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# A NOTE ON DISABILITY ISSUES IN THE MIDDLE EAST AND NORTH AFRICA

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## ACRONYMS

CBR	Community Based Rehabilitation
CDD	Community Driven Development
DF	Disability Fund
DPO	Disabled Person's Organization
EMICS	Egypt's Multiple Indicator Cluster Survey
ESCWA	Economic and Social Commission for Western Asia
ESW	Economic Sector Work
GDP	Gross Domestic Product
ICD	International Classification of Diseases
ICPC	International Classification of Primary Care
ICR	Implementation Completion Report
ICT	Information and Communication Technology
IE	Inclusive Education
JSL	Jordanian Sign Language
KG	Kindergarten
MENA	Middle East and North Africa
MNSHD	Middle East and North Africa Human Development
MoE	Ministry of Education
MoH	Ministry of Health
MoSA	Ministry of Social Affairs
MoSAL	Ministry of Social Affairs and Labor
MoSD	Ministry of Social Development
NCFA	National Council of Family Affairs
NDC	National Demographic Committee
NGO	Non-Governmental Organization
NPS	National Poverty Survey
OECD	Organization for Economic Cooperation and Development
OPAC	Online Public Access Catalogue
PAD	Project Appraisal Document
PCBS	Palestinian Central Bureau of Statistics
PNGO	Palestinian NGO
PRCS	Palestinian Red Crescent Society
PTSD	Post Traumatic Stress Disorder
PWD	Persons with Disabilities
SPIP	Social Protection Initiative Project
SWF	Social Welfare Fund
TA	Technical Assistance
UNICEF	United Nations Children's Fund
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNRWA	United Nation Relief and Work Organization
UNSO	United Nations Statistics Office
VT	Vocational Training
WB	World Bank
WHO	World Health Organization
YSFD	Yemen Social Fund for Development

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## TABLE OF CONTENTS

<b>EXECUTIVE SUMMARY.....</b>	<b>I</b>
<b>I. INTRODUCTION.....</b>	<b>1</b>
<b>II. PREVALENCE OF DISABILITIES IN THE MENA REGION .....</b>	<b>2</b>
<b>III. ECONOMIC AND SOCIAL CONSEQUENCES OF DISABILITY.....</b>	<b>5</b>
<b>IV. MAIN CAUSES OF DISABILITIES IN MENA .....</b>	<b>10</b>
<b>V. ADDRESSING DISABILITIES .....</b>	<b>16</b>
A. PROMOTING AN INCLUSIVE ENVIRONMENT.....	16
B. PROMOTING INCLUSIVE EDUCATION .....	18
C. PREVENTION STRATEGIES.....	19
D. INTEGRATED REHABILITATION AND COMMUNITY-BASED SERVICES .....	22
E. SOCIAL PROTECTION FOR DISABLED PERSONS.....	23
F. PUBLIC AND PRIVATE PARTNERSHIP .....	23
<b>VI. CONCLUSIONS .....</b>	<b>26</b>
A. WORLD BANK POLICIES ON DISABILITY.....	26
B. NEXT STEPS.....	27
Annex A: Disability-Related Legislation from Selected MENA Countries .....	29
Annex B: Examples of World Bank Projects in the MENA Region with Disability Components .....	31
Annex C: Proposed Policy Framework Based on Egypt Social Protection Initiatives Project.....	34
Annex D: MENA Country Profiles on Disabilities .....	38
Annex E: EU Disability Assessments: A Comparative Analysis .....	43
Annex F: EU Quotas for Disabled Workers .....	53
Annex G: Employment Rates of People with Disabilities in Europe and USA .....	55
Annex H: Disability Benefit and Retirement Benefits in the U.S. and EU Countries.....	56

## FIGURES

Figure 1: Disability - Poverty Cycle I – How Persons with Disability are More Likely to Become Poor .....	6
Figure 2: Disability - Poverty Cycle II - How the Poor are More Likely to Risk Becoming Disabled .....	6
Figure 3 Main Causes of Work Disabilities in Developed Countries .....	11
Figure 4 Estimated Rate of Work-Related Fatal Accident Per 100,000 Workers .....	12
Figure 5: Fatalities Attributed to Work – Global Trends .....	13
Figure 6: Trends in Fatality Rates Due to Traffic Injuries .....	14

## TABLES

Table 1 Disabled Population, Selected MENA Countries.....	4
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## EXECUTIVE SUMMARY

Disability, as a development theme, cuts across key mission and corporate goals of the World Bank, including poverty reduction, economic growth, and reaching the Millennium Development Goals by 2015. Without ensuring social inclusion and involving disabled people in every aspect of social life, it is unlikely that all the Millennium Development Goals (MDGs) will be met. Poverty and disability are inextricably linked and form a vicious cycle<sup>1</sup>. Poverty can contribute to increases in disabilities among individuals from birth to old age. After the onset of a disability, barriers to health and rehabilitation services, education, employment, and other aspects of economic and social life can trap individuals in a life-long cycle of poverty<sup>2</sup>.

If current policies, practices, and perceptions related to individuals with disabilities, coupled with conditions associated with enduring poverty and socio-economic disruptions, remain, the already high burden of disability on the development of countries in the MENA region will increase over the next two decades.

This Note examines disability in the MENA region with respect to prevalence and main causes of disability, economic and social consequences of disabilities, prevention and risk mitigation mechanisms, and policies and strategies to create the enabling environment which permits persons with disabilities full participation in society, including access to education and labor force, and participation in decision making. Its purpose is to take stock of our current knowledge of disability issues in the region, and to open the door to new ideas and initiatives that will help mainstream disability as a theme across sectors. The report has several main messages.

**Disability has significant implications for social and economic development in MENA.** Excluding individuals with disabilities from social and economic activities will have negative consequences not only on the individuals concerned, but on their families and community. The integration and accommodation of persons with disabilities into the labor market are important ways to reduce both public expenditures and costs borne by families, as well as to ensure the participation of disabled persons in productive work. Formulating policies and plans to integrate individuals with disabilities into all aspects of social and economic life, including education, vocational rehabilitation and employment, will benefit not only the individual, but the society in general. Gender issues among persons with disabilities also require special attention.

**Main causes of disability.** High rates of birth related disabilities and consanguinity, communicable and chronic diseases, weak access to and availability of health services, poor nutrition, accidents and violence, are important determinants contributing to current levels of disability in the MENA region. The region has among the highest rates of traffic accidents in the world, and job related injuries and diseases are on the rise. Poverty, political instability and

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<sup>1</sup> For more on the status of people with disabilities, see Einar Helander, *Prejudice and Dignity—An Introduction to Community-Based Rehabilitation*, 2nd edition, New York: United Nations Development Programme, 1999 Available online at: [http://dag.virtualave.net/p\\_d.htm](http://dag.virtualave.net/p_d.htm). See also Ann Elwan, *Poverty and Disability—A Survey of Literature*, Social Protection Discussion Paper No. 9932 (Washington, D.C.: World Bank, 2000). Available online at: <http://www.worldbank.org/sp/>.

<sup>2</sup> Elwan A 1999. [Poverty and Disability: A Survey of the Literature](#). Washington: World Bank, Social Protection Unit, Human Development Network.

conflicts are also taking a toll on the physical as well as the mental health of the population, with reported increases in incidences of depression.

**Epidemiological and demographic transitions affect patterns of disability.** The region is undergoing both epidemiological and demographic transitions, which are resulting in changing patterns of mortality, morbidity and causes of disability. Over the next decades, these twin transitions will lead to an increase in non-communicable diseases as well as injuries and work related diseases in most countries in the MENA Region. This, in turn, will change the overall patterns of disabilities and the interventions required to address them. Increasingly, disabilities associated with chronic conditions and both intentional and unintentional injuries are becoming a major cause of long-term disability in MENA countries.

**Policies and programs to prevent disabilities need to be strengthened.** Disabilities add to social costs due to the high cost of treatment and care, and also have a negative impact on labor productivity. Much of these costs could be avoided through appropriate prevention and mitigation mechanisms. MENA countries face the challenge of reducing current high rates of disabilities resulting from (i) the large numbers of individuals with disabilities whose conditions can be mitigated with appropriate interventions, and (ii) weaknesses in primary and secondary prevention mechanisms, especially those addressing the emergence of new causes of disability. These mechanisms include prevention and management of chronic diseases, work related injuries, road accidents, mental health problems, and of newly emerging infectious diseases. Much work remains to be done to strengthen public policies and programs to prevent disabilities by reducing their occurrence and their long-term impact through early identification of the risk factors and introduction of preventive measures.

**Policies and programs to promote an inclusive environment for persons with disabilities are limited and need to be strengthened.** Persons with disabilities face a major barrier to their integration in society from discrimination in a variety of forms, including social stigma, physical barriers to access to buildings and transport, and lack of access to health services, education, and employment. Formulating policies and programs to integrate individuals with disabilities into all aspects of social and economic life, including access to health services, education, employment, and participation in civil society and decision making process, is economically beneficial not only for the individuals concerned but to society in general.

Despite some progress over the last decade, public policies in MENA countries do not yet promote an inclusive environment for persons with disabilities. Public policies and programs on prevention of disabilities or mitigation of their long-term impact on affected individuals are not well developed or systematically implemented in the region. A comprehensive approach to prevention of work-related injuries, diseases, and road traffic accidents is lacking in nearly all the MENA countries. Education systems in the MENA region continue to exclude the majority of the disabled school-aged population at the primary level and almost the entirety of this population at the university level. Different types of inclusive education policies and programs are starting to emerge in some of the countries in the region, mainly as part of national quality enhancement agendas or educational strategic plans. However, these efforts remain limited in scope.

Coverage of health services and social security arrangements reach only a fraction of persons with disabilities. Physical rehabilitation services by government-sponsored programs vary significantly among countries in the region and tend to be concentrated in urban areas. Some

countries provide medical services only for certain type of disabilities, leaving other disability groups without access to care.

A review of existing labor legislation in the region shows that provisions for job-related accidents and injuries are included, but since large numbers of workers operate in the informal economy, they are not covered by such legislation. Thus, significant segments of the labor force are not protected against social and economic risks in the event of work-related injuries or disease, which lead to a temporary or permanent disability. Legislation also exists in most MENA countries to provide some form of social protection for persons with disabilities, but enforcement is poor due to limited resources and implementation capacities within governmental and judicial bodies. There are few organizations and associations of disabled that advocate for the rights of persons with disability, and which can hold governments accountable for the enforcement of legislation.

At present, policies and programs on disability in MENA countries appear to be random and marginal. Mainstreaming disability as an important aspect of development will require a multi-sectoral approach grounded on solid empirical evidence and involving dialogue among a broad spectrum of stakeholders. This dialogue should then lead to policies, programs and investment strategies that are based on priorities identified in well-informed national strategies. Disability strategies in MENA countries should include a balanced approach among interventions that focus on prevention, mitigation, rehabilitation, and inclusion.

## **Next Steps**

Governments in the region could undertake many concrete and immediate steps for mainstreaming disability in the region. Many countries already have legislation related to disability that is not enforced and policies that are not implemented.

However, in order to address disability issues in a comprehensive way, the countries will benefit from engaging in regional and national dialogue and building a shared vision and partnerships among local, national and international stakeholders. Each country in the Region will need to develop its own strategy grounded on empirical evidence as a foundation for sustained commitments and engagement of the various stakeholders. Such a dialogue should then lead to the implementation of policies, programs and investments that reflect the priorities articulated in a well-informed national strategy.

**Promote the development of National Disability Strategies.** National strategies should provide the framework for (i) formulating disability-related legislation and developing institutional capacity of government and non-government agencies providing services to persons with disabilities; (ii) integrating disability policies and programs into existing investments and programs on health, education, infrastructure, transport and social protection services and benefits; and (iii) disseminating knowledge about the causes and prevalence of disability, and assessing their impact on the country's social and economic development .

**Establish a regional dialogue.** MENA countries will benefit from a regional forum to promote dialogue and exchange of information, experiences and knowledge about effective policies, strategies and programs to address disability in the region. Developing an effective national strategy on disability is a complex undertaking involving multiple sectors. Countries will benefit by learning from examples in other countries and regions, and by creating partnerships with major international and regional stakeholders, such as the UN organization, the Arab

Organization of Disabled People, regional disability organizations, international NGOs working in disability, donors and others.

**Support Interventions.** Mainstreaming disability in World Bank and donor funded projects is an immediate step that can be implemented even before comprehensive national strategies are developed. This can include: (i) use of existing infrastructure projects (roads, mass-transit) and urban development projects in the region to provide support to Ministries of Public Works, Planning and municipalities to develop infrastructure access guidelines for persons with disabilities (PWD). Infrastructure projects can also serve as pilots for the incorporation of barrier free design and their evaluation; (ii) use existing Community Development and Social Funds to support disability initiatives led by PWD including capacity building for organizations and associations of PWD so that they can lead the activities for inclusion; (iii) use municipal development programs to build capacities of local government to provide services to PWD; and iv) pay attention to PWD inclusion issues in education and health projects.

**Promote data production and knowledge dissemination.** For the medium term, further research on disability issues is needed to fill the current knowledge gap on disability prevalence, its impact on social and economic development, and the effectiveness of various prevention, risk mitigation, rehabilitation and integration programs.

An immediate task would be to catalogue existing surveys, assess their usefulness for analytical purposes, and develop cost-effective and timely approaches to collecting data. Sharing experience among regions within the Bank will be an important step towards filling the knowledge gap and developing complementary activities. Also, based on poverty mapping techniques, the Bank is developing a methodology for estimating the poverty rates of small vulnerable groups which could be used to measure correlations in the incidence of disability and poverty in the MENA region. These could be supplemented by qualitative research methods that probe into the causal relations among the key determinants. MENA countries could profit from lessons learned in other regions with regard to data collection and analysis on disability through collaboration with international and regional institutions such as the WHO, UNICEF, ESCWA, United Nations Statistic Division, and OECD.

## I. INTRODUCTION

1. Disability, as a development theme, cuts across key mission and corporate goals of the World Bank, including poverty reduction, economic growth, and reaching the Millennium Development Goals by 2015. The eight Millennium Development Goals (MDGs) are: i) eradicate extreme poverty and hunger; ii) achieve universal primary education; iii) promote gender equality and empower women; iv) reduce child mortality; v) improve maternal health; vi) combat HIV/AIDS, malaria, and other diseases; vii) ensure environmental sustainability; and viii) develop a global partnership for development.

2. Without ensuring social inclusion and involving disabled people in every aspect of social and economic life, it is unlikely that all the MDGs will be met, either globally or within the MENA region. Disabled people are disproportionately represented among those living in chronic poverty. There is growing evidence on the association between poverty and disability. Conditions associated with poverty such as poor education, nutrition and lack of access to health services or safe living and working conditions increase the risk of disabilities that can occur from birth to old age. Disabled persons and their families often fall into and are unable to escape from poverty because of discrimination, lack of access to health and rehabilitation services, and lack of opportunities for education and employment.

3. Social stigma and discrimination against persons with disabilities is a common occurrence in the MENA region, not only in the physical and cultural environment surrounding persons with disabilities, but even within their own families. Thus, social exclusion limits the opportunities open to persons with disability to participate as full and productive members of the society. The integration and accommodation of persons with disabilities into the labor market are important ways to reduce both public expenditures and costs borne by families, as well as to ensure the participation of disabled persons in productive work. Disabilities put a disproportionately higher burden on women than on men, whether as persons with disabilities or as caretakers of persons with disabilities. The goal of universal primary education cannot be achieved without an inclusive education: children with disabilities will need equal access and opportunities to education as other children. Fostering partnerships among national and local governments, disabled peoples organizations (DPOs) and NGOs, and the international community will be an important strategy for sustaining these efforts.

4. This Note looks at disability in the MENA region in respect to prevalence and main causes of disability, the economic and social consequences of disabilities, prevention and risk mitigation mechanisms, and policies and strategies to create the enabling environment which permits persons with disabilities to participate fully in society, including having access to education and the labor force, and participation in decision making. Its purpose is to take stock of our current knowledge of disability issues in the region, and to open the door to new ideas and initiatives that will help mainstream disability as a theme across sectors

## II. PREVALENCE OF DISABILITIES IN THE MENA REGION

5. There is no single definition of disability nor a single method of drawing boundaries between disabled and non-disabled people in social policy. As an example, work-related disability could be defined as the loss of ability to perform specific productive functions, or as a reduction in the capacity to work compared to a fully-able worker, due to an impairment resulting from a medical condition. In the context of broader social policy, disability could be defined in terms of a lack of access to full participation in society. An impairment arising from a medical condition does not necessarily imply an ongoing work disability. Work-related disability in government sponsored or mandated programs, such as disability insurance schemes, is usually defined for cases in which the underlying condition and subsequent impairment prevent the affected individual from performing work that the individual would otherwise be qualified to undertake. It is possible that identical medical problems could be assessed differently depending on the skills required for specific jobs.

6. In connection with government sponsored programs and cash benefits for disabled persons, a consistent definition of disability is not readily available even among the industrialized nations. Disability assessments throughout the European Union are based on four distinct working models that combine two different dimensions of medical and non-medical assessment<sup>3</sup> (for more information on OECD policies, see Annex E). In general, systems that de-emphasize the medical model tend to define disability more broadly and embrace a wider range of policies to address the needs of the disabled. This broader approach generally leads to a regulatory setting in which relatively less attention is paid to effective targeting of programs. On the other hand, systems that emphasize medical assessments have a clearer definition of disability, but may miss the broader socioeconomic context in which disabilities occur.

7. In addition to problems of comparability across countries, within any particular country, governments and NGOs often do not apply the same definitions and standards. In the MENA region, methodological and definitional differences result in incomplete and inconsistent data. It illustrates the need for a system of common definitions and measurement of disability prevalence, while at the same time leaving sufficient flexibility to reflect the diversities in programs and benefits available in each country. This lack of reliable information on disabilities is limiting the ability of governments and other institutions to develop and implement effective policies and programs for inclusive development, that fully integrate disabled people and their families into the economic and social life of their communities.

8. The International Classification of Functioning, Disability and Health (ICF) developed by the World Health Organization draws upon the social model of disability, and has been the starting point for recent developments in disability measurement<sup>4</sup>. In the ICF, disability is not an “all or nothing” concept. People are not classified based upon a medical condition, but rather on a detailed description of their functioning. This functioning is broken down into three domains: Body Structure and Functions, Activities, and Participation. The first domain relates to very specific capabilities, for example being able to lift one’s arm over one’s head. Activities pertain

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<sup>3</sup> OECD disability definitions are based on four working models, which are grouped around the countries that use them. They are: (i) low medical evidence and high discretion (Denmark); (ii) low medical evidence and low discretion (U.K., Netherlands, Ireland); (iii) high medical evidence and high discretion (France, Germany, Belgium, Austria, Italy & Spain to some extent); and (iv) high medical evidence and low discretion (Portugal, Greece, Germany & Austria to some extent)

<sup>4</sup> See the ICF homepage at [www3.who.int/icf/icftemplate.cfm](http://www3.who.int/icf/icftemplate.cfm)

to particular tasks, such as getting dressed. Participation refers to higher order activities that are integral to economic and social life, such as being able to hold a job. Moreover, the ICF incorporates the social model by including information on how a person's ability to function is affected by the environment they face<sup>5</sup>.

9. As the International Classification of Functioning, Disability and Health is not yet implemented, the current global prevalence of disability has been estimated only in broad orders of magnitude, and national estimates vary considerably, and are generally not comparable. The UN notes that disability rates calculated from diverse national data collection sources are not yet comparable, given differences in survey design, definitions, concepts, and methods<sup>6</sup>. Estimated disability rates tend to be higher in developed than in developing countries. The use of differing measurement instruments<sup>7</sup>, the older age structure, and greater capacity to observe and diagnose different types of disabilities in developed countries are likely factors that contribute to the higher reported rates of disability in developed countries. Thus, international comparisons can be misleading if the methodological differences are not taken into account.

10. Estimates of the prevalence for individuals living with a physical, sensory (deafness, blindness), intellectual, or mental health impairment vary from 300 to 600 million people worldwide<sup>8</sup>. WHO estimates that disabilities affect about 10 percent of the world's population<sup>9</sup>. Applying this proportion to the MENA region would result in a disabled population of approximately 30 million. Based on country level data available through United Nations Statistics Office (UNSO)<sup>10</sup>, high and low estimates of the disabled population have been calculated for selected countries in the region.

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<sup>5</sup> World Bank - Data Toolkit - Daniel Morton Mont - Unpublished document

<sup>6</sup> UN Disability Statistics Compendium, 1990, p 30. The UN points out that comparison within national data sets can reveal reasonably consistent relationships between disability and other demographic and socio-economic variables; and that the quality of survey data on disability has been found to be of similar quality to other types of survey data, such as educational attainment or marital status.

<sup>7</sup> In addition to the type of measurement instrument used, estimates of the proportion of disabled people in a population can also vary depending on whether disabled people are identified using a 'disability screen' or an 'impairment screen.' African and Asian countries tend to use impairment screens in their censuses, surveys and registration systems and generally report lower rates than the countries of Europe and North America, which tend (with some exceptions) to use disability screens. Ibid., p. 15.

<sup>8</sup> United Nations, 1993. [Standard Rules on the Equalization of Opportunities for Persons with Disabilities](#). NY: General Assembly Resolution 48/96. December.

<sup>9</sup> Fifty-fourth World Health Assembly (May 22, 2001) endorsed the second edition of the international classification of functioning, disability and health .

<sup>10</sup> United Nations Statistics Office (UNSO), Metts (2004)

**Table 1 : Disabled Population in Selected MENA Countries**

<b>Disabled Population Estimates, 2002</b>		
	<b>Low Estimate</b>	<b>High Estimate</b>
Algeria	1,158,100	3,098,700
Djibouti	7,000	69,300
Egypt	2,608,500	6,979,500
Iran	2,519,700	6,741,900
Iraq	725,200	1,940,400
Jordan	196,100	524,700
Lebanon	133,200	356,400
Morocco	1,113,700	2,979,900
Syria	510,600	1,366,200
Tunisia	358,900	960,300
West Bank & Gaza	125,800	336,600
Yemen	193,000	1,910,700
Total	9,649,800	27,264,600

Source: Metts (2004).

11. Table 1 presents the results for ten countries in MENA. The range of prevalence estimates is between 1 and 10 percent of the population for countries like Djibouti and Yemen, and between 3.5 and 10 percent for the other countries of the region. For the group of countries in the table, which comprise a total of 250 million people, the range of people with disabilities is estimated between 9 and 27 million people.

### III. Economic and Social Consequences of Disability

12. Poverty and disability are inextricably linked and form a vicious cycle<sup>11</sup>. Poverty can contribute to increases in disabilities among individuals from birth to old age. After the onset of a disability, barriers to health and rehabilitation services, education, employment, and other aspects of economic and social life can trap individuals in a life-long cycle of poverty<sup>12</sup>. The literature on the relationship between poverty and disability in developing countries tends to be limited, focusing on what is already generally known about health, disabilities, poverty, and vulnerable populations, but does not offer deeper insights into their causal relationship. Much of it also relies on anecdotal evidence and case studies.

13. It is often noted that disabled individuals are poorer, as a group, than the general population, and are more likely to become poor; and that individuals living in poverty are more at risk of becoming disabled than the non-poor. Well-being is associated with the ability to work and fulfill various roles in society<sup>13</sup>. But the links between poverty and disability do not appear to have been systematically examined, even in developed countries<sup>14</sup>. Disability adds to the risk of poverty, and conditions of poverty increase the risk of disability. Exclusion and marginalization reduce opportunities for the disabled to contribute productively to the household and the community, and increase the risk of falling into poverty. Further investigation will be needed in several areas, including: production of coherent data sources, and analytical work to allow more detailed examination of poverty-related factors, such as discrimination in access to jobs, educational opportunities, and social services, modeling of potential ‘poverty paths’ in populations that have a particular disability pattern, a special vulnerability, or are at particular risk of poverty. Particular attention must be paid to the links among gender, disability and poverty.

14. Available international data suggests that disabled people have lower education and income levels than the rest of the population. They are more likely to have incomes below the poverty level, and less likely to have savings and other assets than the non-disabled population. These findings hold for both developing and developed countries. Analysis of case studies in some developing countries shows that higher disability rates are associated with higher illiteracy rate, poorer nutritional status, lower immunization coverage, lower birth weight, higher unemployment and underemployment rates, and lower occupational mobility<sup>15</sup>.

15. Figure 1 illustrates the reasons why disabled people experience a disproportionately higher rate of poverty, and Figure 2 displays the ways in which being poor increases the likelihood of getting an impairment and becoming disabled.

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<sup>11</sup> For more on the poverty status of people with disabilities, see Einar Helander, *Prejudice and Dignity—An Introduction to Community-Based Rehabilitation*, 2nd edition, New York: United Nations Development Programme, 1999 Available online at: [http://dag.virtualave.net/p\\_d.htm](http://dag.virtualave.net/p_d.htm). See also Ann Elwan, *Poverty and Disability—A Survey of Literature*, Social Protection Discussion Paper No. 9932 (Washington, D.C.: World Bank, 2000). Available online at: <http://www.worldbank.org/sp/>.

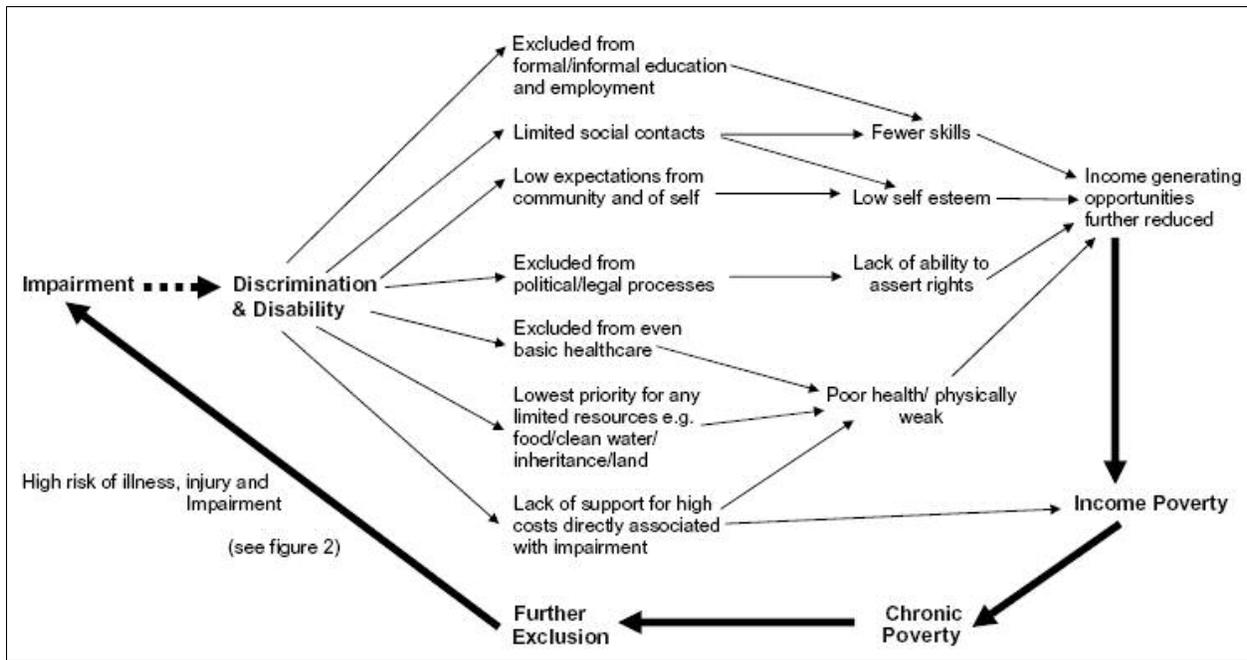
<sup>12</sup> Elwan A 1999. [Poverty and Disability: A Survey of the Literature](#). Washington: World Bank, Social Protection Unit, Human Development Network.

<sup>13</sup> Consultations with the Poor (Brock, 1999), pp. 1, 29.

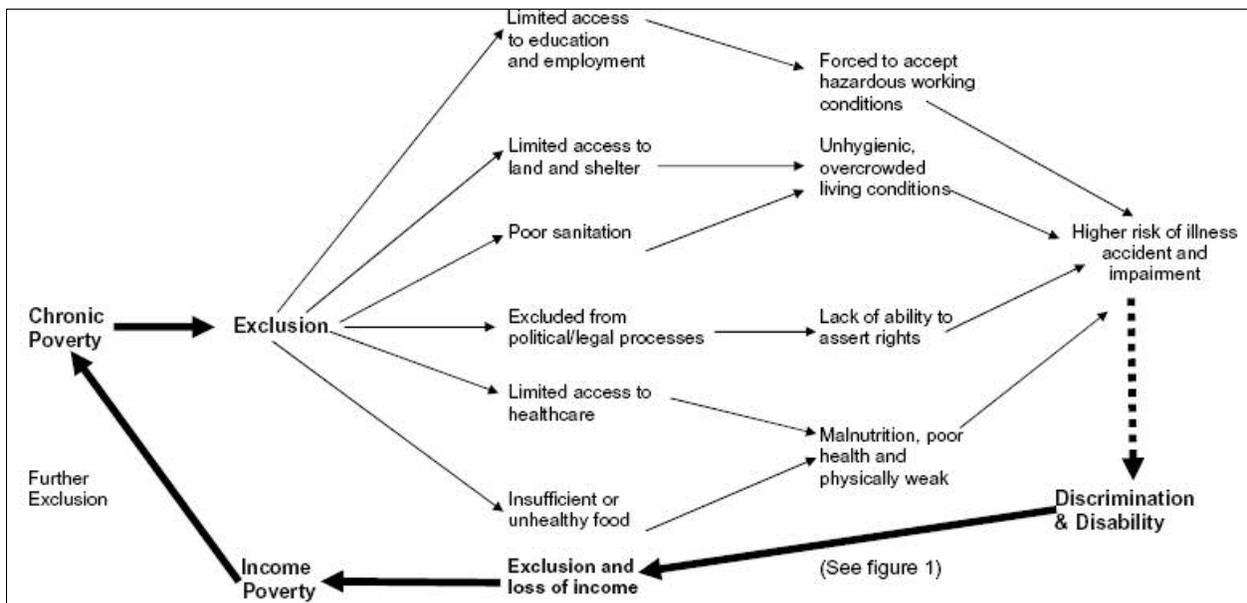
<sup>14</sup> From the preface to the papers from the conference “Disability, Exclusion & Poverty: A Policy Conference”, organized by the Combat Poverty Agency, the Forum of People with Disabilities and the National Rehabilitation Board, 1994.

<sup>15</sup> [Social Protection Discussion Paper Series](#) Ann Elwan: Poverty and Disability - A Survey of the Literature, December 1999, Social Protection Unit, Human Development Network, The World Bank

**Figure 1: Disability - Poverty Cycle I – How Persons with Disability are More Likely to Become Poor**



**Figure 2: Disability - Poverty Cycle II - How the Poor Are More Likely to Risk Becoming Disabled**



Source: Rebecca Yeo and Carren Moore. "Including Disabled People in Poverty Reduction Work: Nothing About Us, Without Us". ([www.elsevier.com/locate/worlddev](http://www.elsevier.com/locate/worlddev)) World Development (2003) Vol. 31, No. 3, pp. 571–590, Elsevier Science Ltd.

16. With regard to gender differentials, international evidence suggests disability rates for women seem to be higher than those for men in developed countries, but lower in developing countries. The percentage of males and females classified as disabled is partly determined by the

type of screening instruments used. In general, survey-based data yielded higher disability rates for women than men in developed countries, and lower rates for women in developing countries. One hypothesis is that severe impairments may be male-dominated and additional survey probes are needed when surveying women using impairment screens<sup>16</sup>.

17. Another possibility is that females with disabilities in developing countries may be under-reported or may receive less care and die sooner. For childbearing age groups, females tend to face slightly higher risks, possibly due to ill health resulting from too many pregnancies, inadequate health and medical care, and poor nutrition. A global estimation of Disability Adjusted Life Years<sup>17</sup> (DALY) showed that disabilities among children were slightly higher among males than for females. At ages 15-59, disability rates for females were on the whole, slightly higher than for males in developing countries; and at ages over 60, the rates for males tended to be higher than for females<sup>18</sup>. Studies in developed countries generally find that most congenital disabilities are more common in males. Data on school aged children generally shows more boys have a disability but this may result not only from a higher underlying rate, but because more attention is paid to boys and there is more concern about difficulties they may be having. Also, stigma, drop-out rates and ability to get married is generally a bigger problem for disabled girls than disabled boys, so they are more likely to be hidden. Studies from Yemen and Egypt point to a higher prevalence of disability among boys, which researchers attribute to a concurrently higher mortality among disabled girls (Abu-Habib, 1997)<sup>19</sup>. Based on the sources reviewed, it appears that further analysis is needed before definitive statements can be made regarding gender differentials<sup>20</sup> in any particular developing country or region<sup>21</sup>.

18. The integration and accommodation of persons with disabilities into the labor market are important ways to reduce both public expenditures and costs borne by families, as well as to ensure the participation of disabled persons in productive work. Formulating policies and plans to integrate individuals with disabilities into all aspects of social and economic life, including education, vocational rehabilitation and employment, increases benefits not only for the individual, but also for society in general<sup>22</sup>. Incomes foregone by persons with disabilities are compounded by the opportunity cost to the family care giver, who might otherwise be participating in the labor force. When disability affects the head of a household, the impact on a family's welfare can be devastating. In many cases, women in families with Persons with Disability face the additional burden of having to provide an income to the household, taking care of the family, including the disabled family member, providing for disabled victims of conflict, and dealing with the social stress that often results from shifting gender roles in the household. This double-burden takes an additional toll also on the mental health of women.

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<sup>16</sup> [Social Protection Discussion Paper Series](#) Ann Elwan : Poverty and Disability - A Survey of the Literature, December 1999, Social Protection Unit, Human Development Network, The World Bank

<sup>17</sup> The Disability Adjusted Life Year is quantitative indicator of burden of disease that reflects the total amount of healthy life lost, to all causes, whether from premature mortality or from some degree of disability during a period of time.

<sup>18</sup> [Social Protection Discussion Paper Series](#) Ann Elwan : Poverty and Disability - A Survey of the Literature, December 1999, Social Protection Unit, Human Development Network, The World Bank

<sup>19</sup> Unpublished paper entitled "Women with Disability in Egypt", by Dr. A. Ghanem, University of Sanaa', 1993, presented to the seminar on "The roles of the family in integrating disabled women into society" in Amman, 1994; cited in Abu-Habib, 1997, p.2.

<sup>20</sup> Khan and Durkin: citing results from Bangladesh, report a higher prevalence of disability in girls aged two to nine years than in boys of the same age, and attribute it to the priority given to the male child in Bangladeshi cultures.

<sup>21</sup> [Social Protection Discussion Paper Series](#) Ann Elwan : Poverty and Disability - A Survey of the Literature, December 1999, Social Protection Unit, Human Development Network, The World Bank

<sup>22</sup> Chollet , A study commissioned by the US Department of Housing and Urban Development, 1979

Children in families with PWD in developing countries are also less likely to attend education or have higher drop-out rates.

19. The MENA region is confronting emerging causes of disability that accompany socio-economic and demographic changes, including aging populations, work-related injuries, accidents, increases in non-communicable diseases, and stress-related mental health problems. At the same time countries must address the needs of a large segment of the population that continues to be exposed to disability due to communicable diseases, malnutrition, political violence, armed conflict and poverty. Although it is hard to precisely calculate the burden of disability and the trends that will come with industrialization and mechanization, it is clear that the economic and social consequences of disabilities are already very high, both to the public, as well as to the individuals with disabilities and their families.

20. The economic implications of excluding persons with disabilities from earning-generating activities are of increasing interest in the development literature<sup>23</sup>. Despite some progress in the recent decade, public policies in MENA countries do not yet promote an integrated approach. This results in individuals with disabilities being excluded from contributing socially and economically to society.

21. Unemployment has been associated with health hazards related to economic difficulties, chronic social problems, unfavorable lifestyles, risk behavior and psychological problems as well as, in some instances, higher mortality (for OECD policies on minimum quota for employment of disabled workers please see Annex G). In MENA countries, the informal economy and high rates of unemployment affect the young, and increasingly also prime-age workers who are experiencing longer periods of unemployment.

22. Gender unemployment rate differentials in MENA countries are the highest in the world. In 2003 the female unemployment was 6 percentage points higher than for males. This indicates that disabled women in MENA are likely to face even higher obstacles to entering the formal labor force. In developed countries like US for example, it has been found that men with disabilities are almost twice likely to have jobs than women with disabilities. In addition, there are special problems related to vulnerable and underserved groups such as child workers and people with disabilities who have poor access to education and job opportunities<sup>24</sup>.

23. When thinking about disabled people and jobs, it is important not only to look at it from the perspective of skills required for a specific job, but also to think of how the job is structured. Jobs can be built around the functional capacity of individuals. This technique is used in Disability Management programs in many developed countries in job coaching programs that are part of vocational rehabilitation programs.

24. Numerous socio-economic changes will influence trends of work-related injuries and diseases in the working populations of both developing and industrialized countries. The overall impact of development on occupational health will likely bring new occupational health programs that will help prevent exposure to many of the traditional physical, chemical, biological and mechanical hazards. At the same time, new job requirements, the increased needs for processing and analyzing information, and several control room-like activities may increase the psychological problems of work such as mental stress. With industrialization and development, some conditions that now may have only marginal effects can become major

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<sup>23</sup> Mitra, 2004.

<sup>24</sup> Global strategy on occupational health for all: Recommendation of the second meeting of the WHO Collaborating Centers in Occupational Health

disabling factors, and physical impairments may become less important than mental impairments. New job requirements, work methods and equipment also place a high demand on the learning needs and capacities of workers. Poor mental health also reduces the productivity of workers. Moreover, the break down of social support systems related to industrialization of the region is likely to contribute to a further increase in depression rates.

## IV. Main Causes of Disabilities in MENA

25. Causes of disability are diverse in MENA and are country specific. However, it is a common assumption that: (i) in the poorer countries, under-nutrition and inefficient or inaccessible health services result in a higher prevalence of disabilities, (ii) in most countries with rapid urbanization, traffic-road accidents are a major cause of disability, (iii) in tribal communities, consanguinity is still a major cause of some inherited disabilities, and (iv) on-going wars, violent country conflicts in civilian areas, landmines and easy access to domestic weapons are all underlying causes behind the rising number of disabled persons in the MENA region<sup>25</sup>. Much of the disability in MENA countries stems from preventable impairments, and a large part of the disability could be mitigated through treatment, or alleviated through rehabilitation and other forms of care.

26. Nutrition is particularly important, but knowledge of various forms of malnutrition and their effects on health and intellectual development and disability are only recently acquired and data do not yet exist to evaluate the magnitude of their effects. Countries like Iran, Iraq and Yemen have malnutrition rates for children under five years of age that are higher than the average for lower middle-income countries, but their impact on disabilities will require future studies.

27. Most countries in the MENA region are currently undergoing both epidemiological and demographical transitions, which will result in changing patterns of mortality, morbidity and causes of disability. Over the next two decades countries in the MENA region will be profoundly influenced by these demographic transitions. At present, MENA countries are at substantially different stages of demographic transition. Yemen and Djibouti, both low-income countries, are in the early stage of demographic transition, with relatively high rates of fertility and mortality. The middle-income countries of Algeria, Egypt, Iran, Lebanon, Morocco and Tunisia have declining fertility and mortality rates. Upper middle-income countries such as Saudi Arabia and Oman appear to be in transition, with continuing high birth rates but low mortality rates, whereas United Arab Emirates and Kuwait have made the transition to low fertility and low mortality rates. These demographic changes will affect the age structure and disease patterns, which in turn will result in different manifestations of disability.

28. Age is strongly correlated with disability, as measured in terms of Years of Life with Disability (YLD) rates. Generally, disabilities associated with diseases and injuries increases with age and disabilities are higher among older age cohorts in all regions of the world. The percentage of disabilities due to congenital causes decreases with age, while that associated with diseases and injuries rises. In developed economies, the YLD rates for men age 60 and over are more than four times higher than those for men age 15-44 years<sup>26</sup>. As the MENA countries go through demographic transitions, they will face the challenge of addressing an increasing burden of disabilities due to non-communicable diseases and injuries, while still addressing the burden of disabilities due to communicable diseases and poor maternal and child health.

29. **Injuries** are becoming an increasingly important cause of long-term disability and ill health in MENA countries. Little is known about the frequency of disabilities among injured populations, and about the distribution of various types of impairments and disabilities

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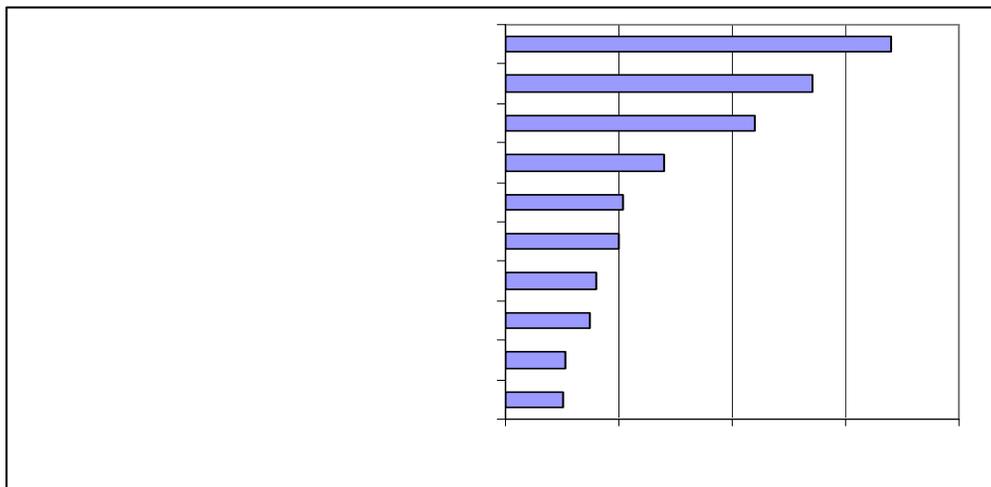
<sup>25</sup> The World Bank: Consultancy Report March 15th to June 30th , 2004; Manal Hamzeh Al Smadi and Karen Saba: Mainstreaming Disability in MENA- Review and Recommendations

<sup>26</sup> Emily S. Andrews: Disability Insurance: Programs and Practice, The World Bank 1998

originating with accidents. Injuries are commonly classified based on “intentionality.” Most road traffic injuries, poisoning, falls, fire and burn injuries, and drowning are unintentional. Intentional injuries include interpersonal violence (homicide, sexual assault, neglect and abandonment, and other maltreatment), suicide, and collective violence (war).

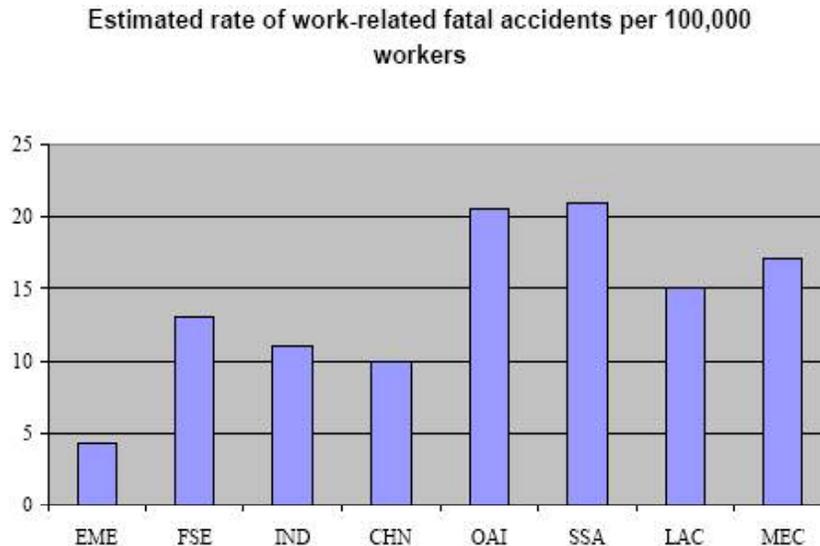
30. According to estimates by the ILO, the number of **job-related injuries and illnesses**, which annually claim more than two million lives around the world, appears to be rising in MENA countries, most likely due to rapid industrialization<sup>27</sup>. As the diseases pattern changes, the main causes for work-related disabilities will also shift. It is estimated that about 17 percent of work disability in developed countries is caused by arthritis or rheumatism, followed by back or spinal problems (14 percent), heart disease (11 percent), lung and respiratory problems (8 percent), and high blood pressure (6 percent)<sup>28</sup>.

**Figure 3 Main Causes of Work Disabilities in Developed Countries**



33. Figure 4 shows that the estimated rate of work-related fatal accidents was around 16 per 100,000 workers in the Middle East, a high rate by comparison with other regions. All developing regions featured a rate that is two to five times the rate found in the established market economies.

**Figure 4 Estimated Rate of Work-Related Fatal Accident Per 100,000 Workers**



Key: EME - Established Market Economies; FSE - Formerly Socialist Economies; IND - India; CHN - China; OAI - Other Asia and Islands; SSA - Sub-Saharan Africa; LAC Latin America and the Caribbean; Middle East Crescent.  
Source: ILO, 2005

34. Although methods used to estimate incidences of accidents and diseases are basically similar, there are some important differences. Existing data reported to the ILO by member states has been used as baseline data. This has been complemented by national and regional sources, such as data from the European Union. Countries that report workplace accidents accurately were taken as benchmarks while also accounting for populations not covered by the existing reporting systems. These often include agricultural workers and the self-employed. In countries where no reliable data was found, proxy sources were used. This means that in each region, those ILO member states that best report workplace accidents were used as a reference value. Average fatal accident rates were calculated for the reporting populations in three different economic sectors: (i) agriculture, fishing and forestry; (ii) manufacturing industries, including mining and construction; and (iii) service industries.

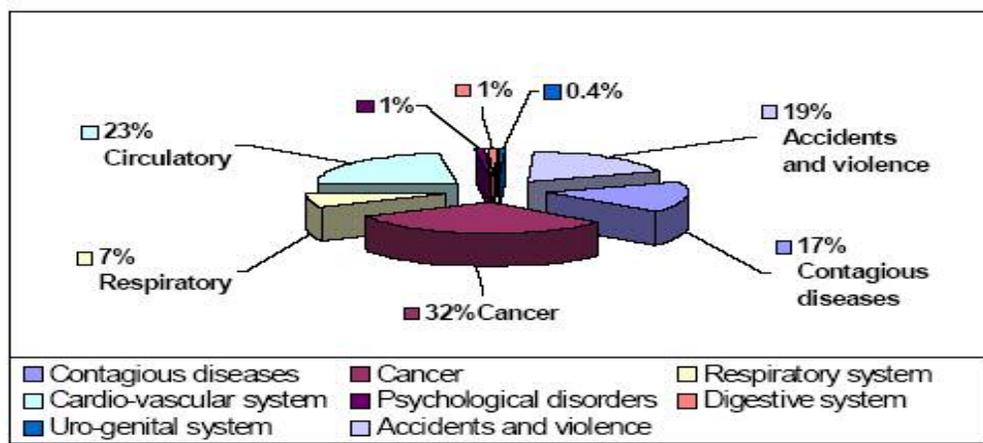
35. In the MENA region, women are more likely than men to work in the informal sector. Their occupational or work-related disability is likely to be under-reported often resulting in misleading statistics. For example, home-based injuries are likely to affect women more than men. Women's work in the informal sector puts them at a disadvantage when it comes to coverage by formal disability schemes.

36. While accident figures are generally reasonably well reported, the same cannot be said for occupational or work-related diseases. In addition to difficulties related to recognition and

identification of factors contributing to work-related diseases, it may be very difficult to reach workers in the informal sector, entrepreneurs and the self-employed. Work-related diseases are those where work is one of several components contributing to the disease. About 120 million occupational accidents with 200,000 fatalities are estimated to occur annually and some 68-157 million new cases of occupational disease may be caused by exposures at work<sup>29</sup>. Despite these high estimates, it is likely that work-related diseases are under-estimated in the developing countries.

**Figure 5: Fatalities Attributed to Work – Global Trends**

Fatalities Attributed to Work



Source: ILO: World Day for Safety and Health at Work 2005: A Background Paper

37. **Road traffic injuries** are a growing public health issue, disproportionately affecting vulnerable groups of road users, including the poor. Death rates from road accidents in 2002, which can be used as a proxy for injuries from road accidents, are high. More than half of the people killed in traffic accidents are individuals aged between 15 and 44 years – often the breadwinners in a family. Furthermore, road traffic injuries cost low income and middle-income countries between 1 percent and 2 percent of their Gross National Product. Worldwide, it is estimated that road traffic accidents kill 2.4 million people, which would be more than those dying due to malaria, TB or HIV/AIDS.

38. As shown in Figure 6, below<sup>30</sup>, the mortality rate per 100,000 population caused by road traffic injury in MENA is among the highest in the world. About 130,000 people died in road accidents in MENA in 2002<sup>31</sup>. These figures would suggest that there is a high rate of road-accident related disability in the MENA region.

<sup>29</sup> ILO: World Day for Safety and Health at Work 2005: A Background Paper.

<sup>30</sup> WHO disability and Injury prevention: Road safety is no accident – World Health Day – New Delhi, April 2004

<sup>31</sup> The World Bank: Health Sector Brief, 2003

**Figure 6: Trends in Fatality Rates Due to Traffic Injuries**

Region ~	No of Countries	1990	2000	2010	2020	% change 00-20	2000 Fatality rate	2020 Fatality rate
EAP	15	112	188	278	337	79.8%	10.9	16.8
ECA	9	30	32	36	38	18.2%	19	21.2
LAC	31	90	122	154	180	48.1%	26.1	31
MNA	13	41	56	73	94	67.5%	19.2	22.3
SA	7	87	135	212	330	144%	10.2	18.9
SSA	46	59	80	109	144	79.8%	12.3	14.3
Low-In	121	419	613	862	1124	83.3	13.3	19
High-In	35	123	110	95	80	-27.8%	11.8	7.8

Kopits E Croper M, Traffic Fatalities and Economic Growth , World Bank,

EAP- East Asia and Pacific, ECA- East Europe & Central Asia, LAC, Latin America & Caribbean, MNA- Middle East & N. Africa, SA- South Asia, SSA- Sub-Saharan Africa

39. **Conflicts** are another major cause of disability in MENA. Recent examples include the conflicts in Algeria, Iraq and West Bank and Gaza. In addition to the direct effect of violence, competing demands on scarce human and financial resources in post-conflict countries result in reduced attention to primary, secondary and tertiary prevention mechanisms, which result in conditions that exacerbate disabilities.

40. Data from the West Bank and Gaza shows that the ongoing conflict has had a sharp negative impact on employment and income among Palestinian families. Malnutrition rates among young children, as a consequence of conflict, are increasing. Once considered one of the best in the region in terms of health outcomes, Iraq has also suffered the consequences of three major wars, resulting in the poorest health outcomes in the region - well below levels found in countries of comparable income. As a result, the prevalence of physical disabilities and chronic mental problems among the working age population in Iraq has climbed dramatically<sup>32</sup>. Physical disabilities, combined with mental health problems, could easily present the highest burden of disease in Iraq today, significantly affecting the ability of a large proportion of the population to participate in economic activities.

41. The breakdown of community support systems and the limited access to health services and rehabilitation services have had a devastating effect on the disabled in Iraq. The Government's difficulties in providing basic health services have had a particularly negative impact on recent victims of acts of violence. Complications from injuries are common and frequently result in severe additional disabilities due to lack of appropriate treatment. The capacity of the Government to provide treatment to the victims of war and other violent acts is limited; many complications occur, and reconstructive surgery and rehabilitation services are severely limited. In the current context, the case of Iraq illustrates the double burden of the need to provide adequate care for the recent victims of violence, as well as maintain care of those whose disabilities are not related to the recent conflict.

42. Poverty, instability and conflicts also take a toll on the **mental health** of the population, and are manifest in the heightened incidence of depression and Post Traumatic Stress Disorder

<sup>32</sup> IRAQ Health Policy Briefs.

(PTSD). In analyzing the burden of mental health, it is essential to make a distinction between those who are clinically ill, which represent a small percentage of affected individuals, and those who suffer from more general mental stress. It is difficult to assess the extent of the mental health burden, but recent research shows that in post-conflict societies, mental health disorders are widespread and represent a major obstacle to economic development through lost productivity, loss of learning capacity, and cost of treatment and care. Recent large-scale epidemiological surveys have shown that in traumatized populations, depression can be up to seven-fold the baseline level in non-traumatized societies, and PTSD can be up to ten-fold the baseline<sup>33</sup>.

43. Detailed estimates of mental health disability vary widely, and often vary within the same country<sup>34</sup>. Traditional epidemiological classifications do not adequately capture some of the more recently recognized phenomena, such as mild mental health disability thought to be a result of under-stimulation of children in disadvantaged societies. These factors suggest that disabilities due to mental health issues, especially in conflict and post-conflict countries, may be one of the significantly underestimated issues in the MENA region.

44. **Emerging new communicable diseases present a potential future disabilities risk.** While the prevalence rates of HIV/AIDS in MENA countries are relatively low compared with Africa, South and Southeast Asia, and the Caribbean, low prevalence does not equate to low risk, and the situation may change rapidly if adequate preventive measures are not taken. HIV/AIDS is a debilitating disease and its spread could significantly increase the number of disabled in the population. Many countries in the MENA region have enough evidence of risk factors to warrant immediate and urgent investments in prevention programs. HIV/AIDS epidemics are sensitive to changing economic and social factors, and it is essential to ensure that surveillance methods in the MENA region detect meaningful changes where they are most likely to occur. Inadequate surveillance methods can overlook outbreaks in marginalized social groups. Too often, individuals with disability are not included in HIV/AIDS prevention and AIDS outreach programs because it is assumed that they are not at risk of HIV/AIDS infection. The Global Survey on Disability and HIV/AIDS<sup>35</sup> conducted by Yale University and the World Bank has proven this assumption wrong. Individuals with disability have equal or greater exposure to all known risk factors for HIV/AIDS infection. Men and women with disabilities are even more likely to be victims of violence and less likely to obtain legal protection or prophylactic care<sup>36</sup>.

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<sup>33</sup> World Bank-financed Post-conflict Mental Health Project in Bosnia Herzegovina, and LSMS survey.

<sup>34</sup> Elwan A 1999. [Poverty and Disability: A Survey of the Literature](#). Washington: World Bank, Social Protection Unit, Human Development Network.

<sup>35</sup> The World Bank, Yale University, 2004: [Global Survey on Disability and HIV/AIDS](#)

<sup>36</sup> Groce N, Trasi R 2004. [Rape of individuals with disability: AIDS and the folk belief of virgin cleansing](#). The LANCET, Vol. 363:1663-1664, May 22.

## **V. Addressing Disabilities**

45. A comprehensive strategy for disability should include the prevention of disabling conditions, address the disabling conditions to limit their effects, and ensure the integration of disabled persons into social and economic life. In order to achieve these ends, strategies should address disability in all its dimensions to best facilitate social inclusion and poverty reduction. Approaches to analyzing health risks, service supply and demand, and the performance of the health care sector from a disability perspective will require a multi-sectoral framework that goes beyond the traditional medical and social approaches to disabilities.

46. Disability is a cross-cutting issue, and all sectors contributing to sustainable development must consider the negative consequences of excluding individuals with disabilities from opportunities to contribute to the growth and development of their families, communities, the larger society and the economy. Mainstreaming disabilities in MENA region should focus on promotion and inclusion, through the development of national and integrated disabilities strategies, and commitment to national and local dialogue.

### **A. Promoting an Inclusive Environment**

47. Physical and cultural barriers discriminate against persons with disabilities. The social stigma associated with disability makes it common for families to “hide” family members with disabilities and restrict their access to education, rehabilitation services, and job opportunities. Among persons with disabilities who face lesser degrees of social stigma, a major barrier for their integration in society comes from discrimination in the form of impediments to accessible infrastructure to education and health services, and employment.

48. Public policy on disabilities in MENA countries tends to be focused on a medical approach, and does not yet adequately incorporate an integrated approach that promotes an inclusive environment. This results in disabled individuals being excluded from contributing socially and economically to society. There are few organizations that advocate for the rights of individuals with disabilities and that can hold governments accountable for the actual enforcement of legislation and regulations to protect the disabled, or that can advocate for better access to mass transit, public toilets, sidewalks, crossings, telephones, employment rights, etc. Lack of adequate infrastructure and transport facilities remains a major impediment to social and economic inclusion in the region. Documenting the impact of poor physical access for individuals with disabilities, and its effect on social and economic development, is an important strategy for promoting an inclusive environment in the region.

49. Inclusion of people with disabilities needs to occur also through the empowerment of those individuals. There are very few PWD organizations, led by people with disabilities, in the MENA region, that could move the process of integration forward, advocate for the rights of PWD and hold institutions and even governments accountable so that laws that protect PWD are enforced. In the Asia region for example, a strong regional network of PWD led organizations is supporting efforts of PWD to live and move independently, to advocate for better access on mass transit, public toilets, better laws for employment rights etc. Without the empowerment of PWD, social stigma will probably persist and the laws will not be sufficient to address inclusion.

50. MENA countries have seen a number of important legal and policy initiatives in the area of disability. A number of MENA countries have issued disability-related legislation, reflecting varying approaches to mainstreaming disability (for more information on OECD policies please

see Annexes E, F, G and H). Unfortunately, the legislation is usually limited in scope and addresses disability only as a small component. The implementation is usually delegated to an executive authority that is neither qualified nor has the resources or capacity to achieve the stated goals.

51. For example, during the 1990s a number of special laws were promulgated by royal or presidential decrees (Jordan, Egypt and Yemen) for persons with disabilities. These provided a legal framework for special privileges such as tax deductions, and employment opportunities for the physically challenged to participate in sporting events. However, these limited actions did not create a momentum for wider outreach. Representation of disabled persons on councils or boards responsible for enacting laws has remained limited. In Yemen, a special Disability Fund was created by law in 2002 with sustainable financial resources; but weak human resource capacity and inefficient public finance systems have minimized impact.

52. In 2001, the 56<sup>th</sup> session of the UN General Assembly proposed establishing a Special Committee to study the question of a new international convention on promoting and protecting the rights of individuals with disabilities<sup>37</sup>. In August 2002, the Ad Hoc Committee on International Convention<sup>38</sup> was designated to consider proposals related to a comprehensive and integral international convention to promote and protect the rights and dignity of individuals with disabilities. Also, the publication of “The Arab Human Development Report of 2002,”<sup>39</sup> examined the deterioration of certain aspects of life in Arab-MENA countries, and the negative impact on disabled individuals. As a result, the International Conference on the Rights of Persons with Disabilities<sup>40</sup> was held in October 2002 and paved the way for the Arab Decade of Disabled Persons, 2004-2013<sup>41</sup>.

53. Subsequently, the Council of Arab Ministers of Social Affairs, through the League of Arab Nations, reported “in order to meet the needs of integration of deaf persons into society and pursuant to a decision of the Council of Arab Ministers of Social Affairs, an Arabic sign-language dictionary for the deaf has been published.” The dictionary has not yet been adopted by all the Arab States, and is not widely used by the Arab satellite television broadcasting stations since it only includes 1,500 sign-language terms.

54. In May 2003, the Economic and Social Commission for Western Asia (ESCWA) organized and led the Arab Regional Conference on Norms and Standards Related to Development and the Rights of Persons with Disabilities-Beirut Declaration<sup>42</sup>. In parallel, ESCWA has started an initiative in MENA cities to promote accessible buildings<sup>43</sup> by publishing design manuals for a barrier-free environment.

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<sup>37</sup> General Assembly resolution 56/168.

<sup>38</sup> [Ad Hoc Committee on International Convention](#)

<sup>39</sup> [The Arab Human Development Report of 2002](#)

<sup>40</sup> [The International Conference on the Rights of Persons with Disabilities](#)

<sup>41</sup> [Arab Decade of Disabled Persons, 2004-2013](#) The ten main points identified for the Decade are: education; health; legislation; rehabilitation and employment; the disabled woman; the disabled child; accessibility and transport; globalization, poverty and disability; information and awareness; and recreation and sports.

<sup>42</sup> [The Beirut Declaration](#) announced that disabled persons, particularly in the Arab countries, face major challenges that prevent them from assuming normal roles on an equal footing with other citizens in their societies and state that the primary factors that give rise to discrimination, marginalization and which affect the right to development are based on structural, institutional, legislative, procedural, and cultural obstacles.

<sup>43</sup> Accessibility for the Disabled: A Design Manual For A Barrier Free Environment and Accessibility for the Disabled in the Urban Environment in the ESCWA Region Planning and Design Solutions.

55. These regional initiatives point to a growing awareness and commitment among the MENA countries to take a more concerted approach to promoting an inclusive environment for persons with disability. As an example of good regional cooperation in MENA, regional sports events are organized for people with physical impairments on a regular basis and with growing popularity among general population. In fact, the region has a good track record on developing sports events for the disabled both locally and regionally. There is an Arab Sports Federation for Disabled people as well as a Regional Special Olympics Network. These efforts could be scaled up, particularly at community and school level.

## **B. Promoting Inclusive Education**

56. Inclusive education represents a major shift in thinking about the role of schools, from one that prepares children to “fit” into existing schools to one that prepares schools to adapt to meet the learning challenges of all children. The aim of inclusive education is to provide quality education for learners who have been excluded from education, or whose participation within centers of learning has been limited, and coincides with the objective of providing community-based education for all. Unfortunately, inclusive education is often confused with the practice of training number of special education teachers who will teach parallel programs. In practical terms, inclusive education is just a more child centered approach to teaching. Inclusive education, therefore, brings together Community Based Rehabilitation and Special Needs Education Agendas with the overall Education for All Initiative<sup>44</sup>.

57. Unfortunately, educational systems in the MENA region continue to exclude more than 95 percent of the disabled school-aged population at the primary level, and almost entirely at the university level. However, several types of inclusive education policies and programs are starting to surface in the region and are included as part of national quality enhancement agendas and/or educational strategic plans. For example, Tunisia has declared its commitment to inclusive education for the disabled and is providing the needed resources under its Tenth Development Plan (2002-2006), and Jordan has adopted partial inclusion of disabled students enrolled in “resource” classrooms.<sup>45</sup> In Egypt, however, disabled students are excluded from public schools due to misperceptions<sup>46</sup>.

58. The role of governmental institutions, working in cooperation with international agencies and local NGOs, is in promoting inclusion in local communities and schools, and supporting the infrastructure and technical capacity of the educational system to provide quality inclusion education for all. This role entails developing a national policy, and institutional and individual capacity building to include teacher training at all levels of the educational system, all to provide child-centered learning environments that overcome barriers to learning for all students, and promote the principles of a culture that recognizes "diversity" rather than "disability".

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<sup>44</sup> Hannu Savolainen and Hanna Alasuutari, “Introduction,” Meeting Special and Diverse Educational Needs, edited by Hannu Savolainen, Heikki Kokkala, and Hanna Alasuutari, Ministry of Foreign Affairs of Finland, Helsinki, 2000, page 11

<sup>45</sup> Providing temporary, late, and partial support for certain kinds of Disabled children, e.g., resource classrooms in certain schools, and after-school tutoring, or speech therapy – instead of language and reading in-classroom early intervention

<sup>46</sup> In the past 5-10 years, educational authorities resisted or refused access to disabled children in regular schools. This was due to arguments about practical difficulties in access, and not necessarily about the actual efficacy of inclusion as an approach or philosophy. As a result significant time was lost and many children were and will be excluded.

59. Overall, national development strategies in MENA lack a clear conceptualization of disability as a development priority, as do some donor development strategies. Noble intentions are often pronounced, but these are not translated into the introduction of modern inclusive education policies and practices for disabled children and youth. Announcements for starting inclusive education abound - but without specialized knowledge, technical capacity, and a coherent multi-disciplinary strategy, constraints remain to any successful adoption of inclusive education, starting from national Ministries of Education and ending with local schools and communities. Denial by public officials prohibits a pro-active policy on inclusive education. This problem will likely be compounded by rapid population growth, which will strain the capacity of existing educational systems to provide quality basic education for the general population.

60. In general, government educational administrations lack the knowledge, technical capacity and administrative structures to support the transition of local NGOs from providing services for disabled in an institutional settings or by tertiary-service approach for the severely disabled, to inclusive community-based services, which integrate education, primary health care, and early intervention.

61. Programs in the MENA region have yet to establish early identification, diagnoses, and intervention, including timely medical services, and comprehensive educational and multidisciplinary rehabilitation services<sup>47</sup>. Since public education does not include the deaf in their programs in many countries, it is also likely that less evidently disabled individuals also are excluded. Sign language is normally recognized as a first- or second-language, but it is not taught in most new Early Childhood Education programs. This means that almost all deaf children are excluded, even those who have some residual hearing loss though they have auditory exposure to direct (non-incident) verbal language stimulation<sup>48</sup>. Deaf native users of indigenous sign languages in all MENA countries are excluded from the process of “Mother” Sign Language documentation and later from teaching and modeling for young deaf students.

62. Current education, training, and employment programs directed to youth could be made more inclusive by promoting the participation of youth with disabilities. Some recent initiatives for special education/inclusion programs in Egypt, Jordan, and Tunisia illustrate the potential to include students with certain types of disabilities in mainstream schools, although current coverage is still low and uneven.

### **C. Prevention Strategies**

63. MENA countries face the challenge of reducing current high rates of disabilities, caused by (i) large numbers of individuals with disabilities whose conditions could be mitigated with appropriate health and social interventions, and (ii) weaknesses in primary and secondary prevention mechanisms, especially those that address the new emerging causes of disability. These include prevention and management of chronic diseases, work related injuries, road accidents, mental health problems, and newly emerging infectious diseases like HIV/AIDS. Much work remains to strengthen public policies and programs to prevent disabilities by

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<sup>47</sup> Some grants are given to NGOs to conduct early identification. Mainly money is spent on equipment and first steps without a thorough identification and intervention plan. Many times, the rehabilitation equipment that is donated needs a comprehensive and sustainable rehabilitation service that is not possible.

<sup>48</sup> Many of those countries are funded and reporting that they are “developing” what is called “sign language dictionaries.”

reducing their occurrence and their long-term impact through early identification of the risk factors and introduction of preventive measures.

64. Prevention efforts could be universal, or be restricted to a select population (i.e. prevention targeted at high-risk groups) or to an indicated population (i.e. prevention for individuals with an identified risk). **Primary prevention** efforts are directed toward reducing the actual occurrence of disabilities. Primary prevention efforts include direct interventions such as genetic counseling, immunization programs, improved maternal care, as well as introduction of regulations and legislation such as the use of seatbelts and protective gear such as helmets, and other risk management and mitigation measures.

65. Primary prevention efforts implemented through early childhood development initiatives, where there is a strong link between nutrition, health and education systems, can substantially reduce and mitigate the consequences of disabilities. Family involvement, especially in the case of mental disabilities, is essential. Despite improvements in overall regional health outcomes, health outcomes remain poor in low income countries and rural areas of the MENA region. These disparities in health outcomes present a challenge to the policy makers, and indicate continuing high risk of disabilities due to disease<sup>49</sup>.

66. High rates of injuries, which are the leading cause of death and disability among the most economically productive age group for both high and low-income countries of the region, illustrate weaknesses in primary prevention of disabilities. Road traffic accidents and injuries are preventable. In 2002, deaths due to road accidents in the low-income MENA countries were as high as 264 per 100,000 – second only to Sub-Saharan Africa<sup>50</sup>. In high-income countries, an established set of interventions has contributed to a sharp reduction in the incidence and impact of road traffic injuries. These include the enforcement of legislation to control speed and alcohol consumption, mandating the use of seatbelts and crash helmets, and the safer design and use of roads and vehicles.

67. Road traffic injury prevention must be incorporated into a broad range of activities, such as the development and management of road infrastructure, the provision of safer vehicles, law enforcement, mobility planning, and provision of health services, child welfare, urban and environmental planning. A new example of a road traffic injuries prevention effort is the World Bank supported Iran Road Safety project now under preparation. The role of the health sector in injury prevention is to strengthen the evidence base, provide appropriate pre-hospital and hospital care and rehabilitation, conduct advocacy campaigns, and contribute to the implementation and evaluation of interventions. However, prevention of road traffic injuries illustrates the paradox that the health sector plays only a small role in prevention while infrastructure, law enforcement and education play the key roles in this area.

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<sup>49</sup> Infant mortality rates and maternal mortality rates remain high in low income countries and in rural areas of the MENA region. Infant mortality rates range from 8 deaths per 1,000 live births in the United Arab Emirates to 99 in Djibouti. Maternal mortality rate variation also shows a wide range of variation by countries, with 5 deaths per 100,000 live births in Kuwait, compared with 570 deaths per 100,000 live births in Djibouti. Stunting among children affects 6 percent of children in Qatar but 39 percent in Yemen<sup>49</sup>. Routine immunization coverage rates for children are generally high in the region with most countries reporting immunization coverage over 90 percent against preventable child diseases (Bahrain, Egypt, Islamic Republic of Iran, Jordan, Kuwait, Lebanon, Libya, Morocco, Oman, Saudi Arabia, Syrian Arab Republic, Tunisia, United Arab Emirates and Palestine), but, recent polio outbreaks in Yemen and Djibouti indicate major problems in the health care delivery systems in these countries (Source: The World Bank (2003) Health Sector Brief..

<sup>50</sup> The World Bank (2003): Health Sector Brief.

68. Technology transfer is one of the major factors behind economic development in both the industrialized and developing countries. Technology transfer may take place in several different ways; in production processes introduced by multinational corporations, or by foreign investors, or as a licensed import of foreign technology. If performed according to the best practice principles proposed by the ILO and other international bodies, technology transfer can have a highly positive impact on productivity and occupational health and safety. There are numerous examples, however, of the transfer of hazardous and obsolete technologies from industrialized countries to developing countries, resulting in higher occupational related injuries. Faced with a rising incidence of occupational related injuries and disabilities, the World Health Organization (WHO) and the International Labor Office (ILO) are highlighting the need to promote a preventive occupational safety culture worldwide.

69. As already noted, there have been a number of important legal and policy initiatives in the area of disability<sup>51</sup> in MENA region countries. These have the potential to create an enabling environment for a more rigorous introduction of preventive measures. Unfortunately, most of this legislation reflects a very limited perception of disability (see Annex A), and is further hampered by lack of enforcement capacities.

70. **Secondary prevention** strategies aim at reducing the duration or severity of disability. These activities provide early identification of disabling conditions, and prompt treatment and intervention to minimize disability development. WHO estimates that only 1-2 percent of disabled persons in the developing world have access to rehabilitation services. Access to health and rehabilitation services varies widely within the MENA Region<sup>52</sup>. Thus limited coverage by social protection programs and wide disparities in terms of access to health services suggest that there is a need to pay close attention to strengthening secondary prevention programs in the MENA region.

71. There is no consistent policy in the region to ensure access to secondary prevention services for persons with disabilities. In some countries, there is a tendency for the health care system not to treat certain disability groups. In Yemen, where the health care system is very weak and inaccessible for large parts of the population, persons with disabilities have even less access to care. In Jordan and Syria individuals with disabilities are entitled to care in the public health care system for programs ranging from prevention and early detection and diagnosis to treatment of impairments, referrals and counseling for families. The degree of participation of persons with disabilities in the planning and evaluation of such secondary prevention programs ranges from “never” in Djibouti, “sometimes” in Jordan, Morocco and Syria, to “often” in Lebanon.

72. **Tertiary prevention** aims at limiting or reducing the effects of a disorder or disability that is already present. It involves long-term care and management of a chronic condition, correction of the disability by medical interventions or through the use of aids, and by adopting other strategies where the disabled person can lead an active and normal or near-normal life. The main aim of such programs is to increase social awareness of disabilities and the needs of

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<sup>51</sup> (i) publishing of the Arab Human Development Report of 2002, (ii) launching of the Arab Decade of Disabled Persons, 2004-2013, and (iii) appointment of a Special Rapporteur on Disability of the Commission for Social Development for the period 2003-2005, Sheikha Hessa bint Khalifa bin Hamad Al-Thani of Qatar

<sup>52</sup> Djibouti has only 0.2 physicians per 1,000 persons while Lebanon has 2.1 per 1,000, compared with a regional average of 1.2. The number of hospital beds proportional to total population ranges from 0.6 beds per 1,000 persons in Yemen to 4.3 beds per 1,000 persons in Libya, with a regional average of 1.9 beds.

persons with disabilities, and encourage their full integration in society. In the MENA region, programs that address tertiary prevention remain extremely limited in scope.

#### **D. Integrated Rehabilitation and Community-Based Services**

73. Physical rehabilitation services by government-sponsored programs vary significantly among countries in the region. Djibouti, Egypt, Morocco and Syria reach less than 5 percent of the disabled population, while Jordan and Lebanon cover somewhere between 6-20 percent of their respective disabled populations. Iran covers from 41 percent to 60 percent of the population with disabilities. In Djibouti, rehabilitation services are provided essentially for individuals with mobility impairments. In most other countries, services cover deaf and blind individuals, the handicapped, individuals with learning challenges, and individuals with disabilities due to chronic diseases and mental illness. In Yemen, government-sponsored rehabilitation programs cover mobility impairment and the blind. Several local NGOs have established rehabilitation programs for deaf and mentally handicapped children. However, almost all governmental and NGO rehabilitation services in Yemen are urban-based and do not reach individuals with disabilities in rural areas.

#### **Rehabilitation Services in Iraq**

In Iraq, the breakdown of community support systems and limited access to health and rehabilitation services has had a devastating effect on the disabled. The Government's difficulties in providing basic health services have had a negative impact on recent victims of acts of violence. Complications from injuries are common and can result in severe additional disabilities due to lack of appropriate treatment. The capacity of the Government to provide treatment to the victims of war and other violent acts is limited. Prior to May 2003, there were 11 centers providing rehabilitation services in Iraq, most of which have suffered extensive damage. Existing centers dedicated to rehabilitation and the manufacture of prosthetic limbs have been looted and most of the facilities have suffered heavy physical damage recently. Partial reconstruction has taken place, but only two centers are fully operational. There are three hospitals for spinal injuries, one each located in Baghdad and Salah-il-Deen, and one former army hospital, that provide special care for the disabled. Existing local capacity for the manufacture of artificial limbs could reach 5,000 per year if raw materials were available. However, it must be noted that the technology has dramatically evolved during recent years, and once the centers are rehabilitated, new equipment reflecting updated technology should be provided and the staff retrained. Many complications occur and reconstructive surgery is limited in scope and quantity. In the current context, the Government of Iraq has the double burden of providing adequate care to the recent victims of violence, as well as maintaining care of those whose disabilities are not related to the recent and on-going conflicts.

74. In many of the MENA countries, the largest share of rehabilitation services and assistive devices are provided by NGOs, but the number of disabilities covered is limited, with very few organizations providing services for mental health or learning disabilities. Many of these services have been evolving from medical rehabilitation services towards more comprehensive, multi-sectoral and integrated programs, including health care, education, vocational training, income generation programs and community participation and inclusion<sup>53</sup>. Such cross-sectoral

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<sup>53</sup> New Approaches in the Health Sector: Meeting the Needs of People with Disabilities Ronald Wiman, Einar Helander, and Joan Westland June 2002.

approaches require long-term investment not only in technical and management capacity building, but also in community participation and empowerment of individuals with disabilities. Community based approaches that emphasize integrated services have often been found to be more cost-effective,<sup>54</sup> but with the field sufficiently new, “best practice” may not yet be fully identifiable.

## **E. Social Protection for Disabled Persons**

75. Developed countries have already introduced a number of effective measures to reduce the risk of disabilities, mitigate the consequences and create inclusive environments for the disabled (for examples of EU and US policies see Annexes E to H). In recent years, however, public interest in the design of disability insurance and cash-benefits programs has increased in the developed countries, as expenditures have risen sharply due to aging populations and poorly structured disability benefits programs. Broader disability issues, including those associated with disability insurance and disability cash benefit programs, have also gained in prominence, as advocates have started to demand full civil rights for persons with disabilities throughout the world. In many developing economies, including those in the MENA region, the support and care of persons with disabilities remains solely with the family.

76. Government sponsored social safety net schemes in many MENA countries do not reach large numbers of the population with disabilities. As a large proportion of the working age population is in the informal sector, formal social insurance programs reach only a limited segment of the population. For example, in countries like Morocco and Syria, less than 20 percent of the population is covered by social insurance schemes that could potentially provide disability benefits. For families living with PWD, voluntary community support and NGOs often remain the only alternative sources of support in the absence of government programs.

77. It is possible that with further economic development and industrialization private voluntary disability insurance will emerge as an alternative to government programs. However, the market for disability insurance is particularly prone to adverse selection, and disability insurance claims are strongly subject to moral hazard. As there are many opportunities to exaggerate a disability claim to meet the criteria set by the insurance company, private insurers tend to set extremely stringent criteria to prevent fraud. Due to the stringency of these standards, individuals with disabilities often end up being excluded from coverage. The development of mandatory national standards could level the playing field for the disability determination process, but their enforcement will be a challenge.

## **F. Public and Private Partnership**

78. Local NGOs play a key role in MENA countries in reaching out to persons with disabilities, through a combination of own funding, donor financing, or public funding. Local NGOs providing rehabilitation services are, in the great majority of cases, dependent on donor or public funding. The interaction between government agencies, NGOs and communities often lacks a clear governance system. Coordination between NGOs, communities and local governments requires an institutional framework geared for cooperation, which is not always evident, and for capacity building of all stakeholders.

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<sup>54</sup> See [http://www.who.dk/eprise/main/WHO/AboutWHO/Policy/20010827\\_1](http://www.who.dk/eprise/main/WHO/AboutWHO/Policy/20010827_1).

79. Many local NGOs do not adequately employ a community-based approach or interact enough with the affected families. They often use old rehabilitation techniques and are not sufficiently exposed to inclusive education policies, pedagogical methods, and practices. Frequently, they do not evaluate their programs to ensure that activities provide the target population with the means to live independent and productive lives. Nor do they deal with mild and moderate degrees of disabilities, which are either not diagnosed or misdiagnosed. This group among the disabled falls between the cracks of both health and educational systems, since neither system is able to implement early identification programs using cost-effective tools and protocols. Local NGOs target individuals with disabilities who are registered as disabled, showing severe disabilities or exhibiting “noticeable” late behavioral symptoms.

80. On the other hand, government programs often lack the mandate, knowledge and resources to guide and monitor local NGO activities and support their transition towards inclusive community-based services, which integrate education, primary health care, and early intervention. The existing legislation and programs reflect governmental commitment, and provide a basis for systematic and strategic work in the future (for more examples on current legislation see Annex A). However, as enforcement remains limited and implementation capacity weak, legislation alone does not guarantee benefits for individuals with disabilities.

81. On a positive note, a number of initiatives addressing disability in the region are emerging to address several bottlenecks, including development of public-private cooperation models in the area of disability. The Social Protection Initiatives Project (SPIP) in Egypt demonstrated that a community-based Inclusive Education Model is a feasible entry point for inclusion of children with disabilities. A network of local NGOs supports the disability component, managed by the Ministry of Social Affairs. Inclusion was piloted in formal and non-formal education programs to instill the principles of a culture that recognizes "diversity" rather than "disability". As a result, the Ministry of Education issued a decree in 2005 supporting the enrollment of disabled children in formal schools turning these schools into inclusive associations.

82. Another good example of public-private partnership is a program supported by the Yemen Social Fund for Development (YSFD). Guidance and a framework for public-private cooperation was piloted under YSFD. The guidance was translated into legislation for the management of government centers by NGOs, with ongoing governmental support and financial commitment (see Annex B). Results have been variable, but in some cases with very significant improvements. The YSFD not only finances disability programs implemented by local NGOs, but also finances buildings, equipment and capacity building to sustain their work<sup>55</sup>. YSFD initiatives have also fostered inclusive education reaching out to blind, deaf, physically disabled persons and children with mental health disabilities. YSFD further supports the training of teachers to enable them serve children with disabilities. These initiatives, however, are urban-based, and there are very few local NGOs working in rural areas, where many of the poor and disabled live. The leadership role played by the YSFD has not yet been resulted in government engagement in disability.

83. Yet another example of public-private partnership can be found in West Bank and Gaza, where the Palestinian Authority initiated systematic cooperation with local NGOs in the area of service provision for the disabled. The Palestinian National Committee for Rehabilitation is composed of representatives from local NGOs providing rehabilitation services and the Ministry

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<sup>55</sup> Coleridge, Peter, 2004. “Yemen Social Fund for Development: A Review of its Disability Programme”.

of Health. A number of NGOs, such as the Abu Rayya Center for physical rehabilitation, receive a large part of their budget requirements from the Palestinian Authority. In recent years, the capacity of the Palestinian Authority to support the NGOs to respond to the demand of an increasing number of disabled individuals has been severely constrained due to the precarious fiscal situation created by the *intifada*.

## VI. Conclusions

84. The challenge facing MENA countries is to address multiple and changing causes of disability that are driven by economic development and demographic and epidemiological transitions. The new challenges include disabilities caused by work-related injuries, road accidents, age-related noncommunicable diseases, and stress-related mental health problems. At the same time, they will need to address the persistent and continuing risk of disabilities prevalent in low income settings, such as risk due to communicable diseases and malnutrition, as well as the aftermath of political violence and armed conflict.

85. Addressing disabilities should not be understood as a vertical program but as a cross cutting development theme. Policies and programs to integrate persons with disabilities into all aspects of social and economic life benefit not only the individual but contribute to social and economic development more generally. Individuals and households with disability faces barriers to health and rehabilitation services, education, employment, and other aspects of economic and social life, and they are more likely to be trapped into a life-long cycle of poverty. To be effective, disability policies and programs will also need to develop effective primary, secondary and tertiary prevention strategies.

86. Despite some progress in recent years, government policies and programs in most MENA countries do not yet promote an environment in which persons with disability are able to participate and contribute to social and economic development. Programs to prevent disabilities or mitigate their effects are also not well developed or implemented systematically. Interest in inclusive development is growing within governments, civil society, and the development community, but efforts in these areas are constrained by the lack of research exploring the link between disability and poverty, and by evaluations of good practices that can make inclusive development possible.

### A. World Bank Policies on Disability

87. In the area of disability, the World Bank is working at a global level to ensure full participation of people with disabilities in its development work and thereby reduce the risk of economic and social exclusion. Interest in inclusive development is growing within governments, civil society, and the development community. Efforts to promote these policies are, *inter alia*, constrained by the lack of research exploring the link between disability and poverty, and evaluations of good practices that can make inclusive development feasible and acceptable within the existing social and cultural context. Developed countries have already introduced many effective measures to reduce the risk of disability, mitigate its consequences and create inclusive environments for the disabled, and these investments have already started to pay back (for examples of OECD policies for disabled see Annexes E to G).

88. As part of its mission to fight poverty in all its forms, the Bank is committed to finding and supporting effective approaches to preventing disabilities, addressing the needs of people with disabilities and ensuring their full participation in the development process. To this end, the Bank could mainstream disability components into investment projects in infrastructure, education, healthcare, and employment. It could also contribute to this objective through technical assistance in data collection, research and analysis, sharing knowledge and international experiences, and advocating for inclusive environments among policy and decision makers.

89. The Bank's involvement in disabilities in the MENA region is at an introductory stage. A number of initiatives addressing disabilities in the region are being supported by the World Bank (see Annex B), including projects involving public-private cooperation. These projects suggest ways to overcome the existing bottlenecks. Disability is a cross-cutting issue that will require close coordination among many players from different sectors.

## **B. Next Steps**

90. Governments in the region could undertake many concrete and immediate steps for mainstreaming disability in the region. Many countries already have adequate legislation related to disability. But it is not well enforced and policies are often not implemented. To address disability issues in a comprehensive way, MENA countries would benefit from engaging in regional and national dialogues, and from building a shared vision and partnerships among local, national and international stakeholders. Each country in the Region will need to develop its own strategy grounded on empirical evidence as a foundation for sustained commitments and engagement of the various stakeholders. Such a dialogue should then lead to the implementation of policies, programs and investments that reflect the priorities articulated in a well-informed national strategy.

91. **Promote the development of National Disabilities Strategies.** National strategies should provide the framework for (i) formulating disability-related legislation and developing the institutional capacity of government and non-government agencies providing services to persons with disabilities; (ii) integrating disability policies and programs into existing investments and programs on health, education, infrastructure, transport and social protection services and benefits; and (iii) disseminating knowledge about the causes and prevalence of disability, and assessing their impact on the country's social and economic development .

92. **Establish a regional dialogue.** MENA countries will benefit from a regional forum to promote dialogue and exchange of information, experiences and knowledge about effective policies, strategies and programs to address disability in the region. Developing an effective national strategy on disability requires taking a multi-sector approach. Countries will benefit by learning from examples in other countries and regions, and by creating partnerships with major international and regional stakeholders, such as the UN organizations, Arab Organization of Disabled People, International NGOs working in disability and others.

93. **Support Interventions.** There are immediate steps that could be implemented even before comprehensive national strategies are developed. Mainstreaming disability in World Bank and donor funded projects is an immediate step that can be implemented even before comprehensive national strategies are developed. This can include: (i) use of existing infrastructure (roads, mass transit) and urban development projects in the region to provide support to Ministries of Public Works, Planning and municipalities to develop infrastructure access guidelines for persons with disabilities (PWD). Infrastructure projects can also serve as pilots for the incorporation of barrier free design and their evaluation; (ii) use existing Community Development and Social Funds to support disability initiatives led by PWD including capacity building for organizations and associations of PWD so that they can lead the activities for inclusion; (iii) use municipal development programs to build capacities of local government to provide services to PWD; and iv) pay attention to PWD inclusion issues in education and health projects.

94. **Promote data production and knowledge dissemination.** For the medium term, further research on disability issues are needed to fill the current knowledge gap on disability

prevalence, its impact on social and economic development, and the effectiveness of various prevention, risk mitigation, rehabilitation and integration programs. An immediate task would be to catalog existing surveys, assess their usefulness for analytical purposes, and develop cost-effective and timely approaches to collecting data. Sharing experience among regions within the Bank will be an important step towards filling the knowledge gap and developing complementary activities. Also, based on poverty mapping techniques, the Bank is developing a methodology for estimating the poverty rates of small vulnerable groups, which could be used to measure correlations in the incidence of disability and poverty in the MENA region. These could be supplemented by qualitative research methods that probe into the causal relations among the key determinants. MENA countries could profit from lessons learned in other regions with regard to data collection and analysis on disability through collaboration with international and regional institutions such as the WHO, UNICEF, ESCWA, United Nations Statistic Division, and OECD.

## Annex A: Disability-Related Legislation from Selected MENA Countries

### Egypt

1. *Child Legislation No. 12 of 1996, "Care and Rehabilitation of the Disabled Child (Chapter 6)*, "The government or the Republic is responsible to protect childhood." It "emphasizes the right for special social, medical, educational, and vocational services." Most of the above responsibilities are within the MoSA. The definition of a Disabled child in this legislation is reflecting the limited scope and philosophy of this text as a basis for mainstreaming and inclusion.<sup>56</sup>
2. *Labor Law No. 39 of 1975 as Amended in 1982*. Disabled People's employment quota was increased from 5 percent.
3. Other accessibility legislation are not established, e.g., the "Deaf are not allowed to drive unless it is proven medically that they use a hearing aid."
4. Egyptian Sign Language is recognized but without any mechanism to either license or monitor interpreters; yet many programs is interpreted on Egyptian Television very poorly.

### Jordan

1. *Legislation for the Care of the Handicapped No. 12 of 1993* is limiting too many kinds of disabilities. Most of its attention and government resources are devoted to the physically handicapped. Disabled People themselves did not participate in its development, nor are they well represented in its actual implementation.
2. *Traffic Law No. 314 of 1984, Article 5 as Amended in 1987*, gives the Deaf the right to drive without any special conditions and obliges the Road and Traffic Authority to provide a JSL interpreter during driving qualification exams, if necessary.
3. *Criminal Law No. 9 of 1961, Article 230* entitles the judge to appoint and pay for a sign language interpreter if the witness or accused is Deaf (or Mute) and is illiterate.
4. Jordanian Sign Language has received some attention since 1988; Deaf volunteers and professionals initiated a Jordanian Sign Language -interpreted weekly news program on Jordanian Television. In this, Jordan set the wave for all Arab television to "legitimize" local Arab sign languages to be used on national television. A mechanism to license and monitor interpreters professionally remains to be established.
5. The Ministry of Public Works and Housing published the Jordanian National Building Council: The Code of Building Requirements for the Disabled (1993) yet has not systematically enforced it.<sup>57</sup>

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<sup>56</sup> "A "handicapped person" means the person who needs rehabilitation services" and a deaf person means the person who cannot be taught through his "speech and hearing capabilities"

<sup>57</sup> Al-Khammash, Karim Mousa. "The Code of Building Requirements for the Disabled." In the proceedings of the Scientific Day for the Activation of Application of the Code of Building Requirements for the Disabled. Ministry of Public Works and Housing and Union of Jordanian Engineers. Amman, September 1995.

## Tunisia

1. *Legislation No. 80 of June 2002, Chapter 4*<sup>58</sup> is based on the national action plan of 2002-2007, “The New Educational Reform.” It aims to give equal schooling opportunity for ALL and has a Guide for providing the conditions for ALL students with special needs by 2015. Tunis will be leading in this new educational and non-medical approach by including Disabled children functionality. Tunisian officials are proud that this is a dynamic process welcoming diversity and differences.
2. Other accessibility legislations are not established, e.g., the “Deaf are not allowed to drive unless it is proven medically that they have 40 percent residual hearing.”
3. Tunisian Sign Language interpreters are working in more than one public arena without a licensee.
4. Disabled People’s are not represented on the National Counsel for the Disabled.

## Yemen

1. *Law No. 61 of 1999* on the Care and Rehabilitation of Disabled Persons defines disability and entitles persons with disabilities to rights of education, employment, health and rehabilitation services.
2. *The Social Welfare Fund (SWF)*, established in 1996, represents one of the most important social safety net programs in the country. It provides monthly cash transfers to the very poor. In 2002 the SWF beneficiaries numbered 429,950 of which 55,150 (13 percent) had one form or another of disability.
3. *Law No.2 of 2002 established the Disability Fund (DF)*<sup>59</sup>. The DF provides financial support to government programs targeting disability, and also supports NGO activities.
4. *Ministry of Education Decree No. 407 of 1999* entitles children with disabilities to enroll in public schools within their vicinity and exempts them from school fees. In 2000 the ministry established a Unit for Inclusive Education, which in 2003 was upgraded to the status General Directorate.
5. *Yemeni Sign Language* was first developed in 1995 initiated by Oxfam-UK in partnership with the Yemeni Association for the Rehabilitation of the Deaf, with technical support from the Holy Land Institute for the Deaf in Jordan. Since then it has been used widely in formal training for the deaf. Following initiatives by the Yemeni Deaf Association, the government now supports daily television news with sign language. The Yemeni Sign Language Dictionary is now being expanded and developed with the support of the YSFD.
6. *Accessibility legislation* concerning construction codes for buildings and roads does not exist. This is as yet not on the public agenda either of municipalities or of advocates on disability, such as the Union of Associations of the Disabled.

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<sup>58</sup> Originated from the first educational legislation after independence (*Legislation No. 118, 1958*) which gave the right to free education for ALL). This is the reason why mothers in the early 1980’s were able to enroll MR and HH-Deaf kids in their neighborhood schools.

<sup>59</sup> The financial resources of the DF are drawn entirely from internal Yemeni sources: principally from the government central budget as well as from a surcharge of YER 5 per packet of cigarettes sold.

## **Annex B: Examples of World Bank Projects in the MENA Region with Disability Components**

### ***1. Egypt Social Protection Initiatives Project - Community-based programs for including children with disabilities in educational activities***

The experience gained through the Bank-financed Social Protection Initiatives Project (SPIP) demonstrated that a community-based Inclusive Education Model is an ideal and feasible entry point for inclusion of children with disabilities. Inclusion was piloted in formal and informal education programs to instill the principles of a culture that recognizes "**diversity**" rather than "**disability**". The pilots were implemented in kindergartens in slum areas in Cairo, community schools in rural Upper Egypt, and in literacy classes and libraries in urban areas. For children in Kindergartens, a SPIP pilot promoted flexibility in curricula and acceptance among young children and their parents of the diversity principle. One NGO relied on the "Child to Child" Strategy to promote inclusion of disabled children with other children in extracurricular activities to raise awareness at the community level.

Using an Arabized "Index for Inclusion" to train school teachers, staff and community workers, educational processes were rendered more sensitive to the inclusive education model. Another NGO produced an Educational Kit to support the practice of the "Rights-Based Approach" and "Child to Child" strategy to the inclusive education model. Inclusion in literacy classes was also piloted in rural Upper Egypt and Cairo slum areas where specialized curricula for the visually impaired and the deaf using Braille and Sign languages were used respectively. The role of community workers was critical in promoting the principles of the model. A network of NGOs and community workers was established to sustain this approach at the community level.

At a policy level, in 2005, the Ministry of Education issued a decree supporting the enrollment of disabled children in formal schools. Turning these schools into inclusive associations was a top priority. A particular focus of the Ministry is targeting KGs to promote positive values for tolerance, cooperation and accepting differences.

### ***2. West Bank and Gaza: Helping the Disabled through NGOs and Social Safety Net***

Services for the disabled are provided through the Palestinian Authority, through its network of hospitals and primary health care centers, as well as by NGOs and the United Nations Relief and Works Agency (UNRWA), which works with refugee populations. In the absence of a national policy on disability, existing services are provided in an *ad hoc* fashion, remain largely under-developed and focused on provision of long-term institutional care. The capacity of the Palestinian Authority, NGOs and UNRWA to respond to the demand of an increasing number of disabled has been hugely constrained by the precarious fiscal situation that these service providers face, whereby they depend almost exclusively on donor funding to sustain their services. All this speaks to the need for the donor community to work with the Palestinian Authority and NGOs on developing a comprehensive approach to addressing and mainstreaming disability across all sectors.

The Bank has been supporting service delivery for disabled populations through its **Palestinian NGO Project (PNGO)** which provides grant funding to Palestinian NGOs to enable them to sustain their services to marginalized communities. Since 2000, the project provided grant financing for a total of 34 projects that target disabled people as their direct beneficiaries. These projects supported investments in physical infrastructure, as well as the provision of technical assistance to NGOs working in this sector. Thus, the project helped finance the construction

***A Human Face on a Bank-supported Initiative:*** Muhammad Nazzal, a deaf Palestinian man is now leading Al-Amal (HOPE) Association for the Deaf, a recipient of a PNGO developmental grant in the amount of US\$ 243,906. Muhammad is a vivid example of a person who does not give up. He obtained a professional diploma in sign language from Cairo and came back to his country with a determination to assist his fellowmen. He established Al-Amal Association, which first relied on limited local donations. Today, Al-Amal is a well-known association located in Qalqilia, led by an entire Board and management deaf team. The association provides both educational and vocational services to deaf and speaking children and youth from all over the West Bank.

of rehabilitation centers and the upgrading of specialized facilities, the provision of technical aids such as wheel chairs, the provision of training programs to teachers and family members on how to handle individual cases of disability, the provision of vocational training to disabled persons as an empowerment tool, in addition to a range of outreach programs and studies on various aspects of disability in the West Bank and Gaza. Of the total project budget, an estimated US\$3.5 million had been allocated to services for the disabled.

The Ministry of Social Affairs' Social Hardship Case Program – the Palestinian Authority's main social welfare scheme – uses disability as one of the main eligibility criteria for providing cash benefits. According to a recent analysis done by the Bank, up to 37.1 percent of the beneficiary households have at least one physically or mentally disabled person. In fulfilling the Ministry of Social Affairs' objective of reforming the Social Hardship Case Program, the Bank is providing assistance through the **Social Safety Net Reform Project** to define revised eligibility criteria, which will ensure that disability is well addressed in the definition of eligibility and targeting.

### ***3. Yemen "Isnad" - A Model of Government Support to the NGOs***

Following the 1962 revolution in Yemen, the Ministry of Social Affairs (currently Ministry of Social Affairs and Labor) was mandated to provide rehabilitation and special education to children and youth with disabilities. A number of urban-based rehabilitation centers were established, with boarding services for students from rural areas. They offered special education that was customary for the time and basic vocational training that stereotyped the capabilities of persons with disabilities. They provided very little interaction with mainstream society, and fell behind the evolving development concepts.

Despite their poor performance and limited budgets, these centers kept operating only because of the high demand for free services. Management systems and finances were unattractive to more qualified staff. Support from the private sector was not forthcoming due to lack of financial confidence in the public sector. Children and youth with disabilities had no institutional alternatives, despite the low levels of care and rehabilitation offered.

A number of competent local NGOs began their own rehabilitation and support services. More flexible and willing to pilot new approaches, they received training and introduction to new development concepts. They succeeded in mobilizing financial support from private businesses and development institutions, and benefited from capacity-building activities with regional and international movements and institutions. However, with limited financial and human resources they could expand services only slowly, and were unable to meet increasing demand or develop programs of outreach to the most vulnerable.

The variation in quality between government services and those offered by NGOs was nevertheless obvious. The MOSAL sought ways of reforming its centers, and of benefiting from NGO capabilities through partnership mechanisms. With financial and technical support from the Yemeni Social Fund for Development (YSFD), which was itself supported by the Bank's Social Fund Project, a number of workshops were held, analyzing the situation in the centers, the limitations of public sector management and financial systems, the value-added work of NGOs, and the role of the private sector in developing the social sector. Participants included representatives from the ministry, from governorates, from NGOs and the private sector. The proposals that emerged recognized that NGOs had advantages of flexibility in fundraising, and that they were more trusted by private sector.

With facilitation by external consultants, scenarios evolved for the improvement of government services by NGOs. Frameworks for mutual relations and procedures were elaborated. These were then translated into legislation for the management of government centers by NGOs, with ongoing government support and financial commitment. Results have been variable, but in some cases with very significant improvements. Where deteriorating conditions were discouraging families, confidence has been returning. The educational approach taken by one center, with proper grouping of needs and assistance, supervision of boarders after regular school hours and proper food, has led to a tripling of intake. Special education up to the sixth grade is adapted after that children are integrated into regular schools. Improved services and transparent systems are now encouraging the inflow of further support to these centers.

## **Annex C: Proposed Policy Framework Based on Egypt Social Protection Initiatives Project**

### **CONTEXT:**

The Egyptian Social Protection Initiatives Project provided critical support to the development of a policy framework for addressing the needs of persons with disabilities. In addressing disability-related challenges, this initiative focused attention on engaging and eliciting support among stakeholders at three different levels:

- **Government-level response:** A legal framework citing the rights of the disabled based on equity principles is available. However enforcement mechanisms and tools are lacking and resources within the national budget directly targeting the needs of the disabled are limited. The distinction of responsibilities and roles among central and local government institutions while explicit in laws and decrees, is not clearly understood nor effectively performed by government staff
- **Household-level response:** Family reaction to disability across Egypt is rather negative and favors exclusion of the disabled. Knowledge and financial resources represent a challenge for middle and low income families in rural and likewise urban areas.
- **NGO/welfare response:** The NGO response is characteristically traditional in terms of providing assistive equipment that is not always easy to manage by the disabled. A few NGOs have invested in a knowledge capacity that has offered venues for the disabled to engage in simple activities.

As a pilot program, the Social Protection Initiative Project (SPIP) offered a new platform for demonstrating disability management through operational approaches and practices that mobilized and integrated the 3 response levels while addressing a reasonable degree of geographical outreach and a diverse group of beneficiaries. The project also provided technical and financial resources to promote the principles of inclusive development.

The disability component of the project was managed by the Ministry of Social Affairs (MOSA) through the Project Implementation Unit and operated by a set of NGOs. In a technical advisory capacity, Save the Children UK was commissioned to provide overall guidance and supervision to the NGOs. Based on the SPIP experience, a number of important lessons have been identified that can contribute to a more effective policy framework for disability management.

## **A POLICY FRAMEWORK FOR THE EFFECTIVE MANAGEMENT OF DISABILITY**

The principles underlying the proposed policy framework are based on developing the quality of the response delivered by the government, the household level and the NGOs to address the needs of disabled groups effectively irrespective of the type of disability, the geographical location where they reside and the level of family income. The proposed policy framework will rely on an agenda that aims at changing the mindset of all stakeholders at all levels. More particularly, the proposed policy framework aims at:

- Developing a technical resource base with high connectivity at the central, regional and sub regional levels.
- Decentralization of service delivery
- Inter-sectoral coordination at all levels between ministries, governorates, suppliers and NGOs
- Mobilizing financial resources to support the sustainability of the disability support and management agenda at the national, regional and sub regional levels.
- Effective monitoring, impact evaluation and planning using a bottom up approach
- Developing the supply sector (assistive equipment) based on acceptable scientific and affordable standards.

In order to implement the proposed policy framework the following interventions are proposed to be initiated:

### **A. INSTITUTIONAL**

#### **At the Central Level:**

- Activation of the Higher Council for Disability and reviewing the representation of institutions on its board
- Reviewing the profile of "Rehabilitation Offices" at the governorate level and developing their mandates to become more effective instruments in terms of their outreach and monitoring capacity.
- Develop the capacity of the Department of Social Rehabilitation in light of its role to provide supervision and monitoring of the work done at the regional and sub regional levels as well as its role in supporting the mobilization of resources within the national budget for the disability agenda

#### **At the Governorate Level (regional and sub regional):**

- Setting up a multi-sectoral Disability Operational Taskforce to determine socioeconomic and cultural challenges facing disabled groups and support the work of NGOs and communities by removing bureaucratic barriers within their sectoral jurisdiction.
- Addressing capacity gaps in terms of staffing and additional skills required in the Rehabilitation offices and others that play a role in supporting disabled groups.
- Setting up within each governorate, sub regional taskforces and facilitating their

networking on a periodic basis\_as tools for outreach, experience exchange, advocacy and monitoring household and community-level interventions.

**B. OPERATIONAL:**

**At the Central level:**

- Institutional arrangements for pipeline projects improve targeting, technical assistance, outreach and strategic troubleshooting.
- Institutional capacity building should be structured in such a way so as to target central, regional and sub regional staff in ways that reflect their distinctive roles and responsibilities.
- Launching a national dialogue on the rights of the disabled that aims at changing societal mindset on the one hand and on the other hand advocates for the enforcement of laws and promoting special incentives for effective inclusion. Examples include\_tax exemption on assistive equipment, physical adaptation of public buildings and facilities.
- Sensitizing the mass media and communication products to promote inclusion by mainstreaming disability-related issues in regular programs targeting children and adults rather than producing programs specifically targeting disabled groups.
- With respect to contractual arrangements between Ministry of Social Affairs and NGOs in disability-related activities, the following lessons represent the basis of a policy to be adopted such arrangements to be more effective:
  - (a) Criteria should be established to guide the work of NGOs in disability-related activities. NGOs should be able to demonstrate a reasonable degree of sensitivity and experience in dealing with particular community characteristics. An NGO pre-selection profile is a good tool for this type of assessment.
  - (b) Orientation for NGOs should be provided prior to final selection in order to brief NGOs on the project cycle and the address their inquiries before submitting their final proposals.
  - (c) The procurement package should be designed taking into account efficiency, consistency and quality standards.
  - (d) In the final contract, the Ministry should consider copyrights issues regarding printing, reproduction and distribution of materials produced in the lifetime of the contract and others produced by the NGOs and used by the project. For the latter, a separate protocol can be signed between MOSA and the NGOs.
  - (e) Contracts with NGOs should be subject to review and auditing to ensure quality and timeliness of delivery. In case of unjustified delays, the contract should allow MOSA to apply penalties and/or termination.
- Enhancing the linkages between leadership among NGOs and communities on the one hand and policy makers on the hand to ensure effective policy responses and better targeting.
- Decentralizing service delivery

**At the Governorate Level (regional and sub-regional):**

- Through the rehabilitation offices, mapping disabled groups using household and community techniques to determine more accurately the size of target groups and support priority-based planning at the central and regional levels.
- Creating incentives for community and NGO networks to enhance a spirit of competitiveness among a wider group and across a wider outreach. For example acknowledging leadership, best practice, innovation and effective research.
- Developing a list of consultants/specialists at the regional/sub regional levels and define their relevant expertise in a database accessible through printed and electronic format to rehabilitation offices, NGOs and the community via sub regional authorities, telephone directories etc...
- Promotion of technically sound, user friendly, interactive (where feasible) kits (regional television, community and household charts, audiovisual demonstration, community learning events etc...) among poor families to support CBR.

## Annex D: MENA Country Profiles on Disabilities

### *Egypt*

The official definition<sup>60</sup> of the Department of Social Rehabilitation of the Handicapped in the Ministry of Social Affairs (MoSA) announces the count or admits prevalence of the labeled or categorized disabled in Egypt. In more than one source, prevalence of the Disabled in Egypt is quoted at 3.5 percent of the total population, or 2 million out of 63 million (1996). Yet the admitted prevalence among children is 7.5 percent, of which 75 percent are with a cognitive-intellectual disability, 15 percent with a physical–mobility disability, 4 percent with a hearing disability, and 6 percent with a visual disability.<sup>61</sup> However the estimate of the Egyptian population for 2004 is 76 million, which may mean an additional half million Disabled Egyptians are now within the count.<sup>62</sup>

#### (i) Non-official sources

The 1997, Egypt’s Multiple Indicator Cluster Survey (EMICS) of UNICEF and the Social Research Center of the American University of Cairo reported age-specific data that is not consistent with the official data. EMICS had a simple classification for each Disability and asked a general question on each in a house-to-house survey. EMICS concluded that under the age of 5 years, there are 5 percent with speech disabilities and 0.2 percent are with hearing and visual disabilities. Yet at 5-14 years of age “0.7 percent are with speech disability, 0.85 percent are with hearing disabilities and 1.3 percent are with visual disabilities”.<sup>63</sup>

Specialized hospitals have also been collecting information on specific disability conditions. For example Ain Shams University Hospital’s Audiology Department runs a neonatal screening program.<sup>64</sup> The 2003 results of this screening program indicate a high prevalence of congenital hearing loss among the neonatal patients. So far it is implemented on a small sample of a specific population, so the results cannot be generalized to the population. The Institute of Hearing and Speech of the Public Council of Hospitals and Teaching Institutes (MoH), Cairo, which provides the largest free public service in this field, presents its annual statistical report with the numbers of tests conducted in each department, but without any other information relevant to disorders, etiologies, age, and other key indicators. This makes it difficult to interpret or analyze the data for the purpose of detecting trends in different categories of disabilities.

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<sup>60</sup> “A handicapped person means the person who needs rehabilitation services’ and a deaf person means the person who cannot be taught through his “speech” and hearing capabilities.”

<sup>61</sup> Central Authority for Public Mobilization and Statistics (1996).

<sup>62</sup> Country Profile on Disability - Egypt, March 2002. Japan International Cooperation Agency, Planning and Evaluation Department.

<sup>63</sup> [Egypt’s Multiple Indicator Cluster Survey \(EMICS\) Social Research Center, AUC, Child Well-Being in Egypt \(1997\)](#).

<sup>64</sup> Sadeq, E., Neonatal Screening in the Specialized Hospital of Ain Shams University of Cairo (2003). Unpublished study. Conducted specialized screening tests, TEOAE, on 365 newborns admitted to NICU in 2002. 272 (74.6 percent) passed the test while 93 (25.4 percent) failed the test. In 2003, 253 newborn were tested, 194 (76.7 percent) passed the test and 59 (23.3 percent) did not pass the test.

## ***Jordan***

The official (2001) estimates of the Ministry of Social Development (MoSD) report that the total percentage of all Disabled persons in Jordan is 12.6 percent of the population.<sup>65</sup> The total number of children served in MoSD-registered institutions is 16,719, or 7.94 percent of all disabled children. In 2003, the National Counsel of Family Affairs (NCFA)<sup>66</sup> estimated that more than 230,000 disabled children lived in Jordan with disabilities of varying types and severity.<sup>67</sup> This constitutes about 10 percent of the young population.<sup>68</sup>

NCFA confirms that categories of Disabilities registered and served in existing institutions include Attention Deficit Disorder, Down's syndrome, autism, mental retardation, cerebral palsy, deaf, and blindness. This is a wide spectrum of disabilities but this information is neither used nor recognized by the MoSD or the Ministry of Education (MoE). The NCFA recognizes there are "identified and underserved" disabled children and estimates them at around 218,000, or 92 percent of the total number of children with disabilities.<sup>69</sup> In the same 2003 study, the NCFA reported that around 2,000 children are served in "resource rooms" in MoE schools, that is, about 1.5 percent of all estimated school-aged Disabled children are recognized or served in MoE schools.<sup>70</sup> It is worth noting here, that this number includes the student population enrolled in private schools in Amman with "special education" services since the beginning of 1980's. The number of children who need specialized interventions is usually as high as 40-60 percent of the kindergarten population.

NGOs in Jordan have a significant history of service for the Disabled and their families. The process of data collection from NGOs has been a complex and inaccurate exercise, since the NGOs provide different kinds of services of various quality levels.

Hearing loss ranks as the most frequently occurring birth defect in the world,<sup>71,72, 73</sup> and in Jordan as well. An ongoing clinical professional project in Jordan has already tested 8,000 neonates in 2004 and is coming up with data that is yet to be published. Preliminary results show that the incidence of congenital hearing loss is 9/1000 for children with no risk factor and 11-18/1000 for high-risk children.<sup>74</sup> It shows that the

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<sup>65</sup> A Study of Disabled Care Centers in Jordan, 2001, UNICEF.

<sup>66</sup> Jordan Country Study on Disadvantaged Children: Qualitative and Quantitative Description of the Current Situation with Respect to Disadvantaged Children in Jordan, National Counsel for Family Affairs, Jordan, May 2003.

<sup>67</sup> Jordan's population is more than 5 million inhabitants (2000), 2,300 of which are under 18 years. The Situation of Children, Youth, and Women in Jordan, UNICEF, 2000.

<sup>68</sup> National Demographic Committee (NDC), 2000.

<sup>69</sup> NCFA was a major partner in designing MoE's national plan for Early Childhood Education and funded by the WB-part of ERfKE.

<sup>70</sup> See NCFA, May 2003.

<sup>71</sup> US Government Agency for Healthcare Research and Quality, [www.ahrq.org](http://www.ahrq.org), 2001.

<sup>72</sup> Range of estimates of prevalence of newborn hearing loss is from 1.3-6/1000 live births. The definitions used to describe the hearing loss and the population being studied explains much of the discrepancy in prevalence data. In the US 3/1000 are born with a significant hearing loss, i.e., 33 every day and 12,000 each year.

<sup>73</sup> This may be 10-20 times higher among infants in the NICU than in the healthy nursery population.

<sup>74</sup> Al- Masri, M. Ph.D.; Attias, J., Ph.D.; Jbara, R., MSc; Prat, H., Ph.D.; (May 2004). *Neonatal Hearing Screening Program: The Incidence of Congenital and Early Onset Sensor neural Hearing Loss in Jordan.*

incidence of a significant permanent hearing loss in Jordan is 6-7 times higher than that of the United States. At least five babies are born every day in Jordan with a severe permanent hearing loss<sup>75</sup>. To put this into Jordan's current context, it means since the start of the new millennium and by the end of 2004 there will be a minimum of 73,000<sup>76</sup> very young Jordanian citizens with a serious hearing problem. Consanguinity, mother's age, smoking, and socioeconomic status seem to raise the incidence of congenital or early onset hearing loss.<sup>77</sup>

After the age period from birth to six years, many communication difficulties, developmental delays or disorders begin to show in the population. The origin of these problems, like different types and degrees of hearing-listening and language-speech problems are congenitally, environmentally, or medically related. Accumulated evidence over the period of 1995-2004 in a regular inclusive school setting shows that a large category of children enter school with a hearing-listening and language-speech disability that will prevent them from succeeding in school.<sup>78</sup> In Jordan's current context, it can be expected that at least 10 students in each classroom (one-third), or around 50,000-60,000 children, will start the academic year unidentified, undiagnosed, and therefore not served in the classroom or at home.<sup>79</sup>

### ***Palestinian Territories***

The 1997 Population, Housing and Establishment Census included a module designed to measure the disability prevalence in the West Bank and Gaza territories. Conducted by the Palestinian Central Bureau of Statistics (PCBS), it defined a disabled person as one:

“...suffering from a clear and evident weakness in performing certain activities due to continuous difficulties emanating from a physical, mental or health state

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Summary of an unpublished paper. Research is funded by the Middle East Hearing Association for Management of Hearing Loss (MEHA-Jordan).

<sup>75</sup> If Jordan has 150,000 to 200,000 new birth registries a year and according to Al Masri et al., May 2004, the incidence, is 9-110/1000 (incidence of 9 percent in the no-risk-factor group to 11 percent in high-risk-factor group) then we have 4-6 (no-risk-factor group) every day and 40-60 (risk-factor group) Deaf kids born every day. In addition, the high incidence of hearing loss in Jordan might be due to tribal consanguinity, which is about 65 percent of the sample in Al Masri et al., May 2004.

<sup>76</sup> 40 minimum born daily with a congenital HL (of the risk factor and no risk factor groups) = 40 \*5 years \* 365 days = 73,000. This amounts to 14,600 every year, i.e., 9-10 percent of the annual birth registry of Jordan.

<sup>77</sup> Al- Masri, et al. (May 2004).

<sup>78</sup> Hamzeh Al Smadi, M., and Qanawati, L. (2004). Al-Miran Group for Advanced Sciences in Hearing, Language-Speech, and Deafness/Amman. *Summary of Annual Reports for CCP in ASG from 1995-2004*. This evidence was the result of a comprehensive Al-Miran Group Communication Care Program© implemented in the Ahlyyah School for Girls (ASG) in Amman. Over the past nine years, this group of audiologists and language-speech pathologists supervised the management of around 40 percent of children from KG1 to fourth grade. Those children represent a wide spectrum of types and degrees of hearing-listening and/or language-speech difficulties.

<sup>79</sup>By the year 2005-2008, Jordan's Ministry of Education will automatically be inheriting and admitting the above two groups of children in its schools for the Deaf and/or in its regular schools (not considering the ones who already are in primary schools, hidden and forgotten).

that lasted for more than six months. Disabilities resulting from a bone break or a disease lasting for less than six months are not considered disabilities.”<sup>80</sup>

According to PCBS, the census reported just over 46,000 Palestinians (or 1.8 percent of the population) with disabilities. The five most prevalent disability categories among the Palestinians were mobility (over 30 percent), visual impairment (14.6 percent), mental disabilities (14.5 percent), and multiple disabilities (7.9 percent). About one third of the reported disabilities were related to congenital conditions, and another third to diseases, while about 10 percent were related to traffic accidents and other non-work injuries. About 5 percent of the disabilities were related to “war”. More than half (55 percent) of the disabled persons in the 5-24 age cohort were enrolled in regular education programs, and about 25 percent of persons with disabilities were employed.

With the start of the intifada in September 2000, disabilities related to injuries and mental disorders rose significantly, as reported both, by the Gaza Mental Health Center, and the Palestinian Counseling Center.<sup>81</sup> While the 1997 Census data reveals that the two main causes of Disability in the Palestinian Territories are first, congenital and second, as a result of disease, it allows a breakdown of disability prevalence by age groups. The age profiles of Disability due to congenital conditions and to disease are inversely correlated. So, while prevalence of disability due to disease rises with age, in the case of disability for congenital reasons, prevalence is high for young age groups and declines for older age groups.

### *Yemen*

Yemen is a country with high population growth rate (3.2 percent in 2004 down from 3.7 percent in 1994), high poverty incidence (42 percent), low social indicators (see Table 2), customary practice of early and consanguineous marriage, early pregnancy, and high rates of illiteracy among women. Immunization coverage is not universal and is lacking particularly among the poorest in rural areas. These factors suggest that disability prevalence demand attention, but data on disability in Yemen are limited and conflicting. Available surveys exclude several categories of disability, including behavioral, speech and learning disabilities.

The *1994 Population, Housing and Establishments Census* gave a disability rate of 0.54 percent of the population (16,000) and the *1999 National Poverty Survey* indicated a rate of 1.7 percent (177,000). These figures could be interpreted to suggest that disability is on the rise, or they could illustrate problems of definition. Interviewers lack training in gathering information in ways that do not discourage the family from revealing the existence of family members with disabilities. Indeed, the 1994 census questions on disability opened formally with the stigmatizing phrase: “*May God forbid – do you have a member with disability?*”

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<sup>80</sup> Palestinian Central Bureau of Statistics, *Population, Housing and Establishment Census-1997, Disabled Persons in the Palestinian Territory*. June 2000. p. 18

<sup>81</sup> Policy Research Incorporated. *Envisioning a Comprehensive Palestinian Rehabilitation System*. December 2001

The *PAPFAM Yemen Family Health Survey* of 2003 concluded that 2.8 percent of the population suffers from at least one form of handicap. The 2004 Population, Housing and Establishments census and the 2005 Household Budget Survey both included several questions on disability. Technical support was provided, interviewers were better trained, and the surveys applied common definitions and classifications. Accordingly, it is expected that data will improve in the near future. The *1999 National Poverty Survey* (NPS) indicated mobility and hearing disabilities to be the most prevalent types of disability (33 percent and 17 percent respectively). The 1994 census and the NPS both indicated that congenital factors and complications in childbirth and delivery are among the main causes of disability.

Although a number of international NGOs and an increasing number of local NGOs have been active in the field of disability for at least the past 15 years, very little attention has been given to data collection and/or specialized research in disability. In 1999, a house-to-house survey conducted in one district of Aden City by Ministry of Social Affairs and Labor (MOSAL) and Radda Barnen revealed that 6.2 percent of the population under 18 years of age was disabled. Another house-to-house survey, in Taiz and Lahaj cities, revealed 1.4 and 1.7 percent respectively of the under-18 population to have disabilities.<sup>82</sup>

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<sup>82</sup> “Yemen’s Disadvantaged Children”, draft report by HCMC,SFD and WB, February 2003

## Annex E: EU Disability Assessments: A Comparative Analysis

Disability assessments throughout the EU undertake four distinct working models which combine two different dimensions of medical and non-medical assessment. The working models and the countries that use them are described in the following table:

<p>A. Low medical evidence and high discretion</p> <ul style="list-style-type: none"> <li>• Denmark</li> </ul>	<p>C. High medical evidence and high discretion</p> <ul style="list-style-type: none"> <li>• France</li> <li>• Germany</li> <li>• Belgium</li> <li>• Austria</li> <li>• Italy &amp; Spain to some extent</li> </ul>
<p>B. Low medical evidence and low discretion</p> <ul style="list-style-type: none"> <li>• U.K.</li> <li>• Netherlands</li> <li>• Ireland</li> </ul>	<p>D. High medical evidence and low discretion.</p> <ul style="list-style-type: none"> <li>• Portugal</li> <li>• Greece</li> <li>• Germany &amp; Austria to some extent</li> </ul>

There is no ideal method of drawing boundaries between disabled and non-disabled people in social policy. The systems which de-emphasize medical evidence models (models A and B) score highly on the criterion of social policy relevance. Model D is the model which is most consistent with establishing a general disability status which might be used across a wide range of policies. Model D is usually found in regulatory settings where little attention is paid to the effective targeting of scarce resources. The establishment of a general status of disability does not appear to be consistent with targeting resources to those most in need.

### The Assessment of Incapacity or Inability to Work – Examples from EU

The following description of Incapacity Assessments is based on the report: European Commission, *Definitions of Disability in Europe: A Comparative Analysis*, 2002.

#### Austria

*Diagnosis* - Emphasis on getting a full description of the person's medical condition, usually by specialist doctors either employed by the insurance agency or external doctors.  
*Standardized descriptions of working life*- The doctor answers a series of questions about what general work conditions are 'reasonable' for the person, without taking in account age and previous work experience.

*Job abilities or requirements specific to the person*- The applicant must describe his/her predominant profession of the last 15 years on the application form.

## Belgium

*Diagnosis-* The medical council performs a standard medical examination. If there is any doubt about the records provided by the person's doctor, the diagnosis will be revisited.

*Standardized descriptions of physical or mental capacity.* The presence of functional limitations are sought which may limit work performance; however no standard instruments are used to identify functional limitations.

*Standardized descriptions of working life.* The assessor calculates the 'residue-earnings' which represent the amount a person could earn in the occupation he/she could perform despite the incapacitating limitations and is in accordance with educational and professional training. However, there are no instruments used for this assessment, so the estimation of earnings is a matter of judgment for the assessor.

*Job abilities or requirements specific to the person.* The degree of loss a person has suffered is assessed relative to the earnings of a similar person without the incapacitating condition; in practice, the previous earnings of the person providing the benchmark.

*Personal and social circumstances specific to the person.* In practice, the assessment concerns the person's prospect of successful re-integration into the labor market. If the limitations in job prospects are not due to functional limitations, then the person may be referred to unemployment insurance.

## Denmark

*Diagnosis-* The interpretation of 'vocational ability' is strongly linked to medical diagnosis. There have been reforms to move away from the 'essentialist' diagnostic approach as it is criticized on the grounds that the person's potential work ability is not explored.

*Standardized descriptions of working life-* The assessment is made on the basis of experiences in the course of the vocational rehabilitation process.

*Standardized descriptions of physical or mental capacity-* Alongside "working ability", the concept of 'functional reduction' has been developed to capture the medical aspects of reduced ability.

*Personal and social circumstances specific to the person-* A comparison will be made between the likely income from any employment which corresponds to the strength and skills of the application, in view of their education/training and the occupational background, and the normal income of a person having undergone similar education/training in the same region. Other factors such as age, occupation, address and employment prospects are considered as should any other factors deemed important in the given circumstances.

## Finland

*Diagnosis/impairment/descriptions of capacity.* Sickness certificates contain a diagnosis and the doctor's certification that the person is unable to work. When the application for

the disability pension is made, the medical certificate certifies the disability by giving a diagnosis and an account of how the person is functionally impaired by his/her medical condition.

When a person is unemployed before becoming sick, the medical certificate is framed in more general terms, indicating that the person's condition limits his/her scope for work in general, rather than relating to the specific demands of the occupation.

For National Pension, 'social' disabilities such as alcoholism are not sufficient to qualify: there must be other relevant factors. These may be diagnostically-oriented (e.g. medical complications) or functionally-oriented (e.g. ability to do basic physical or mental actions).

### France

#### *Invalidity Pension*

*Diagnosis.* For sickness benefits, the treating doctor must indicate precisely the medical justification for stopping work.

*Personal and social circumstances specific to the person.* According to the law, eligibility is determined not only by the gravity and the nature of the affections or infirmities noted, but also by the age of the subject, his/her physical and mental capacities, vocational training and prior work activities. (Art.L 341-3 Code S.S.) The concept of invalidity takes account of medical criteria and also the criteria of professional and social nature.

#### *Adult Disability Benefit (AAH)*

*Diagnosis-* The assessment involves two parts: first the assessment of percentage of handicap (which falls into 3 bands: A (0-<50 percent), B (50-<80 percent) and C (80 percent+), and the second, the decision about whether a person in Band B is unable to work. The basis of the guide refers to the WHO concepts of impairment.

*Impairment-* The headings used in the Guide Barame are very similar to the impairment listing in ICIDH-1. However, the form for the medical report by the treating or other doctor uses different headings. (The medical report is important as two-thirds of applicants are not medically re-examined.)

*Standardized descriptions of physical or mental capacity-* In the medical report, the consequences of impairment are described in terms of spheres of autonomy, rated A (able to do totally, habitually and correctly), B (can do partially, non-habitually, not correctly) or C (cannot do at all). The spheres are: Coherence, Orientation, Personal Hygiene, Dressing, Eating, Continence, Transfers, Moving around inside the home/Outside the home and Communication at a distance.

*Job abilities or requirements specific to the person-* The initial medical report indicates the effect of the handicap on the person's ability to do his/her current job, noting the arrangement of the workplace, hours of work, difficulties, mobility and absenteeism.

## Germany

*Diagnosis*-Sickness certification is undertaken by the treating doctor. When the application is made, the treating doctor provides a report indicating the diagnosis, current complaints, the background to the illness, the current treatment, results of medical examinations and other medical findings (weight, height, blood pressure, test results, etc) and the history and duration of the illness. Should the Medical Service of the Pension Institute decide that examination is required; a medical report utilizing ICD-10 with additional coding is provided for indicating the symptoms of the condition.

*Impairment.* Medical reports commissioned by the insurance funds also contain an open heading for function limitations, with specific headings to indicate if the person is: deaf, blind, mentally handicapped or wheelchair user.

*Standardized descriptions of working life.* The fund's medical report includes a "social medical assessment" in which the person's capacities in the general labor market are indicated. This includes positive and negative elements. Under positive elements are included assessments of capacity to do: do heavy/medium/ fairly light/ light work; stand, sit, walk-all day/some of the time; work shifts – day/evening or night. Under the negative elements included in the assessment are: medical/psychological ability to deal with work requiring concentration, adaptiveness, flexibility, responsibility, contact with the public. Sensory capacities: seeing, hearing, and speaking. Posture and agility: use of hands, bending, walking up steps, carrying.

The assessment also indicates conditions which would be dangerous to the person: dampness, draughts, temperature variations, factors leading to allergic responses, noise, frequently changing times of work. The medical expert making the summary recommendation on medical eligibility uses detailed guides which describe the impact of medical conditions on a person's potential performance. Considerable emphasis is put on consistency between the diagnostic account of the person's medical condition and the account of the person's limitations in the labor market, using these guides.

*Job abilities or requirements specific to the person.* On the claims form, the claimant indicates his/her educational and professional history. The degree of loss a person suffers is assessed relative to the earnings of a similar person without the incapacitating condition. When the medical assessment indicates partial incapacity, the fund must establish that appropriate work is available; otherwise a full benefit must be paid.

## Greece

*Diagnosis*- Determination for disability is made under two parts: 'medical invalidity', which refers to the identification of the medial condition, degree and duration of impairment, and 'insurance invalidity' refers to the assessment of the reduction in earnings capacity. The determinations are undertaken by Health Committees. There are a range of provisions for certain diagnoses and conditions such as paraplegia, tetraplegia, thalassemy (Mediterranean anemia) and blindness. For social assistance, there are special provisions for those with: blindness, spastic encephalopathy, AIDS, Hansen's

disease, deaf-mutes, paraplegia, tetraplegia and severe mental retardation (IQ<30). There are also provisions for those with kidney disease and diabetes.

*Impairment.* The Guide for the Evaluation of the Disability Rate (1993) is applied by health and Certification Committees. It presents scales and ranges for the determination of the degree of disability resulting from specified medical conditions. It is divided into chapters based on areas of medical specialty: internal pathology, skin and subcutaneous tissue, psychiatric and neurological, orthopedic, ear-nose-throat, surgical, eye and apnea and occupational diseases.

*Job abilities or requirements specific to the person.* The Guide allows for the determination of the degree of invalidity to be influenced by the work that the person normally does, e.g. whether the job is intellectual or manual. Some specific occupations are limited by specific impairments. In making determinations, the committee is concerned with assessing the degree of loss since the commencement of work/insurance meaning that pre-existing conditions (e.g. from childhood) may not result in a high degree of invalidity.

*Personal and social circumstances specific to the person.* The committee may also take in account: individual characteristics such as age and gender, education and social factors. In addition to the incorporation of these factors into the determination of 'medical' invalidity, the insurance authorities may raise the percentage of invalidity determined by the Health committee by up to 17 percent (to take in account of the labor market and other social factors).

### Ireland

*Diagnosis-* For a claim which starts with sickness, the claimant's own doctor initially certifies incapacity (provided the doctor is certified under the Social Welfare Acts). The doctor is asked to specify an 'incapacity' which is a medical diagnosis or description of symptoms. Officials in the Department of Social, community and Family Affairs code the condition and set a referral date according to the code. If the claim continues, it is referred for medical assessment.

*Standardized descriptions of physical or mental capacity.* The Medical Review and Assessment (MRA) procedure is undertaken by Medical Assessors. They record the claimant's medical and surgical history in respect to the claim. Additionally, they note the claimant's work history, educational and vocational qualifications and record the claimant's statement about the medical condition and its effect on 'the performance of ordinary activities of life/work-related activity'. The assessor provides a 'clinical description' of the effects of the medical condition upon the claimant's health in terms of the following functional areas: Mental health, Learning, Consciousness, Balance, vision, Hearing, Speech, Continence, Reaching, Lifting/Carrying, Manual dexterity, bending/kneeling/squatting, Sitting, Standing, Climbing stairs and Walking. In each area, the condition is indicated by the categories: normal, mild, moderate, severe, profound.

*Standardized descriptions of working life.* The final part of the Medical Review Assessment process is the “Work Capacity Assessment’. The assessor considers whether he/she is capable of any of the work categories specified. These categories are combinations of job effort (light, moderate, heavy) and skill level (lesser/ semi/ skilled) – in total of 9 categories from A light/skilled to I heavy/lesser skilled. The assessor also describes why the claimant is incapable of work, with reference to functional assessment.

*Standardized descriptions of daily life.* The guidance for medical certifiers state that “in cases where there is no prospect of an early return to work the certifier should consider the question of ability to work in relation to work about the house rather than to the previous occupation. This will apply in particular to people who look after their own home during illness and who are unlikely to return to their former occupation in the near future.”

### Italy

*Diagnosis.* Initially a medical practitioner chosen by the patient fills in an INPS questionnaire, stating the diagnosis.

*Impairment.* Medical practitioners employed by INPS carry out a medical assessment and make a medical legal report. The assessment involves a complete examination of the functioning of the main physical systems. The diagnosis of the patient’s own doctor is reviewed and other health conditions may be noted by INPS practitioners. However, the assessment cannot be based solely on the medical protocols. The law indicates that there must be a personal evaluation of residual working capacity, which precludes total reliance on standardized tables.

*Job abilities or requirements specific to the person.* The assessment is based on the work usually and prevalently done by the claimant. The job done by the claimant is assessed using a detailed questionnaire which highlights features of the work: heaviness, work position (sitting, standing, etc), environment (humidity, temperature, use of stairs and ladders), use of machines and particular instruments. The protocols developed by INPS link diagnosis to functional limitations and in particular, to difficulties in performing certain types of work.

### Netherlands

*Diagnosis.* The medical diagnosis is taken from the records provided by the person’s treating physician. Once application for benefits is made, the claimant’s earning capacity is assessed in two stages: 1) by developing the claimant’s ‘capacity profile’ and 2) by examining the effect of the limitations in capacity on potential earnings. Step 1) the capacity profile, is developed by an insurance physician, step 2) by a labor expert, both of whom are employees of the social insurance administration.

*Standardized description of physical or mental capacity.* The main procedure in Step 1 is an oral interview where the physician records the claimant’s account of his/her health problems and ability to undertake different activities. In practice, some 35-40 percent of claimant’s are assessed as having ‘no lasting capacities left’ at Step 1. This decision is

due to the claimant being hospitalized, in residential care or bedridden, is unable to cope for himself/herself and depends on others for his daily tasks, or is unable to cope mentally and is hindered in social relationships. Physicians use a standardized approach for measuring the claimant's function ability to perform work, which defines 28 different types of tasks. For most tasks, the assessor rates the claimant as 'normal' or 'not normal'.

*Standardized descriptions of working life.* The process moves to step 2): assessing the degree of loss of earning capacity, this is done by a labor expert. This expert also interviews the claimant and obtains information on his/her education, skills and experience. To determine the remaining earning capacity, the expert identifies the jobs the person can still do. The formal instrument used by the expert to identify possible jobs is the Function Information System (FIS). The system contains descriptions of thousands of jobs existing in the Dutch labor market, recording: work pattern, wages, job level, job requirements, job description, and the functional capacity demands of the job expressed in terms of the scores on the 28-point standard used by the physician at step 1). The expert uses this computer database to identify at least three jobs the claimant could do. If three jobs cannot be identified, the claimant is assessed as fully disabled.

*Job abilities or requirements specific to the person.* The degree of loss a person has suffered is assessed relative to the earnings of a similar person without the incapacitating condition; in practice, the previous earnings of the person provide the benchmark.

#### Norway

*Diagnosis/Impairment.* A doctor is required to certify the medical condition. The diagnosis must be acceptable by international standards and the ICPC, ICD-9 or ICD-10 is used for coding purposes. The doctor is supposed to judge whether the medical condition restricts the person's 'functional ability' that leads to impairment. No standardized descriptions have been used so far, but the government is considering adopting more standardized descriptions of the type and form of impairments.

*Job abilities or requirements specific to the person.* The doctor assesses what consequences the impairment has for the person's work capacity. While assessing, the doctor is expected to consider the patient's ability to return to work, past employment and other types of work. The doctor is to provide prognosis, i.e. estimate the expected duration of the medical condition, the impairment and the diminished work capacity. According to the National Insurance act which mandates causal links between the disability and the diminished work capacity, the doctor is required to assess how great impact the disability has on the diminished work capacity.

*Personal and social circumstances specific to the person.* When the National Insurance Administration decides to what degree the person's earning capacity has been reduced it is supposed to consider the person's age, general abilities, education, work experience, prospects for employment locally as well as elsewhere it is reasonable that the person seeks work.

## Portugal

*Diagnosis/Impairment.* The ‘reporting doctor’ always conducts an examination and provides a diagnosis. The recommendation of the reporting doctor is based on the national List of Incapacity (Decree-Law 341/93). While similar to the American Medical Association Guides, the list is organized around diagnostic categories such as neurology, dermatology, endocrine system, etc. To complete the assessment, the doctor must indicate the chapter and section relating to the diagnosis and put down the ‘coefficient of incapacity’ as indicated in the table. This coefficient can be adjusted; the doctor has to explain the adjustment. The form provides columns for calculating the ‘global coefficient of incapacity’ from the individual coefficients for each impairment.

*Job abilities or requirements specific to the person.* The Guide allows for the determination of the degree of invalidity to be influenced by the work the person normally does. Some specific occupations are indicated as limited by specific impairments.

*Personal and social circumstances specific to the person.* While the structure of the Guide might suggest that the application is rigid and predictable, the actual application indicates that the doctor retains a high level of discretion in determining exactly what the impact of impairment is on a particular person.

## Spain

*Diagnosis.* The Equipos de Valoración de Incapacidades (Offices for Assessment of Incapacity) obtains the clinical file from the Health Service, and/or any medical report from the National Institute for Social Security work inspection service along with other medical data. The assessment of the person’s limitation or impairments is based on the doctor’s knowledge of the nature of the illness or injury.

*Impairment.* The Informe Medico de Síntesis (Summary medical report) assesses the ‘residual functioning capacity’ of the worker and sets this against the demands or requirements of the job the worker was doing and/or general requirements in the labor market. The instruments for doing this are more oriented towards impairment than towards standardized descriptions of physical or mental capacity.

*Job abilities or requirements specific to the person.* The application for the assessment of the permanent disability indicates the date of stopping work and its cause, the habitual occupation of the worker, his/her professional category and a description of the actual work that was done.

*Personal and social circumstances specific to the person.* The attitude or self-assessment of the worker is not, and cannot be, taken into account in the evaluation, which must rest on an objective comparison of the functional limitations with demands of work.

## Sweden

*Diagnosis/ Impairment/ descriptions of physical or mental capacity.*

A medical certificate from the person's own doctor is required after 7 days. After 28 days of sickness more extensive medical certification is required, which indicates: the diagnosis of symptoms, medical examination undertaken, functional and work capacity. The certificate is completed by the person's own doctor and reviewed by a doctor engaged by the Social Insurance Office.

*Job abilities or requirements specific to the person.* At step 5 in the step-by-step process, the person's ability to take on another normally available job without vocational rehabilitation is considered. This assessment is usually done by a labor official and may involve a dialogue with the advisory medical doctor employed by the social insurance institution, in cases where medical diagnosis and/or impairment consequences are difficult to interpret.

*Personal and social circumstances specific to the person.* The final step of the step-by-step process is reached when it is thought that there is not prospect of the person taking a normally-available job, even with rehabilitation. At this stage, the question for determination is whether the person's work capacity is for a considerable time or permanently reduced. Legislation requires that there are causal links between diagnosis and work capacity, rather than to other personal factors such as lack of education or low skills. Factors such as age, education and settlement area should, in principle, only be considered in exceptional cases where special circumstances prevail.

### United Kingdom

*Diagnosis.* Sickness certification is done at the beginning of a claim by the person's own doctor. After 28 weeks, the doctor provides the Benefits Agency with more extensive medical information relating to: diagnosis of the main incapacitating condition, an indication of disabling effects of the condition, current treatment or progress, indication of whether the patient is able to travel to an examination and advice given to the patient on ability to perform usual occupation. Claims of diagnosis are based on the ICD chapters.

*Standardized descriptions of daily life.* If the exempt condition is not present, the client is sent a questionnaire which is modeled on the Personal Capacity Assessment (PCA) test.<sup>83</sup> If the self-completed PCA gives the client the requisite number of points and is consistent with the medical evidence provided by the doctor, an award may be made. If there are inconsistencies or the PCA doesn't give enough points, the client is referred for medical assessment by BA Medical services. Those with less severe mental health conditions are referred for a mental health assessment.

The approved doctor conducting the medical assessment interviews the client on: occupational history and reason for stopping work, clinical history, domestic situation, own account of problems and functional limitations and how a typical day is spent. Based on this information, behavior observed during the assessment, medical knowledge about the effects of the person's condition, and findings of any clinical examination

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<sup>83</sup> The Personal Capability Assessment - A Guide for Medical Practitioners. Website: [www.dwp.gov.uk/medical/percap.pdf](http://www.dwp.gov.uk/medical/percap.pdf)

which may be undertaken to select or verify the appropriate descriptor for a person's functional capacity, the approved doctor completes the PCA, or, in the case of mental health problems, the mental health assessment.

The PCA is set out in a Schedule to the Social Security (Incapacity for Work) Regulations 1995. It consists of 14 activities: walking, climbing stairs, continence, remaining conscious, etc. Each activity has several 'descriptors' attached to it which indicate the frequency and severity of limitation to the activity, e.g. for speech the descriptors range from 'cannot speak' (15) through 'strangers have great difficulty understanding speech' (10) to 'no problem with speech' (0). The threshold of incapacity for benefit purposes is reached by scoring 10 points on the mental disability descriptors or 15 points from the mental and physical descriptors.

## Annex F: EU Quotas for Disabled Workers

“All quota systems call for employers to employ a set percentage of disabled persons. Systems vary, however, particularly in relation to the obligatory or non-obligatory nature of the requirement, and the nature and effectiveness of sanction where an employer fails to meet the requirement.”<sup>84</sup> Currently, if obligatory requirements are not met, some countries impose levies, which are often considered by companies, to be an additional tax to be paid and a more attractive option than hiring PWDs.

In all countries with quotas, there is a system of registration as a disabled person which is independent from actual work status. This registration is only used for quota purposes and not as a way of determining eligibility of other benefits or services. In some countries, like Spain, companies complying with the quota enjoy preferential treatment in contracts with the government.

In spite of the varying quotas’ and their accompanying requirements, a study for the European Commission found no examples where country quota systems achieved their targets<sup>85</sup> (O’Reilly, 2003).’ The EU employment quota model, beginning in the 1940’s, was introduced under the charity/welfare model. In today’s context of the equal opportunity/employment rights, using the employment quota model to stimulate employment for PWDs no longer seems appropriate.

### Country Quotas<sup>86</sup>

#### *Austria*

Quota system in place with approximately two thirds of quota places filled each year.

#### *Belgium*

3 percent quota of new positions in certain public sector organizations with potential jobs for PWDs identified and then active recruitment measures taken. Fulfilling quotas at National level has been more effective than at the local level.

#### *Denmark*

No quotas, but legislation provides for preferential job access for PWDs in the public sector. There is also preferential access to licenses for certain commercial activities.

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<sup>84</sup> O’Reilly, Arthur, “*Inclusive Society: How do we go about integrating persons with disabilities into the labour market? A future perspective*” Presented at conference “Education and Vocational Opportunities for All”, Reykjavik, Iceland; November 2003.

<sup>85</sup> Ibid.

<sup>86</sup> References: 1. European Commission, “*Benchmarking Employment Policies for People with Disabilities*” ECOTEC Research and Consulting Limited, 2000. 2. O’Reilly, Arthur, “*Inclusive Society: How do we go about integrating persons with disabilities into the labour market? A future perspective*” Presented at conference “Education and Vocational Opportunities for All”, Reykjavik, Iceland; November 2003

### *France*

Private and public sector organizations with more than 20 staff have to meet at 6 percent quota or contribute to a fund that finances actions for PWDs. In 1997, only 37 percent of these organizations reached or exceeded the quotas. 37 percent of organizations had no disabled employees, while 19 percent with some disabled employees made contributions. Instead of fulfilling the quota agreement, organizations can sign agreements to develop employment strategies for PWDs, including recruitment, rehabilitation, training and retention. By 1995, 10 percent of private sector organizations, falling under the quotas, had signed such agreements.

### *Germany*

For private and public sector organizations with more than 16 employees, the quota is 6 percent of the workforce. The average quota attained in 1997 was 3.9 percent (O'Reilly, 2003). For those who did not comply in 1996, 76 percent of private organizations, a total of 511 million euro were paid.

### *Greece*

Organizations with 50 or more employees must employ PWDs in at least 2 percent of the workforce. Non-compliance fines are imposed. In banks, public sector and local authorities, a proportion of vacancies in special occupations (messengers, night watchmen, cleaners, and receptionists) must be reserved for "people with special needs".

### *Ireland*

A 3 percent disabled quota exists for public services. Fulfillment of quotas differs greatly when figures are broken down by public service functions and departments.

### *Luxembourg*

Quota scheme with varying levels for employment of PWDs in private and public organizations. There are penalties for non-compliant employers, however collaborative working schemes between employers and employment services is preferred to compulsion.

### *USA*

No quota system is in place. Americans with Disabilities Act (ADA) covers all organizations with 15 or more employees. It includes increasing access to employment for PWDs, providing effective remedies for current or potential workers with disabilities, and increasing employer willingness to hire and retain PWDs.

## Annex G: Employment Rates of People with Disabilities in Europe and USA<sup>87</sup>

Considerable variations in the employment rates of PWDs are apparent throughout the EU countries. The total employment rate for people with moderate disabilities varies from 27 percent in Ireland to 54 percent in Germany, with an EU average of 43 percent. For those with a severe disability, it ranges from 13 percent in Spain to 37 percent in France, with an EU average of 22 percent (Grammenos, 2003). Employment averages, combined for moderately and severely disabled people, in the EU result in a 33 percent overall employment rate.

In the U.S., more than 3.5 million people between ages 16 to 64 with disabilities receive Supplemental Security Income (SSI) benefits. Only 2.32 percent of these people are working and earning more than \$500 a month, the earnings threshold for determining whether benefits will continue. Similarly, of the 4 million beneficiaries who receive Social Security Disability Income (SSDI), only .33 percent earned more than \$500 a month (NCD, 1997). In a report by The Urban Institute, researchers calculated that there were 11.3 million working age adults (18-64) with disabilities of whom 37 percent were working in 1994-1995 (DOL, 2001).

### EU Country Employment rates of PWDs

	Moderate disability	Severe disability
Denmark	53%	17%
United Kingdom	47%	18%
Austria	49%	28%
Deutschland	54%	27%
Portugal	53%	31%
France	51%	37%
Luxembourg	40%	28%
Netherlands	44%	26%
Finland	50%	22%
Ireland	27%	15%
Belgium	37%	18%
Italy	29%	17%

Source: (Eurostat, 2001)

<sup>87</sup> References: 1. Grammenos, Stephano. *Illness, Disability and Social Inclusion*, 2003  
National Council on Disability (NCD) *Removing Barriers To Work: Action Proposals for the 105<sup>th</sup> Congress and Beyond*, 1997. 2. U.S. Department of Labor (DOL) *Statistics About People with Disabilities and Employment*, 2003 <http://www.dol.gov/odep>

## **Annex H: Disability Benefit and Retirement Benefits in the U.S. and EU Countries<sup>88</sup>**

### **USA**

According to the U.S. Social Security Administration (SSA), one can get Social Security disability benefits, through Social Security Disability Insurance (SSDI), until the retirement age of 65. After reaching the age of 65, their disability benefits automatically convert to retirement benefits, but the benefit amount received remains the same.

### ***European Union***

In the EU countries, the entitlement of disability benefits usually comes with age limitations with the statutory retirement age, when disability benefits may be converted to old-age benefits. Disability benefits are usually paid out by one of two programs: Old age, Disability, and Survivors or Work Injury.

### **Benefits by Country**

#### ***Austria***

The maximum disability pension is 60 percent of the assessment base. After receiving old age pension, the combined total disability pension, supplementary pension and children's pension can not exceed 100 percent of the assessment base.

#### ***Denmark***

The basic disability pension (income-tested) and the disability supplement (income-tested) are payable from ages 18 to 64. For those with work-related disability, the pension ceases at age 65, and a lump sum of 4 years' benefit is paid.

#### ***Finland***

Universal disability pension is available only for those permanently incapacitated from work from the ages of 16-64. For work-related disability, a basic disability pension is equal to 85 percent of earnings for a total disability, up to age 65; thereafter, 70 percent of earnings.

#### ***France***

Old-age allowances and supplements are given to disabled, at the age of 60. Otherwise, disability pension is given to those under age 60 with a loss of at least 2/3 of earning capacity. The disability pension is 50 percent of average earnings in the best paid 10 years, if incapable of any professional activity, up to a maximum of 1,238 Euro a month. For work-related disability, the disability pension is equal to 100 percent of average earnings during the last 12 months, up to the base-earnings ceiling.

#### ***Germany***

Work-related pension is allocated at 66.6 percent of the previous year's earnings if 100 percent disabled. This results in the equivalent of a full pension.

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<sup>88</sup> **References:** 1. Social Security Administration 1, *Social Security Programs Throughout the World: Europe*, 2004. 2. Social Security Administration 2, *The Official Website of the U.S. Social Security Administration*, 2005. <http://www.ssa.gov/>

*Greece*

For an assessed degree of disability of 80 percent or more (severe), 100 percent of pension is paid. For assessed degree of disability of 67 percent to 79.9 percent (ordinary), 75 percent of the pension is paid.

*Italy*

At retirement age, and if the person satisfied the qualifying conditions for old-age pension, the disability pension ceases and the old-age pension is awarded.