POVERTY REDUCTION STRATEGIES:
THEIR IMPORTANCE FOR DISABILITY

> "Addressing disability is a significant part of reducing poverty. Bringing disabled people out of the corners and back alleys of society, and empowering them to thrive in the bustling center of national life, will do much to improve the lives of many from among the poorest around the world."
>
> James D. Wolfensohn

Disability and Development Team

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EXECUTIVE SUMMARY

i. In recent years, Poverty Reduction Strategy Papers (PRSPs) have made substantial headway in increasing country ownership of poverty reduction strategies and opening the policy dialogue between government and civil society[1]. In the process, PRSPs have emerged as a key instrument for reducing the poverty of poor households.

ii. There is a wide consensus that disabled persons, being disproportionately poor, are among the population groups that should benefit from the poverty reduction programs of PRSPs. The issue, however, is whether they are de facto excluded from benefiting from current poverty reduction strategies. As argued by the ILO[2], PRSPs do not meet the needs of disabled persons because they are based on a limited social protection policy that conveys a wrong impression about the abilities and aspirations of the majority of disabled persons. Furthermore, they do not reflect the basic principles of the modern approach to disability adopted by the United Nations[3].

iii. This report is an attempt to assess the validity of the mentioned argument by reviewing the disability policy content of PRSPs. In doing so, the report focuses on whether the specific poverty dimensions of disabled persons are acknowledged and the critical interventions for improving the economic and social integration of disabled persons are included in PRSPs.

iv. The methodology that was followed consists of ranking the extent to which the elements of modern disability policy were included in the documents that were reviewed. In total, some 33 PRSPs and 11 Progress Reports that document their implementation were the main subject of the exercise. Eight recent Country Assistance Strategies (CAS) and two Poverty Reduction Support Credits (PRSCs) were also reviewed to check the extent to which the initial policy commitment of PRSPs was reflected in the Bank's own strategy and policy-based lending.

Increased Disability Content of PRSPs

v. Until recently, disabled persons were nearly "invisible" in PRSPs. The word "disability" and its synonyms were mentioned less than three times on average in the 2000 PRSPs. In 2001 and 2002 the situation started to improve, driven by a few PRSPs (e.g. Senegal and Honduras) that included a much stronger focus on disability. In 2003, the issue of disability became more prominent, especially among Eastern European countries such as Armenia, Azerbaijan and Kyrgyzstan. This trend continued in 2004 with the Union of Serbia and Montenegro PRSP.

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[1] See for example: "Poverty Reduction Strategy Papers: Progress in Implementation". IMF; World Bank. July 2003.

[2] "Disability and Poverty Reduction Strategies: How to ensure that access of persons with disabilities to decent and productive work is part of the PRSP process". Discussion Paper, November 2002, ILO.

[3] "Standards Rules on the Equalization of Opportunities for Persons with Disabilities". Resolution 48/96, March 1994. General Assembly, United Nations.

vi. Progress across regions and in developing the various components of the disability strategy has remained uneven. Partly for historical and institutional reasons related to the importance of pensions and transfers for the government budget, disability issues have received more attention among Eastern European countries. They have received the least attention in the Africa region.

Role of Disability Policies for the Successful Implementation of PRSPs

vii. Strengthening the disability policy focus of PRSPs is essential to the success of their strategies for two reasons. First, disabilities are a significant factor of extreme poverty in developing countries. Unless disabled people are included in the poverty reduction strategy of PRSPs, it is unlikely that most of the Millennium Development Goals will be met. Second, disabled persons form a large group of population that is currently excluded from contributing to the economic and social development of their countries. Bringing them into the mainstream of economic activities would lead to a substantial increase in welfare and GDP.

viii. **Disability and extreme poverty**. The great majority of PRSPs (73 percent of PRSPs) recognize that disabled persons are among the poorest households and are exposed to high poverty risks. However, few PRSPs describe the poverty risks faced by disabled persons and in particular, the specific exclusion mechanisms that prevent them from accessing poverty reduction programs. In total, 23 percent of PRSPs only mention the exclusion and stigma experienced by disabled persons, but even in these cases there is no recognition of the cumulative nature of disabilities.

ix. Most disabilities in developing countries are preventable or treatable. But if they are left unaddressed, they generate social exclusion and stigma which, in turn, generate another series of social disabilities. Thus, disabled children may find themselves excluded from attending primary schooling and participating in the social life enjoyed by other children. This in turn leads to exclusion from accessing higher education and training. Over time, the initial disability has been compounded by a series of cumulative social disabilities, which result in the extreme poverty experienced by most disabled persons and their families in developing countries.

x. **Disabled persons are a large group**, but its size remains a matter of controversy. At one extreme are the estimates generated by Population Census. These estimates, derived by applying a narrow definition of disabilities, suggest that 2 to 3 percent of population suffer from the most extreme forms of disabilities. Other countries, which have adopted a much broader definition of disabilities, have reported a much higher rate of prevalence –as high as 20 percent of the population.

xi. Most of that group can and is eager to participate in the economic and social development of their country. This is the case of the disabled children, who are currently excluded from schools. According to UNICEF statistics, less than 3 percent of disabled children are enrolled in schools. But this also applies to most disabled adults, who are excluded from productive employment, but have the potential to be engaged in productive activities. The desire of disabled adults to gain access to a productive and

decent job is particularly noticeable from the comments expressed by the associations of disabled persons, which participated in the preparation of PRSPs. Their top concern is always the lack of access to employment. Bringing them into the development process could result in a substantial increase in GDP as the size of the potential labor force of disabled persons is large. This is apparent from recent surveys of Latin American countries, which show rates of labor force participation of disabled persons varying from 15 percent (Chile) to 80 percent (Brazil). Yet, most PRSPs fail to include adequate interventions that would allow disabled persons to access employment and other economic opportunities.

Incomplete Disability Policy Agenda

xii. Historically, little has been done by most societies to improve the lives of disabled people. In developing countries, disability interventions have consisted mainly of small scale rehabilitation, training and sheltered employment projects, often implemented by charitable organizations and NGOs[4]. Overall, these projects have never reached a significant share of the target group of disabled persons due their high costs and inadequate amount of available financing.

xiii. **Social Protection Focus of Disability Polic**y. In recent years, efforts have been undertaken in several developing countries to better address the needs of disabled persons. They are reflected in the increased disability focus of PRSPs. In total, close to 67 percent of PRSPs mention interventions such as income transfers, insurance or pensions for disabled persons. Such social protection measures are important for those disabled persons who may need financial support or assistance with activities of daily living. However, they do not address the specific needs of the larger group of disabled persons who could be productively employed.

xiv. **Integration in pro-poor growth strategy**. Nearly all the poverty reduction strategies outlined in PRSPs emphasize the essential role of pro-poor growth in reducing poverty. To that effect, they propose specific measures for increasing the participation of the poor to economic development. But very few PRSPs recognize that this goal also applies to disabled persons: 37 percent of PRSPs only explicitly mention that the objective of disability policy is to bring disabled persons into the development process.

xv. The inclusion of disabled persons in rural development is particularly important for poverty reduction. Since most poor households reside in rural areas, PRSPs give special importance to agricultural growth and the removal of constraints that prevent poor rural households from participating in rural growth. The implementation of this strategy is relevant for disabled persons as a disproportionate share live in rural areas. Yet, specific measures to increase the participation of disabled persons to economic growth in rural areas are never mentioned.

xvi. A few PRSPs mention interventions to facilitate the access of disabled persons to economic opportunities. But they are mainly directed at firms in urban areas as they

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[4] Coleridge, Peter. "Disability, Liberation and Development". Oxford, 1993

consist of interventions such as improving the physical accessibility of work places (13 percent), putting in place legislation against discrimination (23 percent) or promoting the employment of disabled persons (10 percent). Examples are mainly found among Eastern European countries, and especially the Azerbaijan, the Union of Serbia and Montenegro, and Kyrgyzstan PRSPs.

xvii. **Human capital development**. Nearly all PRSPs include interventions to increase access to education and health services as the acquisition of human capital is viewed as essential for poor households to benefit from economic growth. Nevertheless, these measures rarely address the specific needs of disabled children and adults.

xviii. The objective of ensuring the access of disabled children to the **education** services of the Ministry of Education is mentioned by 33 percent of PRSPs. Examples include the Malawi and the the Union of Serbia and Montenegro PRSP, which describe in detail the education policy towards disabled children. A broader group of PRSPs (63 percent) indicates that specific education services will be strengthened, but they fail to clarify whether this will be achieved by providing access of disabled children to the regular classes of the Ministry of Education or by establishing separate educational institutions targeting disabled children only. The latter case would run contrary to the increasingly accepted approach of including disabled children within the regular classes of the Ministry of Education.

xix. The same reservation applies to **training programs** mentioned by 57 percent of PRSPs. Historically, such interventions have been provided by charitable organizations or NGOs with specialized training programs been set up for disabled persons only. The broad result has been to provide second-rate training to disabled persons. The alternative endorsed by the United Nations is to provide access to existing training programs by ensuring that these programs are adapted to the specific needs of disabled persons.

xx. The **health needs** of disabled persons are better addressed by the proposed health interventions. Nearly all PRSPs mention nationwide **prevention programs** that have the potential of reducing disabilities such as poliomyelitis, leprosy, malaria, and HIV/AIDS (93 percent of PRSPs). Strong emphasis is also given to early childhood interventions (90 percent of PRSPs). A good example of such policies is provided by the Madagascar PRSP. However, only a minority of PRSPs (43 percent) includes specific rehabilitation measures such as the training of orthopedic surgeons, provision of appliances or the building of rehabilitation centers, which are important for improving the quality of services for disabled persons. The most glaring shortcoming is the lack of attention given to mental disorders, alcohol and drug use. According to WHO data, neuropsychiatric disorders are the main factors of disabilities (measured in terms of lost days of life), and especially for women.

xxi. Sensory and intellectual disabilities as well as those caused by traumatic accidents such as traffic accidents, which are a rising cause of disabilities in developing countries, also receive little or no attention.

Risks of Evaporation of Policy Commitments

xxii. Overall, the main shortcoming of the PRSPs' disability strategy is that the interventions are implemented in a context of scarce information on the importance and type of disabilities in the population, lack of understanding of the specific needs of disabled persons and absence of coordination of interventions. These factors are creating a high **risk of evaporation of the initial policy commitment**.

xxiii. PRSPs display a much stronger emphasis on stating policy commitments than on providing budgets for implementation and identifying the associated targets and indicators which matter for monitoring. For example, while 63 percent of PRSPs mention the objective of providing education services to disabled children, only 20 percent indicate the budgets required and/or the targets to be attained.

xxiv. Additional evidence is provided by the weaknesses of the links that should extend from PRSPs to Country Assistance Strategies (CAS) and Poverty Reduction Support Credits (PRSCs). Such links should be particularly strong in the cases of PRSPs with strong focus on disability. But this does not seem to be the case. In the Africa region, the Ghana CAS is the only one to mention disability and to display some links with the relatively strong disability focus of its PRSPs.[5] However, this link does not translate to its PRSC. Senegal is another country with a strong PRSP focus on disability. In this case, disability issues are discussed in the PRSC which includes the preparation of disability strategy and implementation during the next PRSC. A similar example is provide by the Vietnam PRSC.

Success Factors in Disability Strategies

xxv. The increased emphasis given by recent PRSPs to disability interventions is a positive change. But given the current patchwork of fragmented and uncoordinated interventions, the way forward must rely on scaling up interventions, building capacity, implementing institutional changes to address the multi-sectoral nature of disability interventions and strengthening the monitoring of outcome. These goals can be attained by:

- Defining a National Disability Strategy through a participatory and more comprehensive process that would empower and mobilize disabled persons from local communities to the national level with financial support;

- Establishing or strengthening the national entities in charge of the preparation of the National Disability Strategy with broad stakeholder representation from the public and private sector (trade unions, employers and disabled persons) and with access to high level decision making within government.

- Strengthening existing implementation arrangements or setting up innovative mechanisms in order to reach the beneficiaries at the local level.

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[5] A study on disability is planned for FY06.

- Setting a clear and transparent mechanism for monitoring the implementation of disability programs.

xxvi. **National disability strategy**. Several countries have under preparation either a social protection strategy or a policy document concerning the revision of pensions. A more comprehensive approach should be pursued by preparing a National Disability Strategy that would cover all aspects that are relevant to the formulation of a disability policy. The preparation of such a strategy can help rationalize the existing large number of small scale initiatives and place them in a comprehensive framework of poverty reduction. A recent example is provided by the Zambia Disability Action Plan.

xxvii. An important issue to be addressed is the institutional framework. Some countries have chosen to set up a specific agency and to entrust it with the task of preparing the National Disability Strategy. For example, a National Disability Council with broad stakeholders' participation (including disabled persons) was established in the case of Honduras. The alternative would be to strengthen the capacity of existing ministries (such as the Ministry of Social Affairs) to prepare a multi-sectoral strategy.

xxviii. In order to adequately address the specific needs of disabled persons, the strategy must rely on strong links with other sector reports and assessments. In particular, it needs to be grounded in a comprehensive **analysis of the poverty issues** of disabled persons. Without serious consideration of how initial impairments result in social disabilities and poverty later on in life, poverty reduction programs will continue to bypass disabled persons. In many cases, an important constraint is the lack of data concerning disabled persons. Progress in that area could be achieved by adding a specific disability module to envisaged household surveys or designing a questionnaire that could be added to Population Census. The on-going work carried out by the Washington City Group on Disability Measurement is therefore an important step forward[6].

xxix. The emphasis on a **multi-sectoral approach** lies at the heart of the rationale for a National Disability Strategy. Its objective is to address the shortcomings of the traditional social protection analysis by putting a strong emphasis on leveling the playing field so that disabled persons can have access to the economic opportunities offered to other social groups by the PRSPs. Traditionally, such measures were implemented through a number of ad hoc interventions carried out by various agencies and charitable organizations under the umbrella of the government ministry responsible for welfare policies. This framework greatly increases the likelihood that disabled persons will have access to second class programs because these programs are not in a position to benefit from the technical expertise of the sectoral ministries. The suggested alternative is to mainstream interventions as part of the regular services provided by technical ministries. As a result, education services for disabled children would be provided by the Ministry of Education as proposed for example by the Serbia PRSP.[7] Similarly, training and employment services would be offered by the Ministry of Labor, etc.

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[6] For a description of their work, see: www.edc.gov/nchs/citygroup.htm

[7] Included as part of the PRSP for the Union of Serbia and Montenegro.

xxx. In doing so, **special attention needs to be given to two social groups who are particularly neglected, namely disabled children and disabled women**. Increasing the access of disabled children to education services is an important priority. Unless specific measures are implemented, the goal of providing universal primary education (one of the objectives of the Millennium Development Goal initiative) won't be met. Women, who are disabled, bear a double burden and because of that are more than ever the target of exclusion, stigma and violence. However, disabled women remain invisible in all the gender action plans included in PRSPs.

xxxi. **Participatory process**. A key challenge is the invisibility and lack of political voice of disabled persons. Because of their physical, sensory or mental impairments, disabled individuals suffer from social exclusion and invisibility, which extend to the political field. Disabled People's Associations are rarely involved in policy discussions. As a result, the specific situation of persons with disabilities does not get recognized and their needs are not addressed.

xxxii. An important lesson that emerged from the review of PRSPs is that the involvement of disabled persons in the preparation of PRSPs provided substantial benefits. The main result was to increase the focus of the PRSPs' interventions on the area that matter the most to disabled persons, namely the lack of access to employment. In contrast, whenever disabled persons were not strongly involved, the economic focus of disability interventions remained weak, and even

xxxiii. **Implementation mechanisms**. The PRSPs' commitments to disability interventions will not become a reality unless budgets are identified, mechanisms are put in place to allow for increased funding to reach the beneficiaries in local communities, indicators are identified and a regular monitoring of outcome takes place.

xxxiv. So far, the translation of PRSPs programs into annual government budgets remains a work in progress. In principle, the costs of implementing the poverty reduction programs are provided in PRSPs. In practice, this information is rarely relevant because government budgets are prepared by functional categories (salaries, goods and services, and capital expenditures) that do not match the program categories used by PRSPs for summarizing poverty reduction programs. In most cases, specific budgetary tools such as Medium-Term Expenditure Frameworks are needed to link budgetary inputs to poverty reduction programs.

xxxv. A challenge faced by all PRSPs is how to scale up and coordinate interventions at the local level. The prevailing institutional model for disability intervention is based on the concept of Community Based Rehabilitation (CBR). The principle of community-based intervention is endorsed in almost all PRSPs, but its implementation faces a number of constraints that need to be addressed. These include: (i) lack of local government capacity to implement disability interventions; (ii) lack of institutional mechanisms for coordinating interventions; and (iii) strong resistance from most central governments to the contracting of services to civil society organizations as well as using

special mechanisms such as social funds for reaching local beneficiaries[8]. Coordination of interventions at the central level is unlikely to be effective because it is at the local level that the specific needs of disabled persons can best be identified. This implies that the funding of local government budgets will have to increase.

xxxvi. Given the range of issues that are still unresolved in most developing countries, the scaling up of disability interventions will have to rely on a strong monitoring of programs to determine which activities are effective and should be expanded further and which are not or could benefit from additional capacity building. Currently, monitoring of disability interventions is an extremely weak area of PRSPs. Policy matrices usually contain a mixture of subjective goals and process indicators that are rarely quantified. Some PRSPs (mainly the most recent ones) include outcome indicators such as the number and percentage of disabled children enrolled in schools and the number and percentage of disabled persons who are employed. However, none of these indicators appear in the core list of indicators which usually receives the greatest attention. This is the case even for the PRSPs which have the highest policy focus.

xxxvii. An unfortunate result of these shortcomings is that it becomes extremely difficult to assess the implementation of the PRSPs' disability policies. Nearly all Progress Reports fail to document the extent to which the disability-related interventions that were outlined in the PRSPs have been implemented. To a large extent, the issue is not limited to disability interventions, but seems to be the symptom of a much broader issue, which is the lack of uniformity in the coverage of Progress Reports. While some Progress Reports such as the 2003 Uganda Progress Report provides a comprehensive analysis of the poverty reduction programs, others remain extremely limited in their coverage.

xxxviii. **Conclusion**. A worldwide commitment to ensuring the full economic and social integration of disabled persons is now in place. It is reflected in various declarations of the United Nations and legislation of most countries as well as in the increased disability focus of PRSPs. In order to translate this commitment into actual improvements in the lives of disabled people, the following measures are recommended:

- PRSP Guidelines need to be developed. They would identify the key elements of disability policy that need to be addressed during the preparation of PRSPs. Given its multi-sectoral dimension, disability should be treated as a cross-cutting issue in PRSP documents.

- A working definition of disability needs to be formulated in line with international definition. This definition would provide a common framework for carrying out qualitative and quantitative analysis of census and surveys. Most of this work has been initiated by the Washington City group with the goal of testing one or two sets of questions in Censuses in several developing countries.

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[8] Social Funds involve setting up ad hoc disbursement mechanisms, outside the regular budgetary channels.

- A Disability Action Plan should be prepared based on a strong participatory process. It would outline a multi-sectoral approach and priorities for interventions. This Action Plan should be informed by sectoral reports, including poverty assessments, which would provide an in-depth analysis of the poverty dimensions of disabled persons, and in particular, of the mechanisms that result in the exclusion of disabled persons from poverty reduction programs.

- The implementation and monitoring of interventions should be scaled up. To achieve this objective, the costs of disability interventions should be estimated and translated into annual government budgets and their implementation should be monitored with participation of Disabled People's Organizations. At a minimum, indicators should include: (i) the number and percentage of disabled children enrolled in school; and (ii) the number and percentage of disabled adults employed.

- The implementation of disability interventions should be mainstreamed in other policy documents that are linked to PRSPs. These include Country Assistance Strategies and Poverty Reduction Support Credits.

I - INTRODUCTION

1. Poverty Reduction Strategy Papers (PRSPs) were introduced in late 1999 as a key instrument for extending debt relief under the Heavily Indebted Poor Countries (HIPC) initiative. Since then, some 38 PRSPs have been prepared. While most PRSPs are found in Africa (20), other regions are well represented with six PRSPs in Asia, seven PRSPs in Eastern Europe, four in Latin America, one in MENA.

2. PRSPs have made headway in increasing the country ownership of growth and poverty reduction strategies, opening the policy dialogue between government and civil society, and putting poverty reduction at the center of development planning. An important consequence of this process has been to greatly enhance the analysis of poverty trends by highlighting some of the factors that account for poverty as well as identifying the groups that are particularly at risk of falling into poverty, i.e. the so-called vulnerable groups. While the definition of vulnerable groups varies substantially, it is usually defined in PRSPs to include disabled persons.

3. The purpose of this report is to assess the extent to which the various developmental challenges faced by disabled persons are addressed in recent PRSPs. The fundamental motivation for such a review is to assess whether the social protection approach pursued in PRSPs and outlined in the Poverty Source Book addresses the poverty risks faced by disabled persons. As argued by organizations such as the ILO[9], a more comprehensive strategy that would provide social protection <u>and</u> ensure the participation of disabled persons in economic development may need to be implemented.

4. In ensuring that the PRSPs' disability policy agenda addresses the needs of disabled persons, it is important to acknowledge the conflicting tensions that PRSPs face, especially between the objective of being comprehensive and the need to maintain a strategic focus on priority areas. The first objective has often resulted in the inclusion of a long list of government policies and interventions into PRSPs. This defeats the main rationale of PRSPs, which is to provide a strategic vision of poverty and growth issues. To address this concern, this review focuses on the strategic components of disability policy and assesses the extent to which these elements are included in recent PRSPs.

Methodology and Report Structure

5. A total of 33 PRSPs was reviewed for this study (see Annex F). To ensure a fair representation of the current situation, only recently prepared PRSPs –i.e. those completed in 2000-2004—were selected. The corresponding Progress Reports (PRs) prepared in 2003-2004 were also reviewed as a source of information on the implementation of the strategies.

6. The review was carried out by applying a simple methodology. Questions were formulated to assess the extent to which the critical elements of a comprehensive

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[9] ILO, 2002. "Disability and Poverty Reduction Strategies: How to ensure that access of persons with disabilities to decent and productive work is part of the PRSP process". Discussion Paper.

disability policy were included (see Annex E for the questionnaire). A score ranging from 1 to 3 was used to rank PRSPs and PRs[10]. The resulting scores give an overview of the extent to which the poverty issues faced by disabled persons are reflected in PRSPs and whether the policy agenda includes interventions to enhance their economic and social integration.

7. The implementation of the disability programs was analyzed by reviewing whether their implementation was described in Progress Reports and supported by the Bank's Country Assistance Strategies (CASs) and Poverty Reduction Credits (PRCs). For that purpose, nine PRSP countries, which had scored highly in terms of their PRSP disability programs, were selected for review.

8. The report is divided into two parts. The first part reviews the poverty diagnostic of PRSPs and the extent to which the specific poverty dimensions of disabled persons are described. The second part of the report reviews whether the poverty reduction strategies of PRSPs include the critical elements for ensuring the full economic and social integration of disabled persons.

II. DISABILITY AND POVERTY IN PRSPS

Why Focus on Disabilities?

9. The overriding rationale for focusing on disabilities in PRSPs is two-fold. First, disabled persons form a large group of population that is especially affected by various forms of poverty; and second, PRSPs with their stated focus on poverty reduction offer an opportunity to reduce the poverty of this group.

10. **How large is the group of disabled persons?** According to a widely quoted figure from WHO[11], disabled people account for some 10 percent of the population worldwide. In interpreting this number it is important to keep in mind that there are severe conceptual difficulties in defining disabilities. Depending on how disabilities are defined, results vary drastically with the prevalence rate of disability ranging from 0.3 percent to 20 percent[12].

11. At one extreme are countries that rely on population census for estimating the prevalence of disability. These include most of the 38 developing countries for which estimates of disability were available from the United Nations Disability Database (DISTAT)[13]. Typically, the questions used for measuring disability refer to only a few severe physical, sensory and mental impairments (such as for example the loss of vision,

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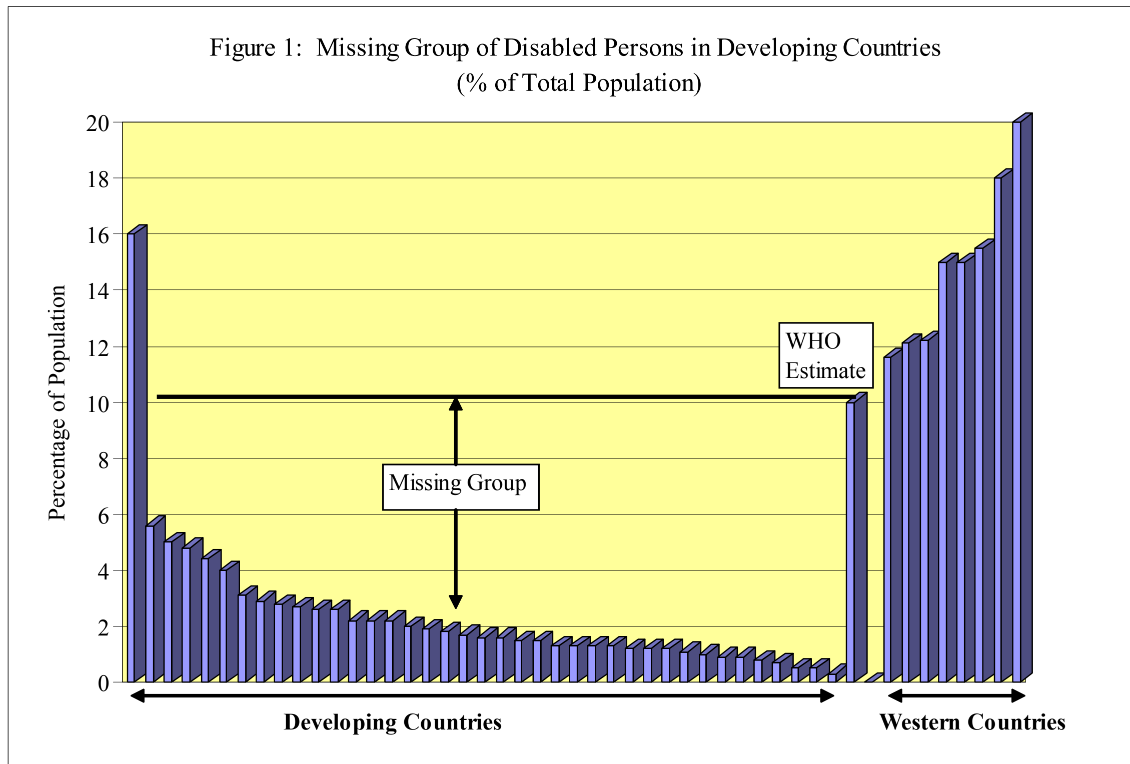
[10] The scores are as follows. A rating of one was given when disabilities were not mentioned; a rating of two was given when disabilities are mentioned, and a score of three was assigned to those PRSPs that included the best interventions or policies.

[11] WHO (1976) A29/INF/DOC/3. WHO. Geneva

[12] Data is from the United Nations Disability Statistics Database (DISTAT). This database summarizes the information contained in various population census and surveys worldwide covering the 1980-90 period. This data base has not yet been updated, but it remains representative. Recent population census reveals rates of disability that are very similar.

[13] See Annex B, Table B2.

capacity to speak and hear, and the loss of limbs) [14]. As disability is defined extremely narrowly, the estimated prevalence rates of disability are low, ranging from 0.3 percent to about 3 percent. This result was found to apply to the vast majority of developing countries (Figure 1). However, when the concept of disability is broadened, the estimated prevalence rate of disability becomes much higher. This is the case when disability is estimated through specific disability surveys.



Source: Annex B, Tables B2 and B3.

12. Dedicated disability surveys typically contain a questionnaire for investigating various aspects of disabilities in greater detail than is possible in population census. As a result, the definition of disabilities is broader and the percentage of disabled persons is found to be much higher. This can be seen from the left-hand side of Figure 1. Among developing countries, the six highest prevalence rates of disability came from specific disability surveys[15]. Additional evidence is provided by those developing countries, which gave estimates of disability both from population census and disability surveys. In nearly all cases, the estimates from disability surveys are higher (see Table B2, Annex B).

13. Disability surveys are usually conducted in developed countries, as they are costly to carry out. However, the questionnaires used for capturing the dimensions of

[14] See for example the disability questions included in the 1993 Columbia Census (Annex 2, Box 1).

[15] Prevalence rates of disability were: Uruguay (16%), Columbia (5.6%), China (5%), Egypt (4.4%), and the Philippines (4.3%). (Table 2, Annex 2).

disabilities vary. Some countries such as Canada and New Zealand attempt to measure disabilities in a social context by focusing on the activity limitations due to impairments (see Annex B, Box B3). Because of underlying methodological differences, it is not possible to compare the results across countries. As shown by the right-hand side of Figure 1, the estimated prevalence rates of disability in Western countries varied from 12 percent to 20 percent of the population.

14. Overall, it seems quite likely that the cross-country differences in disability rates shown by Figure 1 are mainly due to methodological differences in defining disability. This implies that a large share of the disabled population in developing countries is missing from available statistics. Compared to the range of data (from 0.5 percent to 20 percent) shown in Figure 1, the WHO estimate of disability (10 percent of population) may be reasonable. For this reason, Figure 1 takes the WHO estimate of 10 percent of population as a benchmark and compares it to countries' estimates of disability. With the exception of Uruguay (16 percent prevalence rate of disability), the group of disabled people that is "missing" is several times larger than the group that is identified.

15. **Key characteristics of disability in developing countries.** The first one is the **rural dimension of disability.** As shown by Table B2 in Annex B, the proportion of population classified as disabled is higher in rural areas than in urban areas. Given the large share of population that lives in rural areas, disabled persons are mainly found in rural areas.

16. The second characteristic is that **the lack of interventions to improve the economic integration of disabled persons is quite costly**. Typically, disability affects the most the elderly; quite often as much as 50 to 60 percent of the population aged 65 years and over is found to have some kind of disability. But disability also strikes the population aged 15 to 64 years, which constitutes the potential labor force. As shown by Table 1, which includes data from countries that have applied a rather similar, broad definition of disabilities, between 13 and 16 percent of the potential labor force is affected by disability. This suggests that interventions that would facilitate the economic integration of the disabled population would have a significant impact on output.

Table 1: Percentage of Population who is Disabled by Age Groups

	0-14	15-64	65 and over
Canada (1991 survey)	6.9	12.9	46
Australia (1994 survey)	7.0	13.6	50.9
New Zealand (1996 survey)	11	16.3	52
Brazil (2000 census)	4.3	15.6	54

Source: UN DISTAT version 2 and Brazil Institute of Geography and Statistics

17. **Labor force participation of disabled people**. Certainly, a more detailed analysis than is possible in this document is needed to estimate the potential increase in

the labor force that disability interventions could bring about. But even a rapid examination of the employment rates of disabled persons across countries shows a diverse range of rates across countries. Since part of the variation could be due to differences in the way the group of disabled persons is defined[16], it is best to compare surveys that use comparable definitions. This is the case of the Population Census of Bolivia (2001) and Chile (2003), which defined disability in a narrow manner. While 35.4 percent of disabled persons were found to be employed in Bolivia, the corresponding percentage was 15 percent in Chile. In the case of the 2000 Population Census of Brazil, which applied a broad definition of disability, over 80 percent of the disabled adults (30-59 years old) were estimated to be employed (compared to a 95 percent participation rate for non-disabled adults)[17]. These data show that there is a large group of disabled persons that want and can work.

18. The third characteristic is the **poverty dimension of disabled persons[18]**. As shown by Table 2, a disproportionate number of disabled people are found to be poor. A key factor is the low educational achievement of disabled persons compared to the general population. For example, 19 percent of disabled persons were found to have no education compared to 2 percent for the general population (Chile, 2002 Population Census). Other dimensions of poverty also include a much lower access to health care. For example, the 2002 Paraguay Population Census reported that 60 percent of the disabled people did not receive care.

[16] Not surprisingly, the rate of employment of disabled people is found to be higher when disabilities are broadly defined because the identified group of disabled people include disabled persons who have only relatively minor impairments and who can find employment without much assistance.

[17] Data is from the website of the Inter-American Development Bank, Sustainable Development Department: http://www.iadb.org/sds/SOC/site_3096_e.htm

[18] Ann Elwan, 1999. "Poverty and Disability: A Survey of the Literature". Social Protection Discussion Paper No. 9932. World Bank.

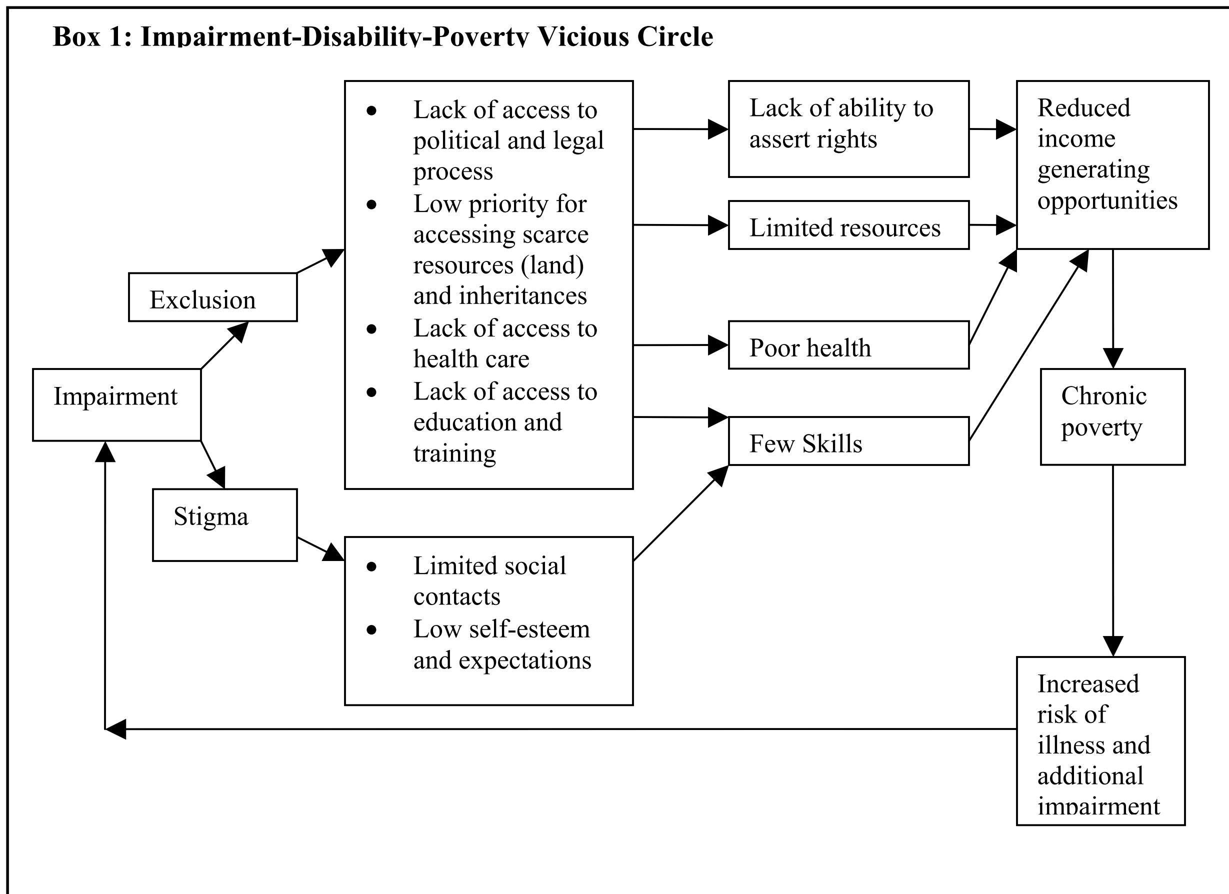
Table 2: Poverty Rate among Disabled Persons and General Population (In Percentage)

	Disabled Persons	General Population
Bolivia 1/	63	63
Brazil 2/	40	29.6
Cameroon 3/	50.6	40.2
Serbia 3/	70	11
Uganda 4/	42	22

Sources:
1/ Bolivia: 2001 Population Census and PRSP data
2/ Brazil : For the purpose of this comparison, the poverty threshold is arbitrarily defined as the percentage of households earning less than the minimum wage rate. Data is from the 2000 Population Census.
3/ PRSP data
4/ Data is for urban areas. See: "Measuring Welfare for Small Vulnerable Groups; Poverty and Disability in Uganda"; Johannes G. Hoogeveen, Dec. 2003

Vicious Circle of Disability and Poverty

19. Box 1 illustrates why disabled people are likely to be disproportionately poor. The fundamental reason is that disabled individuals are faced with discrimination, social exclusion and stigma the moment they are perceived to be affected by impairment. If left unaddressed, these impairments tend to accumulate and translate over time into a series of cumulative exclusions that result in social disabilities and poverty.



Source: Adapted from: Rebecca Yeo and Kareen Moore, 2003.[19]

20. The first set of exclusions concerns the **access to productive activities and employment**. In general, disabled people receive the lowest priority in accessing scarce resources, such as subsidized credits, agricultural inputs, and land. They are unlikely to have access to information as they are faced with a scarcity of translation devices (e.g. Braille), sign-language translators, information on audiotape, or means of accessing information on the Internet.

21. Disabled people are generally excluded from employment because employers rarely consider job applications from disabled persons. Discrimination may not necessarily reflect an explicit policy. It may simply be due to the fact that firms might not have taken explicit measures to accommodate the specific needs of individuals. In most countries the physical environment acts as an effective barrier preventing access by disabled persons. Buildings and public transport facilities are rarely designed to allow access by people with mobility limitations.

[19] Rebecca Yeo and Kareen Moore, 2003. "Including Disabled People in Poverty Reduction Work: Nothing About Us, Without Us" World Development, Vol.31, No3, pp. 571-590.

22. The second set of exclusions restricts the **social integration of disabled people and their access to the services provided to the rest of the population**. Stigma, low self-esteem and discrimination are among many other factors that contribute to excluding disabled people from participating in the social life of their communities. Most important are the difficulties experienced in accessing basic social services such as education and health services, as well as fundamental ones such as accessing courts for enforcing their legal rights.

23. A key consequence is the **low acquisition of human capital**. In many countries disabled children are not required to go to school and, even if they want to enroll, their specific needs are unlikely to be met by schools. But if this is the case, how can such a child gain access to employment when he becomes an adult? And how can such an uneducated adult find a productive job and avoid remaining poor the rest of his life?

24. **These outcomes are, however, largely avoidable**. Most disabilities in developing countries can either be prevented through medical treatment or alleviated through rehabilitation and economic and social policies that address the underlying causes. As shown in Annex B, most of the disabilities incurred in developing countries come from communicable diseases, maternal and peri-natal diseases, mental health disorders and injuries. These impairments could be drastically reduced through treatment and prevention programs. These would entail medical interventions at various stages of life, but especially during the early years of infancy and childhood. They would also include public health programs aimed at preventing diseases that are major causes of disabilities such as leprosy or polio.

25. The second type of interventions concerns mainly the impairments that result in broad stigma, social exclusion, discrimination, and ultimately poverty. But there is nothing inevitable in this outcome as it can be prevented through rehabilitation and by implementing policies that hold the promise of breaking the cycle of disability and poverty. How well Poverty Reduction Strategy Papers (PRSPs) have met this challenge is the topic discussed below.

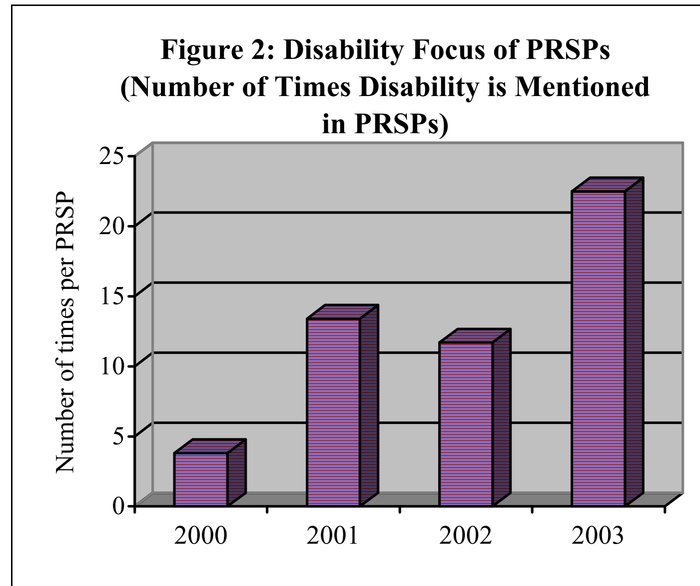
Poverty Dimensions of Disabled Persons in PRSPs

26. Poverty reduction is at the heart of the rationale for PRSPs. PRSPs were established to give more prominence to poverty reduction in the policy agenda supported under World Bank structural adjustment credits. This objective has been substantially attained as all PRSPs discuss poverty trends and their determinants. Progress has also been made in rendering much more explicit the links between development programs and their impact on poverty as well as on estimating the costs of the poverty-related programs.

27. **To what extent have these gains benefited the formulation of a disability strategy?** To answer this question, this section starts by reviewing the disability focus of PRSPs, the poverty analysis of disabled persons and the strategy adopted for reducing the poverty of disabled persons.

28. **Increased focus of PRSPs on disability.** Until recently, disabled persons remained an invisible group in PRSPs (Figure 2)[20]. In 2000, the issue of disability was scarcely mentioned (four times on average). In 2001 and 2002, the situation started to change, driven by a few PRSPs (e.g. Senegal and Honduras) that included a much greater focus on disability issues. However, there were still quite a few PRSPs that barely mentioned disability (e.g. Benin and Niger). In 2003, disability issues started to receive increased attention in PRSPs, but especially in Eastern European countries (e.g. Armenia, Azerbaijan and Kyrgyzstan). This trend continued in 2004 with the Union of Serbia and Montenegro PRSP[21].

Figure 2: Disability Focus of PRSPs (Number of Times Disability is Mentioned in PRSPs)

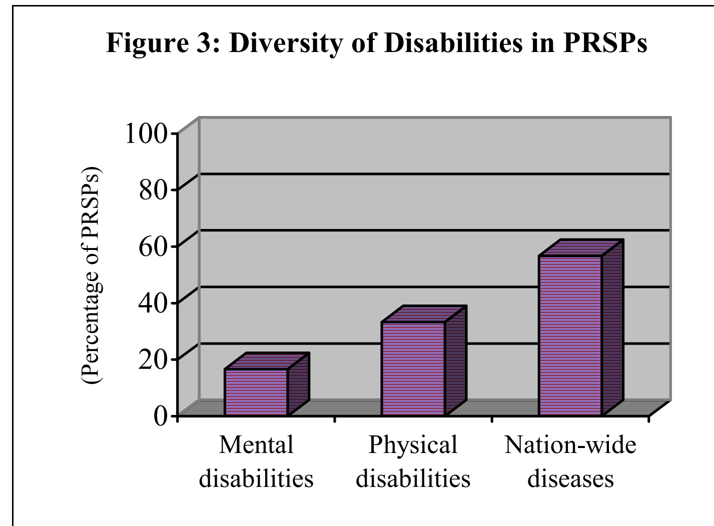


29. The overall result of this trend is that **disabled persons are increasingly recognized to be poor**. Some 73 percent of PRSPs mention that disabled persons are poor. They are generally usually viewed to be part of a broader group of vulnerable households that include women, children, elderly and war veterans. However, few PRSPs provide information on the disabled persons and their poverty dimensions. Most often, the group of disabled is perceived to consist of disabled elderly, war veterans and children. These groups are the traditional targets of social assistance policies, and they are mentioned mostly within that context. However, most conspicuous by their absence are the disabled adults.

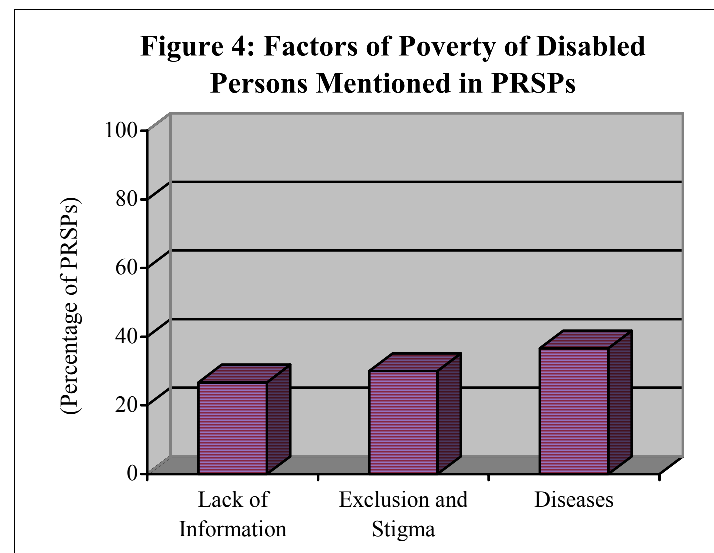
30. In general, disabled persons are viewed as a homogenous group. The diversity of disabilities is rarely mentioned in the context of the poverty analysis. It appears indirectly in the context of nationwide public health prevention programs (such as for malaria, HIV/AIDS, poliomyelitis or leprosis) or early childhood malnutrition), while mental disorders or learning disabilities are the least mentioned (Figure 3).

[20] The PRSP focus was measured by the number of times words such as disabilities, disabled and handicapped appeared in PRSPs excluding titles, table of contents and headings.

[21] As of June 1, 2004, disabilities were mentioned the most in the PRSP for the Union of Serbia and Montenegro.



31. Only 23 percent of PRSPs mention that disabled persons face **specific risks of poverty**. Figure 4 summarizes the main factors of poverty that are mentioned in PRSPs. Disease-related factors (polio, leprosy, HIV/AIDS) appear the most. But the more important causes such as social exclusion and stigma receive little attention in PRSPs. Admittedly, an important constraint is the lack of adequate data concerning persons with disabilities, but steps are rarely taken to collect data.



32. **Best examples**. A few PRSPs attempt to provide a more insightful analysis of poverty. One such example is provided by the Uganda Progress Report (2003), which mentions some of the specific factors of vulnerability affecting children and disabled persons (Annex C, Box C1). The results of various participatory assessments are mentioned throughout the report, which provide an unusual link between poverty assessments and policy choices. In particular, it is one of the few Progress Reports to include interventions to improve health (such as malaria prevention campaign) as being part of the agricultural strategy to increase the participation of the poor to growth.

Uganda's Progress Report also provides a particularly useful example of a policy focus on crosscutting issues. The developmental issues of the poor are thus discussed in a chapter entitled "increasing the ability of the poor to raise their income" while the more traditional issues related to social protection are presented in another chapter "improving the quality of the life of the poor".

33. The Malawi PRSP is one of the few PRSPs to recognize that there is a continuum of disabilities. By focusing on the specific forms of poverty experienced by persons with disabilities, a crucial distinction was made between critical disabilities and others. As an example, the PRSP states explicitly that all children, including those with mild disabilities, will have access to the regular education services of the Ministry of Education. Only those with severe disabilities will receive specialized education services. The recognition that the diversity of disabilities should be addressed by different interventions is extremely well summarized by the policy matrix, which shows interventions ranging from "labor productivity enhancement" to "welfare support measures".

34. Another example is the Serbia PRSP (included as part of the PRSP for the Union of Serbia and Montenegro). Unlike nearly all other PRSPs, it includes a poverty annex that summarizes the key poverty dimensions of disabled persons (Annex C, Box C2). The Montenegro PRSP (2004) is one of the few to include a list of poverty causes that was sent by the Association of Persons with Special Needs during the PRSP consultation process. Among the ten causes of poverty that were identified, unemployment is listed as the first one, which is indicative of the need of disabled persons to become financially independent (Annex C, Box C3).

II. POVERTY REDUCTION STRATEGIES FOR DISABLED PERSONS

35. In developing countries, disability interventions have historically tended to consist of small-scale rehabilitation, training and sheltered employment projects, often implemented by charitable organizations and NGOs[22]. Overall, these projects have never reached a significant share of the target group of disabled persons due their high costs and inadequate amount of available financing. This approach is now gradually been replaced by a broader recognition of the potential of disabled individuals to engage in productive activities and become integrated into the society.

36. The design and implementation of **inclusive policies** is at the heart of the new disability strategy. In addition to the traditional rehabilitation services, anti-discrimination measures and provision of social safety nets, emphasis is now being given to the removal of social and environmental barriers that are preventing disabled persons from accessing the services provided by government as well as existing economic opportunities. These policies are increasingly seen as more cost-effective because they have the potential to increase the income of disabled persons while reducing expenditures on expensive custodial care.

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[22] Coleridge, Peter. "Disability, Liberation and Development". Oxford, 1993

37. There may not be a unique framework that applies to all countries, but usually the successful programs were found to include the following elements:

- *A National Disability Strategy is prepared with the objective of increasing the economic and social integration of persons with disabilities*. The Strategy should be informed by various sector reports and poverty assessments that would identify the poverty dimensions of disabled people and the specific factors that result in their exclusion from poverty reduction programs. In particular, the Strategy should provide for the involvement of the stakeholders in the formulation, implementation and monitoring of the strategy.

- *The strategy is (i) implemented through multi-sectoral programs that are mainstreamed in all government programs; and (ii) delivered through community-based interventions*.

- *The monitoring and evaluation framework is in place.* The costs of disability programs are calculated and translated into annual budgets and targets.

National Disability Strategy

38. Overall, the main rationale of PRSPs is to provide a **strategic view** that reflects the priorities of countries. Having good analytical work in the form of a poverty assessment that includes a specific questionnaire on disability certainly helps identify the poverty dimensions of disabled persons. But this is not sufficient. As shown later on, quite a few PRSPs provide good diagnostics of poverty that are not accompanied by corresponding policy interventions to address the mentioned factors of poverty. The missing element is a National Disability Strategy that would provide a strategic framework for addressing the specific needs of disabled persons that were identified in the poverty assessment. A recent example is provided by the Strategy and Disability Action Plan of Zambia.

39. **Who will prepare and coordinate the implementation of the National Disability Policy**? There are various options. One option would involve establishing a high level institution such as a National Disability Council and entrusting it with the formulation of the National Disability Policy. Under that approach, the Council would be in charge of policy formulation and coordination, but the implementation of specific programs would still rest with sectoral ministries. Another option would consist of giving the responsibility of policy formulation to an existing ministry, such as the Ministry of Planning or the Ministry of Social Affairs. In that case, the role of the Ministry would have to be redefined by strengthening its capacity to formulate a multi-sectoral strategy that extends beyond social protection.

40. **Participatory process**. An essential element in the preparation of the National Disability Strategy is the involvement of stakeholders. While such participation is important for any strategy, it is crucial for addressing the specific situation and needs of disabled persons. As highlighted by the associations of disabled persons that were involved in the preparation of PRSPs, disabled people are faced with a lack of

understanding of the issues they face such as stigma, exclusion and lack of political voice. It is for this reason that the voices of disabled persons should be heard during the preparation of the disability strategy. This requires empowering and mobilizing stakeholders from the village to the national level with money and decision-making authority within a multi-sectoral framework. As shown by the examples discussed later on, involving such associations increases the likelihood that the specific needs of beneficiaries that are the target of sector policies are heard and addressed.

41. **Comprehensive disability policy.** At the heart of a disability policy is the recognition that persons with disabilities are not homogenous. While some individuals may suffer from impairments that result in extremely limited physical autonomy, other persons may have impairments that can be addressed so that these individuals can regain full autonomy. To take into account this diversity, programs need to be formulated accordingly by ranging from social assistance for those persons with zero autonomy to interventions aimed at providing access to productive work for those persons with potential total autonomy. Located in between these two extremes are some individuals with partial autonomy, who require a mix of social assistance and access to work programs. A key implication is that disability policy needs to be comprehensive and multi-sectoral.

Box 2: Key Elements of National Disability Strategy

Objective	• Increase the economic and social integration of disabled persons
Institutional responsibilities	• Strategy is prepared by Agency for Disability with the participation of sectoral ministries and other stakeholders, including Disabled People's Organizations • Strategy is shared with all stakeholders and disseminated widely, taking into account the translation needs of disabled persons • Agency coordinates the implementation of multi-sectoral programs
Monitoring and evaluation process	• Workers' employers and disabled persons' organizations participate in the formulation, implementation and monitoring of disability policy

Mainstreaming of Multi-Sectoral Interventions

42. **What types of interventions are needed**? A broad principle is that interventions should be aimed at providing access to the regular opportunities offered to the general population as well as restoring access to the regular services provided to the rest of the population. In other words, interventions should be access-facilitating tools that compensate for the initial impairments. It should be noted that in many cases disabled persons need such interventions only because policies, which are intended to be universal in principle, are in practice excluding disabled persons.

43. In applying the principle that interventions should provide access to services, care must be exercised to avoid setting up parallel programs or services that only serve disabled persons. Indeed, the temptation is quite strong to set up all sorts of parallel programs under the umbrella of the umbrella of the Ministry of Social Affairs or

charitable organizations. As these programs are not managed by the respective technical ministries, they do not benefit from the expertise of these ministries and they remain second-class programs.

44. **Equalization of economic opportunities.** The most important set of measures concerns the access to employment. Until recently, employment policies for disabled persons consisted mainly of employment quotas, reserved employment schemes and rehabilitation strategies[23]. In keeping with the general policy shift towards inclusive policies, employment policies towards disabled persons are now aimed increasingly at addressing the root causes of unequal access to economic opportunities. As part of this policy, increased emphasis is being placed on developing partnerships between employers, employees and disabled persons, while compulsory rules of employment are replaced by programs that rely on financial incentives[24]. Some of these measures are listed in Box 3.

Box 3: Key Disability Interventions For Increasing Access to Employment[25]

Employment legislation and regulation	• Discrimination in employment is addressed and sanctions are defined • Regulation concerning the physical accessibility of work places and training is introduced • Standards for workplace are defined, including building codes • Financial incentives are provided (wage subsidies, grants, tax credits, relief from social security contributions)
Sectoral employment programs	• Access is provided to productive work in agriculture, small and medium enterprises and cooperative sector, and public works programs • Employment programs are set up for disabled persons in the public and private sector (these programs have a limited impact on employment, but they have a high public awareness value)
Support services	• Support is provided for disabled job-seekers covering employment opportunities, training opportunities, and access to credit
Training programs	• Access to traditional apprenticeship is improved • Training facilities are adjusted to meet the needs of disabled individuals • Specialized vocational training is included into the regular vocational training programs of the ministry in charge of vocational training
Vocational rehabilitation services	• Vocational rehabilitation services, are established including referral services, vocational assessment and formulation of individual rehabilitation plans
Formulation and implementation of policies	• Participation of workers' employers' and Disabled Persons' Organizations in the design, implementation and monitoring of policy.

[23] Metts, Robert L., 2000. "Disability Issues, Trends and Recommendations for the World Bank" Social Protection Discussion Paper No. 0007, World Bank.

[24] A key reason is that employment quotas can have adverse incentive effects. For example, they may force highly qualified disabled people to accept jobs that they would not otherwise have taken.

[25] This list is derived from: "Disability and Poverty Reduction Strategies: How to ensure that access to persons with disabilities to decent and productive work is part of the PRSP process". Discussion Paper, November 2002, ILO

45. Other interventions aimed at increasing social integration and improving governance, are described in Box 4. **Social protection policies** have a role to play in this set of interventions. Some disabled individuals may not be capable of being employed and will need financial support as well as assistance with daily activities of life.

Box 4: Key Interventions for Increasing Economic and Social Integration

Social integration and accessibility of public places	• Provide technical devices for mobility and communication such as wheelchairs, crutches, white cans, sign language translation, Braille machine, paper, audiocassettes. • Increase the physical accessibility of training centers, offices, public buildings and places and homes
Gender issues	• Give special attention to gender issues and the situation of girls and women with disabilities who face a double disadvantage
Access to Information	• Improve accessibility of information for disabled persons • Facilitate internet access to existing international disability research network • Collect and disseminate available information on disability
Social Protection Policies	• Implement social assistance policies and programs for those individuals with disabilities who cannot engage in productive activities

46. **Increased access to health and education services**. As recognized by all PRSPs, increasing access of the poor to health and education services is a key component of any strategy to reduce poverty. This objective is even more important for disabled persons. Without access to education, disabled children are unlikely to be able to find a job later on life, which in turn strengthens the exclusion and social stigma they are facing.

47. Until the 1960s, most countries established specialized educational institutions that only served disabled children. In the 1960s and 1970s school systems in some industrialized countries began to provide inclusive educational programs in view of the mounting evidence that children with mild to moderate disabilities derived greater benefits by being included in such programs than in traditional segregated environments. The principle of inclusive education was endorsed by the Individuals with Disabilities Education Act of 1975 in the United States. However, some industrialized countries still educate large numbers of disabled children in special institutions.

48. Overall, the need for scaling-up educational interventions is clear. According to UNICEF estimates, 3 percent of children with special needs at most are enrolled in school[26]. This suggests that the traditional model of segregated education has not met its stated objective. Inclusive education has instead the potential to bring a much larger group of children into schools. Some 70 percent of disabled children, including children with mild learning difficulties, could attend regular education classes provided the school environment is physically accessible and willing to accommodate these children[27].

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[26] UNICEF. "Children with Disabilities". Education Update, Vol. 2, Issue 4. October 1999.
[27] Same source as footnote 26.

Enrolling these children would help attain the objective of providing universal primary education --one of the key targets of the Millennium Development Goals (MDGs)[28]. Key measures are listed in Box 5.

Box 5: Key Disability Interventions for Improving Access to Education

Improve access to the education services of the Ministry of Education	• Strengthen policy formulation capacity of Ministry of Education (establish special education service unit in Ministry) • Train regular teachers and administrators how to include disabled children in classrooms • Provide services, support and advice for parents of children • Improve physical accessibility of schools and universities • Provide learning material and special equipment (Braille, audio cassettes, sign language, etc.) • Provide scholarships for disabled children

49. Similarly, health interventions would need to be scaled up. Most of the disabilities found in developing countries come from communicable diseases, maternal and perinatal diseases, and mental health disorders, which can be treated. In low-income countries, children's disabilities are usually identified when they are 3 to 4 years old. As a consequence, rehabilitation starts too late. Instead, early detection and intervention should take place from birth to 3 years of age. Strong emphasis would also need to be given to national prevention programs that attack some of the important causes of disabilities such as polio and leprosy.

50. Medical facilities would need to be adapted to ensure that persons with disabilities can access health services, and that valuable services are provided. Measures would include ensuring that facilities are physically accessible, providing sign language translation, training orthopedic surgeons and building specialized rehabilitation centers (Box 6).

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[28] Currently, this target does not propose specific measures for disabled children, which guarantees that the target would not be met.

Box 6: Key Disability Interventions for Improving Access to Health Services

Improve access to health services	• Improve the physical accessibility of health centers • Improve the quality of services provided to persons with disabilities by: o Training orthopedic surgeons o Providing health centers with appliances (ortheses, prostheses, hearing aids, etc.) o Training medical staff to communicate with disabled persons (e.g. provide sign language translation, Braille, etc.) • Establishing/improving medical rehabilitation centers
Strengthen interventions aimed at attacking the initial cause of impairments	• Strengthen national prevention programs against diseases that are a source of disability (polio, leprosy) • Strengthen programs to detect impairments in children early in their life

51. Accompanying these measures would be a shift in professional attitudes. Traditionally, the education of health professionals has been focused on the medical aspect of disability rather than on viewing disabled individuals as persons with a potential for independent living. However, health professionals have a major role to play in enhancing more positive attitudes towards disability. Thus, they need to increase their skills in counseling and collaborating with families and communities.

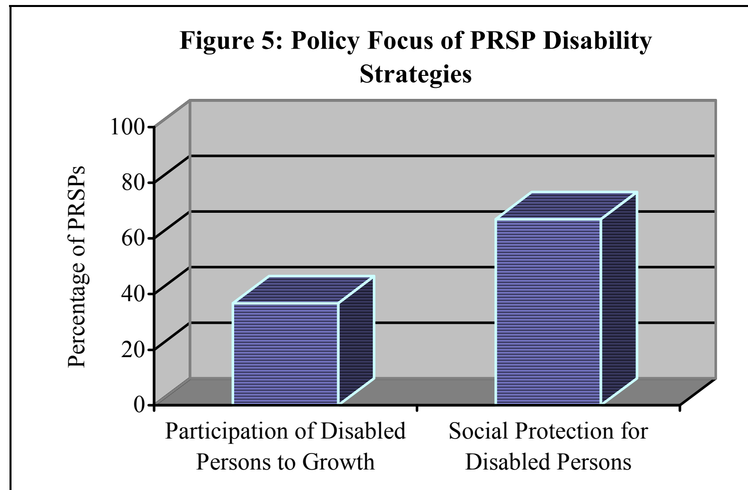
III. How Successful have been PRSPs in Meeting the Critical Elements of Success?

52. How well have PRSPs met the challenge of providing the critical interventions of disability policy? This is reviewed in the following paragraphs by applying a simple scoring methodology that ranks the extent to which PRSPs have addressed the issues of participation in economic activities, integration into the social life of communities, development of human capital and participation in political life. The methodology and the overall results are summarized in Annex E.

Social Protection and Disability

53. A conclusion shared by all PRSPs is that the reduction in household poverty is caused mainly by economic growth with income redistribution measures playing a minor role. This poverty assessment translates into a poverty reduction strategy, which gives the highest priority to stimulating the participation of the poor to economic growth, while the strengthening of social safety nets receives a lower priority. This ranking is, however, reversed in the case of the disability policy of PRSPs.

54. The main focus of PRSPs' disability policy is on strengthening social protection measures, especially for women, children (street children, orphans and working children), infants (through early childhood interventions), the elderly and disabled persons (through the provision of income transfers and pensions). In total, some 67 percent of the PRSPs include some safety nets (insurance, pensions or income transfers) for disabled adults (Figure 5).



Note: The policy focus on growth was measured by the percentage of PRSPs mentioning the objective of bringing disabled people into the development process. The social policy focus was measured by the percentage of PRSPs providing social transfers to disabled persons.

Access to Economic Opportunities

55. **Economic integration.** Nearly all PRSPs include measures (such as credit facilities, land reform, distribution of inputs, etc.) to stimulate the participation of the poor to growth, but only 37 percent of PRSPs state explicitly the objective of bringing disabled persons into the development process. An even smaller percentage mentions increasing the physical accessibility of work places (13 percent), putting in place legislation against discrimination (23 percent), or subsidizing the employment of disabled persons (10 percent). Overall, there is little recognition that disabled people include adults that could become productive and enjoy a normal life.[29]

56. Noticeable exceptions include the Senegal and Ghana PRSPs in the Africa region and the Honduras PRSP in Latin American countries. For example, the Senegal PRSP sets the objective of increasing the economic and social integration of disabled persons. It identifies interventions that span various sectors and extend beyond social protection measures. The most comprehensive policies are found in the Azerbaijan, the Union of Serbia and Montenegro and Kyrgyzstan PRSPs. Measures to facilitate access to economic activities thus include legislative proposals, employment measures (employment quotas, wage subsidies exemption from social security taxes), and provision of grants for the creation of new businesses employing disabled persons. Both the Montenegro and the Albania PRSPs describe an innovative approach (social business model) for disabled persons (see Annex D). Unlike most other PRSPs, environmental constraints are also addressed by revising building standards (to meet the needs of disabled persons), making public transportation accessible to disabled persons and ensuring their access to cultural life and sports events.

[29] As shown by the 2000 Brazil Population Census, over 80 percent of the disabled persons were involved in some form of work.

57. **Rural growth strategy**. With most of the poor residing in rural areas, poverty reduction depends greatly on increasing the participation of poor, rural households to growth. A similar conclusion applies to disabled persons. Based on the available information (see Table B2, Annex B), most of the disabled persons live in rural areas in developing countries and as much as 70-80 percent in Sub-Sahara African countries.[30] Factors contributing to the prevalence of disabilities in rural areas include diseases such as malaria and poliomyelitis, children malnutrition as well as the scarcity of medical infrastructure in rural areas, which prevents access to treatment. Most PRSPs include nation-wide prevention programs and a strong focus on early childhood interventions, but measures to increase the participation of disabled adults to rural growth are never mentioned. One exception is the 2003 Uganda Progress Report, which mentions the reduction of the prevalence of malaria and HIV/AIDS as being part of the rural growth strategy.

Human Capital Development

58. The objective of providing increased access to **education** features prominently in nearly every PRSP. However, it applies to disabled children in only a minority of cases. Few PRSPs mention the objective of ensuring the **access of disabled children to the regular education services of the Ministry of Education** (33 percent). There are, however, some exceptions such as the Malawi PRSP that includes an explicit policy consisting of including children with mild disabilities. The Serbia PRSP provides a detailed description of the current and proposed primary and secondary education system consisting of special schools for children with special needs, special classes in regular schools and classes in regular schools where children with mild disabilities are educated together with other children.

59. Most PRSPs mention the objective of providing **special education services** to disabled children (63 percent). However, it is not clear whether these services will be provided by the Ministry of Education or other agencies catering only to disabled persons and the extent to which the quality of the education will be improved.

60. The provision of **training services** is mentioned in 57 percent of PRSPs Figure 6). This intervention has a long history and a poor record as it consists generally of providing second-rate training (e.g. in the area of handicrafts) to disabled persons. However, it is not possible to judge from the PRSPs whether the mentioned programs are different, i.e. do they provide access to training programs run by mainstream training institutions or do they continue to provide low quality training courses reserved to disabled persons.

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[30] According to the United Nations Disability Database (UN DISTAT), the percentage of disabled persons is slightly higher in rural than in urban areas in developing countries. Since 70 percent of the population of Sub-Sahara African countries live in rural areas, it follows that 70-80 percent of disabled persons also live in rural areas.

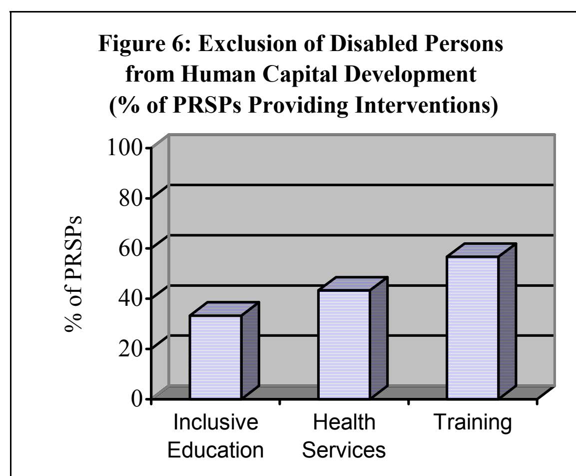


Figure 6: Exclusion of Disabled Persons from Human Capital Development (% of PRSPs Providing Interventions)

61. The specific **health needs** of disabled persons are better acknowledged. Nearly all PRSPs mention nationwide **prevention programs** that have the potential of reducing disabilities such as poliomyelitis, leprosy, malaria, and HIV/AIDS (93 percent of PRSPs). Strong emphasis is also given to early childhood interventions (90 percent of PRSPs). A good example of such policies is provided by the Madagascar PRSP. It also includes explicit measures for improving the access of disabled persons to medical services and it is one of the few to address the issues of drug use and mental health.

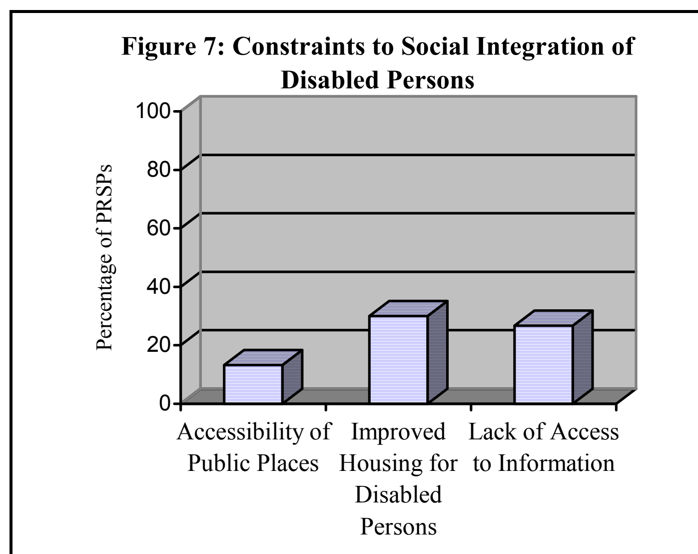
62. However, the majority of disabled persons remain **excluded from health services**. Only 43 percent of PRSPs include measures to facilitate access to health services and to provide services that meet the needs of the disabled (e.g. training of orthopedic surgeons, provision of appliances and building of rehabilitation centers) (43 percent of PRSPs).

63. The main shortcoming concerns mental health, alcohol and drug use. Only 17 percent of PRSPs (such as the Madagascar PRSP) include related interventions. Yet, according to WHO's statistics (Annex B), mental health disorders are the single most important health factor for the female population, accounting for 8.4 percent of lost DALYs (Disability Adjusted Life Years). But mental health issues have an impact that goes beyond lost years of life because of the strong link from mental health to poverty. Addressing female mental health issues has therefore a role to play in poverty reduction strategies. Similar consideration applies to alcohol and drug use among the male population.

64. Other disability issues related to learning difficulties, sensory (hearing and vision impairments) and traumatic accidents (especially traffic accidents which are a rising cause of disabilities in developing countries) receive little or no attention. Certainly, a key constraint is the lack of adequate medical equipment and supply. Among all the PRSPs reviewed, the Kyrgyzstan PRSP is the only one to include an explicit target concerning the supply of wheel chairs.

Social Inclusion

65. Measures to improve the social integration of disabled persons in social life are rarely considered. This is shown by Figure 7, which summarizes the extent to which PRSPs include interventions such as improving the physical access to public places and meeting the housing and information needs of disabled persons.



66. While the lack of access to information is occasionally recognized as a constraint, interventions to meet the specific needs of disabled persons are never mentioned. This is even the case of the recent World Bank initiatives aimed at improving Internet access, which are described in several PRSPs. Computers, Internet and electronic mail have revolutionized the communicative abilities of persons with hearing, visual and/or verbal impairment in developed countries. These new inventions have a similar potential in developing countries as assistive technologies provide disabled individuals with improved social access at a fraction of the cost of the specialized equipment that had been previously developed.

67. A widespread shortcoming is the lack of attention given to the issue of stigma and exclusion. Among African countries the Senegal PRSP is the only one to explicitly mention it and to propose measures to address it (see Annex D). Exclusion interventions features more prominently among the PRSPs for Latin American countries, but mostly as part of the discussion of ethnic groups.

Monitoring and Evaluation

68. **Monitoring is an area of considerable weakness in PRSPs**. It is to the credit of PRSPs that they recognized that the failure of previous poverty reduction strategies to deliver intended results was partly due to the lack of an adequate monitoring and evaluation system. PRSPs still suffer from shortcomings in this area, as the indicators of disability interventions are rarely mentioned. However, there are signs of progress as shown by recent PRSPs (see Annex D).

69. A common constraint to PRSPs is the lack of adequate data. Many countries are using periodic surveys for data collection to measure welfare at the household level. However, the data that is collected generally does not provide information on disabilities. This shortcoming is acknowledged in rare occasions, but steps are rarely taken to improve surveys by including a component focused on disabilities.

70. The on-going work initiated by the Washington City Group on Disability Measurement is therefore an important step. Agreement was reached in 2004 that the short-term priority is to develop a disability measure that would identify those individuals who are at greater risk of experiencing activity constraints due to limitations in functioning (seeing, walking, remembering, etc.). The objective is to generate a set of questions by September 2004 and to test them for use in Population Census.[31]

IV. Challenges and the Way Forward

Incomplete Policy Agenda

71. As shown by the preceding review of PRSPs, the policy focus of disability interventions varies substantially. The PRSPs of Eastern European countries are mainly focused on reforming pensions and shifting from a system whereby care is delivered through specialized institutions to more inclusive policies aimed at opening access to the regular services of government, such as education. In contrast to the stronger policy content of Eastern Countries, disability interventions remain scarce among African and Asian countries. They consist mainly of a number of social services and community-based rehabilitation projects. Overall, disability interventions are implemented in a context of scarce information on the importance of disabilities among the general population, lack of understanding of the specific needs of disabled persons and absence of coordination of interventions. This has led to weak effectiveness of interventions.

72. The poor effectiveness of disability interventions stems from the current patchwork of small-scale, ad hoc and disconnected interventions that do not offer much hope of removing the economic and social constraints faced by disabled persons. These constraints are not isolated. Instead they are equally binding with the result that they can be overcome only through a comprehensive program of coordinated interventions. For example, addressing the constraints preventing disabled children from being educated is certainly important. But the full benefits from such education are unlikely to be attained unless other environmental constraints, such as the lack of physical accessibility of public transport, buildings and work places, are removed. A solution endorsed by several PRSPs is to prepare a National Disability Strategy.

National Disability Strategy

73. The preparation of a National Disability Strategy is mentioned by 30 percent of the PRSPs that were reviewed. Several PRSPs also propose to develop a social protection policy. However, there is a high risk that these documents remain focused on

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[31] For further information, see: www.cdc.gov/nchs/citygroup.htm

social protection policy and do not address the broader issue of the full economic and social integration of disabled persons.

74. An option endorsed by several PRSPs is to entrust the formulation of the National Disability Strategy to a specific agency. This is the case of Kyrgyzstan, Montenegro, Serbia, Pakistan and Honduras PRSPs. For example, the Honduras PRSP proposes the creation of a National Disability Council and a Technical Unit for Integrated Rehabilitation to support the National Disability Council. Participation in the National Disability Council is envisaged to be quite broad consisting of private and public institutions as well as associations of disabled persons.

75. Another option is to entrust the Ministry of Social Affairs with the task of formulating the Disability Strategy. Choosing this option would entail a redefinition of the role of the Ministry of Social Affairs. Instead of being one of providing social interventions only, the Ministry would have to strengthen its capacity to formulate cross-sectoral policies that would be implemented by other ministries. However, the need for capacity building is never mentioned in PRSPs' strategies. In any case, whatever the option adopted, establishing clear roles and accountabilities is especially important because the implementation of disability interventions covers various sectors.

Risk of Evaporation of Policy Commitments

76. It is at the level of implementation that PRSPs face their greatest challenge. On one hand, they are under strong pressure to cover various policy agendas. On the other hand, budgetary constraints limit the number of programs that can be implemented. The overall consequence is a high risk that the initial policy commitment evaporates during the implementation phase. Indeed, as shown by Figure 8, there is a much greater emphasis on stating policy commitments than on actually following through by providing budgets and related targets for disability interventions. For example, some 63 percent of PRSPs mentions the objective of strengthening education services for disabled children, but only 20 percent indicate the corresponding budgets and/or targets. This raises the strong possibility that PRSPs' initial commitments to disability interventions would not be sustained during implementation. There are some indications that such a process is happening.

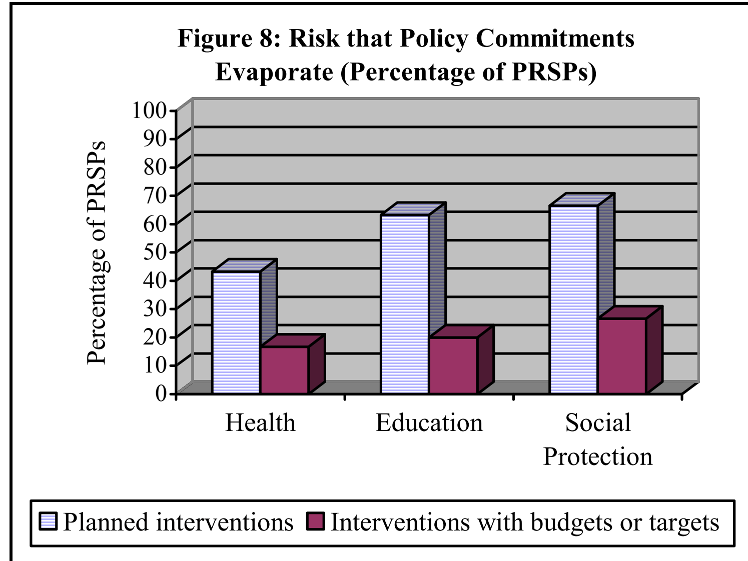

Figure 8: Risk that Policy Commitments Evaporate (Percentage of PRSPs)

77. To the extent that PRSPs are meant to guide the country's relationship with donors, one would expect strong links between PRSPs and donors' provision of support. While the disability links may not be noticeable for all PRSPs, they should be especially apparent in the case of those PRSPs that have a strong disability policy component. But this does not seem to be the case. For example, the Ghana Country Assistance Strategy (CAS) is the only one in the Africa Region to mention the issue of disability, but this issue does not appear in the Ghana Poverty Reduction Support Credit (PRSC). There are other PRSPs with a strong disability policy focus such as the ones for Malawi, Uganda, and to some extent, Cameroon, but disability issues are not discussed in the corresponding CASs or PRSCs. In the Africa Region, the Senegal PRSC is the only one to include a disability policy measure (preparation of disability strategy and implementation during the next PRSC). Bank wide, the Vietnam PRSC is the other PRSC to mention disability. In this case, the preparation of an inclusive education strategy for children with disabilities is proposed as a trigger for the following PRSC.

78. The Honduras Progress Report describes quite well the process of policy weakening during implementation (Box 7). But this is not unique to Honduras. Other Progress Reports also describe a similar outcome, which is explained by the initial lack of strong institutional links between the PRSP and the government budget. To address these shortcomings, governments have, however, stepped up their efforts to improve the budgetary framework.

Box 7: Weakening of Policy Commitment during Implementation. The example of the 2001 Honduras PRSP

In its initial design the Honduras PRSP provided good examples of various interventions concerns disabilities. But as stated by the 2003 Progress Report, the PRSP programs lacked specifications, both in terms of costs and their links with on-going sectoral programs. In total, the implementation of these programs remained disappointing with only 44 percent of programmed expenditures actually taking place in 2002. To address these shortcomings, the Government has now begun a detailed programming effort to determine the resource needed for achieving the goals of the PRSP and for translating these requirements into budgetary categories.

Links between PRSP Programs and Government Budgets

79. Ensuring that disability programs are budgeted is essential for these programs to become a reality. This conclusion was reflected in the costing of poverty reduction programs. While this is certainly a step forward, it does not go far enough. In general, it is not possible to readily convert PRSP programs into the usual budgetary categories (wages, goods and services and capital investment) used for preparing government budgets. An additional complication is that it is not possible to tell whether the estimated costs refer to the total cost of programs (which would include on-going programs that are already part of the government budget) or whether they only consist of incremental expenditures.

80. It is for these reasons that PRSP programs have to be translated into annual budgets that are part of the regular government budget. Such a framework exists in several countries in the form of a Medium-Term Expenditure Framework (MTEF). Having a strong medium-term expenditure framework in place would allow PRSP documents to focus on strategic issues of resource availability for the implementation of programs while leaving the detailed description of programs and their related costs to MTEF.

Funding for Local Governments and Community-Based Organisations

81. Another aspect of the budgetary framework that matters for disability interventions is how to reach the beneficiaries. Because the beneficiaries are part of local communities, scaling up interventions will require increasing local government budgets, strengthening existing disbursement channels, establishing new mechanisms for disbursing funds, making it possible for local governments to contract services to community-based organizations, and building the capacity of local communities to address the needs of persons with disabilities.

82. The prevailing institutional framework for involving local communities is **Community Based Rehabilitation (CBR**) model. This concept first emerged in Europe and North America in the 1960s and was developed as a strategy for developing countries by the World Health Organization in 1976. The objective is to replace expensive, medically-based institutional approaches with more cost effective solutions. While CBR

programs vary depending on the local circumstances, they usually involve the training of village-based CBR, identification of disabled adults and children by communities, and provision of various services aimed at empowering and supporting disabled persons and their families. Quite often, CBR programs are part of a wider group of community development programs.

83. The concept of community-based action is endorsed in almost all the PRSPs, with about half of the documents discussing disability-related interventions at the local government level. However, governments currently face in many countries, and especially in Africa, strong constraints that are preventing a scaling up of interventions at the local level. These constraints range from a lack of capacity at the local government levels to strong resistance to use mechanisms such as social funds that are outside the government budget for reaching beneficiaries. This suggests that the issue of how to ensure that funds reach beneficiaries at the community level has not yet been given sufficient importance in PRSPs. This is an important shortcoming because disability interventions are best identified and implemented at the level of local communities rather than through central government interventions.

Crucial Role of Disabled People's Organizations

84. At the forefront of various initiatives to alleviate the exclusion and poverty of disabled persons are the Disabled People's Organizations (DPOs). DPOs have been the main driving force behind the changes in disability policies in developed countries. A similar process is also noticeable in developing countries.

85. **The most visible contribution of DPOs has been to increase the economic focus of the disability policy agenda of PRSPs**. As shown by Figures 9 and 10, the involvement of DPOs in the preparation of PRSPs has resulted in a different focus of disability policies[32]. This relationship was estimated by constructing two indices. The first index measures the economic content of disability policy[33]. The second index rates whether DPOs participated in the preparation of the PRSPs. As highlighted by Figure 9, there is a positive relationship between the involvement of DPOs and the focus of PRSPs on increasing the economic integration of disabled person.

86. In contrast, a similar conclusion does not hold in the case of social protection policies. Although Figure 10 shows a negative relationship between the participation of DPOs and the PRSPs' focus on social protection policies, the correlation is not statistically significant[34]. One reason is that since the Ministry of Social Affairs participated in the preparation of PRSPs, its policies and its social protection

[32] The regression was statistically significant. The coefficient of the variable measuring the participation of disabled persons was highly significant and the R-square equalled 0.50.

[33] The index was calculated as the average of three indicators. The first and second one rated the extent to which disabled persons have access to education and training services, respectively, and the third one rated whether a legal framework for disability is in place.

[34] The coefficient of the variable measuring participation of disabled persons was not statistically significant in the regression. Social protection policies were measured by whether countries provide pensions and income transfers to disabled persons.

interventions were already reflected in the PRSPs. As a result, the participation of associations of persons with disabilities did not add any new interventions related to social protection. Nevertheless, it is quite striking that the involvement of DPOs did not lead to increased demand on government for additional social transfers, but rather for a chance to contribute to the economic development of their country.

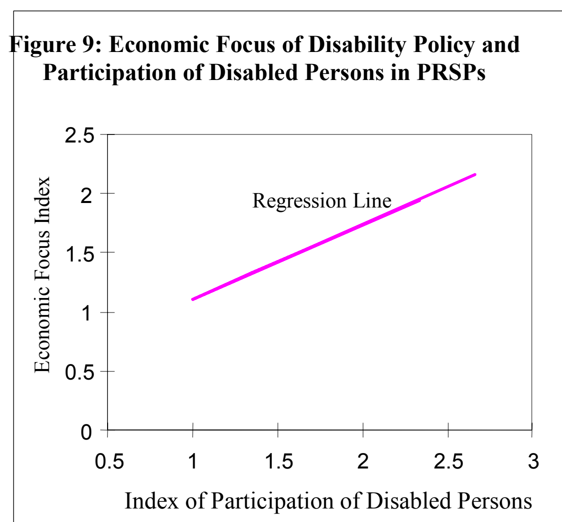

Figure 9: Economic Focus of Disability Policy and Participation of Disabled Persons in PRSPs

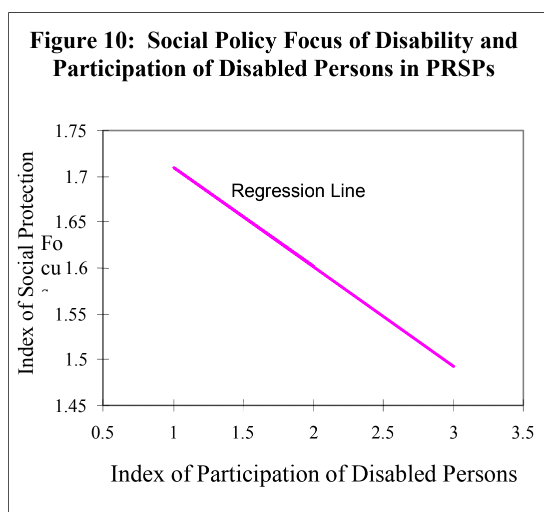

Figure 10: Social Policy Focus of Disability and Participation of Disabled Persons in PRSPs

V. CONCLUSION

87. A global commitment to ensuring the full economic and social integration of disabled persons is now in place. It is reflected in several declarations of the United Nations, various Acts and legislations adopted by most countries as well as in the increased focus of PRSPs on disability issues. The implementation of the increased worldwide commitment to addressing the constraints faced by disabled people is, however, constrained by: (i) a lack of information on the specific situation and needs of disabled people; (ii) the delivery of disability interventions through mostly ineffective small-scale projects; and (iii) a patchwork of often inconsistent and counterproductive disability policies.

88. In order to translate commitment into tangible improvement in the economic and social integration of disabled person, the following steps should be taken:

- PRSP Guidelines need to be developed. They would identify the key elements of disability policy that need to be addressed during the preparation of PRSPs. Given its multi-sectoral dimension, disability should be treated as a crosscutting issue in PRSP documents.

- A working definition of disability needs to be formulated in line with international definition. This definition would provide a common framework for carrying out qualitative and quantitative analysis of census and surveys. This work has already been initiated by the Washington City group with the goal of testing one or two sets

of questions in Censuses in several developing countries. Its implementation should proceed as quickly as possible.

- A Disability Action Plan should be prepared based on a strong participatory process. It would outline a multi-sectoral approach and priorities for interventions. The Action Plan should be informed by sectoral reports, including poverty assessments, which would provide an in-depth analysis of the poverty dimensions of disabled persons, and in particular, of the mechanisms that result in the exclusion of disabled persons from poverty reduction programs.

- The implementation and monitoring of interventions should be scaled up. To achieve this objective, the costs of disability interventions should be estimated and translated into annual government budgets, and their implementation should be monitored with the participation of Disabled People's Organizations. At a minimum, indicators should include: (i) the number and percentage of disabled children enrolled in school; and (ii) the number and percentage of disabled adults employed.

- The implementation of disability interventions should be mainstreamed in other policy documents that are linked to PRSPs. These include Country Assistance Strategies and Poverty Reduction Support Credits.

ANNEX A: DISABILITY CONCEPTS

Impairment-based definition. In the traditional medical and charitable approach disabilities were defined as a physical, sensory, or mental impairment, and they were perceived to be inherent characteristics of individuals. This approach led to the formulation of impairment tables at the beginning of the twentieth century for rating the physical damage from war or industrial injuries. More recently, ratings from damage and internal injuries have been added to these tables.

Impairment-based tables are attractive because they seem to offer an objective basis for setting disability thresholds. In practice, however, it is difficult to rate the severity of a person's impairment independently of its social context. For example, while the loss of hearing can be measured, its effects are likely to be much more severe for a musician than for other persons whose jobs do not depend on hearing to the same extent. Furthermore, it is also the case that not all impairments result in disability. In places where reading glasses are socially acceptable, the partial loss of vision (the initial impairment) does not lead to disability.

Social definition of disability. After the Second World War disabled persons became more active and a driving force for the further development of disability policy. This movement led to a growing recognition of the capabilities of disabled persons as well as the importance of social factors in defining disabilities, which, by the end of the 1960s, became incorporated in a new concept of disability. This concept brought out the interactions between the initial impairments experienced by disabled individual, the structure of their environments and the attitude of the general population as key factors defining disabilities. Disabilities ceased to be perceived as an inherent medically defined attribute of individuals and came to be seen as socially determined.

Important milestones that accompanied these changes included the World Programme of Action concerning Disabled Persons --adopted by the United Nations in 1982-- and the Standard Rules on the Equalization of Opportunities for Persons with Disabilities adopted by the United Nations in 1994.

In 1980 the World Health Organization adopted an **international classification** that made a clear distinction between impairments, disabilities and handicaps. This classification was subsequently revised in the 1990s leading to the adoption of the International Classification of Functioning, Disability and Health in 2001 (Box A1). A key characteristic of the new classification is that it does not attempt to define a unique threshold that would separate disabled people from others. Instead, it highlights the continuum of health status and provides a methodology for rating the functioning of the human body along various dimensions.

Box 1: International Classification of Functioning, Disability and Health (ICF)

The International Classification of Impairment, Disability and Handicaps (ICIDH) was developed in the 1970s and published by WHO in 1980. The classification that was developed differentiated impairment from disability and handicap. Impairment is defined at the level of the organ as a functional/structural abnormality of the body. Disability is viewed as the impact of the impairment on the performance of the individual and is defined in terms of activity or behavioural problems. Handicap is then the overall consequences resulting from disability, which depend on the social environment.

The ICIDH was further revised by WHO and finalized in 2001 under the name of the "International Classification of Functioning, Disability and Health" (ICF). The new classification is organized so as to provide a framework for the description of human functioning and disability along the following three dimensions:

- The **Body dimension** comprises two classifications: one for the functions of body systems, and one for the body structure.
- The **Activities dimension** covers the entire range of activities performed by individuals.
- The **Participation dimension** describes areas of life that individuals have access to.

An important consequence of the new classification is that it recognizes that there is a continuum of health status with varying degrees of impairments and disabilities. Because of this continuum, it is not meaningful to define disabilities on the basis of a single threshold. Instead, several thresholds may need to be defined to take into account differences in the social context of the disability that determine the severity of the impairment.

Disabilities and Definitions in European Social Policies [35]

Various definitions of disability are found in the anti-discrimination laws, social policies and employment policies of European States. A broad definition of disabilities, potentially including even minor disabilities, is used in the implementation of **anti-discrimination laws**. Such an approach is sufficient because these laws are aimed at preventing the act of discrimination rather than at identifying who is disabled.

Social policies face a different challenge. On one hand, they have to establish criteria for establishing eligibility to various benefits; and on the other hand, they have to allocate scarce resources among various disability-related interventions. Disability criteria that affect social policies are therefore more restrictive and vary with the interventions being considered.

Income maintenance. The payment of pensions or benefits to persons found incapable of working is one of the most important interventions both in terms of numbers and expenditures. The main criterion for establishing eligibility is that the person is not working because of lack of work or loss of work capacity or earning capacity. Another

[35] This section is based on the OECD report entitled "Definitions of Disability in Europe: A Comparative Analysis" European Commission, 2002.

approach is to evaluate disability directly by assessing the extent to which a person's functioning is impaired. The benefits provided usually include:

- Contributory provisions which offer a flat-rate of earnings-related benefit; and,
- Non-contributory benefits which provide basic income support, and which may be or may not be means-tested.

Activities of Daily Life (ADLs). Whether a person needs help with basic tasks such as eating, moving and personal hygiene usually stems from health problems. Some countries have therefore chosen to follow a medical-based assessment for defining ADL-related disabilities.

Other countries follow a different approach which requires individuals have to satisfy the tests of inability to work as well as the tests of limitations in performing ADLs. This approach reflects the implicit assumption that work involves more complex activities than ADLs. But this is clearly not always the case: individuals may be able to perform specific work activities and at the same time experience difficulties in carrying out ADLs. The issue is well understood, but it is not easy to solve. It also involves institutional issues. In many countries, assistance with ADLs is financed by the same institutions that provide insurance against work disability. Separating the two would involve finding a new source of financing and a new allocation of institutional responsibilities.

Provisions to assist people who need help, or incur extra costs in performing activities of daily life (ADL) include:

- Long-term care provision;
- Cash benefit provisions for transport costs and special diets;
- Various special tariff rates (transport, public utilities, etc.); and,
- Tax exemptions.

In **employment policy**, disability is usually seen as reducing productivity, or as a disadvantage in finding employment, or as a factor leading to discrimination. A wide range of measures is therefore found to promote the employment of disabled persons. These include:

- Employment quotas for disabled persons, sometimes associated with a levy for unfilled quota places;
- Provision of an appropriate working environment by employers, which may be financed by public funds;
- Temporary or permanent wage subsidies, adaptation grants (paid by employers) and income top-ups (paid to workers);
- Training and rehabilitation services, and/or fee payments, and living allowances for people in training and rehabilitation; and,
- Placement services, job coaching, assistance with interviews, interpreter services, etc.

Consistency and Incentive Issues

Due to the diversity of goals of disability policies, attempts to use a common definition of disability would result in definitions of limited policy relevance. As a result, different definitions of disability are applied depending on the social policy being considered. This raises the issues of gaps in coverage, consistency of definitions and perverse incentives.

Gaps in program coverage. Disability-related interventions can be grouped into two broad categories: those that are aimed at promoting the employment of disabled persons and their access to productive assets, and those that consist of income maintenance programs (pensions, insurance, and income transfers). In the case of employment, the assessment of disability is based on whether a person can continue to function productively, but this may depend on whether specific interventions, such as an adequate physical environment, are provided in the work place. In the case of daily life activities, the assessment is focused on whether a person can carry out daily activities. It is therefore quite possible for an individual to be deemed capable of working, but to be in need of assistance with daily activities, or vice versa. The lack of a common definition of disability was found to result in substantial gaps in program coverage in Europe.[36] Generally, governments attempt to address these gaps by requiring social policy agencies to coordinate their interventions. Another option would be to institutionalize the process by entrusting one agency with both functions.

Incentive issues. Specific provisions of income maintenance schemes usually do not take into account that disabled people may in fact be capable of carrying out productive activities. Most often, income maintenance benefits are not accessible if a disabled person is employed, which may provide strong incentives to remain unemployed. The effect is to discourage the group of disabled persons who could work from actually seeking employment. Instead, incentives should be provided for disabled persons to get employed. A first step would be to ensure that the various criteria defining disabilities are not inconsistent with the broad objective of increasing the participation of disabled people in economic activities.

[36] Across the European Union about 2/3 of the disabled people who indicated that they have a long-term health impairment limiting their daily life activities were estimated not to receive income maintenance disability benefits. See: “Transforming Disability into Ability: Policies to Promote Work and Income Security for Disabled Persons” OECD, 2002.

ANNEX B: THE WORLDWIDE IMPORTANCE OF DISABILITIES

There is little information available on disability in developing countries. An important reason is that the measurement of disability is beset with many problems, including the lack of standardization of definitions. The two main sources of information include the World Health Organization and existing surveys of disabilities.

Health Burden of Disabilities

In 1993, the World Health Organization in collaboration with the World Bank developed a new measure of the burden of disease that included not only the traditional loss of life expectancy due to premature mortality, but also the loss of healthy life due to disability. For each death the number of years of life lost was defined as the difference between the age at death and the expectation of life at that age in a low mortality population. For disability, the number of years of healthy life lost was obtained by multiplying the expected duration of the condition by a weight that measured the severity of the disability in comparison with the loss of life. The estimated losses of years of life due to death and disability were then added and further weighted by age weights and discounted to take into account the declining value of life.

The advantage of this method is to provide worldwide indicators of the importance of various diseases, especially in terms of communicable and non-communicable diseases. Its shortcomings are, however, serious. The most important ones concern the various weights that are applied to disabilities in estimating DALYs (Daily Adjusted Life Years). These weights were derived on the basis of expert opinions, but it is not clear that they reflect social preferences that have been validated. In particular, they imply that the life of disabled persons is valued less than those of persons without disability.

Despite these shortcomings, the estimated DALYs contain some useful information, which highlights the extent to which disability interventions can contribute to improving general welfare. As shown by Table B1, the years lost through disabilities represented 20 percent of the total burden of disease in Africa, 37.5 percent in South-East Asia and 38 percent worldwide.

New trends. Worldwide, the health burden of disabilities is increasing and it is especially affecting developing countries: more than 80 percent of the burden of disabilities comes from developing countries.

Demographics, health transitions, and the emergence of new risk factors are resulting in increasing the burden of non-communicable diseases in many developing countries. Longer life expectancies are contributing to a growing number of older persons and to disabled persons living longer while better perinatal care has increased the survival rates of disabled children.

Injuries due to civil wars, traffic accidents and violence are also increasing. Injuries are an important source of disabilities that affect mainly young adults. To a large extent, it is a hidden epidemic accounting for 30 percent of the entire health burden among men aged 15-44 in parts of the world. In many countries, especially in Sub-Sahara Africa and East

Asia the driving force is the increased burden of road injuries. In addition, HIV/AIDS is now raising the burden of communicable diseases.

Importance of prevention. An important message of Table B1 is that most disabilities in developing countries come from preventable impairments. This is clearly the case of the disabilities that originate from communicable, maternal, perinatal and nutritional conditions (Group I in Table B1). Among that group, nutritional deficiencies, maternal and perinatal conditions stand out in addition to tropical diseases, malaria and HIV/AIDS. Furthermore, a large part of the disabilities resulting from non-communicable diseases (Group II) in Table B1 could either be eliminated through treatment or alleviated through rehabilitation.

Table B1: Health Burden of Disabilities (Percentage of 2002 DALYs) 1/

	Africa	*South-East Asia*	*World*
I – **Communicable, maternal, perinatal and nutritional conditions** o/w:			
HIV/AIDS	1.5	0.3	0.6
Malaria	1.0	0.2	0.3
Tropical diseases	1.1	0.8	0.6
Sub-group I	**3.6**	**1.3**	**1.5**
Nutritional deficiencies	1.5	1.9	1.5
Maternal conditions	1.3	1.5	1.2
Perinatal conditions	0.8	1.2	1.0
Sub-group II	**3.6**	**3.6**	**3.7**
II - Non-Communicable Diseases o/w :			
Neuropsychiatric disorders	4.4	10.6	12.1
Sense organ disorders (vision and hearing related)	2.5	5.3	4.6
Musculoskeletal diseases	0.6	1.6	1.9
Congenital abnormalities	0.4	0.9	0.7
Injuries	2.8	4.9	4.1
Sub-group III	**10.7**	**23.3**	**23.4**
III. Burden of disabilities as % of total burden of health	**20.1**	**37.5**	**38.0**

Note: Burden is defined as the years lost through disability (YLDs) divided by the burden of disease (DALYs). Data is from WHO, World Health Report, 2003

Estimation of Disability in Population Census and Disability Surveys

Limitations of disability statistics. Worldwide, one observes wide variations in the definition of disabilities across countries. UN documents usually mention the figure of 10 percent when discussing the prevalence of disability worldwide, but this source comes

from a relatively old WHO document that reflected more a rough estimate than a sound statistically-based estimate[37].

The United Nations Disability Statistics Database (DISTAT) provides a more recent source of information. Its drawback is that the data has not yet been updated. Nevertheless, it provides a comprehensive view of disability prevalence rates as it includes 179 national studies from 100 countries covering the 1980-90 period. When available, the data is presented by age groups and broken down by rural and urban areas

Two conclusions stand out from this database. First, the estimated prevalence rates of disability vary substantially, ranging from 0.3 to 20 percent of the population of developed and developing countries (Tables B2 and B3). Second, most of the differences between developing and developed countries reflect methodological differences in defining disability.

[37] WHO (1976) A29/INF DOC/3, WHO, Geneva.

Table B2: Rates of Disability Among Low and Middle Income Countries

	(Percentage of Population)					Date	
	Total	Urban	Rural	Male	Female	Census	Survey
Algeria	1.2	n.a.	n.a.	1.4	1.1		1992
Bangladesh	0.8	n.a.	n.a.	0.9	0.6		1982
Benin	1.3	n.a.	n.a.	n.a.	n.a.		1991
Botswana	2.2	n.a.	n.a.	n.a.	n.a.	1991	
Brazil	0.9	0.9	0.9	1.1	0.7	1991	
Cape Verde	2.6	2.1	3	2.9	2.4	1990	
Central African Rep	1.5	n.a.	n.a.	1.8	1.3	1988	
Chile	2.2	n.a.	n.a.	n.a.	n.a.	1992	
China	5	n.a.	n.a.	4.9	5		1987
Columbia	1.8	1.8	1.9	2.1	1.7	1993	
Columbia	5.6	n.a.	n.a.	5.6	5.5		1991
Egypt	4.4	n.a.	n.a.	n.a.	n.a.		1996
Egypt	1.6	1.7	1.5	1.9	1.3	1981	
El Salvador	1.6	1.6	1.6	1.8	1.4	1992	
Ethiopia	3.8	n.a.	n.a.	n.a.	n.a.	1984	
Jordan	2.6	n.a.	n.a.	n.a.	n.a.		1991
Jordan	1.2	n.a.	n.a.	1.5	1	1994	
Kenya	0.7	n.a.	n.a.	0.8	0.7	1989	
Lebanon	1	n.a.	n.a.	1.2	0.8		1994
Malawi	2.9	n.a.	n.a.	n.a.	n.a.		1983
Mali	2.7	n.a.	n.a.	2.9	2.6	1987	
Mauritania	1.5	1.3	1.6	1.3	1.6	1988	
Morocco	1.1	1.1	1.1	1.2	1.1		1982
Namibia	3.1	1.6	3.8	3.4	2.8	1991	
Niger	1.3	1.3	1.3	1.5	1.2	1988	
Nigeria	0.5	0.4	0.5	0.5	0.5	1991	
Pakistan	0.5	n.a.	n.a.	0.4	0.5	1981	
Peru	1.3	1.2	1.6	1.3	1.3	1993	
Philippines	1.3	n.a.	n.a.	1.4	1.3	1995	
Philippines	4.3	n.a.	n.a.	4.9	3.6		1980
Sao Tome & Principe	4	n.a.	n.a.	4.3	3.6	1991	
Senegal	1.1	n.a.	n.a.	1.1	1	1988	
Sri Lanka	2	n.a.	n.a.	n.a.	n.a.		1986
Sri Lanka	0.5	n.a.	n.a.	0.6	0.4	1981	
Sudan	1.6	1.4	1.8	1.8	1.4	1993	
Sudan	1.1	1.2	1.1	1.3	1		1992
Swaziland	2.2	n.a.	n.a.	n.a.	n.a.	1986	
Syria	0.8	0.8	0.9	1.1	0.6		1993
Thailand	1.4	n.a.	n.a.	1.8	1.1		1991
Thailand	0.3	n.a.	n.a.	0.4	0.3	1990	
Tunisia	1.2	1.1	1.4	1.5	1	1994	
Uganda	1.2	n.a.	n.a.	1.3	1	1991	
Uruguay	16	n.a.	n.a.	n.a.	n.a.		1992
Uruguay	11.3	n.a.	n.a.	11.2	11.3	1984	
Yemen	0.5	0.5	0.5	0.6	0.5	1994	
Zambia	0.9	0.7	1.1	1	0.9	1990	

Source: UN Statistics, DISTAT database

Table B3: Prevalence Rates of Disability Among High Income Countries

	(Percentage of Population)			Date	
	Total	Male	Female	Census	Survey
Canada	15.5	15.4	15.6		1991
Australia	18	18.4	17.6		1993
Netherlands	11.6	9.5	13.6		1986
New Zealand	20	19	20		1996
Spain	15	13.3	16.5		1986
UK	12.2	11.6	12.6	1991	
US	15	14.4	15.7		1994
Sweden	12.1	10.6	13.4		1988

Source: UN Statistics, DISTAT database

Methodological differences in defining disability. For developing countries the predominant source of information on disabilities comes from population census, as detailed surveys of disabilities are costly. However, the definition of disability varies substantially. The prevailing method used by most developing countries consists of adding a few questions to a Population Census. As the population questionnaire is already quite long, the disability questions are relatively short, and they define disabilities as consisting of extreme impairments (see for example Box B1). Due to the narrow definition of disabilities, the estimated prevalence rate of disability is found to amount to less than 2 percent of the total population.

Box B1: Questionnaire on Disabilities –1993 Columbia Census

Do you have one or more of the following limitations? Read and mark the choices that apply to you:

1. complete blindness
2. complete deafness
3. complete muteness
4. mental deficiency or retardation
5. paralysis or lack of upper limbs
6. paralysis or lack of lower limbs
7. none of the above
8. Specify?

A second type of census applies a less restrictive definition of disability. Disability is still defined in terms of impairments, but the impairment is broader. For example, instead of asking whether a person is completely blind, the census would ask whether the person experiences vision difficulties. The result is a higher estimated rate of prevalence of the order of 2-4 percent of total population.

Another group of developing countries also rely on disability surveys. This makes it possible to measure disability by asking a longer series of questions than is typically feasible in a census. The main consequence is to define the group of disabled persons much more broadly, which is reflected in a higher prevalence rate of disability. Examples include Egypt (4.4 percent; 1993 survey), China (5 percent; 1987 survey), Columbia (5.6 percent; 1991 survey), and Uruguay (16 percent, 1991 survey).

Differences among developed and developing countries. As shown by the comparison of Tables B2 and B3, the prevalence rates of disability seem to be lower in developing than in developed countries. However, this conclusion seems erroneous as it reflects methodological differences. This can be seen first by looking at developing countries that have estimated disability prevalence rates both through census and surveys. As can be seen from B2, the census estimates are found to be lower than the disability surveys in most cases. Furthermore, the definition of disability used by high-income countries (Table B3) are quite different from the definitions used by developing countries (Table B2). As a result, it is not possible to compare surveys.

High-income countries mainly use detailed questionnaires to investigate disability. Some countries such as Bermuda include detailed questions on impairments (Box B2). Other countries (such as New Zealand) measure disability in terms of activity limitations that are broadly defined (Box B3). The resulting data therefore identifies a higher percentage of the population as having disabilities, typically from 12 percent to 20 percent of the population.

Box B2: Questionnaire on Disabilities - 1991 Bermuda Census

1. Do you have a physical, mental or other health condition or limitation which has lasted for more than six months and which limits or prevents your participation in the activities of daily life e.g., work, recreation, mobility, schooling. etc. Yes No Not stated
2. Does this condition
   a) Limit the kind or amount of work that you can do at a job? Yes No Not stated
   b) Prevent you from working at a job? Yes No Not stated
   c) Limit the kind of amount of activity that you can do at home or at school? Yes No Not stated
   d) Prevent you from going outside the home alone? Yes No Not stated
   e) Prevent you from taking care of your own personal needs, such as bathing, dressing or getting around inside the home? Yes No Not stated
   f) Generally confine you to getting around in a wheelchair? Yes No Not stated
3. Which of the following best describes the condition or conditions which prevents or limits your participation in the activities of daily life?
   1. Arthritis or rheumatism
   2. Heart condition
   3. Serious problem with back or spine
   4. No/limited use or absence of arm(s)
   5. No/limited use or absence of leg(s)
   6. Muscular disease or impairment
   7. Diabetes
   8. Cancer
   9. Serious stomach, kidney or liver condition
   10. Respiratory or lung problem
   11. High blood pressure/hypertension
   12. Hard of hearing or deafness
   13. Poor vision or blindness
   14. Serious speech impediment
   15. Senility or Alzheimer's disease
   16. Mental or emotional disorder
   17. Mental retardation
   18. Other condition
   19. Not stated

Box B3: Questionnaire on Disability - 1996New Zealand Survey

Adults:
1. Can you hear what is said in a conversation with one another person?
2. Can you hear what is said in a group conversation with three other people?
3. Do you have any difficulty speaking and being understood?
4. Can you see ordinary newspaper print, with glasses or contact lenses if you usually wear them?
5. Can you clearly see the face of someone across a room, with glasses or contact lenses if you usually wear them?
6. Can you walk the distance around a rugby field, without resting, that is about 350 meters or 400 yards?
7. Can you walk up and down a flight of stairs that is about 12 steps?
8. Can you carry something as heavy as a 5 kilo bag of potatoes, while walking, for 10 meters or 30 feet?
9. Can you move from one room to another?
10. Can you stand for 20 minutes?
11. When standing, can you bend down and pick something up off the floor, for example a shoe?
12. Can you dress and undress yourself?
13. Can you cut your own toe-nails?
14. Can you use your fingers to grasp or handle things like scissors or pliers?
15. Can you reach in any direction, for example above your head?
16. Can you cut your own food, for example meat or fruit?
17. Can you get in and out of bed by yourself?
18. Do you have a condition or health problem, which has lasted or is expected to last for 6 months or more, that makes it hard in general for you to learn?
19. Do you have a condition or health problem, which has lasted or is expected to last for 6 months or more, that causes on-going difficulty with your ability to remember?
20. Do you need help from other people or organizations because of an intellectual disability or an intellectual handicap?
21. Does a long-term emotional, psychological or psychiatric condition, cause you difficulty with, or stop you from doing everyday activities that people your age can usually do?
22. Does a long-term emotional, psychological or psychiatric condition, cause you difficulty with, or stop you from communicating, mixing with others or socializing?
23. Do you have any other condition or health problem that we have not talked about?

Children:
1. Is --- blind or does --- have trouble with her/his eyesight which is not corrected by glasses or contact lenses?
2. Has --- been diagnosed by an eye specialist as being blind?
3. Does --- use any equipment for seeing, other than glasses or contact lenses?
4. Is --- deaf or does--- have trouble hearing, which is not currently corrected?
5. Does --- use any equipment for hearing such as a hearing aid or an FM system?
6. Because of a long-term condition or health problem, does --- have any trouble speaking and being understood?
7. How well is--- able to make himself/herself understood when speaking with:
a) members of his/her family?
b) His/her friends?
c) Other people?
Alternatives: Completely, Partially, Not at all, and Don’t know.
8. Does --- use any equipment for communication such as a Macaw, a Communication Board or a computer?
9. From time to time, most children have occasional emotional or nervous problems. However, does --- have any long-term emotional, behavioral, psychological, nervous or mental health condition which limits the kind or amount of activity that she/he can do at home, at school or at play?
10. Does --- have a learning disability?

ANNEX C: POVERTY ANALYSIS IN PRSPs

Disabled people in PRSPs. A few PRSPs provide information on the number of disabled persons. For example, ECA countries such as Albania and Kyrgyzstan provide data on the number of disabled people receiving social assistance. The Pakistan PRSP mentions the percent of disabled persons broken down by disability categories.

The most common approach is to rely on qualitative analysis of participatory assessments. An example is the Uganda Progress Report, which summarizes the poverty factors that affect specific vulnerable groups (Box C1). These factors were identified based on community-based consultations carried out in 2003.

Box C1: Factors of Vulnerability - Uganda Progress Report (2003)

Neglected children	Being part of large families Lack of social support and social protection mechanisms Being physically disabled
Persons with disabilities	Discrimination in households and community Lack of ownership of key assets like land Taxation Inability to engage in income generation

Poverty Dimensions of Disabled Persons

Most PRSPs mention that disabled persons are poor, but very few provide information on the poverty dimensions of disabled persons. A key reason is that most poverty surveys do not include disabled individuals as a specific household category. One exception is the PRSP of the Union of Serbia and Montenegro. The poverty annex included in the Serbia PRSP includes a quantitative description of the poverty of disabled persons, and in particular, it documents the exclusion of disabled persons from most services that are available to the rest of the population (Box C2). It thus provides a strong rationale for the policy measures included in the PRSP.

Box C2: Key Characteristics of Poverty Among Disabled People (Poverty Annex of 2004 Serbia PRSP)

Disabled people are disproportionately poor:

- According to the 2001 survey, over 70% of disabled persons with disabilities had a particularly low income and would be ranked among the poor.

Disabled persons have low education levels:

- 50% had no education or had primary education only;
- 7% acquired higher education degrees,
- 10% completed their education in special schools.

Disabled persons have low employment rate:

- 13% are employed
- Only one third of those employed have a workplace adjusted to their needs,
- Only 40% of those employed have appropriate working conditions (starting hours, number of working hours, scope of work and breaks).

Disabled persons have poor access to services, infrastructure and cultural life:

- Education:
    - Physical access to education and other services for disabled persons is unsatisfactory
- Health:
    - Physical access to health care institutions is adequate. However, the effective availability of health care services is low, particularly as concern home visits, rehabilitation or home assistance;
    - The dominant form of rehabilitation is medical rehabilitation while the availability of occupational rehabilitation is scarce;
    - The availability of services differs according to the level of education and work status of the persons with disabilities (there is full availability for 55% of the educated and only for 28% of the uneducated);
- Public Transport: Inaccessible to 38 percent of disabled persons
- Shops: Inaccessible to 53 percent of disabled persons
- Local government services (municipality, Post-Office, Police): Inaccessible to 35 percent of disabled persons
- Movie theaters: Inaccessible to 80 percent of disabled persons
- Libraries: Inaccessible to 83 percent of disabled persons
- Theaters: Inaccessible to 88 percent of disabled persons

The Montenegro PRSP (part of the PRSP of the Union of Serbia and Montenegro) does not include a quantitative analysis of poverty, but it summarizes quite well the main causes of poverty, the principles of disability policy and its main objectives (Box C3). They were developed by a Disabled People's Organization.

Box C3: Poverty Reduction Strategy for Disabled Persons (2004 Montenegro PRSP)

Causes of Poverty of Disabled Persons

- Unemployment
- Low and irregular incomes
- Inappropriate economic policy
- Inadequate social and housing policy
- Lack of understanding within society of the problems of disabled persons
- Inadequate health care
- Inappropriate legislation
- Collapse of economy
- Inadequate and unavailable education system

Principles Guiding Development Policy

- Dignity
- Participation
- Non-discrimination
- Right to compensation

Objectives of Poverty Reduction Strategy Concerning Disabled Persons:

- Provide employment opportunities to disabled persons
- Ensure physical access to buildings
- Provide access to education system
- Establish an adequate social protection system for disabled persons including the application of compensatory rights and the development of various types of support services

ANNEX D: EXAMPLES OF DISABILITY INTERVENTIONS IN PRSPs

This section provides some examples of mainstreaming disability issues in poverty reduction strategies. The text is kept brief as the original PRSP documents can easily be consulted.

Economic and Social Involvement of Disabled Persons

Among Sub-Sahara African countries, the Senegal PRSP is one of the few to state as an explicit objective of disability policy the economic and social integration of disabled persons. The policies are shown in Box D1.

Box D1: Policy Matrix (Disability Interventions) of Senegal PRSP

Objective	Interventions
Improve the health and mobility of disabled persons	• Development and establishment of a national community-based rehabilitation program for disabled persons • Development and implementation of an action plan to ensure access by disabled persons to infrastructure and facilities • Implementation of a special program to monitor pregnant disabled girls • Establishment of a program to ensure better access to functional rehabilitation centres and to orthopaedic equipment and devices • Special equipment and reduction of costs of devices and services commonly required by disabled persons
Promote education and training for disabled persons	• Special facilities within school and university infrastructure • Promotion of universal schooling for disabled children • Distribution of school supplies to young disabled persons • Provision of scholarships for any disabled person • Involvement of disabled persons in literacy programs
Improve the economic and social status of disabled persons	• Development of a national community-based strategy for insertion or re-insertion • Promotion of access by disabled persons to means of production and employment
Combat negative stereotypes about disabled persons	• Campaign to raise awareness of positive life experiences of disabled persons • Support for institutional development of agencies and organizations that promote the rights of disabled persons • Development and adoption of laws to protect and foster the interests of disabled persons

Promotion of Employment

An interesting example of employment policy is provided by the Honduras PRSP. It proposes the creation of a National Disability Council with the participation of employers, employees and disabled persons (Box D2).

Box D2: Institutional Framework for Employment – 2002 Honduras PRSP

- **National Disability Council to be established**:
  - Includes the participation of public and private institutions, including disabled persons.
  - Technical Unit will provide support to the Council for the formulation of National Disability Plan and in establishing a national information system on disabled persons.
- **Law on the Promotion of Employment of Persons with Disabilities**:
  - Ensures the right to remain on the job in accordance with residual ability
  - Sets hiring quotas for disabled persons as follows:
    - 1 disabled person per 20-49 workers
    - 2 disabled persons per 50-74 workers
    - 3 disabled persons per 75-99 workers
    - 4 disabled persons per 100 workers

The Serbia PRSP (part of the PRSP of the Union of Serbia and Montenegro) also shows the specific interventions identified to promote the employment of disabled persons (Box D3).

Box D3: Interventions for Increasing the Employment of Disabled Persons - 2004 Serbia PRSP

Policy	Interventions
Legislative framework	• Law on Employment of Disabled Persons to be prepared. Its objective is the inclusion of disabled persons in society. It envisages the introduction of employment quotas for disabled persons, the provision of special care, occupational rehabilitation and professional training.
Promotion of employment	• Subsidize the employers' contribution (pension and disability insurance, heath insurance and unemployment insurance) during 24 months in the case of new jobs. • Wages of disabled persons are subsidized by 80 percent.
Training	• Fund for the Professional Training and Employment of Disabled Persons is to be set up.

Promotion of Entrepreneurship

Box D4 summarizes a new approach "**social business model**" that is being piloted in in the 2001 Albania PRSP (Box D4). One objective of the model is to provide disabled people, who may be recent graduates with on-the-job training, which may ease their transition from schooling to finding a job.

Box D4: Social Business Model – 2001 Albania PRSP

UNICEF-Tirana supported the creation of the first social business in Albania. YAPS (Youth Albanian Parcel Service) is a postal firm that employs 32 young people from marginalized groups, including orphans, and disabled children. The activity is non-profitable and essentially for the benefit of the public. It was supported by a coalition of private and public organizations that provided initial technical assistance and contributed to the capital cost of the project.

Evaluations of the project have been carried out and are quite positive. The employed young people say they feel useful and their feeling of being marginalized is becoming weaker. At the same time, the customers are also happy with the quality of the service.

The general conclusion is that such model does not provide a miracle solution. However, the social business model is attractive because it increases the possibilities of training of some marginalized groups and their chances for integration into society.

Another approach is to promote the creation of new entrepreneurs among disabled persons. This alternative is found in the PRSP of the Union of Serbia and Montenegro. Box D5 summarizes the main components for Montenegro.

Box D5: Promotion of Entrepreneurship - 2004 Montenegro PRSP

Policy	Interventions	Indicators
Promotion of entrepreneurship	Covers: unemployed, redundant labor, disabled persons, farmers, entrepreneurs Allocation of 3068 euros for each newly created job with a maximum of 5 positions Opening of enterprises employing disabled persons (first enterprise is to expected to employ 180 persons with a capita investment of 1.5 million euros) Opening of workshops for disabled within existing enterprises Opening of enterprises for vocational training, rehabilitation and employment of disabled persons Provision of micro-credit	Employment growth rate Rate of credit recovery Unemployment rate of disabled persons
Promotion of employment	Refunds of disabled persons' wages over a given time period Provision of one-time assistance to employers who hire disabled persons Develop employment programs for disabled persons Address institutional barriers to access to employment	Number of employed disabled persons
Economic empowerment	Draft educational program for disabled persons in compliance with market demands Draft program for disabled persons on acquisition of new skills and learning a new trade in line with labor market demands Establish fund for support of self-employment and formation of association, cooperative for disabled persons	
Social protection	Develop program for disabled persons and their families	Number of programs
Access to environment	Provide disabled persons with better access to environment Develop urban standards for the removal of physical barriers	Developed standards
Education	Development of specific education programs for disabled persons Draft law on children with special needs Inclusion of pre-school children with special needs	Number of enrolled disabled students
Inclusive education	Provision of schooling Establish database on children with special needs	Number of children receiving specific support

Social Protection Policy

The Azerbaijan PRSP is representative of the interventions found in the PRSPs of Easter European countries. It is one of the few to address psychological issues (Box D6). It is also one of the few PRSPs to include the targets of programs and their costs.

Box D6: Social Protection Interventions – 2003 Azerbaijan PRSP

Interventions	Indicators
Develop a national strategy directed at the protection of children, women, the disabled and the elderly rights and improving the regulatory framework governing the protection of child rights	Adoption, and publication of strategy
Develop an action plan to improve social reintegration of children that need special care, including disabled and street children	Action plan developed
Develop protection system for families with children that need special care	Social workers trained Number of poor families receiving child care support
Establish a State Coordination Council on Child Problems	Number of child problem cases referred to the Council
Improve education and training system for social workers, including the employees working in child care institutions	
Rehabilitate Disabled Children Centers and orphanages	Number of centers and orphanages rehabilitated
Develop medical-social rehabilitation within individual rehabilitation programs for disabled people	
Establish a common information system on disabled persons	
Construct houses for disabled persons	Houses constructed
Install necessary facilities for disabled people in transport and public places	Facilities installed
Create Para Olympic health-sport centers for disabled persons	Number of disabled children attending sport facilities Sport health center built
Strengthen targeted social protection for disabled person who need care and assistance, including disabled women, disabled people living alone, and for families with two or more disabled members	Measures developed and implemented
Create guidance centres to provide medical, pedagogical and psychological assistance to the parents of mentally retarded children	Guidance Centres established Number of referrals
Create regional rehabilitation centers for disabled persons	Regional rehabilitation centres created

ANNEX E: QUESTIONNAIRE: METHODOLOGY AND RESULTS

A simple scoring methodology was applied to rank Poverty Reduction Strategy Papers. A number of statements were formulated to capture the key elements that are crucial to the successful implementation of disability policies. Each question was rated on a score of 1 to 3 as follows:

- 1 indicated that the intervention was not mentioned;
- 2 indicated that the PRSP addressed the issue mentioned; and
- 3 indicated that the intervention was among the best found in PRSPs.

The questions used to rank PRSPs are listed below as well as the percentages of PRSPs that included a score of 2 (issue mentioned or interventions included).

I - Poverty Dimensions of Disabled Persons	**% PRSPs with a score of 2**
Vulnerable groups are discussed	90.0
• Disabled people are mentioned as being vulnerable	73.3
Diversity of initial impairment (mental, physical and health) is mentioned	
• Mental	16.7
• Physical	33.3
Specific poverty risk factors are discussed	
• Risks of women, young girls and children are discussed	93.3
• Risks of disabled persons are discussed	
❑ Diseases (malaria, HIV/AIDS, etc.)	36.7
❑ Lack of access to education and health	96.7
❑ Lack of access to information	26.7
❑ Social exclusion of disabled people due to stigma.	30.0
Poverty surveys	
• Lack of data on disabilities is acknowledged as key constraint	6.7
• Planned surveys include components focused on disability	13.3
II – Growth And Poverty Reduction Strategies For Disabled Persons	
Pro-Poor Growth Strategy	
• Includes objective of increasing the participation of disabled people to growth	36.7
Multi-sectoral institutional framework	
• National Disability Policy exists or is being prepared	30.0
• National Agency is responsible for policy formulation	16.7
• Legal framework for disabled persons is discussed	36.7
Interventions are mainstreamed in sectoral growth programs	
• Employment	
o Legislation against discrimination is in place	23.3
o Physical accessibility of work places is improved	13.3
• Agriculture (access to land, inputs)	0

- Industry (quotas, wage subsidies, etc.) 10.0

Education Policy

- Access to education services of Ministry of Education is increased by improving physical accessibility, training of teachers, etc. 33.3
- Specific education services are provided to address specific needs 63.3

Training

- Specialized vocational training courses are strengthened 56.7

Health services

- Access is improved through training of orthopedic surgeons, provision of appliances, physical access, language translator, etc. 43.3
- Interventions address the initial causes of impairments e.g.
  - Drug addiction 10.0
  - Prevention of polio, leprosy, malaria 93.0
  - Mental health 16.7
  - Focus is on early childhood interventions (e.g. malnutrition) 90.0

Social Protection and Integration of Disabled Persons

- Measures are identified to reduce children vulnerability to risks
  - Street children 63.3
  - Working children 33.3
  - Orphans 43.3
- Programs are aimed at facilitating the social integration of disabled adults
  - Physical accessibility of public places is improved 13.3
  - Housing is improved 30.0
- Social programs are established or strengthened, including:
  - Social protection (pensions, insurance, income transfers) 66.6

III – IMPLEMENTATION OF DISABILITY PROGRAMS

Local governments and community-based organizations

- Role and budgets are discussed 63.3

Disability Programs

- Budgets and targets of are quantified:
  - Education 20.0
  - Health 16.7
  - Social Protection 26.7

Monitoring and Evaluation

- Monitoring of disability
  - Some indicators for disabled people are identified 36.7
  - Education indicators 23.3

- **Participatory Process of PRSPs**
  - Representatives of disabled people participated in preparation 36.7

ANNEX F: POLICY DOCUMENTS INCLUDED IN THE DESK REVIEW

Country	PRSPs	Progress Reports	Country Assistance Strategy	Poverty Reduction Credit
Asia				
Cambodia	February 2003			
Mongolia	September 2003			
Nepal	November 2003			
Pakistan	March 2004			
Sri Lanka	April 2003			
Vietnam	July 2002	February 2004		2004
Africa Region				
Benin	March 2003			
Burkina Faso	May 2000	March 2004		
Cameroon	July 2003			
Chad	November 2003			
Ethiopia	September 2002	February 2004		
Ghana	May 2003		February 2004	2003
Kenya			February 2004	
Madagascar	November 2003			
Malawi	August 2002	October 2003		
Mali	March 2003			
Mozambique	September 2001	July 2003		
Niger	February 2002	November 2003		
Rwanda	August 2002			
Senegal	December 2002			
Tanzania	November 2000	May 2003		
Uganda	May 2000	September 2003		
Zambia	May 2002		May 2004	
Eastern European Countries				
Albania	June 2002	July 2003		
Armenia	November 2003		May 2004	
Azerbaijan	May 2003		April 2003	
Georgia	November 2003			
Kyrgyz	February 2003		April 2003	
Union of Serbia & Montenegro	March 2004			
Tajikistan	December 2002		February 2003	
Latin American Countries				
Bolivia	June 2001			
Guyana	September 2002			
Honduras	October 2001	February 2004	May 2003	
Nicaragua	July 2001	January 2004		