

**Implementation of the United Nations  
Standard Rules  
On the Equalization of Opportunities  
For Persons with Disabilities**

Report on the Inter-Country Meeting for the  
Eastern Mediterranean Region  
Cairo (Egypt), 2 – 4 May 2006



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## Executive Summary:

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In 1993, the United Nations General Assembly adopted The Standard Rules on the Equalization of Opportunities for Persons with Disabilities (UNSR), as guidelines to governments on how persons with disabilities can practice their rights as equal citizens. The Rules state in part: *“The principle of equal rights implies that the needs of each and every individual are of equal importance, that those needs must be made the basis for the planning of societies, and that all resources must be employed in such a way as to ensure that every individual has equal opportunity for participation”*<sup>1</sup>.

The World Health Organization (WHO)’s Eastern Mediterranean Regional office (EMRO) organized an inter-country meeting in Cairo from 2 to 4 May 2006, on the implementation of the Rules related to health care. This was done in collaboration with the Disability and Rehabilitation Team at the WHO headquarters (WHO/DAR) and AIFO.

### **The objectives of the meeting were as follows:**

- Discussing the current situation of application of Rules 2 (medical care), 3 (rehabilitation), 4 (support services), and 19 (personnel training) in EMRO countries.
- Identifying major constraints to the implementation of the UNSR.
- Recommending national and regional strategies for overcoming the constraints, and for strengthening the application of these four rules.
- Encouraging regional networking and sharing country experiences towards stronger application of the UNSR.

The UN Special Rapporteur on Disability, H.R.H Sheikha Hessa from Qatar attended the meeting, and eight countries participated. These were: Egypt, Iran, Iraq, Jordan, Lebanon, Palestine, Pakistan, and Sudan. There were representatives from governmental organizations (Ministries of Health and Social Affairs), as well as civil society (disabled people’s organizations and non governmental organizations). For a list of the participants, see Annex 1.

The meeting included country presentations, group discussions and plenary sessions on the four UNSR related to health. For the meeting agenda, see Annex 2.

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<sup>1</sup> The full text of the UNSR is available in English and Arabic at:  
<http://www.un.org/esa/socdev/enable/dissre00.htm>

## Recommendations:

- Ensuring that all persons with different disabilities are given due attention, especially women. There should be **no discrimination** among persons with disabilities.
- Setting up national and regional **rehabilitation councils/authorities** to coordinate different rehabilitation activities. These authorities also have a role in designing relevant training curricula for different personnel dealing with persons with disabilities, and in developing national policies.
- Following a systematic approach in **training** personnel. This includes mainstreaming rehabilitation studies in teaching and tertiary care institutions. Universities are also to be encouraged to start courses on disability and rehabilitation. Persons with disabilities and their families should be involved in the different stages of training (planning, implementation and monitoring). A standardized training curriculum for all EMRO countries and all categories of health workers should be provided.
- Promoting low cost, locally made, high quality **assistive devices** that should be provided free of charge. This can be done through establishing local manufacturing units, and starting national funds to provide persons with disabilities with their requirements of assistive devices.
- **Integrating rehabilitation** services in primary health care (PHC) systems. This should be accompanied by establishing appropriate referral systems with services at the secondary and tertiary levels.
- Establishing national and regional **health management information systems** concerning disabilities.
- Adopting the **community based rehabilitation strategy** (CBR) in national policies. Regionally, CBR should be supported and strengthened by WHO.
- **Sharing information, resources and best practices** nationally and regionally. Resource materials should be exchanged among EMRO countries, preferably in local languages. This could be done through a regional organization which can organize trainings, video conferences and exchange of experiences.
- Having **plans of action** to implement the UNSR. Non governmental organizations (NGOs) and disabled people's organizations (DPOs) must be involved in these plans.
- **Developing a partnership** between WHO and regional bodies - such as the League of Arab Nations and ESCAP - and NGOs and DPOs in different areas related to disability. WHO should also include persons with disabilities as experts in all fields, and encourage similar expert meetings to come up with recommendations for concrete strategies.

## Abbreviations:

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AFRO	Regional Office for Africa - World Health Organization
AMRO	Regional Office for the Americas - World Health Organization
CBR	Community-based Rehabilitation
DAR	Disability and Rehabilitation – World Health Organization
DPO	Disabled People's Organization
EMRO	Eastern Mediterranean Regional Office - World Health Organization
ESCAP	United Nations Economic and Social Commission for Asia and the Pacific
ESCWA	Economic and Social Commission for Western Asia
ICF	The International Classification of Functioning, Disability and Health
ISO	International Standards Organization
MENA	Middle East and North Africa
MoH	Ministry of Health
MoSA	Ministry of Social Affairs
NGO	Non-Governmental Organization
PHC	Primary Health Care
PTSD	Post Traumatic Stress Disorder
SEARO	Regional Office for South East Asia - World Health Organization
UN	United Nations
UNSR	United Nations Standard Rules on the Equalization of Opportunities For Persons with Disabilities
WHO	World Health Organization

## **Preamble:**

In 1993, the United Nations General Assembly adopted The Standard Rules on the Equalization of Opportunities for Persons with Disabilities (UNSR), as guidelines to governments on how persons with disabilities can practice their rights as equal citizens. Although the UNSR are not compulsory, they are regarded as international customary rules under international law. These rules imply a strong moral and political commitment on behalf of member states to take action for the equalization of opportunities for persons with disabilities. The Rules offer persons with disabilities and their organizations an instrument for policy-making and action. They also offer a framework for international collaboration in the field of disability.

The purpose of the UNSR is to ensure that all persons with disabilities exercise the same rights and obligations as non-disabled citizens through the removal of various disabling barriers and maximizing full opportunities for participation. Persons with disabilities and their organizations should play an active role as partners in this process.

The Rules state in part: *“the principle of equal rights implies that the needs of each and every individual are of equal importance, that those needs must be made the basis for the planning of societies, and that all resources must be employed in such a way as to ensure that every individual has equal opportunity for participation”*<sup>2</sup>. According to the UNSR, “equalization of opportunities” means the process through which the various systems of society and the environment, such as services, activities, information and documentation, are made available to all, particularly to persons with disabilities

The twenty-two rules of the UNSR consist of four chapters - preconditions for equal participation, target areas for equal participation, implementation measures, and the monitoring mechanism - and cover all aspects of the social and economic lives of persons with disabilities.

The World Health Organization (WHO) particularly supports the monitoring and implementation of the following health-related Rules, and promotes their use for the development of national policies<sup>3</sup>:

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<sup>2</sup> The document can be ordered free of charge from: Disabled Persons Unit, Department for Policy Coordination and Sustainable Development, United Nations, Room DC2-1302, New York, NY 10017, USA, Fax: +1 212 963-3062. It can also be found on: <http://www.un.org/esa/socdev/enable/dissre00.htm>

<sup>3</sup> More measures towards the implementation of these four Rules are included in the WHO Action Plan (2006-2011).

## **Rule 2: Medical Care**

*States should ensure the provision of effective medical care to persons with disabilities.*

In order to ensure that persons with disabilities have access to medical care, WHO:

- Develops normative tools including guidelines and a global plan of action to strengthen medical care and rehabilitation services.
- Advocates for the implementation of the UNSR.
- Supports countries to integrate medical care services into primary health care (PHC).
- Promotes strategies to ensure that persons with disabilities are knowledgeable about their own condition, and that their rights and dignity are supported and protected by professionals.

## **Rule 3: Rehabilitation**

*States should ensure the provision of rehabilitation services to persons with disabilities in order for them to reach and sustain their optimum level of independence and functioning.*

In its efforts to ensure that persons with disabilities have access to rehabilitation services, WHO:

- Supports countries to integrate rehabilitation services into PHC.
- Facilitates the strengthening of specialized rehabilitation centres, linking the services they offer to community-based rehabilitation (CBR).

WHO gives particular emphasis on CBR, and supports member states in the following areas:

- Preparing guidelines for CBR.
- Initiating and/or strengthening CBR programmes.
- Improving country-level data and information on disability and CBR.
- Documenting evidence-based best practices in CBR.
- Conducting regional and country workshops to promote CBR and relevant guidelines.
- Organizing regional and international training programmes on CBR.

## **Rule 4: Support Services**

*States should ensure the development and supply of support services, including assistive devices and technologies, to assist persons with disabilities to increase their level of independence in their daily living and to exercise their rights.*

WHO assists in ensuring that persons with disabilities have access to support services through:

- Providing assistance for the development of programmes and national policies on assistive devices and technologies.
- Creating a database on the availability of appropriate assistive devices and technologies in low and middle-income countries.
- Promoting relevant research.
- Organizing country and regional workshops.

### **Rule 19: Personnel Training**

*States are responsible for ensuring the adequate training of personnel, at all levels, involved in the planning and provision of programmes and services concerning persons with disabilities.*

WHO currently regards capacity building in the area of disability and rehabilitation as one of its high priorities, and plans are taking place to:

- Advocate for the implementation of the UNSR, in particular Rule 19.
- Develop a package of training materials for health professionals involved in disability and rehabilitation.
- Contribute to preparation of a disability and rehabilitation curriculum for schools of public health, medical schools and other health-related institutions, initially beginning with finalization of a chapter on disability and rehabilitation in WHO's TEACH-VIP curriculum for injury prevention and control.
- Promote the inclusion of disability issues in the curricula of technical and professional schools so that their graduates are able to influence decisions about and facilitate access to services for persons with disabilities.

In 1999, WHO collected information by means of a questionnaire sent to all member states, and to around 600 non governmental organizations (NGOs) working in the field of disability. This questionnaire, developed at the request of the UN Special Rapporteur on Disability, was designed for the purpose of monitoring the implementation of the UNSR. The objective of the survey was to identify government policies in the areas of the four health-related Rules, and to identify strategies adopted and problems encountered during implementation. Out of 191 countries contacted, 104 responded. Among EMRO countries, the responses were received from the governments of Bahrain, Cyprus, Djibouti, Jordan, Kuwait, Lebanon, Morocco, Oman, Saudi Arabia, United Arab Emirates and Syria, and ten local NGOs.

In terms of medical care for persons with disabilities, there is a tendency for the medical care system not to provide this service to certain disability groups in countries like Djibouti, Lebanon and Morocco. In Jordan and Syria all groups of persons with disabilities are included within the medical care system. Programs range from prevention and early detection and diagnosis to treatment of

impairments, referrals and counseling for parents. In Yemen where the medical care system is very weak and inaccessible for large number of people living in rural communities, persons with disabilities hardly have any access to medical care. The degree of participation of disability groups in the planning and evaluation of medical care services ranges from “never” as in Djibouti, “sometimes” (Jordan, Morocco and Syria), to “often” (Lebanon).

Social services in EMRO countries do not reach large numbers of the population who have disabilities. In countries like Morocco and Syria, less than 20% of the population is covered by social insurance schemes that protect against disability. WHO estimates that only 1% to 2% of persons with disabilities in the majority world have access to rehabilitation services. These services are either non-existent or located only in the country capitals.

According to the World Bank note on disability issues in MENA (June 2005), ‘physical rehabilitation services by government-sponsored programs vary significantly among countries in the region. Djibouti, Egypt, Morocco and Syria reach out to less than 5% of the disabled population, while Jordan, Bahrain and Lebanon cover somewhere between 6-20% of their respective population with disabilities. Iran is known to cover from 41% to 60% of the population with disabilities. In Djibouti rehabilitation services are provided essentially for persons with mobility impairments, while in most other countries services include persons with hearing, visual, intellectual impairments, those with learning difficulties, chronic diseases and mental illness. In Yemen, government-sponsored rehabilitation programs cover mobility and visual impairments. Local NGOs have established rehabilitation programs for children with hearing and intellectual impairments. However, almost all government and NGO rehabilitation services in Yemen are urban-based and do not reach out to persons with disabilities in rural areas’.

In addition to government-sponsored programs, eight NGOs working in the area of disability in EMRO countries answered the 1999 WHO questionnaire. The survey indicated that rehabilitation services are provided through CBR programs, in which persons with disabilities, their families and organizations participate. NGOs also partially finance assistive devices and equipment. In most countries, the bulk of rehabilitation services are provided by NGOs, but the number of disabilities covered is limited, with very few available services for mental health and learning disabilities.

NGOs vary substantially in the quality of their services, with many using old rehabilitation techniques with little exposure to new science, tools and practices. NGOs tend not to evaluate their programs nor do they deal with mild and moderate degrees of disabilities, which are either not diagnosed or misdiagnosed.

The Eastern Mediterranean region has a large number of public and private universities. However, very few can produce the type of specialties and/or competencies which would enable the mainstreaming of disability issues. Most university programs suffer from a lack of international knowledge in the area of disabilities. This is reflected by the lack of accreditation programs, continuing education opportunities, and research related to disability. Current education and training programs for professionals in the various fields of disability are inadequate. They usually do not have the full range of knowledge at their disposal to be effective, lack a multidisciplinary approach, and in many cases are not accredited or licensed.

### **Disability in the Eastern Mediterranean Region:**

#### Prevalence:

As with most regions of the world, reliable statistics on the numbers of people with disabilities in EMRO countries is lacking. Although some countries in the region have included disability questions in surveys, differing definitions methodological approaches and variations in human and financial resources, have rendered comparisons among countries a difficult task. WHO estimates that about 10 percent of the world's population, or about 600 million people worldwide, are affected by one form or another of disability. Applying this proportion to the population of EMRO countries would result in an average of 40 million persons with disabilities.

Based on country level data available through UNSO, Metts (2004) has estimated a low and high estimate of persons with disabilities for individual countries. Table 1 presents the results for 10 countries in the Eastern Mediterranean region. The range of prevalence estimates is between 1 and 10 percent of the population for countries like Djibouti and Yemen, and between 3.5 and 10 percent for the other countries of the region. For the group of countries in the table, which comprises a total of 250 million people, the range of persons with disabilities is estimated between 9 and 27 million people.

**Table 1 : Population with Disabilities in Selected EMRO Countries**

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

Source: Metts (2004)

Official statistics tend to provide an incomplete picture of disability incidence since in many EMRO countries available data comes from non-reliable sources, or is constrained by heterogeneous definitions of disability. There is a clear lack of standard definitions of disabilities across countries but also within countries. Also, governments and NGOs do not apply the same definitions and standards. Methodological and definition differences among EMRO countries result in incomplete and inconsistent data, and illustrate the need for the establishment of common criteria for the definition and measurement of disability prevalence.

Causes:

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

Poverty, health, and disability are inextricably linked and form a cycle of events where poverty and disability reinforce each other<sup>4</sup>. Poverty is not only a lack of income. It is also a lack of access to health and education services, work opportunities, and social activities. Poverty can be experienced either at a state level or an individual level. The causes for poverty at state level vary among failed wars, export constraints, corruption, and insufficient national income to support basic services etc. Most EMRO countries have been affected by conflicts with neighboring countries or other political events, leading to constrained development to meet the basic needs of the people. Poverty at an individual level, which can derive from poverty at state level, can result in poor nutrition, poor hygiene, bad sanitation, and reduced access to basic health care.

Despite recent past and pending peace agreements and the resulting economic and development status of EMRO countries, there are significant groups and numbers of poor people who have little opportunity to improve their circumstances. This is due to the economic and developmental status of their country, or their circumstances in their host country as is the case of Palestinian refugees.

Children with disabilities are more likely to be neglected, malnourished, poor or die young. Whilst all children with disabilities face challenges of their rights and are more vulnerable to violence, abuse and exploitation, girls with disabilities are generally more vulnerable than boys with disabilities. Additionally, girls in institutions and in areas of conflict are more at risk of violence and sexual abuse. Within EMRO societies, boys are sometimes more valued than girls, which can result in the delay or the omission of effective rehabilitative interventions for girls with disabilities. Studies from the region have shown that in some communities the number of males with disabilities is greater than the number of females with disabilities. Such data raises questions around the apparent phenomenon of missing females with disabilities. Is it that females with disabilities are more disadvantaged, with a higher social cost and with a higher rate of illness and subsequently premature death relative to males with disabilities? Alternatively, perhaps under-reporting occurs where families 'forget' about the presence of their female members with disabilities, or are hesitant to declare them because of the stigma involved. Both examples point to a female disadvantage and therefore raise the issue of the relationship between disability and gender. Anecdotal evidence seems to point out that women with disabilities have less access to education, rehabilitation services and employment opportunities than men with disabilities<sup>5</sup>.

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<sup>4</sup> For more on the poverty status of people with disabilities, see Einar Helander, *Prejudice and Dignity—An Introduction to Community-Based Rehabilitation*, 2nd edition, New York: United Nations Development Programme, 1999 Available online at: [http://dag.virtualave.net/p\\_d.htm](http://dag.virtualave.net/p_d.htm). See also Ann Elwan, *Poverty and Disability—A Survey of Literature*, Social Protection Discussion Paper No. 9932 (Washington, D.C.: World Bank, 2000). Available online at: <http://www.worldbank.org/sp/>.

<sup>5</sup> Abu-Habib, Lina. *Gender and Disability: Women's Experiences in the Middle East*. Oxfam, 1997.

Across the region many mothers report that they have difficulties in establishing if their children have impairments. These difficulties are rooted in professional and social attitudes and a lack of capacity of appropriately trained staff. The main factors contributing to this situation include:

*Professional attitudes*

- a) Medical staff are reluctant to advise parents that a child has some degree of impairment, and parents are left to discover this by themselves. This action delays the parents' acceptance of the situation, which is vital for the family to effectively support the child for the future.
- b) Medical staff promote the belief that impairments are curable, and therefore encourage the families to proceed with lengthy costly treatments that in the end are shown ineffective. This is due to the fact that early detection of disabilities is not included in most curricula of health professionals.

*Family attitudes*

- a) Parents do not want to believe that their children have some kind of impairment and do not seek appropriate advice as early as possible. Many children with disabilities are viewed as a burden and believed to bring shame on the family. Consequently severely disabled children are hidden away, deprived of nutrition, comfort and all levels of social interaction.
- b) Fathers and other extended family members do not value children with disabilities as much as non-disabled children, and do not always give the necessary support to the mothers to gain a diagnosis and appropriate rehabilitation support.

Communicable diseases, high rates of consanguinity, weak prenatal and child health services, traffic accidents and political violence, are important determinants contributing to current levels of disability in the Eastern Mediterranean Region. Countries like Iran, Iraq and Yemen have malnutrition rates for children under five years of age that are higher than the average for lower middle-income countries. Not all the population in the region has access to improved water sources. For example in Yemen, 31% of the population drinks water from unsafe sources. Infant mortality in EMRO countries is more than one third higher than the average for lower middle-income countries. HIV/AIDS is of increasing concern. In 2002, there were 83 thousand new cases of infection in EMRO countries (Jenkins and Robalino, 2003). Despite the current low levels of HIV/AIDS prevalence as compared to other regions of the world, it is expected that exponential growth in infections will materialize in the future.

Death rates from road crashes in 2002, which can be used as a proxy for injuries from road accidents, are high. The mortality rate per 100,000 population caused by road traffic injury in EMRO countries is among the highest in the

world, about 26.4, compared to 19 for the world as a whole (WHO, 2003). About 130,000 people died in road accidents in the Middle East and North Africa (MENA) in 2002. There are no estimates available on the impact of road accidents on disability but the World Report on Road Traffic Injury Prevention (WHO 2004), states that worldwide, the number of people killed in road traffic crashes each year is estimated at almost 1.2 million, while the number injured could be as high as 50 million

Military and civil conflict is another source of disability in EMRO countries. Ongoing examples include the conflicts in Afghanistan, Algeria, Iraq, the West Bank and Gaza. Data from the West Bank and Gaza shows that the ongoing conflict has had a sharp negative impact on employment and income among Palestinian families, and malnutrition rates among young children are on the rise. Because of such conflicts, the provision of basic health, education and water services has become erratic. In the recent past, the Iran-Iraq war had a high impact in terms of disabled combatants. In addition to the most visible aspects of physical injury, there is also the mental and psychological impact from exposure to traumatic events. There is evidence of increased domestic violence in the West Bank and Gaza during the intifada, and there is anecdotal evidence of long-term adverse effects on school performance of children exposed to traumatic events. It is difficult to assess the extent of Post Traumatic Stress Disorder (PTSD) in Iraq. However, based on the experience gained during recent conflicts, expert opinion suggests that at least 15 % of the population may experience mental distress severe enough to require treatment.

#### Recent Developments:

During the past few years, the Eastern Mediterranean region has witnessed a number of important initiatives, raising the issue of mainstreaming disability. During the 56th session of the UN General Assembly (2001), it was proposed to establish a Special Committee that would be responsible for studying the question of a new international convention on promoting and protecting the rights of persons with disabilities.

In August 2002, the Ad Hoc Committee on the International Convention was designated to consider proposals related to a comprehensive and integral international convention to promote and protect the rights and dignity of persons with disabilities. As a result, the International Conference on the Rights of Persons with Disabilities<sup>6</sup> was held in October 2002, and paved the way for the Arab Decade of Disabled Persons, 2004-2013<sup>7</sup>.

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<sup>6</sup> Persons with disabilities comprised 60 percent of the 300 participants.

<sup>7</sup> The ten main points identified for the Decade are: education; health; legislation; rehabilitation and employment; the disabled woman; the disabled child; accessibility and transport; globalization, poverty and disability; information and awareness; and recreation and sports.

In May 2003, the Economic and Social Commission for Western Asia (ESCWA) organized and led the Arab Regional Conference on Norms and Standards Related to Development and the Rights of Persons with Disabilities. In June 2003, Sheikha Hessa bint Khalifa bin Hamad Al-Thani of Qatar, was appointed as the Special Rapporteur on Disability for the Commission for Social Development for the period 2003-2005, to take a leading role in protecting the rights and dignity of persons with disabilities at the Arab regional level. In addition, and within a theme that has evolved over the past years, ESCWA is ensuring that ESCWA cities are more humane by being made accessible and user-friendly by all<sup>8</sup>.

At the country level, a number of Eastern Mediterranean countries have issued disability-related legislation, reflecting varying approaches to mainstreaming disability. Some current legislation is “rights-based” (broad), and includes disability as a small component. The components are usually delegated to an executive authority that is neither qualified nor has budgetary means to achieve the goals set forth. Enforcement mechanisms and resources for disability services are limited.

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<sup>8</sup> Accessibility for the Disabled: A Design Manual For A Barrier Free Environment and Accessibility for the Disabled in the Urban Environment in the ESCWA Region Planning and Design Solutions. Available in Arabic and English.

## Meeting Report:

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In May 2001, the Disability and Rehabilitation team of WHO (WHO/DAR) organized an international consultation in Oslo, Norway, in collaboration with disabled people's organizations (DPOs) and organizations of health professionals on the theme of "Rethinking Care – from the Perspective of Disabled Persons". In the same period, in consultation with the UN Special Rapporteur on Disability, WHO/DAR carried out a survey in 68 countries in all world regions about the implementation of the UNSR, specifically with regards to four rules related to health care (i.e., rules 2, 3, 4 and 19). As a result of these initiatives, it was recommended to strengthen the implementation of UNSR at country level. In consultation with regional offices of WHO, WHO/DAR proposed the organisation of inter-country meetings involving representatives from ministries of health and social welfare and national DPOs. The aim of these inter-country meetings was to promote the implementation of the UNSR.

The first inter-country meeting on the implementation of the UNSR was organised in SEARO in 2003. AFRO organized the second meeting in 2004. The AMRO region held its meeting in 2005. The present meeting was the fourth inter-country meeting, and it took place in Cairo (Egypt) from 2 – 4 May 2006.

### **Objectives:**

- Discussing the current situation of application of Rules 2 (medical care), 3 (rehabilitation), 4 (support services), and 19 (personnel training) in EMRO countries.
- Identifying major constraints to the implementation of the UNSR.
- Recommending national and regional strategies for overcoming the constraints, and for strengthening the application of these four rules.
- Encouraging regional networking and sharing country experiences towards stronger application of the UNSR.

### **Participants:**

The UN Special Rapporteur on Disability, H.R.H Sheikha Hessa from Qatar attended the meeting, and eight countries participated and sent their representatives. These were: Egypt, Iran, Iraq, Jordan, Lebanon, Palestine, Pakistan, and Sudan. There were representatives from governmental organizations (Ministries of Health and Social Affairs), as well as civil society (disabled people's organizations and non governmental organizations). Annex 1 provides a full list of the participants and their contact information.

### **Opening Session:**

Dr. Hussein Gezairy, WHO Regional Director for the Eastern Mediterranean Region formally inaugurated the meeting. In his welcoming speech, Dr. Gezairy pointed out that among an estimated 600 million persons with disabilities world wide, more than 40 million live in EMRO countries. He noted that the high incidence of disability in the region is caused by the many natural and man made disasters to which the region is prone. He acknowledged that persons with disabilities in the region have been included in different social areas for many years. However, the region still suffers from barriers to accessibility.

Dr. Gezairy then highlighted the most significant international actions in the transition of disability services from a “charity” to a “rights-based” approach. A major milestone to this effect was the adoption of the UNSR by the UN General Assembly in 1993. WHO’s contribution to the implementation of the UNSR was its launch of a global survey to monitor four Rules pertaining to health. This was conducted by the UN Special Rapporteur on Disability in 1999. He presented some of the survey results, which suggest that the Rules need more strengthening.

Another main landmark by WHO has been the development of the International Classification of Functioning, Disability, and Health (ICF), officially endorsed in 2001. This was followed by a resolution during the fifty-eighth World Health Assembly by all member states to improve the lives of persons with disabilities, support CBR, and include a disability component in national health policies and programmes. The resolution committed WHO to support member states in these efforts.

Recognizing the many challenges facing persons with disabilities, Dr. Gezairy emphasized their right to enjoy all aspects of life equally with non disabled citizens. He indicated that the only way to implement the UNSR is to involve persons with disabilities and their organizations, which is an area that still needs to be worked on. He advocated more development of community-based initiatives, and utilizing EMRO’s considerable experience in this area in order to change public attitudes regarding the provision of high quality life for persons with disabilities.

In her speech, the UN Special Rapporteur on Disability, H.R.H Sheikha Hessa, noted that the UNSR represent a set of moral obligations that apply to member states, local governments, the public and private sectors, service providers, families, and any social structure or individual dealing with persons with disabilities. The UNSR serve as policy guidelines, tools for policy making, proposals for concrete action, and a base for technical, economic and international cooperation. They identify barriers to the inclusion and participation of persons with disabilities, and help governments to remove them.

The UN Special Rapporteur explained that the overarching principle governing the UNSR and which gives them moral and political authority is the concept of equalization of opportunities. She then moved on to the area of health,

emphasizing that it is a human rights issue that needs to be accessed by all, particularly infants and children with disabilities. Among many factors denying the right of persons with disabilities to health, Sheikha Hessa mentioned the inaccessibility of the physical environment, lack of relevant information and of health awareness.

The rights based approach to disability was a principle which the UN Special Rapporteur used to discuss the subject areas of the meeting, namely access of persons with disabilities to medical care, rehabilitation, support services, and trained personnel. She emphasized that persons with disabilities should be provided the same level of health-related services within the same system as non-disabled members of society. Sheikha Hessa ended her speech by encouraging the participants to come up with strong ideas towards the implementation of the UNSR.

Dr. Federico Montero, presented the efforts of WHO/DAR - of which he is the coordinator - and its commitment to implement the four Rules related to health care. The importance of these four rules stems from the fact that they are prerequisites for the equal participation of persons with disabilities.

He mentioned some of the most important events related to disability in the last 30 years, and commented that there is still a lot of activities to be done in relation to disability. He considered disability as part of human diversity, and that the foundation of a dignified life is the right to health, which involves much more than medicine.

Dr. Montero discussed the availability, acceptability, accessibility, affordability and quality of medical and rehabilitation services. He stressed on the need to strengthen rehabilitation services, which are currently the weakest component of PHC. This is important given that rehabilitation is a powerful tool for empowering persons with disabilities and their families.

In his presentation, Dr. Mohamed Yassamy, Regional Adviser for Mental Health and Substance Abuse (WHO/EMRO) gave a historical perspective on perceptions relating to persons with disabilities in the Eastern Mediterranean Region, and the mixed attitudes towards them.

### **Proceedings of the First Day:**

The first session of the day started with a presentation by Dr. Sunil Deepak, in which he highlighted the results of the 1999 WHO/DAR Global Survey on the Implementation of the UNSR, most particularly the key challenges facing their implementation in different areas of the world.

### Country Reports:

Dr. Nawwaf Kabbara (Lebanon) and Dr. Syed Fazle Hadi (Pakistan) were nominated as chairperson and rapporteur for this session.

Participating countries presented reports about the status of implementation of Standard Rules (2,3, 4 and 19), highlighting the main successes and challenges. A brief summary of the country reports is presented in the following section, while the full country reports are presented in Annex 3.

#### **Egypt:**

Ms. Nani Saleh, chairperson of a DPO for parents of children with intellectual impairments presented a report on the situation of disability in Egypt. She pointed to the increasing shift from a charity to a rights based approach in dealing with disability. She mentioned some statistics about the prevalence of disability, and available services. She indicated that the employment quota for persons with disabilities is largely not applied.

#### **Iran:**

Mr. Mohammad Mahmuzadeh, Deputy for Rehabilitation of the Isfahan Welfare Organization presented Iran's report. He mentioned the prevalence and incidence of disability. He also explained the status of the different rules related to health care.

#### **Iraq:**

Dr. Sabah al-Rubayi, Director General of Specialized Services and Medical Operations Department in the Ministry of Health discussed the main issues related to disability in Iraq. He emphasized the link between disability and mortality, which results from the deficiency in trained personnel and medical facilities. Although there is a lack of reliable statistics, there are indicators towards an increase in the prevalence of disability due to the violent conditions in which Iraqis have been living for decades. He then presented the different services available to persons with disabilities in Iraq.

#### **Jordan:**

Dr. Salem Al Majali, Consultant of Physical Medicine and Rehabilitation at the Ministry of Health, presented the current situation of disability in Jordan. He indicated the challenges in estimating prevalence and in providing enough services for the growing population with disabilities.

**Palestine:**

Ms. Hana Quaymary, Director General of People with Special Needs, highlighted the efforts of the Ministry of Social Affairs in the West Bank. She discussed disability prevalence, available rehabilitation services, the challenges facing the implementation of the UNSR, and the need for better outcomes. In order to better implement the UNSR, Ms. Quaymary suggested a systematic approach in training, implementing the disability law, having an accurate disability data base, having a holistic approach towards rehabilitation, and promoting partnership between the government and civil society.

Dr. Khamis Elessi, Head of the Medical Rehabilitation Team at Al-Wafa Hospital, gave an overview of the hospital services as well as the most common impairments in Gaza.

**Pakistan:**

Dr. Syed Fazle Hadi, Executive Director of the Pakistan Institute of Medical Sciences (PIMS) at the Ministry of Health, presented the main activities of PIMS particularly with regards to the 2005 earthquake. He gave a background on the situation of disability, including the health system, main rehabilitation services, and disability legislations.

In the second presentation from Pakistan, Dr. Maryam Mallick described WHO emergency efforts in response to the earthquake disaster.

**Sudan:**

The Sudan report presented a real picture of the successes and challenges facing the application of the UNSR. The involvement of persons with disabilities in rehabilitation, and the availability of assistive devices in some areas were the main successes. As for the challenges, they included the lack of implementation mechanisms and of trained personnel, and the discontinuation of the family based rehabilitation programme.

***Discussion:***

Following the country presentations, these issues were raised in the plenary session:

- The Eastern Mediterranean Region lacks reliable data about disability. Factors that affect the quality, reliability and completeness of disability data were: how statistics are generated, who generates them, when they are generated, and what definitions are used to generate them. Although standardized definitions such as ICF exist, the spectrum and definitions of disability are still being decided upon by the member states during the

drafting of the UN Convention on disability. Dr. Montero mentioned WHO's efforts to assure that the upcoming World Report on disability and Rehabilitation can contribute and support Member States, to produce more robust and evidence based data. The process of writing the report aims to provide a framework to help member states collect data in a uniform manner. He further stressed on the importance of paying attention on what can be done to improve and strengthen the services needed by persons with disabilities, even in the absence of accurate data on disability.

- Dr. Kabbara commented that there is no clear direction towards the social and rights-based approach in EMRO countries, and that the medical approach is still much more prevalent. He emphasized the idea that both approaches are linked, and that the more we move towards the social approach, the less medical cost.
- The role of persons with disabilities and their organizations was not very apparent in the country presentations, especially with regards to their partnership with other stakeholders. It is therefore important to be critical of ourselves and look at the gaps in order to be able to improve the situation of persons with disabilities.
- H.R.H. Sheikha Hessa mentioned that her office has finished gathering data from the latest global survey on the implementation of the UNSR and that it is now being analyzed. The initial analysis suggests that there is an overlap between different national bodies providing services for persons with disabilities, and that there is lack of awareness among the different sectors/stakeholders.
- The link between disability and mortality was established, particularly in the case of areas of conflict and natural disasters. This is due to the deficiency in specialized medical personnel and facilities.

## **Review of Rules:**

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### **Rule 2 - Medical care:**

The rest of the day was dedicated to discussions about Rule 2. Dr. Nawwaf Kabbara (Lebanon) and Dr. Salem Al Majali (Jordan) were nominated as chairperson and rapporteur for this session.

The group discussions were preceded by a presentation by Dr. Deepak, where he highlighted some of the major issues linked to medical care services for persons with disabilities. These included different approaches to service delivery, difficult access to medical care, lack of multi-disciplinary teams, difficulties in early detection, the focus on curative aspects, and the plight of persons with severe disabilities.

Following Dr. Deepak's presentation, the participants were divided into three groups, which raised the following issues:

- There are several factors that prevent persons with disabilities from benefiting from good quality, affordable, acceptable and accessible medical services. These include inadequate financial resources, limitations of existing health facilities and infrastructures (including physical inaccessibility), lack of legislations, low level of awareness among decision makers, shortage of information, negative attitudes towards persons with disabilities, high cost of medical services, and discrimination. Access to medical services is particularly at a disadvantage at the community level, which lacks trained doctors and health professionals, and for young children with impairments.
- Possible ideas to improve access of persons with disabilities to medical services include drafting laws and enforcing those that exist, implementing screenings, audiometric and visual tests for newborns, raising community awareness and advocacy about disability, improving the capacities of NGOs to provide services in areas that lack them, forming a national rehabilitation authority or monitoring body, providing information about available services (see Box 1), equipping hospitals with facilities for early detection and intervention, increasing accessibility of medical services, training medical and paramedical staff, strengthening the referral system, and expanding the medical insurance coverage to all persons with disabilities.

### **Box 1**

#### Accessibility of Public Services in Lebanon

In 2006, the Arab Organization of Disabled People (AODP) issued a booklet on the accessibility of public services in Lebanon. It includes governmental and non-governmental services such as ministries, restaurants, syndicates, international NGOs, schools and hospitals among others.

- With regards to reasons behind the inadequacy of some components of the medical care system, the participants highlighted the lack of long term strategies for health care, deficient coordination among different medical facilities, and unavailability of statistics on disability. Suggested solutions to improve these components included the establishment of multi-sectoral consultative committees.
- The participants acknowledged the importance of implicating DPOs in planning and evaluating medical care services, and remarked that this is not widely practiced in the Eastern Mediterranean region. This results from the limited number of DPOs, their underestimation by society, lack of awareness (among persons with disabilities and decision makers), and to the fact that social integration has not been encouraged for persons with disabilities and their organizations. Increased participation of DPOs in the area of medical services can be encouraged by enhancing the education of persons with disabilities, supporting the establishment of DPOs and building their capacities, in addition to having legislations to support the socioeconomic mainstreaming of persons with disabilities.
- The participants discussed the reasons why medical care services may not carry out early detection of disabilities. These included lack of resources, awareness, and adequate training of health workers. This can be overcome by screening for the causative factors of disability, improving the general health system, and providing health education.
- The costs of medical care are often too high for persons with disabilities and their families. This can be overcome by the involvement of the private sector (to cover insurance costs in partnership with governments), provision of information about available insurance schemes, promotion of local production of assistive devices and aids, and increasing the number of trained personnel.
- It was acknowledged that medical care services are lacking in rural areas and disadvantaged urban neighborhoods. This results from the fact that specialists are not willing to provide services to these areas. This can be

overcome by the promotion of community based rehabilitation services, establishing basic rehabilitation units at the grassroots level, and involving focal persons such as lady health workers.

- Prevention of disabilities can be encouraged through public awareness, establishing rehabilitation centres, screening for some diseases such as thyroid disorders and phenylketonuria.

### **Proceedings of the Second Day:**

Dr. Ibrahim El Nekheikli (Egypt) and Mr. Atif (Pakistan), were nominated as chairperson and rapporteur for the second day of the meeting.

### **Rule 3 - Rehabilitation:**

The first session started with a presentation by Dr. Deepak on rehabilitation services, and the gaps which the WHO/DAR survey revealed in terms of the application of rule 3. He mentioned that in many cases, rehabilitation is given low priority in terms of financial allocations, and that sometimes the private sector plays a major role in providing rehabilitation services in areas where they are not provided by the government. Other problems facing rehabilitation services are that they are not multi-sectoral, are far from each other and are not accessible. He drew attention to the fact that many resources are spent on surveys, leaving little resources to implement what is needed. He therefore recommended that surveys should be conducted when there is a will and resources to do something concrete. He gave an overview of the different approaches to rehabilitation such as the institutional, outreach, and community based rehabilitation, and concluded his presentation with the role of persons with disabilities in rehabilitation activities.

Following Dr. Deepak's presentation, the participants were divided into three groups to discuss Rule 3. The group discussions raised the following issues:

- Persons with disabilities, their families and organizations must be involved in all stages of rehabilitation services: planning, implementation and evaluation. They should also be included as rehabilitation experts and consulted as to their needs and what can improve their quality of lives.
- National rehabilitation strategies should be developed, including different rehabilitation approaches such as CBR, outreach and independent living. There should also be formal national councils/authorities to coordinate

rehabilitation services. Such councils should not be managed by any ministries.

- Rehabilitation services are not enough in some countries due to lack of resources, and difficult terrain. A cost effective way of dealing with these problems is to have focal persons in each area/district/county to identify persons with disabilities and refer them to appropriate services in other regions. A prerequisite for this is developing strong referral systems.
- Another reason why rehabilitation services are not currently effective is that rehabilitation personnel have limited knowledge about specific impairments. There is particular shortage in speech and occupational therapists and vocational trainers. This requires training the rehabilitation team working with persons with disabilities and their families. In this regard, regional and international cooperation is encouraged. Tools to diagnose and assess the type and extent of disabilities should also be developed, and guidelines for dealing with each disability and injury should be formulated.
- If rehabilitation services exist, they are usually not comprehensive, which requires the promotion of integrative rehabilitation systems initiated from the grassroots level.
- It is important to promote the CBR strategy at community level, due to its potential in overcoming current deficiencies in the provision of rehabilitation services. The success of such programmes will be ensured with the active involvement of persons with disabilities. CBR programmes must be multi-sectoral and deal holistically with persons with disabilities.
- The extent of available rehabilitation services should be determined through needs assessments, listings of existing services, and starting data banks at central, district and local levels. The resulting information should be disseminated through the internet and mass media. Particular focus should be given to provide such information to the community level.
- Rehabilitation departments at district hospitals should be expanded to provide a minimum level of rehabilitation services, and funds should be allocated by the State to provide free rehabilitation services.
- In addition to the role of the State, NGOs should also be involved at the grass root level for the provision of rehabilitation services.

- Through its offices, WHO should bring to the attention of policy and decision makers issues such as resources, awareness and advocacy and other problems facing different countries in providing appropriate rehabilitation services.

#### **Box 2**

##### Shift in Rehabilitation Services in Pakistan

The average stay in a veterans' hospital for persons with paraplegia was 13 years, and some patients stayed for 29 years. The system, which gave the patients many benefits, made them develop a dependence on it. A change in hospital management took place, with a view towards allowing patients to live independently. The patients were given vocational training and provided with knitting and sewing machines. They were then sent home with all the assistive devices they required (e.g., orthopedic beds), and a monthly stipend for personal assistance. Initially, the patients resisted this change. However, when they experienced living independently in their communities, they became satisfied.

#### ***Discussion:***

The group presentations were followed by a discussion where the following issues were raised:

- Dr. Montero stressed on the importance of including a rehabilitation component in dealing with acute illnesses such as spinal cord injuries and strokes. Acute health care should be given more attention since it now comes at the end of the continuum of rehabilitation services.
- There is a need for a high level governmental body to support and coordinate activities in rehabilitation and make sure that professionals and the disability movement are working in harmony. This is particularly needed in the cases of countries which have resources and little coordination. Persons with disabilities must be implicated in this committee.
- With regards to the type of rehabilitation services, Dr. Montero said that there is a need for both CBR as well as institutions. This does not mean having expensive equipment, because rehabilitation can be performed with very simple equipment. What is needed is to change attitudes in institutions (through training personnel), so that rehabilitation professionals

work more in partnership with persons with disabilities and their families. This will largely improve the effects of rehabilitation.

- Dr. Yassamy highlighted the importance of involving local communities in providing at least minimum rehabilitation services, particularly in disadvantaged areas (e.g., urban slums, rural areas and conflict situations).
- With regards to referral systems, Dr. Montero stressed that the development of rehabilitation services should be promoted on the community, district, and national levels. It is particularly important to ensure that a rehabilitation component is introduced within existing services.
- There was a lot of debate and discussion about CBR. According to Dr. Kabbara's experience, some CBR projects were not very successful, and were more like outreach programmes. He advocated a paradigm shift into the independent living approach, where persons with disabilities are in charge of their life and living as autonomous as possible. Persons with disabilities proved to be successful in implementing such programmes, because of their will to change, which professionals often lack. The idea that CBR is a strategy/philosophy not a programme was stressed, and the link between it and class/wealth was raised. It was concluded that independent living can be an underlying goal in all rehabilitation programmes, and there should not be a division between it, CBR, and outreach projects.
- Governments should be forced to provide adequate rehabilitation services and put disability high on their agendas. The UNSR are a tool that can be used to raise awareness to promote development of rehabilitation and medical services, and ensure that persons with disabilities have access to them.
- Care must be taken to have a coordinated, comprehensive and multi-sectoral approach that will ensure the sustainability of rehabilitation services. Integrated programmes are preferred to vertical ones because they are more cost-effective.
- There is a need for national disability plans due to the current lack in strategic planning with regards to rehabilitation.

#### **Rule 4 - Support Services:**

The second session of the day was devoted to Rule 4 related to the provision of support services. After a presentation by Dr. Deepak, the participants were divided into three groups, whose discussions raised the following issues:

- Existing facilities for the provision of assistive devices should be mapped and disseminated through disability resource centres.
- Local manufacturing of simple assistive devices at reduced costs (e.g., Jaipur foot) should be encouraged through incentives such as tax exemption and interest-free loans to local organizations. Public and private partnership should also be developed. Persons with disabilities and their families must be involved in different stages of providing an assistive device, and their feedback regarding the quality and effectiveness of the device must be taken into account.
- Prescription of assistive devices should be given by licensed authorized organizations. Technicians should be trained on the provision of assistive devices through master and degree programmes.
- Distribution of free assistive devices should be given to those in need through mechanisms such as Bait-ul-Mal, zakat, social security, medical insurance, assistive devices fund, and governmental funds for needy persons. Rental services should also be available.
- All imported assistive devices, their spare parts and raw materials should be tax exempted.
- Patients with life-long needs like spinal cord injuries must be provided with ripple mattresses, wheel chairs, toilet chairs, and transfer boards, etc.
- Research and development regarding assistive devices should be conducted in collaboration with international disability NGOs and technical institutes.

- Persons with disabilities and their families should be trained for the use and maintenance of assistive devices.
- The unavailability of personal assistance can be solved through CBR services which involve the stakeholders, and the allocation of government funds.
- Recommendations to improve support services included: issuing a disability card by national health organizations, fair allocation of national budgets to all types of disabilities, involving persons with disabilities in the decision making and planning of all strategies concerning them, encouraging volunteerism (see Box 3), improving accessibility, and having government subsidies for the production of assistive devices.

### **Box 3**

#### Volunteerism in Palestine

In order to graduate from Palestinian universities, students must complete 300 hours of volunteer work. This was suggested as a mechanism in order to provide assistance to persons with disabilities.

#### ***Discussion:***

- A question was raised about the use of zakat money with persons with disabilities and whether it can be considered as charity. The answer was that zakat is not a charity, but rather a form of taxation for muslims. It is the right of needy muslims to receive it, whether they are disabled or non disabled. Therefore, there is no stigma attached to it, and its use to cover different requirements and needs of persons with disabilities.
- It is essential to assure that governments provide assistive devices as part of public services in addition to their efforts in providing medical care and strengthening rehabilitation. This results from the fact that assistive devices are a prerequisite to any efforts towards equalization of opportunities. Governments should also reduce working hours of care-givers so that they are able to care for persons with disabilities.
- Consulting persons with disabilities and their families in providing support services must be a reality, because professionals are often not in touch with

actual needs. One example from Palestine is that hospital patients tell doctors that they do not need prosthesis and orthosis. What they need is re-adaptation of their house.

#### Box 4

#### Consulting Persons with Disabilities in Support Services

In the aftermath of the earthquake in Pakistan, wheelchairs were distributed to the affected areas. When WHO staff returned later, they found that the wheelchairs were sold and replaced by donkeys because they were more appropriate to use in the rugged mountainous terrain of the region.

Similarly, urine bags were not used by persons with disabilities who thought that they would return the urine back to the body. They were replaced by Pepsi bottles.

These two examples draw attention to how important it is for professionals to consult persons with disabilities with regards to support services.

- All types of disabilities must be treated equally, and there should be no discrimination among different groups of persons with disabilities.
- Some countries have few DPOs. It therefore becomes very important to empower and facilitate groups of persons with disabilities to form DPOs and build their capacities to develop income generation activities in addition to lobby for their rights. It was mentioned that funds for personal assistance were managed better through DPOs than the governments.
- Dr. Yassamy emphasized the need to focus on personal assistance, particularly that many countries do not have home care systems even in the private sector. After an injury, there is no house care after the patient is released from hospital. One possibility is to have mobile health support units that is discounted or free and provided by professionals, lab technicians, who visit homes. This is much less costly than the cost of not giving support, and policy makers should be convinced of adopting this policy. Volunteers should also be encouraged to participate in such home care, especially that the culture of volunteerism is prevalent in EMRO countries.
- Dr. Montero drew attention to the fact that personal assistance is not confined to home settings. It can be needed in educational settings, e.g., hearing students helping deaf students in schools and universities.

- All health services should be accessible. Ministries of health should have a mandate that private clinics are accessible.

### **Proceedings of the Third Day:**

#### **Rule 19 - Personnel Training:**

The first session of the third day was devoted to discussion of Rule 19 (personnel training). Ms. Maryam Nikpoor (Iran) and Ms. Hana Quaymary (Palestine) were nominated as chairperson and rapporteur for this session.

After an introduction from Dr. Deepak, the participants were divided into three groups according to type of organization they belonged to (Ministry of Health, Ministry of Social Affairs and DPOs/NGOs).

The following issues came up from the group discussions:

- There are several problems related to training personnel, including the following:
  - Policy makers consider training as waste of time and money, so they allocate a small amount of the budget for it.
  - Personnel are paid low salaries and are provided no incentives by the government, which leads to their demotivation.
  - Training professionals is very costly, and there is a shortage of training institutes.
  - Lack of expertise in the field of rehabilitation for the provision of training.
  - Lack of training materials/curricula, and if available, there are not always culturally and linguistically appropriate.
  - Persons with disabilities are usually not involved in the development of curricula and training modules.
  - Women with disabilities have no access to training, particularly about activities of daily living.
- Suggested solutions related to training personnel were:
  - Sensitization, orientation and training of regular school teachers to be able to include children with disabilities in their classrooms.
  - Increasing staff incentives and salaries.

- Adopting a systematic approach in training
  - Adapting available training curricula culturally and linguistically.
  - Mainstreaming disability issues in general curricula.
  - Establishing more training institutes for speech and occupational therapy.
  - Establishing a training strategy at all levels. Different professionals (e.g., doctors, nurses, etc.) should be trained on detecting and screening disabilities.
  - Setting up training standards by the international disability community that are accepted by the State.
  - Updating training regularly.
  - Directing training through different professional associations as a pre-requisite for receiving a training license.
  - Establishing a training network between EMRO countries (e.g., an integrated multi-disciplinary course on disability, where different subjects and disciplines are delivered to medical personnel.
  - Governments should take their roles in training in coordination with universities, NGOs, persons with disabilities.
- With regards to the types of training required, the participants mentioned degree courses, capacity building (increasing capabilities to face new challenges, and advocacy and awareness for communities and care givers.
  - Concerning trainees, the participants mentioned that they can be rehabilitation professionals such as doctors, occupational, speech and physiotherapists, etc., other professionals such as engineers and teachers, managers and staff of NGOs, persons with disabilities leading DPOs, personal attendants of persons with severe disabilities, as well as rehabilitation and non rehabilitation professionals.
  - With regards to trainers, the participants stressed that trainers must be certified. Trainers could be persons with disabilities and their families, qualified organizations having expertise such as NGOs, INGOs, universities, DPOs, and qualified personnel.

**Box 5**  
Personnel Training in Iran

Iran follows a systematic and successful system for training its rehabilitation professionals. There is a University of Social Welfare and Rehabilitation Science, which offers academic courses in different rehabilitation specialties as well as practical experience. Half the graduates (the most successful) join the staff of the State Welfare Organization. During their work at the Welfare organization, staff are periodically assessed. If they successfully pass the assessments, they are promoted and the State funds their graduate studies. If they fail these assessments, they are demoted and not given the opportunity to pursue further studies.

***Discussion:***

- During the discussion, it was mentioned that even non-qualified people (e.g., mothers of children with disabilities) could and should be involved in training. To illustrate this point, an example was mentioned from Pakistan, where there was an acute shortage after the earthquake. In the absence of medical professionals, rehabilitation workers were given basic training in order to fill the existing gap. They proved to be successful, and after a few months, they worked under the supervision of professionals. Other participants felt that non-qualified people (e.g., mothers) should take part in shaping training, and in providing role models. However, unless they are trained and qualified, they should have no training responsibilities so as not to provide wrong information.
- Dr. Montero raised the issue of criteria for defining who is qualified or not. He commended the idea of networking among countries because some countries have developed courses and training materials, which can be modified according to each place's special circumstances. He gave an example of the training provided by the University of Alexandria.
- A need for accreditation bodies and authorities that monitor everything related to training was mentioned.
- Both the UN Special Rapporteur and Dr. Montero emphasized the need towards family empowerment and involving persons with disabilities in all stages of the rehabilitation process. It was mentioned that there are strong barriers by professionals to recognize this, because of their training which makes them rather inflexible.

- Dr. Yassamy mentioned that involvement of families in rehabilitation should be given careful attention. This results from the fact that sometimes professionals may depend too much on families, leading about 80% of caretakers to develop deep depression. He suggested providing families with support and assistance, particularly within projects which depend on families.
- Dr. Montero drew attention to the fact that information about sexual and reproductive health is more difficult to give to children and adolescents with disability, and many professionals do not want to take responsibility for it.
- With regards to the UNSR, the UN Special Rapporteur mentioned that the four rules discussed in the meeting are vital to give opportunities to persons with disabilities to achieve full participation, and that they should be complemented by other rules. She emphasized that UNSR should be used together with other instruments such as national plans. This results from the fact that the UNSR are not morally binding and on their own, they can not achieve far-reaching results. This is unlike the UN Convention, which is going to be legally binding. Therefore, governments, DPOs, civil society, and UN agencies should work together to achieve best results of the UNSR.
- Dr. Hussein Abouzaid talked about the necessity of having maximum actions at the PHC level and not in specialized centers.
- The UN Special Rapporteur mentioned that while some countries are familiar with and implement the UNSR, others do not know about them. She mentioned successful examples from Latin America, where good work is being done with limited resources. In some countries, there is collaboration with different organizations to apply the UNSR. The UN Special Rapporteur presented some of the activities she is organizing to activate the application of the Rules, such as meetings for Arab women with disabilities. A main obstacle facing her is funding because few member states participate financially in such activities.
- Dr. Montero mentioned the presence of other UN Special Rapporteurs and how important it is to collaborate with them. With regards to funding, he advocated the need for someone to give full attention to the funding issue in the Eastern Mediterranean region.
- Dr. Alaa Sebeh suggested the start of an e-mail group to share documents, experiences and good practices.

## **General Recommendations:**

### ***National Level:***

- Ensuring that all persons with different disabilities are given due attention, especially women. There should be **no discrimination** among persons with disabilities.
- Setting up national and regional **rehabilitation councils/authorities** to coordinate different rehabilitation activities. These authorities also have a role in designing relevant training curricula for different personnel dealing with persons with disabilities, and in developing national policies.
- Promoting low cost, locally made **assistive devices** that should be provided free of charge. This can be done through establishing local manufacturing units, and starting national funds to provide persons with disabilities with their requirements of assistive devices.
- Establishing **health management information systems** concerning disabilities.
- Following a systematic approach in **training** personnel. This includes mainstreaming rehabilitation studies in teaching and tertiary care institutions. Universities are also to be encouraged to start courses on disability and rehabilitation. Persons with disabilities should be involved in the different stages of training (planning, implementation and monitoring). A standardized training curriculum for all EMRO countries and all categories of health workers should be provided.
- **Integrating rehabilitation** services in primary health care (PHC) systems. This should be accompanied by establishing appropriate referral systems with services in the secondary and tertiary levels.
- Adopting **community based rehabilitation strategy** (CBR) in national policies.
- Having **plans of action** to implement the UN Standard Rules. NGOs and DPOs must be involved in applying this plan.
- **Sharing information, resources and best practices.**

### ***Regional Level:***

- Setting up national and regional **rehabilitation councils/authorities** to coordinate different rehabilitation activities. These authorities also have a role in designing relevant training curricula for different personnel dealing with persons with disabilities, and in developing national policies.
- Establishing **health management information systems** concerning disabilities.
- **Sharing information, resources and best practices.** Resource materials should be exchanged among EMRO countries, preferably in local languages. This could be done through an organization which can organize trainings, video conferences and exchange of experience.
- Establishing a **standardized training curriculum** for all countries and all categories of health workers.
- **WHO** should support and strengthen the CBR philosophy on the regional level. A partnership between WHO and regional bodies - such as the League of Arab Nations and ESCAP - and NGOs and DPOs in different areas related to disability should be developed. WHO should include persons with disabilities as experts in all fields, and encourage similar expert meetings to come up with recommendations for concrete strategies.

### **Closing Session:**

In the closing session, Dr. Jama presented the participants with greetings from Dr. Gazairy. He said that the report is a beginning for implementation, and that there must be monitoring mechanisms for the UNSR. He stressed on the importance for national institutions to collaborate with the UN Special Rapporteur, and was optimistic of the good results that can take place in EMRO countries. He referred to the gaps that the meeting identified in terms of training personnel, and there is a lot to do in the health sector to be fully compliant with the four rules. He requested EMRO and the WHO headquarters to support member states to implement meeting recommendations. He further said that the recommendations of this meeting will be shared in the next regional meeting which will take place in Iran. He concluded by thanking the participants and the organizers and Dr. Montero.

Sheikha Hessa started her closing remarks by thanking the organizers who gave her this opportunity to listen, learn, and participate. She said that part of her job is to link the Eastern Mediterranean region with other regions and experts.

She commended the good discussions that took place, and mentioned that there will be plan for more meetings and visits related to the promotion of rights of persons with disabilities (e.g., upcoming parliamentary meetings). She asked governments to fund activities to encourage the participation of persons with disabilities. She mentioned that in her work, she focuses more on developing countries because they need her work and effort more than developed countries, and gave successful examples from Guinea. She concluded by emphasizing the need to be proactive and collaborate with different bodies.

In response, Dr. Hussein Abuzaid mentioned that WHO is happy to collaborate with the office of the UN Special Rapporteur to implement her mandate.

Dr. Yassamy thanked all those who participated in the success of this meeting: Sheikha Hessa and her team, the distinguished guests from participating countries, the sincere support from Dr. Montero and Dr. Deepak, the rapporteurs, the WHO team headed by Dr. Gazairy.

**Annex 1**  
**List of Participants**

No.	COUNTRY	NAME	POSITION - ADDRESS	E-MAIL
1.	<b>Egypt</b>	Dr. Sayeda Abu Alsood	Deputy of the General Department for Social Rehabilitation. Ministry of Social Solidarity. Cairo.	
2.		Dr. Ibrahim El Nakhely	Director General of Children with Special Needs Directorate. Ministry of Health and Population. Cairo.	<a href="mailto:dr_elnekhely@yahoo.com">dr_elnekhely@yahoo.com</a>
3.		Ms. Naeema Ismail Saleh	Chairperson of the Right to Live Association For the Intellectually Disabled. Cairo.	
4.	<b>Iran</b>	Dr. Mohsen Shati	Executive Administrator of Community Based Rehabilitation. Ministry of Health and Medical Education. Teheran.	<a href="mailto:mohsen_shati@yahoo.com">mohsen_shati@yahoo.com</a>
5.		Ms. Maryam Nikppor	Teheran.	<a href="mailto:zotrehnik485@yahoo.com">zotrehnik485@yahoo.com</a>
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**Annex 2  
Meeting Agenda**

<b><u>Tuesday, 2 May 2006</u></b>	
Opening Session:	Dr. Hussein Gezairy, Regional Director – EMRO. H.R.H. Sheikha Hessa, UN Special Rapporteur on Disability. Dr. Federico Montero ,Coordinator DAR/HQ. Dr. Taghi Yasamy, RA/MNH – EMRO.
Coffee Break	
Morning Session	"WHO/DAR Survey on the Application of the UN Standard Rules and its Implications". Dr. Sunil Deepak , WHO/DAR Consultant.
	Country presentations (1)
Lunch	
Afternoon Session	Country presentations (2)
	Discussion of Rule 2 (Medical Care Services) Introduction to Rule 2: "Medical Care Services for Persons with Disabilities". Dr. Sunil Deepak , WHO/DAR Consultant.
	Coffee Break
	Plenary discussion on medical care services.
<b><u>Wednesday, 3 May 2006</u></b>	
Morning Session	Discussion of Rule 3 (Rehabilitation Services) Introduction to Rule 3: "Rehabilitation for Persons with Disabilities". Dr. Sunil Deepak , WHO/DAR Consultant.
	Coffee break
	Plenary discussion on rehabilitation services
	Lunch break
Afternoon Session	Discussion of Rule 4 (Support Services) Introduction to Rule 4: "Support Services for Persons with Disabilities". Dr. Sunil Deepak , WHO/DAR Consultant.
	Coffee break
	Plenary discussion on support services.
<b><u>Thursday, 4 May 2006</u></b>	
Morning Session	Discussion of Rule 19 (Training of Personnel) Introduction to Rule 19: " Training of Personnel for Persons with Disabilities". Dr. Sunil Deepak , WHO/DAR Consultant.
	Coffee Break
	Plenary discussion on training of personnel and general recommendation.
Closing Session	Dr. Jama, Deputy Regional Director – EMRO. H.R.H. Sheikha Hessa, UN Special Rapporteur on Disability. Dr. Federico Montero ,Coordinator DAR/HQ. Dr. Taghi Yasamy, RA/MNH – EMRO.
Lunch	

### Annex 3 Country Reports:

#### ***Egypt:***

- Rule 2 (medical care):
  - Medical care services are available in Egypt and are provided by governmental and non governmental bodies. However, they cover only a small percentage of actual needs.
  
- Rule 3 (rehabilitation):
  - Rehabilitation services are available in Egypt and are provided by governmental and non governmental bodies. However, they cover only a small percentage of actual needs.
  - There have been governmental efforts supported by the First Lady to upgrade institutions for children with intellectual impairments.
  
- Rule 19 (personnel training):
  - Teachers in some institutions for children with intellectual impairments were trained as part of a project to upgrade public special education institutions.
  - One DPO (the Right to Live) established a centre to train professionals.
  
- Success in the Implementation of the UNSR:
  - Collaboration between various ministries and NGOs.
  - Raising awareness about disability issues.
  
- The Major Constraints to the Implementation of the UNSR:
  - Available services do not cover needs, particularly in rural areas and urban areas outside big cities.
  - High level of poverty among persons with disabilities.
  - Inaccessibility of public services.
  - Funding problems facing NGOs and DPOs.

## ***Iran:***

- Rule 2 (medical care):
  - Medical services are provided nation-wide by the Welfare Organization, which is a department of the Ministry of Health and Medical Education.
  
- Rule 3 (rehabilitation):
  - The Welfare Organization provides medical rehabilitation services in centres for physiotherapy, occupational therapy, audiometry, speech therapy, etc.
  - There are social rehabilitation services available to persons with visual and intellectual impairments and the elderly (e.g., educational courses, training programmes, caring centres, sanitariums).
  - There are more than 100 vocational rehabilitation centres available to persons with intellectual impairments.
  - There is a national CBR program (currently covering 30 provinces). The program is under the aegis of the Welfare Organization and runs within the PHC referral framework.
  
- Rule 4 (support services):
  - The Welfare Organization has centres for orthopedics, and distributes yearly a considerable number of free hearing aids, wheel chairs, different walking sticks, Braille typewriters, cassette recorders and other support services.
  
- Rule 19 (personnel training):
  - Different professionals such as physicians, PHC managers and therapists were trained on CBR.
  
- Success in the Implementation of the UNSR:
  - Collaboration between various ministries and organizations.
  - Presence of a disability law.
  
- The Major Constraints to the Implementation of the UNSR:
  - Work opportunities are not enough after persons with intellectual impairments receive vocational rehabilitation.

## ***Iraq:***

- Rule 2 (medical care):
  - There are three hospitals for spinal cord injuries and one for the disabled.
  
- Rule 3 (rehabilitation):
  - There is a hospital for medical rehabilitation.
  - There are 12 rehabilitation center providing different therapeutic and rehabilitation services.
  - The Ministry of Labor and Social Affairs operates special institutions for persons with physical, hearing, visual and intellectual impairments. It also provides vocational training.
  
- Rule 4 (support services):
  - There are 12 prosthesis and orthosis factories, which can produce up to 5000 limbs annually.
  - Medical supplies and aids are available.
  
- Rule 19 (personnel training):
  - There are qualified staff: rehabilitation physicians, physiotherapists, prosthetis/orthotists, occupational therapists, specialists in the rehabilitation of persons with visual impairments, social workers, and speech therapists.
  
- Success in the implementation of the UNSR:
  - Preparation of a draft national strategy for persons with physical disabilities.
  
- The major constraints to the implementation of the UNSR:
  - Shortage in qualified personnel.
  - The unstable context, which increases the risk of having disabilities and decreases the government capacity to properly deal with disabilities.
  - Poverty and lack of social services.
  - Shortage in the production of artificial limbs (20000 required annually, and maximum 5000 are produced).
  - Lack of coordination between relevant bodies.
  - Lack of national policy on disabilities.
  - Many NGOs lack resources and capacity.
  - Administrative changes, e.g., in abolishing the Inter-ministerial Commission on Disabilities, and transferring the facilities it operated to the Ministry of Health.

## **Jordan:**

- Rule 2 (medical care):
  - There are programmes for prevention, early detection and diagnosis, and treatment of impairments.
  - There is referral to different services.
  - There is regular medical treatment provided for persons with disabilities.
  - Detection methods are available in mother and child health care units.
  - Medical care is provided free of charge by government ministries.
  - PHC services cover villages and urban areas.
  - Availability of medial and paramedical personnel at the local, district, provincial and national levels.
  
- Rule 3 (rehabilitation):
  - Implementation of CBR and institutional rehabilitation programmes at district, provincial and national levels.
  - There are programmes for rehabilitation techniques and for counseling parents.
  - Rehabilitation services cover between 6 – 20% of persons with different types of disabilities.
  - Rehabilitation services are provided by the government, private and voluntary sectors.
  - There is a national institute for CBR.
  - Rehabilitation services include vocational rehabilitation, and residential care.
  
- Rule 4 (support services):
  - Assistive devices and equipment are partially financed by the government, social insurance schemes, NGOs and by persons with disabilities themselves.
  - The government provides different types of assistive devices and equipment.
  - Provision of assistive devices includes their production, distribution, maintenance and information about availability.
  - Support for families with children with disabilities is partially financed by the government and NGOs.
  - Availability of sign language interpretation services.
  
- Rule 19 (personnel training):
  - Training is a high priority in Jordan.
  - Some agencies are training their personnel.

- Disability issues are included in the training curriculum of different professional groups.
- Success in the Implementation of the UNSR:
  - Collaboration in the area of CBR between local and international NGOs and governmental bodies.
  - Some services are available to children with disabilities as part of the public system.
  - Medical care providers are often family members and sometimes professionals paid by the State or by NGOs.
  - Medical care is provided free of charge by government ministries.
  - Villages and urban areas are covered by PHC and CBR.
  - DPOs participate in different stages and aspects of rehabilitation and support service provision.
- The Major Constraints to the Implementation of the UNSR:
  - Rapid growth in population with disabilities.
  - High cost of providing rehabilitation services.
  - Rehabilitation services usually do not involve persons with disabilities and their communities.
  - Only working adults and between 21 – 40% of the population are covered by social insurance schemes.
  - Absence of a national rehabilitation program.
  - Some groups do not receive rehabilitation services.
  - Personal assistance is not provided.
  - Persons with disabilities are not involved in staff training programmes.
  - Rural and remote areas are at a disadvantage with regards to disability services.
  - CBR and outreach programmes do not cover need.

## ***Palestine:***

- Rule 2 (medical care):
  - Ministry of Health (MoH) provides diagnosis and medical care.
  - There is medical insurance for all persons with disabilities provided by the Ministry of Social Affairs (MoSA).
  - UNRWA provides medical care services.
  
- Rule 3 (rehabilitation):
  - There are rehabilitation services by the MoH.
  - There is a referral system from the MoH to local NGOs.
  - There are vocational rehabilitation centres.
  - 174 NGOs are working in the field of rehabilitation.
  - There are specialized rehabilitation services.
  - There are CBR and outreach programmes (some run by NGOs and some by UNRWA).
  - MoSA covers rehabilitation fees in NGOs.
  - UNRWA covers rehabilitation fees for refugees in NGOs.
  
- Rule 4 (support services):
  - MoSA covers fees of assistive devices and equipment.
  - UNRWA provides assistive devices and equipment.
  
- Success in the Implementation of the UNSR:
  - Programmes applying the CBR strategy are successful.
  
- The Major Constraints to the Implementation of the UNSR:
  - Increase in number of persons with disabilities.
  - There are challenges and delays facing the implementation of the 1999 disability law.
  - Lack of financial resources.
  - Absence of a national policy for rehabilitation.
  - Deficiency in trained professionals.
  - Shortage in training programs related to rehabilitation.
  - Lack of coordination between relevant stakeholders.
  - Absence of programmes working on empowerment of persons with disabilities and enabling their social integration.

## ***Pakistan:***

- Rule 2 (medical care):
  - Directorate of Special Education provides medical and para-medical support to persons with disabilities.
  
- Rule 3 (rehabilitation):
  - There is a National Council for the Rehabilitation of Disabled Persons.
  - The Directorate of Special Education provides vocational training.
  - There are five National Training Centers for Persons with disabilities.
  - The National Trust for the Disabled establishes model institutions for the rehabilitation of persons with disabilities. It also prescribes and undertakes specialized programs of training and instructions for persons with disabilities.
  - The National Institution for the Handicapped (MoH) provides diagnostic, therapeutic and rehabilitative services.
  - There is free medical cover for persons with disabilities.
  - There are five rehabilitation centres.
  - The CBR strategy is adopted.
  
- Rule 4 (support services):
  - The Directorate of Special Education provides specialized aids and equipment.
  - There are artificial limb centers.
  
- Rule 19 (personnel training):
  - The Directorate of Special Education trains special educators.
  - The National Institute of Special Education develops specialized training courses for teachers of governmental and non-governmental institutions as well as special courses for parents and community leaders.

## ***Sudan:***

- Rule 2 (medical care):
  - Persons with disabilities are provided with the same level of medical care within the same system as non-disabled members of society.
  - Persons with disabilities are provided within the health system with regular treatment and medicines which they may need to preserve and improve their level of functioning.
  
- Rule 3 (rehabilitation):
  - The government and NGOs provide rehabilitation services.
  - Persons with disabilities in six states out of 25 have access to rehabilitation services.
  - Persons with disability participate in the design and organization of rehabilitation services through their organizations, and are involved in rehabilitation services as trained teachers, instructors and counselors.
  
- Rule 4 (support services):
  - The Ministry of Social Welfare (MOSW) supports development, production, and distribution of assistive devices and disseminates knowledge about them, with the support of Zakat chamber and NGOs.
  - Sign language courses are provided.
  - Available technology and local materials are used to produce simple inexpensive assistive devices (artificial limbs centers), with the involvement of persons with disabilities.
  - Assistive devices are financially accessible to all persons with disabilities in six states.
  - Special requirements of girls and boys are considered concerning the design, durability and age-appropriateness of assistive devices and equipment.
  
- Rule 19 (personnel training):
  - Not all medical and paramedical personnel are trained and equipped to give medical care to persons with disabilities. There is still no mechanism to achieve this.

- There is a strong need to train medical care providers to not give inappropriate advice to parents, thus restricting options for their children.
  - Most authorities providing services in the disability field give adequate training to their personnel.
  - The principle of full participation and equality are reflected in the training of professionals in the disability field, as well as in the provision of information on disability in general training programs.
  - There is a need to develop standardized training programs in consultation with DPOs.
  - Persons with disabilities are involved in the current training programs as teachers, instructors or advisors.
- Success in the Implementation of the UNSR:
    - A disability act was approved and endorsed in 2005.
    - There is a national policy and strategy for disability.
    - Persons with disabilities are organized in different unions (for the deaf, blind, physically handicapped).
- The Major Constraints to the Implementation of the UNSR:
    - Weak political commitment towards disability problems.
    - The social welfare rehabilitation council for persons with disabilities is ineffective due to lack of budget, offices, and trained personnel.
    - Lack of coordination between relevant governmental bodies.
    - Lack of trained personnel in the field of the disability (official and community levels).
    - Lack of equipments and supplies.
    - Lack of rehabilitation programs for persons with severe disabilities.
    - Lack of personal assistance programs in all states.
    - Lack of early detection and intervention units.
    - There are no implementation mechanisms for persons with disabilities to receive medical care within the health insurance system (according to the Disability Act).
    - There are no multidisciplinary teams of professionals specialized in early detection and assessment.

- There is no national rehabilitation program (family based rehabilitation program was stopped).
- Persons with severe disabilities have no access to rehabilitation services, due to the lack of trained personnel and other needs.
- Most rehabilitation services are available to persons living in six states out of 25.
- There are no personal assistance programs, and there is strong need to design and develop such programs.
- Local community workers are not trained in early detection of impairment.
- There are no mechanisms for the government to implement its responsibilities in ensuring adequate services for persons with disabilities.
- There are no training programs targeting community workers, and there is strong need to design and develop such programs.