J et al., (2004), 'A picture of amputees and the prosthetic situation in Haiti,' in *Disability and Rehabilitation* 26(4), pg:246-252
- <sup>191</sup> Kolbe, A and Muggah, R (2011), 'Securing the State: Haiti Before and After the Earthquake,' in ch.8 in Graduate Institute of International Studies, Small Arms Survey (2011), *States of Security*, Geneva: Small Arms Survey
- <sup>192</sup> Ibid
- <sup>193</sup> IRIN (2010), 'Haiti: Emergency sheds light on needs of pre-quake disabled, 15 September 2010, Available at <http://www.irinnews.org/Report/90484/HAITI-Emergency-sheds-light-on-needs-of-pre-quake-disabled>, Accessed: 29 April 2012
- <sup>194</sup> Bureau du Secrétaire d'Etat à l'Intégration des Personnes Handicapées (2012b), 'Vote de la loi sur l'intégration des personnes handicapées,' 29 March 2012, Available at <http://www.seiph.gouv.ht/vote-de-la-loi-sur-l%E2%80%99integration-des-personnes-handicapees/>, Accessed: 1st May 2012
- <sup>195</sup> Handicap International (n.d), 'Access to services Guide'
- <sup>196</sup> Adapted from Convention on Cluster Munition (2008), Article 4 and 5
- <sup>197</sup> United Nations Coordinating Actions on Small Arms (2012), 'International Small Arms Control Standard: Glossary of terms, definitions and abbreviations,' ISACS 01.20, pg:8
- <sup>198</sup> Ibid:9
- <sup>199</sup> United Nations Office of Disarmament Affairs (2011), 'International Ammunition Technical Guideline: Glossary of terms, definitions and abbreviations,' IATG:01.40
- <sup>200</sup> United Nations Coordinating Actions on Small Arms (2012), 'International Small Arms Control Standard: Glossary of terms, definitions and abbreviations,' ISACS 01.20, pg:12
- <sup>201</sup> WHO (2001) in 'Making it Work' (2010), Handicap International
- <sup>202</sup> United Nations Coordinating Actions on Small Arms (2012), 'International Small Arms Control Standard: Glossary of terms, definitions and abbreviations,' ISACS 01.20
- <sup>203</sup> World Health Organisation (2001), 'International Classification of Functioning, Disability and Health'
- <sup>204</sup> United Nations Coordinating Actions on Small Arms (2012), 'International Small Arms Control Standard: Glossary of terms, definitions and abbreviations,' ISACS 01.20, pg:17
- <sup>205</sup> Adapted from Convention on Cluster Munition (2008) Article 5
- <sup>206</sup> Adapted from Convention on Cluster Munition(2008) Article 5
- <sup>207</sup> WHO (2002), 'World Report on Violence and Health,' pg:5
- <sup>208</sup> United Nations Coordinating Actions on Small Arms (2012), 'International Small Arms Control Standard: Glossary of terms, definitions and abbreviations,' ISACS 01.20, pg:20





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