Disability Monitor Initiative
Middle East

Rights, Social Innovation and Policy Reforms

Access to Social Services for Persons with Disabilities in the Middle East

Multi-stakeholder reflections for policy reform

2009

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Axelsson, Charlotte and Barrett, Darryl, *Access to Social Services for Persons with Disabilities in the Middle East – Multi-stakeholder Reflections for Policy Reform,* Disability Monitor Initiative-Middle East, CBM and Handicap International, 2009.

THE DISABILITY MONITOR INITIATIVE

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The authors are also thankful to numerous colleagues and partners from local organizations in the Middle East, who provided information and shared their experiences regarding the situation of social services in their countries. This report also serves as a testimony of their unwavering commitment and efforts to achieve positive changes in this sector. A special thanks to Diana Chiriacescu for letting the authors use her two reports from the Disability Monitor Initiative program in South East Europe.

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The authors are very grateful for their valuable comments and recommendations during the report's elaboration.

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The report has been realised thanks to the financial support of:
CBM, Handicap International and The Swiss Agency for Development Cooperation

Foreword

It is an honour to have been asked to write the Foreword to this report which aims at shedding light on the situation of persons with disabilities with regard to access to social services in the Middle East.

It is an impressive and comprehensive report, based on a review of services available, their quality, affordability, accessibility and how accountable they are. Information has also been gathered from interviews with persons with disabilities and their representative organizations. In the spirit of "what is good for us is good for all", the report also calls for a review of social policies; urging governments to deal with issues of poverty, health care, rehabilitation, education and employment for persons with disabilities. I believe that one of the main strengths of this report is the light it sheds on inclusive, holistic services that are currently available, thereby providing a guide to good practices that can be adopted by various service providers in the region.

The report provides a clear and methodical assessment of the current situation in the region, starting with the general attitude towards persons with disabilities to the reasons (economic, political, and social) for the lack of sufficient, accessible and appropriate services.

It is important for decision makers and legislative authorities to recognize that the adoption of the United Nations Convention on the Rights of Persons with Disabilities goes beyond paying lip service to the belief in preserving and protecting the rights of persons with disabilities. It is only through the provision of services that meet the needs and demands of persons with disabilities, that they have equal opportunities to realise their fundamental rights and become active, productive and contributing members of society.

Additionally, it is important for service providers and organizations to recognize that there can be no full enjoyment and exercise of rights so long as the voices of persons with disabilities are not heard—particularly on the issues that concern them. However, unless persons with disabilities are given the tools through which they are able to exercise their rights (e.g. accessible, appropriate, essential services) they will remain a marginalized group dependent on the goodwill and benevolence of society.

This report will serve to provide decision makers, service providers and persons with disabilities themselves, with introductory information about what is necessary for sound decision making, appropriate and accessible services, and a platform from which to advocate for improvements and recognition of their rights.

It is with great pleasure that I read this report and I hope that many will find it as interesting and as useful in making strides towards full enjoyment of human rights in the region.

Hissa Al Thani,
Former UN Special Rapporteur on Disability

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Acronyms and Abbreviations

AHS	Al-Hussein Society for the Habilitation/Rehabilitation of the Physically Challenged
AIDS	Acquired Immunodeficiency Syndrome
AODP	Arab Organisation of Disabled People
ASD	Autism Spectrum Disorders
BASR	Bethlehem Arab Society for Rehabilitation
CBM	CBM
CRPD	UN Convention on the Rights of Persons with disabilities
DCP	Disability Creation Process
DFID	Department for International Development, United Kingdom
DMI-ME	Disability Monitor Initiative Middle East
DPO	Disabled People's Organisation
EC	European Commission
EU	The European Union
GDP	Gross Domestic Product
HDI	Human Development Index
HI	Handicap International
HIV	Human Immunodeficiency Virus
ICF	International Classification of Functioning, Disability and Health
ILO	International Labour Organisation
IMF	International Monetary Fund
INGO	International Non-governmental Organisation
LAS	The League of Arab States
LPHU	Lebanese Physically Handicapped Union
MDG	Millennium Development Goals
ME	Middle East
MIW	Making it Work
NGO	Non-governmental Organisation
SGI	Services of General Interest
SSGI	Social Services of General Interest
UN	United Nations
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNICEF	United Nations Children's Fund
UNDP	United Nations Development Programme
UNRWA	UN Relief and Working Agency for Palestine Refugees in the Near East
WHO	The World Health Organisation
WTO	World Trade Organisation

Glossary

Accessibility

An accessible environment allows for free and safe movement, function and access for all, regardless of age, sex or condition. It is a space or a set of services that can be availed by all, without obstacles, with dignity and as much autonomy as possible.

Accessibility can be defined at three levels:

1. Accessibility of the **built environment**, which includes housing and private buildings, as well as public spaces and structures.

2. "**Geographic accessibility**", which refers to the ability to circulate. Everybody should have the opportunity to choose their means of transport, to go from one place to another according to their needs, abilities and budget. This dimension is usually included within the previous one, as in CRPD Article 9, but various field experiences have shown that in many cases, free movement has to be addressed *per se* in addition to the settings and buildings.

3. Access to **information and communication** which means, accessible media, easy information dissemination and data that are within reach.

Accreditation

Accreditation is a voluntary process that offers service providers recognition for obtaining standards of excellence defined by an accreditation agency.[1]

Community-based services

Services provided at the community level, organised in partnership with or by the members of the community with the participation of or in consultation with users in the prioritisation of needs, planning and the evaluation of services.

Community based rehabilitation (CBR)

CBR is a strategy within general community development for the rehabilitation, equalization of opportunities and social inclusion of all persons with disabilities. It is implemented through the combined efforts of persons with disabilities, their families, organizations and communities, and relevant government and non-government health, education, vocational, social and other service providers.[2]

Contracting of social services

This refers to the process in which the State secures a contract with a social service provider, either public or private, to deliver the services that the State is responsible to guarantee the access for. In this report, contracting also pertains to situating the acquisition services into a legally binding agreement.

1 Bilson, A., and Gotestam R. Improving Standards of Child Protection Services - A Concept Paper, UNICEF Innocenti Centre, (Florence: UNICEF and World Bank: 2003).
2 ILO, UNESCO and WHO. CBR: A Strategy for Rehabilitation, Equalization of Opportunities, Poverty Reduction and Social Inclusion of People with Disabilities: Joint Position Paper, (WHO: Switzerland: 2004).

Disability

Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments, which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.[3]

Mental health disability – is a term that describes persons with disabilities due to mental disorders or illnesses. Examples include: schizophrenia, paranoia, major depressions, bipolar disorders, substance and drug abuse disorders or Alzheimer's disease.

Intellectual disability, sometimes still wrongly referred to as 'mental retardation' – is a disability characterized by significant limitations both in cerebral or logical functions such as reasoning, learning, problem solving and in adaptive behaviour, which covers many everyday social and practical skills. This disability commonly originates before the age of eighteen.[4]

Decentralisation

The process by which responsibilities, capacities and resources are transferred from the State level (central authorities, government) to authorities and decision-makers at the local level (municipalities and decentralised bodies of the ministries).

De-institutionalisation

Refers to the change in the provision of services for persons with disabilities - from institutional, segregated settings and practices towards community-based services that are person-centred and promote social inclusion and human rights.

Enabling system

An enabling system is a system of services oriented towards supporting people with disabilities to reach and maintain their optimal level of independence and social participation. This is achieved by ensuring them equal access to mainstream medical, social, education and employment services existing at the community level, with individualised support services based on needs, expectations, and a referral system to disability-specific services as may be required.[5]

Gate-keeping

Gate-keeping is the system of decision-making that guides effective and efficient targeting of services for persons with disabilities and other vulnerable groups.[6] In its large sense, gate-keeping mechanisms are referral procedures and processes of guiding and directing users towards services, defined within a legal framework.

Inclusive Development

Inclusive development is a rights-based change process that promotes equality among and the participation of the largest possible section of society, especially groups that face discrimination and exclusion. It ensures that persons with disabilities are recognized as rights-holding equal members of society, entitled to contribute to the development process. Inclusive development can be implemented at both the national and local levels.[7]

3 UN Convention on the Rights of Persons with Disabilities Article 1.
4 American Association on Intellectual and Developmental Disabilities (AAIDD) http://www.aamr.org/content_ 100.cfm?navID=21
5 Adams, L., Axelsson, C., and Granier, P. Beyond De-institutionalization: The Unsteady Transition towards an Enabling System in South East Europe, (Handicap International South East Europe: Belgrade: 2004).
6 Bilson, A., and Gotestam, R., 2003
7 Axelsson, C. A Guidance Paper for an Inclusive Local Development Policy, (Handicap International, SHIA and HSO: Lyon: 2008): p.16. www.make-development-inclusive.org

Licensing/authorization

A mandatory procedure carried out by authorities, wherein providers are given the permission to deliver social services, after complying with minimum quality standards or criteria determined at the national level in the particular domain of intervention.[8]

Mainstreaming disability

It *"…is the process by which the State and the community ensure that persons with disabilities can fully participate and be supported to do so within any type of structure and service intended for the general public, such as education, health, employment and social services..."*[9] Effective mainstreaming of disability issues into legislation, policies and services requires the inclusion and participation of persons with disabilities in decision-making processes in all its aspects, at all levels of government, and at every stage, including planning for, implementation and evaluation of the effectiveness of these policies.

Monitoring of social services

A continuous process of systematic collection of information, according to specific indicators, meant to provide the managers of a service as well as other relevant stakeholders with data on the extent of improvement and achievement of a particular service's objectives.

Quality Standards

Pertains to a set of criteria that can be used to monitor the management, provision and quality of services, as well as their expected and actual outcomes; they ensure equitable and transparent delivery of services to the intended beneficiaries.[10]

Regulatory mechanisms in the field of social services

Refers to sets of interrelated instruments meant to control, coordinate and improve the provision of social services at the system, individual and service provider levels. Regulatory mechanisms are defined by central public authorities and implemented by central and/or local authorities or agencies, mandated to do so. They manage: (a) the demand for and access of users to social services, (b) the supply of these services by various providers and (c) the actual provision of social services.[11]

Services of General Interest

Services of General Interest (SGI) in the European Union cover "both market and non-market services considered by the public authorities as general interest and submitted to specific public service obligations". Examples include: energy, telecommunications, audiovisual broadcasting and postal services, water supply, waste management, education or health.[12]

8 Chiriacescu, D. Shifting the Paradigm in Social Service Provision: Making Quality Services Accessible for People with Disabilities in South East Europe, (Handicap International: Sarajevo: 2008).
9 Axelsson, C., 2008: p. 16.
10 Bilson, A., and Gotestam, R., 2003.
11 Chiriacescu, D., 2008.
12 Green Paper on Services of General Interest, COM 2003/270 final/, European Commission and http://ec.europa.eu/employment_social/spsi/ssgi_en.htm

Social Services[13]

In the context of this report, the concept of social services covers a large and diversified range of services, intended to improve the standard of living of the population, especially of individuals and groups in vulnerable situations. They are linked to national welfare schemes and are important tools for the implementation of public policies in the fields of social protection, non-discrimination, poverty reduction and exclusion. They are not conditioned by the contribution of the users, but enhance the capacities of individuals for full inclusion and participation in society. They respond to social needs and social deficits, which the market either cannot manage or can even be generated by the market. States are responsible for ensuring the access of all citizens to social services.

Social Services of General Interest

Social services of General Interest (SSGI) are a specific type of service of general interest; this means that these do not target a particular sector of the population. The EU categorizes social services into two broad types of services, the functions and organisation of which may vary significantly across the EU: on the one hand, statutory and complementary social security schemes and on the other hand, other services provided directly to the person that play a preventive and socially cohesive role, such as social assistance services, employment and training services, social housing, child care or long-term care services. These services play a vital role in societies and provide an important contribution to the fulfilment of basic EU objectives such as social, economic and territorial cohesion, attainment of high levels of employment, social inclusion and economic growth.[14]

Territorial (geographical) maps of services

The territorial maps are charts of existing and needed services at specific geographical levels (e.g., municipality, department, or region), renewable within specific intervals of time (e.g., 3-5 years). Any proposal for opening new social services, or for extending provision of existing ones, is generally analyzed in relation with these territorial charts.

Twin-track approach for an inclusive society

Promotes the equalization of opportunities and establishment of an inclusive environment, which implies that inclusive services and mainstreaming disability into overall policy-making are ensured and targeted disability actions and services to ensure empowerment of individuals and Disabled People's Organisations are supported.[15]

Universal Design or Design-for-all

An approach to the design of products, information packages, services and built environments accessible to everybody, including persons with disabilities, regardless of their impairments or specific needs.[16]

13 Description based on the EC Communications, as well as on the perspective of several European platforms that are active in the field of social services - Social Platform, Eurodiaconia, EASPD.
14 European Commission, http://ec.europa.eu/employment_social/spsi/ssgi_en.htm.
15 The twin-track approach originated in a policy paper of DFID: Disability, Poverty and Development, 2000. http://www.dfid.gov.uk/pubs/files/disability.pdf .
16 EDAMAT. www.edamat-europe.org.

EXECUTIVE SUMMARY

PART A – THE IMPORTANCE OF ENSURING ACCESS TO SOCIAL SERVICES

Introduction

This report is the first in an anticipated series of reports to be produced by the Disability Monitor Initiative – Middle East (DMI-ME) and is aimed at introducing disability stakeholders to key concepts and topics to support advocacy efforts for enhancing the rights of persons with disabilities. The report will inform on theory and practice related to social services in the Middle East, enabling activists and interested stakeholders to combine this information to influence policy change for persons with disabilities.

It takes a general view of disability issues across the region, highlighting both opinion from key stakeholders (services users/DPOs, services providers and authorities) and identifies trends in service provision in healthcare, education, livelihood and social protection. Recommendations are provided from stakeholders themselves, regarding ways to move forward on ensuring greater access to services at micro (personal/organisational) and macro (national policy/systems) levels.

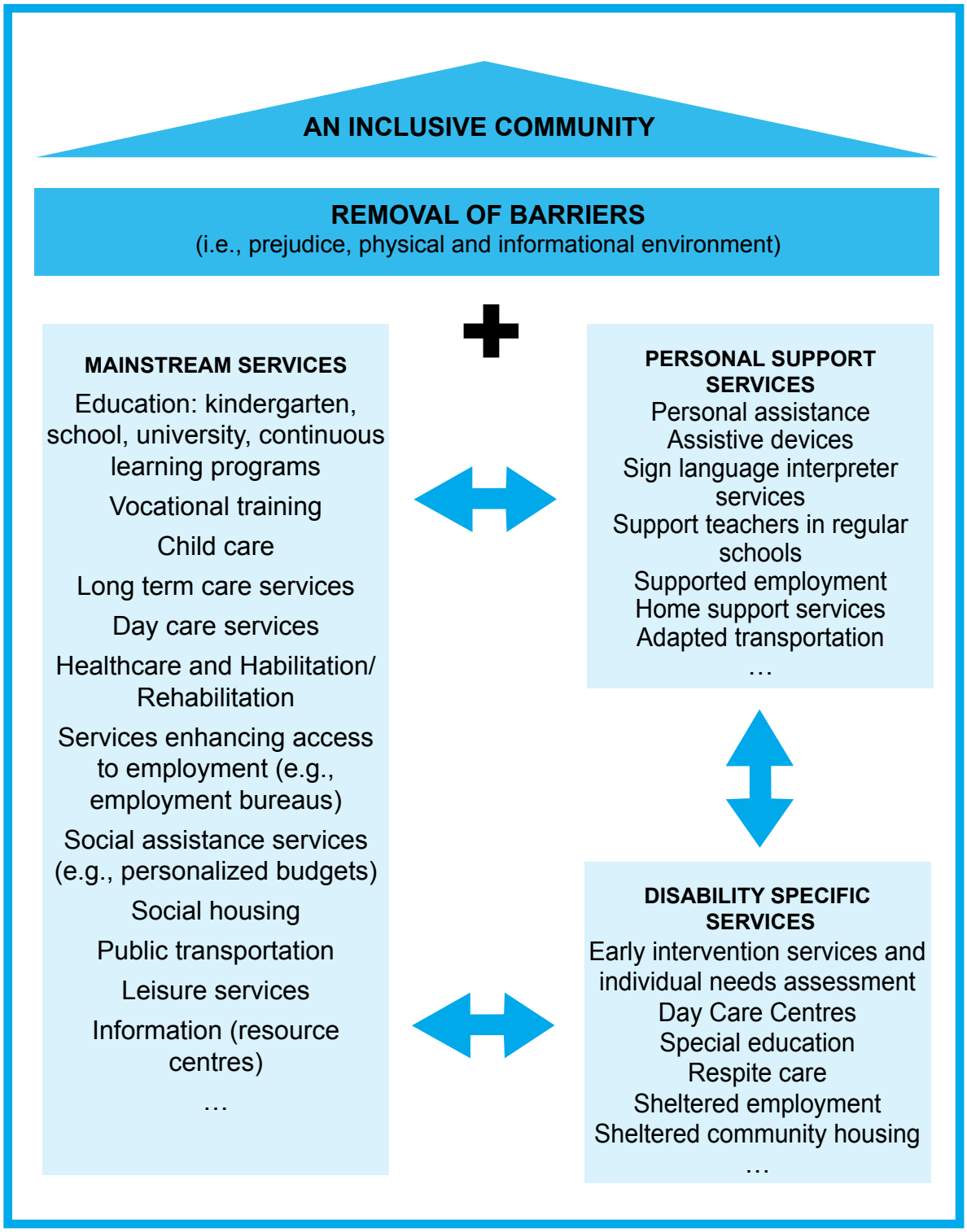
The DMI-ME is an advocacy initiative that gathers and disseminates information on relevant disability topics underpinning the move towards full participation and equal opportunities of persons with disabilities. The objectives of the DMI-ME include reporting on *social innovation and on legislation and public policies*. Through the publication of DMI-ME journals, research into good practice in service provision, national workshops, a regional legislative review, development of a website and the production of this report, the DMI-ME aims at using knowledge of successful grass roots innovation and experiences in order to influence public policy related to persons with disabilities in the Middle East.

Disability and Poverty

The Middle East region is home to a diverse range of social and economic conditions from the very rich to the extremely poor. The reality is however, that persons with disabilities are usually more highly represented in poorer groups and disability and poverty become interlinked in a cycle that is self-perpetuating unless intervention at various levels occurs. This part of the report explores the relationship between poverty, development and disability, including a perspective on the classification of disability.

This section of the report also looks at issues around social inclusion and key factors that contribute to the risk of a person becoming socially excluded. With factors of exclusion high for persons with disabilities, their capacity to influence policy change to improve their situation becomes more limited. Social services as a means of inclusion and a tool for enabling persons with disabilities to participate greater in society are discussed in light of the CRPD and the context of the Middle East. Through many development initiatives occurring in the region, opportunity exists to mainstream disability in development and the concept of the *twin-track approach* is introduced as a means of reducing barriers for inclusion of persons with disabilities.

The twin-track approach (below) in the social services sector is an important concept for stakeholders to recognise in regard to the inclusion of persons with disabilities in society through the provision of different types of social services depending on needs and demands of the user.



Throughout the activities of the DMI-ME, stakeholders indicated limitations in current social policy related to disability and also how there was a limited knowledge of disability inclusive policies or how to construct them. This part of the report explores areas of social policy and disability, linked to how this impacts advocacy efforts in line with the DMI-ME vision of influencing policy changes from the ground-up.

PART B: STAKEHOLDERS PARTICIPATION IN ENSURING ACCESS TO SERVICES

This section of the report highlights some of the key findings through various national workshops in the region, interviews, field visits and other research, in which the three main stakeholders in the provision of social services were given the opportunity to reflect on their own and each other's roles and responsibilities.

Roles and responsibilities of User's/DPOs, Service Providers and Authorities

A positive aspect of the DMI-ME process with regards to the national workshops that provided much of the information of this report was the feedback from stakeholders about the importance of collaborative meetings such as those, which involved these three main actors. Through participatory dialogue, debate and activities, greater understanding was presented, of the potential and of the limitations faced by each main stakeholder group.

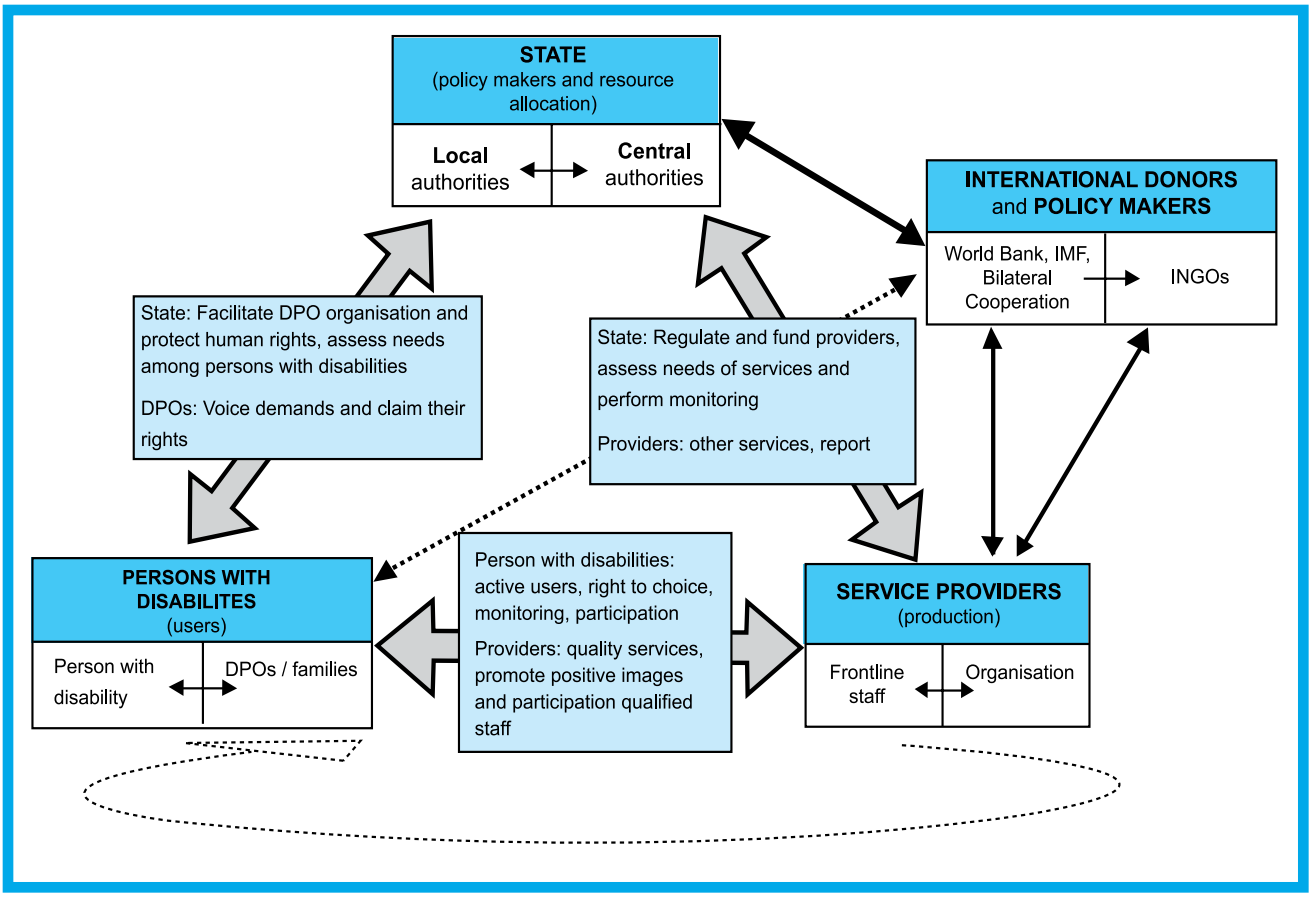
The main actors of the social services system throughout the Middle East are presented for stakeholders to be aware of the different relationships and links. Although authorities remain responsible for regulating this type of service provision system, other actors play essential roles in ensuring that persons with disabilities have access to services that they need or demand. These groups define and implement the regulatory system that governments, apart from their responsibility to provide sufficient funding, need to install for effective monitoring and control.

The table below presents a summary of the roles and responsibilities of actors involved in the above scheme of regulation of social services. In order for disability policies to improve, actors need to be aware of their roles and responsibilities and how they contribute to ensuring the rights of persons with disabilities.

ACTORS	ROLES AND RESPONSIBILITIES
<u>STATE</u> • Central authorities	• Ensuring fundamental rights • Regulating social services • Distributing resources and financing social services • Evaluating demands at macro level and planning of services (gate-keeping) • Monitoring quality • Ensuring availability and quality of professionals
• Local (regional) authorities	• Providing social services / delegating and contracting out • Assessing demands at local and regional levels (gate-keeping) • Coordinating local planning and ensuring compliance with national legislation, policies and strategies • Monitoring quality • Promoting participation of persons with disabilities • Financing (cash or in-kind)

SOCIAL SERVICE PROVIDERS • Public providers • Non-profit organisations • For-profit companies • Religious organisations • Informal providers (families and volunteers)	• Ensuring quality of services • Assessing individual demands • Providing services and adequate accessible information • Promoting positive images amongst the community • Adapting to users' needs • Ensuring the right of users participation
USERS OF SOCIAL SERVICES • DPOs • Persons with disabilities • Families and/or legal representatives of persons with disabilities.	• Rights-holders with responsibilities • Participate in service planning and provision, monitoring and evaluation • Represent users and advocate for their rights, including the creation of adequate services for persons with disabilities

The formulation of the table (above) into a schema (below) highlights the roles and responsibilities of main actors in ensuring social services for persons with disabilities in the Middle East.



PART C: REGULATION AND LEGAL IMPLICATIONS

As an introduction to the concepts related to regulation of services, this part addresses more of the theory around the stakeholder positions and the positive and negative aspects related to developing better regulatory mechanisms. Additionally, a view on the legislation in relation to social services and the CRPD is presented by way of highlighting the limitations and opportunities to better develop both practical regulatory mechanisms and also legal frameworks to support these.

A set of comprehensive regulatory mechanisms allows public authorities to assess the demands and needs of persons with disabilities and determine who are eligible for entitlements and support enshrined by laws. If designed and implemented well, these mechanisms contribute to the establishment of an effective support system to persons with disabilities, a good method of monitoring of the situation of persons with disabilities and the services they access together with the optimal allocation of resources. This chapter introduces a regulatory framework that typically governs social services delivery. There is a risk that, if not properly developed, these mechanisms could misinform the situational analysis of persons with disabilities and make way for an inequitable distribution of public support.

Some of the main regulatory mechanisms in a social services system are presented in the table below as an example of what could be included in a system that controls the distribution of service provision with respect to supply and demand.

GATE-KEEPING MECHANISMS (Referral, information and direct access to social services)	At the level of the general system of social service (macro): • Assessing demand (which types of services are in demand and needed to ensure fulfilments of rights) • Elaboration of territorial maps of demands and services • Defining national access criteria to social services At the individual level (micro): • Assessment of the individual situation • Decision-making and orientation to community services
QUALITY-RELATED MECHANISMS (Quality principles and/or standards)	• General principles (rights-based, values and non-prescriptive standards) • “Technical” standards, taking into account more specific quality requirements for different categories of services
CONTRACTING AND FUNDING MECHANISMS	• Call for offers/tenders/project applications for social services at the local or national levels • Licensing/authorisation of social service providers • Purchasing and contracting of social services at the community level • Funding of social services at the community level

THE INTERNAL REGULATORY MECHANISMS (at the level of the service provider)	• Internal regulations (i.e., human resources, relations with users, or safety regulations) • Quality management and improvement procedures • Strategic planning procedures and follow-up • Internal and external communication procedures • Evidence-based decisions and measures • More generally, manuals of policies and procedures
MONITORING AND EVALUATION MECHANISMS	At the level of the system of social services (macro) • Monitoring of social service provision at the local level • Periodic evaluations and articulation of the gate-keeping system at the macro level At the level of service providers (micro) • Internal evaluation of service providers (self-evaluations) • External evaluations of the social service • Auditing and control procedures • Regular monitoring of service delivery
OVERALL SYSTEM OF INFORMATION AND FEEDBACK	• Data collection and flow of information that ensures the transparency of the system at all levels, and facilitation of decision-making and planning

Linked to the regulatory mechanisms instituted by authorities and supported by other stakeholders, a strong and appropriate legislative base at a national level is vital to ensure regulation is transparent, inclusive and rights based. This chapter also looks at the various national legal provisions with respect to some of the social service areas presented in this report and in light of the CRPD.

PART D: TRENDS TO ADDRESS SERVICE PROVISION PRACTICES

The DMI-ME program is about sharing knowledge of good practices as an advocacy tool to influence policy change from the grassroots level up. Through this process, the team developed tools to assess service provision in line with basic criteria (accessibility, availability, affordability, accountability and quality) with respect to the CRPD. These tools were used across the region, the results of which are presented with recommendations for stakeholders to better develop services that ensure a greater access for persons with disabilities.

Accessibility

Referring to not only physical features of the built environment (e.g. ramps or rails), it was shown that mainstream services (e.g. primary schools or hospitals) in the region are generally inaccessible for persons with disabilities, with specialised disability services (e.g. special education settings, rehabilitation clinics) being more physically accessible but still quite

limited. Information and communication accessibility features were also not widely observed in comparison to physical accessibility features. Stakeholders such as DPOs and some larger service providers reported having increasing knowledge of the principles of accessibility and the importance of these for inclusion of persons with disabilities.

Availability

Services in the region exist mainly in larger cities, with less available services in rural areas. With factors such as poverty, limitations in public transport, conflict and political instability, lack of numbers of qualified service professionals and limited information of existing services, stakeholders identified that persons with disabilities in the region are limited for choice and diversity of services. A positive aspect evident in some areas was the development of outreach and CBR services that greatly impact on some isolated and rural parts of the population being able to access basic types of educational and / or rehabilitative services.

Affordability

The reality of the poverty situation for many persons with disabilities in the Middle East makes this criterion very relevant. Service providers generally were very sensitive to the issue of affordability of their service to users, however the development of formal criteria to assess eligibility for free or no-fee services remains to be realised. Also service providers were generally limited in their capacity to address ancillary expenses to accessing the service, such as transportation and accommodation, particularly for users travelling from outside of urban centres.

Accountability

Part of the development of good practices in the provision of services, or in the development of good policies, is the involvement of persons with disabilities at every stage of the process. In the region, propagated in part by the continual dominance of the medical model, users are excluded from strategic service and policy decisions which ultimately impact on the relevance of the service to them and empowerment of users within the system.

Quality

This report does not attempt to report on practices that were considered to be ‘best practices’, as the improvement of access to services for many persons with disabilities in the region is not only about the quality of the service, but rather about other criteria listed above. Quality is however important in that the likelihood of good quality services being present in rural versus urban areas is low and this issue of quality of services is often linked to funding opportunities, status of the provider and innovation of the service.

Recommendations for DPOs and Service Users

The report offers an opportunity for service users and DPOs to better understand that they have clear roles and responsibilities in the improvement of access to services. It is important that users and DPOs understand and integrate the various concepts of this report to become well-informed counterparts to often more experienced authority or service provider representatives.

Recommendations for Authorities

Governments that have signed and ratified the CRPD have clear legal obligations to persons with disabilities in their respective countries. Even in those countries that have not ratified the CRPD, broad human rights principles and limited domestic legislation imply a degree of responsibility. Quite often this responsibility does not always come with relevant knowledge of how to effectively impact the lives of persons with disabilities at either a policy or practice level. This report provides clear opportunities for authorities to obtain a greater understanding on ways of authorities to move forward at ensuring greater access to services for persons with disabilities.

Recommendations for Services Providers (public and private)

The practical focus of this report, places an emphasis on observing, documenting and sharing good practice in service provision for persons with disabilities. Through various mechanisms of the project, service providers are exposed to tools in which to provide better services and ultimately contribute to the empowerment of persons with disabilities in the region, through greater inclusion of disability in service provision mechanisms.

PART A

THE IMPORTANCE OF ENSURING ACCESS TO SERVICES

Chapter 1. Background of the report

Access to social services for persons with disabilities in the Middle East may seem like a vague or new concept for some people, but research and current trends in development indicate that ensuring that people have access to basic services is a means of addressing social inequality and reducing poverty. Despite the fact that the Middle East region is characterized by diversity in politics and culture, persons with disabilities share many common issues regarding equality, inclusion and their ability to participate in society on an equal basis with non-disabled persons. This report intends to be an introduction to some concepts and frameworks around social services for actors who are involved in their regulation (i.e., authorities, services providers and users/DPOs). By discussion of the different roles and responsibilities of these stakeholders in the target countries of the Disability Monitor Initiative Middle East (DMI-ME), it is expected that there will be a greater understanding of how each of these actors can contribute independently and collaboratively to ensure better access to services for persons with disabilities in the region. In addition to the analysis of stakeholder roles and responsibilities, trends in service provision in the region are determined to provide information on good practices and identify areas for improvement from a service perspective; in so doing, greater inclusion and better access to services for persons with disabilities in the region are ensured.

1.1 Introduction to the DMI-ME report

The decision to focus on **access to social services** for persons with disabilities as a main theme was due to the interests of DPOs and NGOs (such as CBM and HI) in encouraging a stronger link between rights of persons with disabilities and access to services. This focus is supported by international thinking from bodies such as DFID, the European Union, the World Bank and various national governments, along with other international non-governmental organisations working in development and humanitarian assistance. Research and good practice experiences on how to best target and positively influence the lives of persons with disabilities at the community level indicate that facilitating access to social services in developing countries is a means for inclusion and ensuring equal opportunities.

The interest for a report such as this one, concerning disability and social services in the Middle East, is also related to the significant number of ratifications and signatures to the United Nations Convention on the Rights of Persons with Disabilities (CRPD), creating good momentum for the DMI-ME Steering Committee[17] to introduce the issue of access to social services as one method of ensuring that the rights of persons with disabilities are promoted and protected.

Participatory assessment and review of the situation in 2005

In 2005, to better understand the situation around disability policies and services in the Middle East, Handicap International (HI) implemented a participatory stakeholder review in Egypt, Jordan and Lebanon.[18] Although the review only assessed the situation among three of the seven countries comprising this current report, it can serve as a reference to monitor changes and innovation in the field. The evaluation took a participatory view on services and policies

17 The DMI-ME Steering Committee includes DPOs, NGO service providers and INGOs involved in the disability field. This is further presented in chapter 1.5.

18 Axelsson, C. and Sharkawy, G. Taking a step forward: Views from Stakeholders on Disability Policies and Services in Egypt, Jordan and Lebanon, (Handicap International Regional office Middle East: 2006).

related to disability and reflected the point of view of a relatively large number of the major stakeholders in the disability sector in 2005. Results provide different aspects for comparing the progress in the region.

The stakeholder review presented a picture of three countries with many common challenges and opportunities. Key findings in these countries were described as six-fold:

1. The main weaknesses in all countries were the lack of enforcement mechanisms to ensure that policies are respected and implemented and adequate financial and human resources are allocated for the implementation of the legislation. The elaboration of the CRPD was generally considered to be a powerful instrument to guide legislation and policymaking once adopted.
2. The **organisation and capacities of persons with disabilities for self-representation** vary considerably across the three countries. Several associations struggled to recruit new members and to overcome a charity and medical approach to disability policy and services. In general, participants expressed genuine will to improve the coordination and unification of the different interests amongst the DPOs and a strong interest to learn from the experiences of others, both in the region and elsewhere.
3. In 2005, **National Councils of Disability existed both in Jordan and Lebanon**, which were considered to be an excellent base from which to advance the interests of persons with disabilities at the national level. These National Councils however, should be recognised by, and actually be representative of the entire disability movement in their respective countries, and there were some concerns amongst the participants on improving this representation.
4. **The access to adequate services** in the fields of healthcare, education, employment and social protection in general was considered to be quite poor in all three countries. Some improvements have been noted in the last few years, but for example, there was still an unequal geographical distribution of rehabilitation services, which were mainly available in the larger cities.

   The lack of education and access to proper rehabilitation was also said to strongly undermine the potential of persons with disabilities to enter into vocational training programs and consequently, access **employment opportunities**. This was identified among the stakeholders as a major cause of exclusion and poverty.

   In 2005, all three countries lacked properly defined policies for reliable **social protection** and sufficient financial compensation for the extra costs of disability.
5. According to the findings of the review, the situation in terms of accessibility was improving but still far from satisfactory. Many environmental barriers were said to exist in all three countries; buildings and public transportation were largely inaccessible, sign language interpreters in public services were almost non-existent, access to accurate information limited and the general population displayed a lack of respect for the accessibility interventions that have been implemented.
6. In all three countries, participants expressed a prevailing negative attitude towards persons with disabilities and a high level of social exclusion. This matter was thus suggested as an important issue to work on, wherein all community stakeholders should be involved.

A summary of related recommendations from this Stakeholder Review in 2005 is interesting to note for comparison with how the situation has developed regarding service provision and can be found in Annex 4 of this report. It is clear that in 2005, some of the findings regarding

the organisation and voice of DPOs, the adequate access to certain services and the overall negative attitudes towards persons with disabilities in the region are relevant still today and are addressed, amongst other issues, in this report.

1.2 Methodology of the report

This report has taken a **regional view** about the main stakeholders in the regulation of social services (authorities, DPOs/users and service providers) and certain social services sectors (health and educational services, social protection and employment and livelihood services). Regional trends on stakeholders' opinions and good practices have been identified from various sources and serves as a starting point for anticipated further in-depth discussion, analysis and reporting at national and local levels.

The methodology of this report was conceived based on previous similar initiatives around the world, and its application is part of an international programme aiming to address public policy gaps in issues, among them, policies in social services provision for persons with disabilities (see Box 1.). The concept of the Disability Monitor Initiative (DMI) was initially launched in South East Europe by Handicap International and its partners as a method of trying to influence policy change from the ground up, through observation and reporting of practices and policies that affect persons with disabilities. The success of the ongoing DMI in South East Europe resulted in a similar process commencing in the Middle East in 2008, with the support of CBM and a regional group of disability organisations forming the DMI-ME Steering Committee, currently comprised of CBM and HI together with Bethlehem Arab Society for Rehabilitation (BASR), the Arab Organisation of Disabled People (AODP), Lebanese Physically Handicapped Union (LPHU) and the Al-Hussein Society for the Habilitation/Rehabilitation of the Physically Challenged (AHS).

The first report of the DMI-ME is a culmination of many different formats of research, fieldwork, observation and consultation with disability stakeholders, national workshops and publications that have taken place over a two-year period from December 2008 to August 2009. The information gathered has been compiled and organised to present some of the main social services sectors needed for improving the quality of life of persons with disabilities: healthcare, education, employment and livelihood opportunities and social protection services and the roles and responsibilities of the main stakeholders involved in regulation of social services.

The report has been designed to take a **general view of the countries and stakeholders involved**, and not assess the situation at a country-specific level. By using a regional perspective, several topics for more in-depth research at a later stage and through the future DMI-ME activities have been identified; it is anticipated that more specific country analyses or research can take place. As with any report of this nature, there were various challenges to its production, including limited reliable data from the field, inadequate published disability information relevant to the region and the logistical drawbacks of obtaining data from a diverse and conflict-affected area. Much of the information contained in this report is gained from observation or the expressed opinion of local stakeholders.

Countries covered by the report

The countries covered within this report include Egypt, Iraq, Jordan, Lebanon, occupied Palestinian territories, Syria, and Yemen. These are countries that are clearly different politically, economically, culturally and socially but with respect to service provision and broad disability-related issues, have nevertheless illustrated many similarities.

1.3 The structure of the report

Chapter 1 introduces some of the background to the DMI-ME and the development of this report, including the previous work done in the area of social services and stakeholder opinion in the past three years.

Chapters 2 and 3 presents the theoretical basis for looking at access to services for persons with disabilities, constructing social policies for promoting the full inclusion of persons with disabilities and looking at the concepts of the twin-track approach, inclusive development and mainstreaming of disability into policies and services. Finally, it also looks at how grassroots organisations and DPOs can improve their advocacy strategies for achieving equal opportunities and full participation of persons with disabilities.

Chapter 4 identifies the main stakeholders in the provision of social services and their roles and responsibilities in regulating a social services system. Some points of view from regional stakeholders are later presented on interesting reform initiatives and innovative services. It also identifies some gaps and presents a discussion on what can be done to improve the current situation, share responsibilities and enhance coordination.

Chapter 5 looks at regulation of social services and the required processes and mechanisms related to their operation.

Chapter 6 outlines the situation of the access of persons with disabilities to social services based on the 4A's criteria (Availability, Accessibility, Affordability, Accountability and Quality) and identifies some regional trends and initiatives. Each chapter is followed by some recommendations for improvement.

Chapter 7 outlines the conclusions and general recommendations for policy reform directed toward the main stakeholders involved: DPOs and service users, social service providers and state authorities.

1.4 To whom this report is addressed

This report is widely addressed to all disability stakeholders interested in promoting and protecting the rights of persons with disabilities, through their inclusion in and access to social services in the Middle East.

For persons with disabilities, this report is a useful tool to increase their knowledge about their rights and responsibilities, and thus improve advocacy regarding their access to social services. Some persons with disabilities take a passive view or are conditioned to adopt this position; it is anticipated that this report will assist DPOs and some individuals and their families to understand the benefit of developing a stronger collective voice for constructive dialogue with policy-makers and other disability stakeholders.

For service providers, this report offers an opportunity for them to further understand the position of the service user in their provision of various social services. This report aims to recognise different aspects to service provision in the region to gain better understanding of the gaps that exist. It is also this report's objective to emphasize that persons with disabilities (the service user) need to be at the centre of the service provision process; otherwise, efforts to effectively meet the demands of persons with disabilities remain inadequate. In addition, it will introduce new

elements in terms of regulating a social services system and the challenges and opportunities this presents to service providers in the future. This report in effect offers a basis for services providers to think more in-depth about the continuous improvement of their own services.

For authorities, (both at the central and/or regional and local levels) this report is aimed to encourage them to more strongly support the voice of DPOs and persons with disabilities and develop and reinforce efficient regulatory mechanisms regarding service provision. It has been recognised that changes in the manner policies are currently developed need to take place and it is anticipated that improvements in policy making processes will take place. This report might support the efforts of meeting the needs and demands of persons with disabilities in their respective countries.

For stakeholders such as **international donors or development organisations,** this report aims to establish the importance of ensuring the access to services in-line with the CRPD (Article 32 clearly defines the responsibilities of the international community) and trends related to service provision for persons with disabilities in the Middle East. Through a better understanding of the situation of persons with disabilities and their lack of access to social services in the region, it is expected that donors and development organisations can take a more proactive role in ensuring their projects and programs contribute to the improvement of the situation for persons with disabilities.

In conclusion, this report is anticipated to be both an introductory description of social services and a tool for activists to advocate for better policies on social services, particularly in consideration of a more bottom-up approach and stronger inclusion of the demands and rights of persons with disabilities.

1.5 The Disability Monitor Initiative-Middle East

The situation of persons with disabilities in the Middle East is still mostly viewed from a medical and charity approach, within a backdrop of a very limited and often outdated legislative and policy frameworks. Together with public providers, a great number of social services are made available by civil society organisations and private for-profit organisations (or companies); however, regulatory mechanisms that are supposed to assess the demand for the services, ensure equal distribution, provide sustainable funds and monitor the quality of the services among these groups are lacking. This has led to significant discrepancies in the access of persons with disabilities to services, limited progress towards inclusion, and a failure to remove the substantial barriers to the participation of persons with disabilities in society.
Many factors are responsible for the current situation of persons with disabilities in the Middle East. These include:

- Limitations in legislative and policy frameworks;
- Lack of quality and effective social services and an unequal geographical distribution;
- Poor coordination and collaboration among stakeholders;
- Political and organisational weaknesses of the disability movement across the region; and
- Limited knowledge on what are the effective interventions that facilitate improvement in the lives of persons with disabilities.

In 2008 CBM and HI launched a regional initiative aimed at monitoring some of the issues that limit the participation of persons with disabilities in society on an equal basis with others; thus the creation of the Disability Monitor Initiative-Middle East (DMI-ME).

The DMI-ME is an advocacy initiative that gathers and disseminates information on relevant disability topics underpinning the move towards full participation and equal opportunities of persons with disabilities.

The **aim** is that the DMI-ME will **serve as a tool** for reporting on critical issues affecting persons with disabilities in an **effort to support** the empowerment of relevant stakeholders through the provision of information.

The three main **objectives** of the DMI-ME are to:

1. **Build up knowledge** on the situation of persons with disabilities;
2. **Examine good practices in terms of social innovation** happening at the grassroots level; and
3. **Monitor and inform about policy reforms** on national, regional and international levels.

The methodology used in the DMI-ME is mainly based on:

- **Reporting on social innovation** - a key feature of the methodology behind the DMI-ME is to gather information at the local level through fieldwork within HI, CBM, partner projects or other means in order to gain first-hand information. It includes consultations with persons with disabilities, their representative organisations, service providers, as well as local and national authorities, observing and sharing knowledge about social innovations carried out by different actors in the region. This includes reporting on the good practices of various service providers that attempt or actually provide inclusive services.

- **Reporting on the situation of legislation and public policies -** The DMI-ME follows the evolution of legislation of some of the countries in the Middle East regarding compliance or otherwise, with the CRPD. Often, the missing link between socially innovative practices and relevant legislation is the development of sound public policies. In the Middle East, a key focus of the DMI-ME is to monitor the development and enforcement of public policies and allocation of public resources, with particular attention to the performance of DPOs, service providers and authorities. The project aims to study policies of multinational and bilateral agencies as well, as they can influence stakeholders from both the private (civil society) and public sectors.

How the DMI-ME operates and its future plans

A regional Steering Committee comprised of civil society representatives of INGOs, DPOs and NGO service providers decides the functions and strategic orientation of the DMI-ME. It is currently comprised of six members operating in the region (see Section 1.2).

Members of the Steering Committee meet regularly to determine and monitor the ongoing activities of the DMI-ME and contribute to them as required. The DMI-ME's activities generally include interviews and field research, producing various publications, conducting workshops and maintaining a website. Currently, the DMI-ME is operating across Egypt, Iraq, Jordan, Lebanon, the occupied Palestinian territories, Syria and the Yemen. In the future, this initiative intends to expand the partnership and have representation from each of the countries included in the project.

Since the commencement of the DMI-ME, several activities have been realised:

- **Three DMI journals** on topics related to the CRPD, social protection and education for persons with disabilities in the Middle East[19] have been produced,

- **Research into good practices in social services** for persons with disabilities across the region was launched, including the development of a unique assessment tool and the organisation of a regional competition for the acknowledgement of good practices (see Annexe 1),

- A **legislative review** of disability-related national legal frameworks has also been undertaken and is due for publishing in 2010, along with this current report on access to social services,

- A series of **national workshops** in the region related to social services was also conducted, and the DMI-ME maintains a website[20] for dissemination on disability-related information.

Activities of the DMI-ME remain centred around the use of knowledge of successful grassroots innovations and experiences to influence public policy related to persons with disabilities in the Middle East.

A combined perspective

In this way, the DMI-ME ensures a holistic perspective in analysing disability issues, looking at **macro level** policies whilst observing on a **micro level** how these policies translate into practice (or not) and how these impact the lives of persons with disabilities. As an **advocacy tool**, the DMI-ME facilitates knowledge-sharing on the ways that local organisations, authorities and international agencies develop and support reforms that promote and enable the full participation of persons with disabilities. It actively contributes to making this knowledge available to assist stakeholders in the implementation of the CRPD.

Whilst broadly looking at disability research, the DMI-ME does not focus primarily on quantitative and typical statistical data, but rather emphasises the exchange of qualitative information to effect socio-political change. Due to the natural tendency of governments to concentrate mainly on figures, the real substance of issues effecting persons with disabilities in the region continues to be ignored. In underscoring the exchange of qualitative information about new practices and observing policy reforms, the DMI-ME brings this innovation to activists wanting to advocate effective policy change in the region.

The thematic focus of DMI-ME activities on **access to social services** has been developed according to issues of the disability movement in the region identified by the multi-stakeholder DMI-ME Steering Committee. More broadly, the topic of access to social services is becoming widely accepted as a key entry point to addressing the social exclusion of marginalised groups and poverty in general, both of which are highly pertinent issues for persons with disabilities in developing countries.[21]

19 www.disabilitymonitor-me.org
20 Ibid.
21 Berry, C., Forder, A., Sultan, S., and Moreno-Torres M. Approaches to Improving the Delivery of Social Services in Challenging Environments, PRDE Working Paper 3, (DFID: 2004).

By having activists promote innovative practices and cite examples of what is working well for persons with disabilities, dialogue with policy-makers is more likely to be constructive and positive, rather than a mere critiquing of the shortcomings of authorities. This innovation of the DMI-ME makes it a unique and effective program in the move to influence policy-makers from the bottom-up.

Box 1. Making it Work[22]

Making it Work (MIW) is a global multi-stakeholder initiative to promote effective implementation of the United Nations Convention on the Rights of Persons with Disabilities (CRPD).

The MIW International Coordination Team and International Advisory Committee oversee and guide the global direction of the initiative. The broad based International Advisory Committee includes: Handicap International, Inclusion International, Leonard Cheshire Disability, Disabled People's International, CBM, Mobility International USA and Inter-American Institute on Disability and Inclusive Development. Projects are driven by steering committees composed of NGOs and DPOs in each locality. Projects have already started in Southeast Europe, Central and South America and West Africa.

Making it Work supports research and advocacy projects at the local, national and regional levels with the overarching aim of contributing towards the full and equal participation of people with disabilities in the economic, political, and social spheres around the world. Its specific objective is to increase the capacities of persons with disabilities and their representative organisations to document evidence of good practices on key disability issues at the local level and to use this to influence development policy and practice in line with the principles of the CRPD.

The CRPD represents a significant step towards addressing the critical poverty and social exclusion experienced by women, men, girls and boys with disabilities and their families. However, in most developing countries there are significant gaps between the standards set by the CRPD and the reality on the ground for persons with disabilities. Whilst many governments have signed or ratified the treaty, they often lack crucial information on **how to develop inclusive policies and programs** that can have a meaningful impact on the lives of disabled individuals.

At the same time, disabled people's organizations (DPOs) in developing countries often lack the capacity for effective advocacy. Hence, the need for a dialogue between DPOs and governments, with quality disability information and evidence of good practice proved to be an excellent catalyst. The MIW approach is focused on the collection of good practices and **constructive advocacy**, where civil society organisations can utilise their knowledge and experience of what works to promote strategies and recommendations for inclusive development; it is designed to influence policies reflecting the rights-based approach, from the ground-up.

22 Written by Rhonda Neuhaus, Making it Work Programme Manager, Handicap International, U.S.A.

The Disability Monitor Initiative (DMI-ME) in the Middle East is also influenced by the Making it Work approach. Based on the current theme of **Access to Social Services**, the DMI-ME Regional Steering Committee has done the following:

- Undertaken research on social services;
- Produced an assessment tool looking at good practices in service provision based on the principles of the CRPD;
- Developed a website about the project;
- Published thematic DMI-ME journals, and,
- Produced this DMI-ME Report and a legislative review about services and laws for persons with disabilities in the region.

In 2010, the DMI-ME report together with the legal review will become part of a toolkit for disability activists in the region interested in advocating for more inclusive practices and policies related to social services.

Whilst *Making it Work*-related projects have already begun around the world, the official launch of the project was made at the UN Headquarters in New York, during the second session of the Conference of States Parties in September 2009. A key achievement of *Making it Work* has been the development of its specific methodology: a step-by-step guideline on "How to Set-up and Manage a Making It Work Project" that supports civil society (DPOs and disability and development NGOs in particular). A practical toolkit will complement the information in this guideline. Further information can be found on the project website: www.MakingItWork-crpd.org.

Chapter 2. Building disability inclusive social services in the Middle East

While there is no large body of research available in the Middle East, the anecdotal evidence from disability advocacy groups and other organisations working to support persons with disabilities clearly demonstrates that persons with disabilities are over represented amongst the population who live in poverty. In addition to the lack of access to quality social services in most of the countries in the region, poor people, and among them specifically persons with disabilities and their families, are more often than not denied the opportunity to participate in decision-making processes that significantly shape their lives.

2.1 Disability and Poverty interlinked in a vicious cycle – unwelcome partners

The World Health Organisation (WHO) today estimates the number of persons with disabilities worldwide to around 600-650 million, with as many as 80 percent of them living in developing countries. This means that some 500 million persons with disabilities are still largely excluded from the main development agendas, at the international, national and local levels.[23] Approximately one in five persons living in absolute poverty have some kind of impairment, confirming the vicious link between poverty and disability that is well-known today and has been reflected in various research and reports.[24,25,26]

When people live in poverty, they usually lack access to basic services, such as healthcare, education, safe employment and proper housing conditions. This puts them in higher risk of serious health problems or accidents, which can then lead to impairments and illnesses. If a person acquires an impairment, he or she usually faces significant barriers to accessing health services, education, employment opportunities and other public services, thus, perpetuating the cycle of poverty and limiting opportunities available that could help him or her move out from this condition of poverty.[27] **Discrimination, social exclusion and denial of rights**, together with **lack of access to basic services** formulate the link between poverty and disability and not the actual impairment alone. [28]

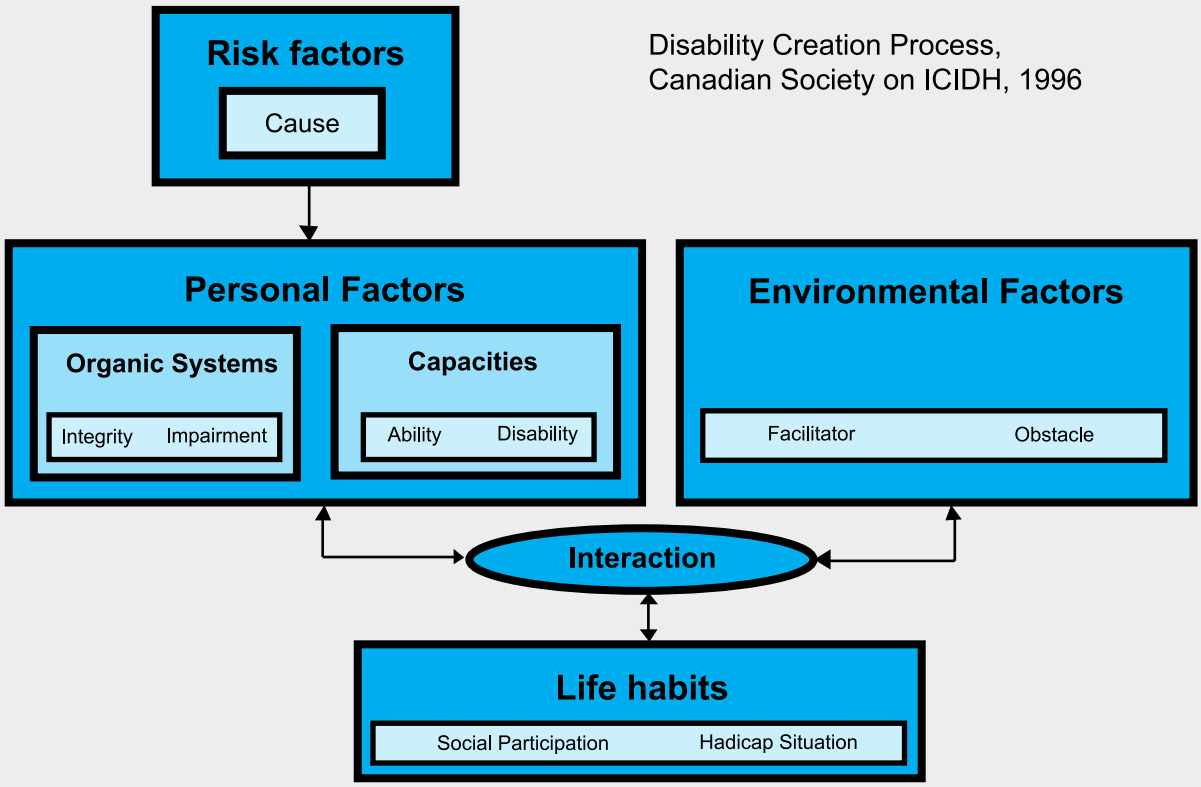
23 These figures can be accessed at WHO website: http://www.who.int/nmh/a5817/en/ as well as STAKES website: http://info.stakes.fi/ssd/EN/disabilityandpoverty/facts/index.htm
24 DFID. Disability, Poverty and Development, (DFID: UK: 2000).
25 Elwan, A. Poverty and Disability A Survey of the Literature, Social Protections Discussion paper Series, (World Bank: Washington: 1999).
26 Yeo, R. Chronic Poverty and Disability. Chronic Poverty Research Centre, Background paper no.4, (Action on Disability and Development (ADD): UK: 2001).
27 World Bank. Disability and Development and the World Bank: A Briefing Summary, February 2, 2005.
28 Axelsson, C. A Guidance Paper for an Inclusive Local Development Policy, (Handicap International, SHIA and HSO: 2008): p. 20. This policy paper was developed as part of a project named "Mainstreaming Disability in Development Cooperation to Break the Cycle of Poverty and Disability in Developing Countries" coordinated by International Disability and Development Consortium (IDDC). www.make-development-inclusive.org

Box 2. Classification systems of health and disability

Once a person faces barriers to accessing basic social services, such as health and education, employment and livelihood opportunities, and an inaccessible infrastructure, he or she is confronted by a situation of disability, or he or she has "become disabled", as it is sometimes expressed. In this sense, disabled refers to the interaction between human performance and the environment, which does not take into account different functioning levels. For example, a wheelchair user is not so much disabled by his or her actual impairment, but by not having access to available and qualitative education, to the labour market or to adequate health services.

Two classification systems relating to disability are the **Disability Creation Process** (DCP)[29] and the **International Classification of Function, Disability and Health** (ICF).[30]

DCP - defines disability as an impediment in a person's life habits resulting from a dynamic interaction between personal (impairment or disability) and environmental (obstacles and facilitators) factors. Disability, therefore, is not a permanent state, but an evolving process that varies depending on the context and environment. According to this model, several types of actions can be undertaken to modify these interactions and achieve social participation: reducing impairment (medical care), developing capabilities (rehabilitation), and adapting to the environment (elimination of physical obstacles, anti- discrimination and accessibility policies).

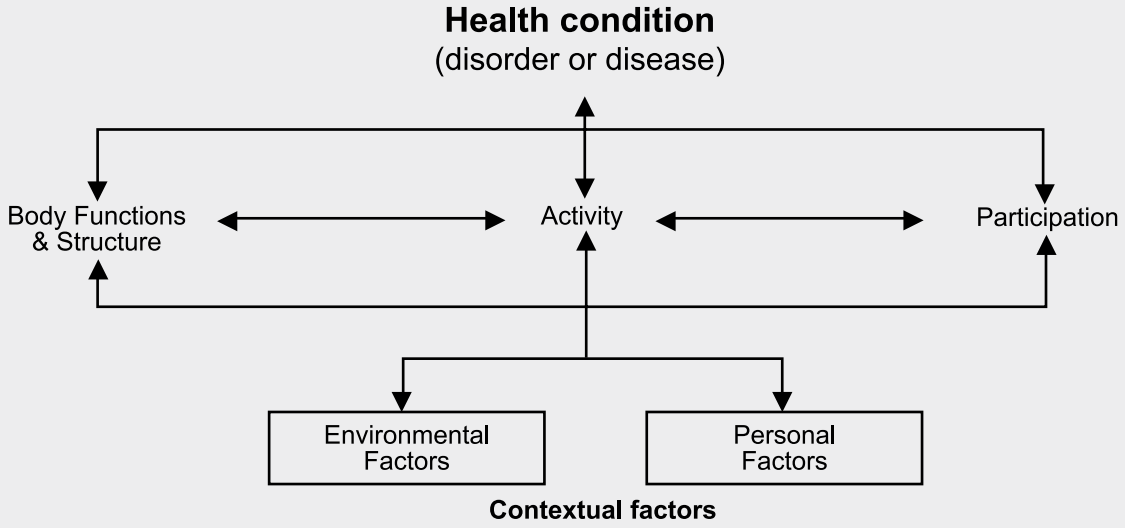


Disability Creation Process,
Canadian Society on ICIDH, 1996

29 Fougeyrollas, P., Cloutie,r R., Bergeron, H., Coté J., and St Michel, G. Quebec Classification: Disability Creation Process. International Network on the Disability Creation Process. http://www.ripph.qc.ca/

30 http://www.who.int/classifications/icf/en/

ICF - The WHO endorsed this classification, which puts the notions of health and disability in a new light as it acknowledges that every human being can experience a decrement in health, thereby encountering some degree of disability. Disability then does not only happen to a minority of humanity. The ICF thus 'mainstreams' the experience of disability and recognises it as a universal human experience. By shifting the focus from cause to impact, it places all health conditions on an equal basis allowing them to be compared using a common metric - the ruler of health and disability. Furthermore, this classification takes into account the social aspects of disability and does not perceive it only as 'medical' or 'biological' dysfunction; it arises out of limitations in activity and participation stemming from the interaction in and restrictions of an unaccommodating environment.



- **Body Structure and Function** - refers to the physiological and psychological functions of body systems (including age and gender);
- **Activities** - pertain to a range of individual deliberate actions, such as getting dressed or feeding oneself; and,
- **Participation** - refers to activities that are integral to economic and social life, such as being able to attend school or hold a job.

Disability organisations' critique of ICF

It should also be noted that while the effort of elaborating a worldwide classification is considered useful by the disability movement, use of the current ICF has not achieved unanimous acceptance among persons with disabilities around the world. This is owing to the fact that persons with disabilities have been poorly consulted while it was being drafted and tested and also because it classifies disability as a health issue, neglecting how it cuts across and is connected to different sectors.

2.2 Ensuring access of persons with disabilities to social services – a pre-condition for social inclusion and poverty reduction

Individual and societal human development and poverty are inevitably linked; and as disability and poverty is equally interconnected in a vicious cycle, the latter has to be defined not only from an economic perspective, but also from the point of **social exclusion and powerlessness**.[31] The UNDP's 2005 Human Development Report, which addresses aid and international cooperation, makes a clear statement of alarm that the progress of achieving the Millennium Development Goals (MDGs) are slowing down and even reversing in some countries. Indeed, the progress among the 20 percent of the poorest part of the population is far slower than in the rest of the population in developing countries, especially in terms of access to healthcare and sustainable livelihoods.[32]

Including disability and persons with disabilities in the MDGs

Most disability organisations and some development NGOs agree that the MDGs will never be reached if **the rights of persons with disabilities are not specifically addressed in the goals and policies for implementation, monitoring and evaluation**.

Recently, the United Nations has highlighted this issue, and drafted a resolution urging member states to ensure that disability indicators are included when reporting on the MDGs.[33] As the achievement of the MDGs has become an internationally recognised aim for development; it is of utmost importance that disability is included.

For example, MDG 2 of achieving universal primary education will not be reached if it does not include in its targets or indicators, children with disabilities. It is estimated that 98 percent of children with disabilities are not enrolled in schools, approximately making up 5-8 percent of all children in developing countries.[34]

This is also true for MDG 4, which refers to halving the rate of child mortality. Currently, mortality rates for children with disabilities under the age of five is approximately 80 percent, with a majority being born into low-income households, presenting them with fewer opportunities to realise their potential.

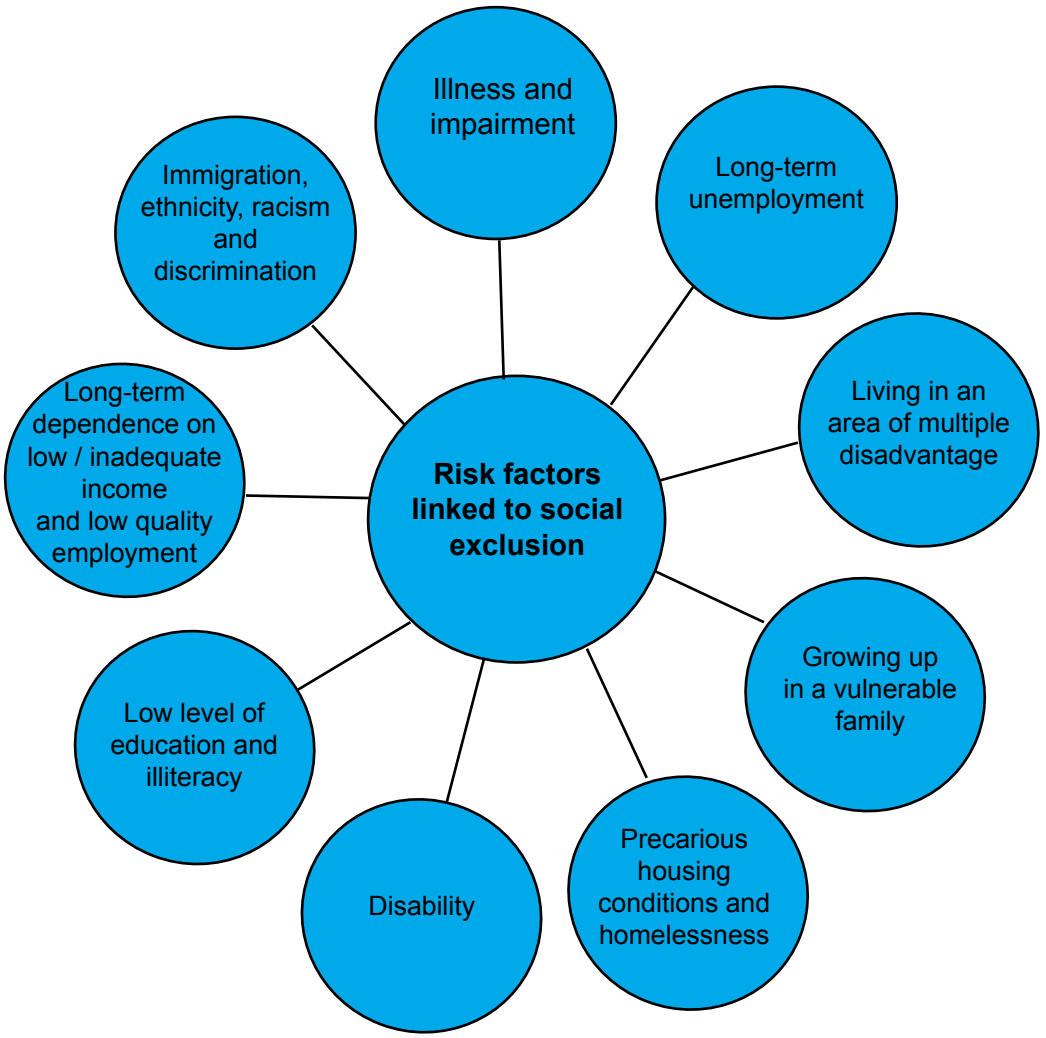
It is also worthwhile to note the double discrimination faced by women with disabilities, and the higher incidence of violence and abuse they are exposed to compared to those without disability.

> *"…Greater equity is a powerful catalyst for poverty reduction…human development gaps within countries are as stark as between countries. These gaps reflect unequal opportunities. Such inequalities are unjust…economically wasteful and socially destabilizing."* [35]

Social exclusion and consequently, **social inclusion**, are concepts increasingly used among international development organisations and disability stakeholders.

31 Yeo, R, 2001.
32 UNDP. International Cooperation at a Crossroads: Aid, Trade and Security in an Unequal World. Human Development Report 2005, (UNDP: New York: 2005): p. 5.
33 UN Enable. Draft resolution on the inclusion of persons with disabilities in realizing the Millennium Development Goals. http://www.un.org/disabilities/default.asp?id=1470
34 UN Enable. Factsheet on Persons with Disabilities. http://www.un.org/disabilities/default.asp?navid=34&pid=18
35 UNDP, 2005: p. 5.

Scheme 1. Risk factors linked to social exclusion[36]



In conclusion, the following dimensions summarizes the link between social exclusion and poverty:[37]

1. It is **multidimensional**: it includes not only income but also a range of indicators of living standards (health, decent housing, security, livelihood opportunities);
2. It is **dynamic**: specific factors determine entry or exit from it;
3. It has a **neighbourhood dimension**: deprivation is caused not only by lack of personal resources but also by unsatisfactory community resources;
4. It is **relational**: it implies inadequate social participation and lack of power; and
5. It implies a major **discontinuity in the relationship of the individual with the rest of the society**.

36 European Commission. Draft Joint Report on Social Inclusion; Part I – The European Union, Commission of the European Communities, COM (2001) 565 final, (Brussels: 2001).
37 Grammenos, S. Illness, Disability and Social Inclusion, (European Foundation for the Improvement of Working and Living Conditions: Dublin: 2003): p. 30.

Persons with disabilities in the Middle East and in the rest of the world face a **cumulative effect of these disadvantages** and are compelled to rely heavily on their families for support. Disability has been and to a large extent still is, considered an individual problem; an impairment or an illness that prevents a person from undertaking daily tasks and participating in society like others who do not have impairments. The traditional response to this medical view on disability has been the creation of measures and policies that promote segregation and protection.

In the few countries of the Middle East where public social policies have included persons with disabilities and their families, social care, residential institutions, medical rehabilitation, or special education have been promoted. Such policies aim to correct or compensate for the disability rather than including it in public social policies within society and removing barriers such as inaccessible education, housing and public transport, employment discrimination and negative attitudes of health workers towards women with disabilities in need of maternal care. Services that could contribute to mitigate these factors are yet underdeveloped in the region and segregated without functional links that facilitate inclusion.

Social and economic development does not reach majority of persons with disabilities

Persons with disabilities and their families in the region continue to fight for their (collective) right to equally benefit from social and economic programs in their respective countries. Social stigma and discrimination prevails and barriers and limited opportunities persist for this group to participate as full and equal members of society. Even though there are few statistics available regarding the situation of persons with disabilities in the Middle East, experiences told by numerous DPOs, individuals with disabilities, parents' organisations, rehabilitation professionals and others concerned about the well-being of persons with disabilities and their families, confirm that social exclusion and higher poverty incidence are found amongst this group of the population.[38]

The past decades have shown a remarkable improvement in several areas of social and economic development in countries in the Middle East: access to healthcare and primary education has steadily improved and Human Development Index (HDI) has increased.[39] Even if this positive trend has shown recent sluggishness or even stagnation, persons with disabilities have not fully benefited from these improvements, reflected in the worsening socio-economic situation compared to the non-disabled members of the population.

Despite some notable enhancements in the promotion of more inclusive service provision and policy, existing services in the Middle East either provided by the state or the private and non-profit sector, are seldom made accessible to persons with disabilities. For example, the education sector continues to exclude a large majority of children and youth with disabilities in its general education system. This is attributed to physical barriers, social stigma, lack of trained teachers, inadequate transportation, absence of policies on inclusive education and the prevailing rigid and conservative method of pedagogy.

38 Grut, L. and Ingstad, B. This is My Life – Living with a Disability in Yemen. A qualitative study for the World Bank, (SINTEF Health Research: Trondheim: 2006). This report describes the challenges faced by persons with disabilities and their families living in three governorates in Yemen: Sana'a, Dhamar and Aden.

39 UNDP. Challenges to Human Security in the Arab Countries, Arab Human Development Report 2009. (UNDP: Beirut: 2009). HDI – Human Development Index, which measures the level or extent of human development based on health and longevity, knowledge and education, and standard of living.

In terms of unemployment, rates are generally fairly high in many countries in the region and the informal market increases in importance as it serves as the main source of livelihoods for a majority of the working population. The high unemployment rates for non-disabled job seekers poses as a major challenge for policy-makers in the region; however, this situation for persons with disabilities is compounded by physical barriers in accessing the built environment of the workplace and attitudinal obstacles due to the social stigma including the employer's lack of belief in the capacity of a person with disability. In general, the lower level of education of persons with disabilities further limits their competitiveness in the open labour market.

Defining social services and social rights in the Middle East

It is impossible to find one commonly agreed upon definition of what social services are in the scarce literature on this topic in the Middle East, and indeed also at international level; this is probably due to the apparent linkages of social welfare systems to cultural contexts, political systems and existing resources. Understanding the types of services, which could be considered as an important factor in ensuring social cohesion while well-being depends on various other aspects; thus, making it irrelevant to strictly define what the services to be developed are. It might be more helpful then to identify the goals a society would like to achieve in terms of social inclusion and well-being, based on national and international legal instruments, demands of the population and available technical and financial resources in each country.

At the level of the European Union for example, there is an on-going process of defining and ensuring that social services are part of **Services of General Interests** (SGI)[40] and being defined therefore as Social Services of General Interests (SSGI).[41] Social Services of General Interest are considered to be **services that are for the interest of everybody, fundamental in ensuring well-being and fighting poverty and exclusion.** Recognized to be the pillars of a European society and economy, they operate on the basis of the solidarity principle (referring to a contributory mechanism).[42]

It is certainly not the intention of this report to impose any external definition of social services for the Middle East region. The idea is to present examples of on-going discussions and debates, both from international institutions and civil society stakeholders concerned about equality and social development. In summary, what appears to be common amongst these debates on social services is that they are important for **facilitating social inclusion** and **protecting fundamental rights**, especially of **marginalised and discriminated groups** of the population. It is likewise acknowledged that social services should be ensured by the state, thus there is a **public obligation** involved.

40 European Commission. Services of general interest, including social services of general interest: a new European commitment, COM(2007) 725 Final, (European Commission: 2007). In this communication from the EC, services of general interest (SGI) are discussed and defined as: "…they can be defined as the services, both economic and non-economic, which the public authorities classify as being of general interest and subject to specific public service obligations. This means that it is essentially the responsibility of public authorities, at the relevant level, to decide on the nature and scope of a service of general interest, which the public authorities classify as being of general interest and subject to specific public service obligations".

41 European Commission. Implementing the Community Lisbon Programme, Social Services of General Interest in the European Union, COM(2006) 177 Final, (European Commission: 2006).

42 It refers to that since these services are provided to people without requesting contributions (such as some employment schemes, or insurances etc), it is gathered from tax payments, and thus people who have salaries make these available with their tax money, in a solidarity perspective, and contribute to the provision of these social services.

A proposition of **which social rights** could be addressed in ensuring access to social services for all populations is proposed below, in anticipation of initiating a discussion amongst stakeholders to further elaborate this concept. Among some European social actors concerned with the idea that services should be ensured to promote social inclusion and equality and combat poverty, these should:

> *"…cover a large and diversified range of services which are intended to improve the living conditions of the population, especially of individuals and groups that face marginalisation and exclusion. These services are linked to national welfare schemes and are important tools for the implementation of public policies in the field of social protection, non-discrimination, the fight against poverty and exclusion. They are not conditioned by the contribution of the users and their aim is to enhance capacities of individuals for their full inclusion and participation in society. They respond to social needs and social deficits, which [the] market cannot manage, or which can be even generated by the market".*[43]

The choice of proposing such a broad view on services with a social function (hereafter in this report called social services) for discussion in this report is based on the fact that there is a range of services in communities impacting the lives of persons with disabilities. In this sense, services are considered to be of particular importance to society as a whole and the personal interaction between service providers and users plays a key role in its delivery such as health, education, labour integration and livelihood opportunities, social protection and in many cases, cultural services.[44] There are several articles in the CRPD, amongst them, Article 19, ('Living independently and being included in the community') that describe the importance of accessing various services within the community:

> *"The States recognise the rights of all persons with disabilities to live in a community and shall take appropriate measures to facilitate this. Among them: the right to choose how and where to live, to have in-home, residential or community support services (such as personal assistance), and to have equal access to common community services available to the citizens".* [45]

Such services must be accessible to people who need them, including persons with disabilities. These benefits could be categorised into **five main pillars:**

1. Health and medical services;
2. Education;
3. Employment/access to livelihood opportunities;
4. Personal support services such as day care services, personal assistants, assistive technologies and devices, sign language interpreters, accessible and affordable housing); and
5. Social protection and social security.

43 Chiriacescu D. Shifting the Paradigm in Social Service Provision: Making Quality Services Accessible for People with Disabilities in South East Europe, Disability Monitor Initiative, (Handicap International: Sarajevo: 2008) (following different description at European level EU, EASPD, Eurodiaconia etc).

44 Munday, B. Integrated Social Services in Europe: A report prepared for the Council of Europe, September 2007. The report can be accessed at: http://www.coe.int/t/dg3/socialpolicies/socialrights/source/Publication _Integrated%20social%20services %20in%20 Europe%20E%20(2).pdf

45 The CRPD provides several articles of rights, which need to be addressed by various services, such as Article 24 (education), Article 25 (health), Article 26 (habilitation and rehabilitation), Article 27 (work and employment), and Article 28 (adequate living standard and social protection), etc.

Box 3. Social security and social protection

Social protection includes, amongst other things, both social insurance and social assistance.[46]

- **Social insurance** is social security financed by contributions and based on the insurance principle; this refers to individuals or households protecting themselves against risk by pooling resources with a number of similarly exposed individuals. This is usually connected to occupational schemes.
- **Social assistance** encompasses public actions that do not require contributions, though benefits are determined through means-testing; it is designed to transfer resources to groups deemed eligible due to deprivation. It should ensure a minimum standard of dignity and provide opportunities to cope with risk situations and rise out of poverty.

Social protection should be seen in a holistic rather than a stand-alone manner; it must be prioritized and integrated into political, economic and social goals.[47]

Article 22 of the Universal Declaration of Human Rights states that *"everyone as a member of society has the right to social security*". Whilst **Article 9 of the International Covenant on Economic, Social and Cultural Rights** refers *to "the right of everyone to social security, including social insurance."*

Article 28 of the UN Convention on the Rights of Persons with Disabilities refers to *"States Parties recognize the right of persons with disabilities to social protection and to the enjoyment of that right without discrimination on the basis of disability, and shall take appropriate steps to safeguard and promote the realization of this right."*

It is important for stakeholders in the Middle East to pay considerable attention to one of the aspects presented above, specifically, **that States remain the *guarantor* of the access to social services, without necessarily having to deliver the services themselves**. This means that even though social services, considered to be of general interest for a country, are made available by private providers (e.g., NGOs, for-profit companies, volunteers), with the local and/or central authorities ultimately having the responsibility of developing related policies and practices that ensure **the quality of these services and the people's access to them**.

Shifting the paradigm of the approach to service provision - from charity to human rights and participation

Providing social services for persons with disabilities in countries in the Middle East is still, in most cases, based on a charitable attitude and medical diagnoses of the impairment. The stakeholder review implemented by HI and its partners in 2005 reflected a prevailing regional charity and impairment-based view of providing services.[48] This trend may to some extent be a reflection of the prominence of religious, both Islamic and Christian, values in Middle Eastern societies, wherein charity plays a central role in supporting vulnerable and excluded groups in society.

There have been a number of faith-based social organisations in operation in the social sector in the region, specifically in the delivery of disability services. Many of them, together

46 CHPI and SAFCD. Social Security Policy Options for People with Disabilities in South Africa: An international and Comparative Review, (The Child Health Policy institute and the South African Federal Council on Disability: 2001): p. 6.
47 UN Social and Economic Council. Enhancing Social Protection and Reducing Vulnerability in a Globalizing World. Report of the Secretary General, E/CN.52/2001/, (United Nations: Geneva: 2001).
48 Axelsson, C. and Sharkawy, G., 2006: pp. 15, 39, 57, and 71.

with other non-profit organisations (e.g., NGOs, foundations and charities), have ended up filling the gap in social service provision, especially for excluded and discriminated groups. Thus, building and modernising social services and related regulatory mechanisms entails taking into account the cultural and religious values that exist among communities; as failure to do so might mean risking rejection of a facility or service that runs counter to religious beliefs or traditions, becoming inefficient in implementation or relating poorly with the target population. There is a recognised need to strike a balance in introducing modernization of services and promoting new standards. As Coleridge writes in a paper aiming to develop a disability strategy in Yemen in 2004:

> "*…charity should not be dismissed out of hand. It can be a sincere expression of compassion, and as such needs to be built on constructively. The feeling of compassion associated with charity can often be the starting point for a deeper understanding of the issues, and therefore lead to a developmental approach".*[49]

2.3 Social Services in the frame of the Convention on the Rights of Persons with Disabilities

The CRPD is a legally-binding instrument within international law, with general principles and specific articles directed at the promotion and protection of the rights of persons with disabilities. To show consideration for these principles and articles, they should be translated into legal reality and embedded in various relevant national and specific disability legislation and policies (i.e., twin-track approach which is described in detail in chapter 2.4).

In this regard, services, including health, education, employment, cultural-related and recreational services and social protection should be regulated in terms of their classification, design, access, monitoring and evaluation and in accordance with the general principles of the CRPD that tend to interact and overlap with one another. For example, services cannot be considered fully **available** without taking into account aspects of **non-discrimination and accessibility**, both of which are general tenets of the CRDP. If the provided services are not **affordable**, the system violates the general principle related to equal opportunities; further, if these services do not enhance participation and inclusion, this would result in the infringement of the second general principle espousing **full and effective inclusion and participation**.

The right to education, health, habilitation/rehabilitation, employment and social protection are treated separately and extensively in Articles 24-28 of the CRPD. In sum, all of these services should be available and accessible to persons with disabilities and their families on an equal basis with others by ensuring reasonable accommodation and adequate personal support services (referring to community support services in the CRPD), taking into consideration the wide diversity of persons with disabilities. Taken as a whole, the general principles as mentioned in Article 3 must be embedded in the different stages of these services - from the needs assessment to the delivery process, until it reaches the monitoring and evaluation phase.

Article 19 of the CRPD represents one of the clearest examples of the impact of equal access to services on inclusion, participation and living independently in community. It highlights the **close link between rights enjoyment and participation** by accessing various types of social services and stipulates that community living, personal assistance and support

49 Coleridge, P. The Social Fund for Development Yemen. Disability Programme Strategy 2004 - 8 .

services provided within the community are all necessary prerequisites to allow persons with disabilities to exercise their right to live independently and participate in activities in their communities without any form of discrimination and on equal basis with others.

Reasonable accommodation and **Universal Design** as defined in Article 2 are not separate legal obligations that can be fulfilled in isolation from other rights, but should be perceived as prerequisites to the enjoyment of rights and access to services. For example, the general obligation stated in Article 4.1 emphasises the State's role in ensuring that Universal Design principles are considered and applied in services for persons with disabilities to ensure their full accessibility to both mainstream services and more specific disability services. Accessibility as a vital prerequisite, which includes the elimination of physical and non-physical obstacles and establishing informed consent for the users, is present throughout the CRPD in Articles 9, 16, 25 and 26.

Box 4. Disability, Development and Human Rights

Traditionally, development was perceived as assessing and addressing the evident needs of the poor and marginalised. Although it aimed to deal with the causes of the problem, the response was often provided through a top-down approach, based on a notion of charity. With the number of instruments promoting human rights increasing and the evidence of progress in developing countries on the decline, the shift towards emphasising the development of the human rights perspective has become stronger.[50] This implies that development programs should be focused on ensuring that fundamental human rights and dignity are respected and basic services are accessed by and available to all as enshrined in the Declaration of Human Rights and other international instruments that have been ratified. In addition, this approach is linked to **participation** as successful development is not achieved in a vertical, top-down manner or with outside intervention only; but rather, through the involvement of the people in decision-making processes, democratic institutions and having a voice in their own growth.

An important challenge – making persons with disabilities visible in development programs

Development policies, approaches and concrete programs that have been implemented so far, have generally not yet succeeded in creating conditions for the improved well-being of **ALL** people and communities. However, there are still several overlooked groups who continue to deal with situations of poverty, vulnerability and exclusion, these include: indigenous populations, immigrants, women, elderly persons, persons with disabilities and minority groups of ethnic, religious, sexual or social backgrounds. Disability has been - and still is - disconnected from mainstream development theories and practices, neglected from being viewed for what it really is - a vital issue in global poverty.

The Convention on the Rights of Persons with Disabilities manifests the paradigm shift in disability; it focuses on persons with disabilities' equal enjoyment of human rights and the need for society to change and become inclusive. In fact, this convention is unique in its kind owing to the two themes that serve as basis for its development:

50 Social Watch. *Rights is the Answer*. Social Watch Report 2008, (Montevideo: 2008).

- **The Disability and Human rights dimension with fundamental questions around disability and social development (i.e., gender, equality, poverty reduction); and**
- **The promotion of mainstreaming disability and an inclusive development approach.**

Many countries of the region have signed or ratified the CRPD (see Chapter 5), representing significant momentum for modernisation of services for persons with disabilities in their respective countries.

2.4 Inclusive social services and mainstreaming of disability

To create more efficient and unbiased development policies and programs that reach the diversity of populations and ensure that all groups in society benefit from its development, public policies at all levels need to integrate the demands and consider the rights of **ALL** individuals, from inception to implementation. The demands of persons with disabilities **are not necessarily based on impairments** as a large majority live in poor conditions and are at the margins of society; **their requests for access to services (i.e., housing, employment, education and healthcare) are the same as with other people facing poverty**.

Inclusive development is a concept that has gained the attention of socially excluded groups and/or organisations working to reduce poverty and inequalities. Of late, with the ratification of the CRPD, it has been emphasized amongst disability stakeholders advocating for the need to **mainstream disability into development policies and social services**. The initiative intends to take the focus away from small and segregated disability services and projects, recognise and respond to the fact that persons with disabilities have the same needs to access social services as others, and ensure that all services are available.

It is also a process that contributes to the goal of establishing an inclusive community and including a disability perspective in development programs and national policy-making, should be perceived as the change agents. It does not intend to modify the main activity or course of project planning; it *"…mainly involves taking the perspectives of persons with disabilities into consideration at each stage of the project cycle. It can be seen as a shift from classical development work to inclusive development"*.[51] Various human rights agreements, among them the CRPD, which likewise confirms this point, and Article 32 on international cooperation state the measures that need to be undertaken to promote the realization of the convention.

The inclusive approach to disability is as well reflected in the following international instruments:

- **UN World Program of Action Concerning Disabled Persons, 1982.** Paragraph 89: *"Matters concerning disabled persons should be treated within the appropriate general context and not separately".*[52]
- **UN Standard Rules on the Equalization of Opportunities for Persons with Disabilities, 1993.**[53] Standard Rule 14.3: *"The needs and concerns of persons with disabilities should be incorporated into general development plans and not be treated separately"*.

51 CBM. Make Development Inclusive: How to Include the Perspectives of Persons with Disabilities in the Project Cycle Management Guidelines of the EC, (CBM: Brussels: 2007): p. 12.
52 The UN World Programme of Action Concerning Disabled Persons can be found at: http://www.un.org/documents/ga/res/37/a37r052.htm
53 The UN Standard Rules can be found at: http://www.un.org/esa/socdev/enable/dissre00.htm

- **UN Convention on the Rights of Persons with Disabilities, entered into force 2008.** Article 32 says that State parties should: *"Ensure that international cooperation, including international development programmes, is inclusive of and accessible to persons with disabilities".* In the preamble of the document, among the general principles of the convention, one of them (Article 3) alludes to the *"Full participation and inclusion in society".*

The World Bank defines inclusive development as the result of a combination of principles and processes that should be considered when States engage in sectoral reform:[54]

- **Inclusion**: persons with disabilities should be accepted as equal partners in development and included as full participants in all development activities.

- **Equity**: persons with disabilities should enjoy equitable access to the benefits resulting from development activities, which should promote non-discrimination and provide them with equal opportunities to participate in every facet of life – civil, political, economic, social and cultural.

- **Access**: persons with disabilities should enjoy rights of entry and use to the built environment, transportation, information, and communications infrastructure, so they can participate in all aspects of life and thus enjoy the full range of human rights.

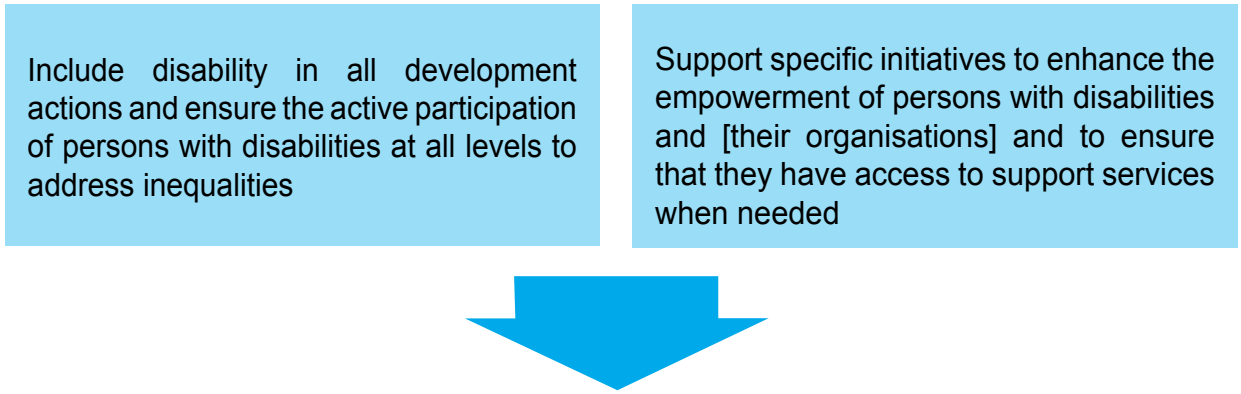
The "twin-track approach" for equal opportunities and full inclusion

Working towards ensuring equal opportunities and inclusion of persons with disabilities in the daily life of their respective communities, the **"twin-track approach"** is preferred and used as a model. Though the concept has already been recognised and used in many other policy areas such as gender and children's rights, DFID initiated its application to the disability sector in 2000. In relation to its own strategies, DFID outlined a twin-track approach to disability and development focusing on *"addressing inequalities between disabled and non-disabled persons in all strategic areas of [its] work"* and *"supporting specific initiatives to enhance the empowerment of people with disabilities".*[55]

54 Guernsey, K., Marco Nicoli, M., and Ninio, A. Making Inclusion Operational.Legal and Institutional Resources for World Bank Staff on the Inclusion of Disability Issues in Investment Projects, (World Bank: Washington DC: 2006): p. 11.

55 DFID. Disability, Poverty and Development, (DFID: UK: 2000). http://www.dfid.gov.uk/pubs/files/disability.pdf

Scheme 2. Twin-track approach in inclusive development[56]



Working towards the realization of equal opportunities and the establishment of an inclusive environment for persons with disabilities with a twin-track approach entails **two things: ensuring inclusive services and mainstreaming disability in overall policymaking while simultaneously supporting targeted disability actions and services to promote the empowerment of persons with disabilities.** In the process of developing and making mainstream social services accessible for persons with disabilities, specific measures and projects need to be implemented to support efforts undertaken to empower users and address existing and urgent requirements of persons with disabilities.

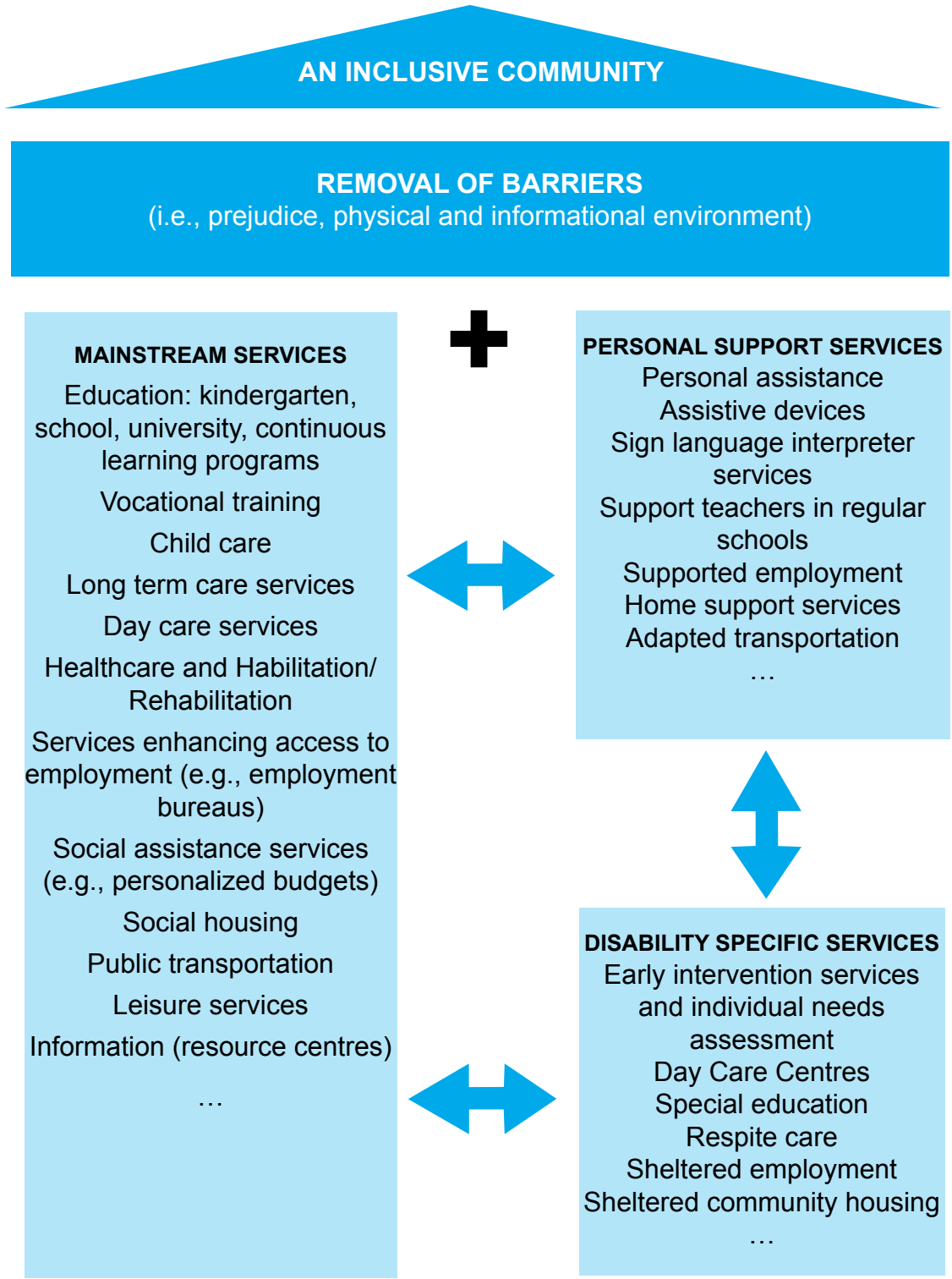
Twin-track approach to social services: towards an inclusive community

Following a **twin-track approach in the social services sector** allows for the establishment of a wide network of community-based services that complement one another, thus ensuring a so-called "continuity of care" and effectively shifting towards social inclusion of persons with disabilities.

It proves to be a useful approach in eliminating erroneous prioritization of choosing between mainstreamed or specific disability services because in an inclusive community, all types of services that lead to the participation of persons with disabilities and the achievement of the full respect of their human rights are equally necessary. The access of persons with disabilities to mainstream services such as education, healthcare, vocational training and employment, housing, social services and social protection, in the community is their fundamental right. Thus, it is imperative that these services should be provided in an inclusive and accessible manner for all categories of citizens, persons with disabilities among others.[57]

56 DFID, 2000: p. 11.
57 Chiriacescu, Diana, 2008.

Scheme 3. Twin track approach in the social services sector[58]



In order to facilitate this process, a specific category of services is developed in the disability sector, called **"personal support services"**, which aim to enhance self-determination and participation of persons with disabilities in society by making available equal opportunities.

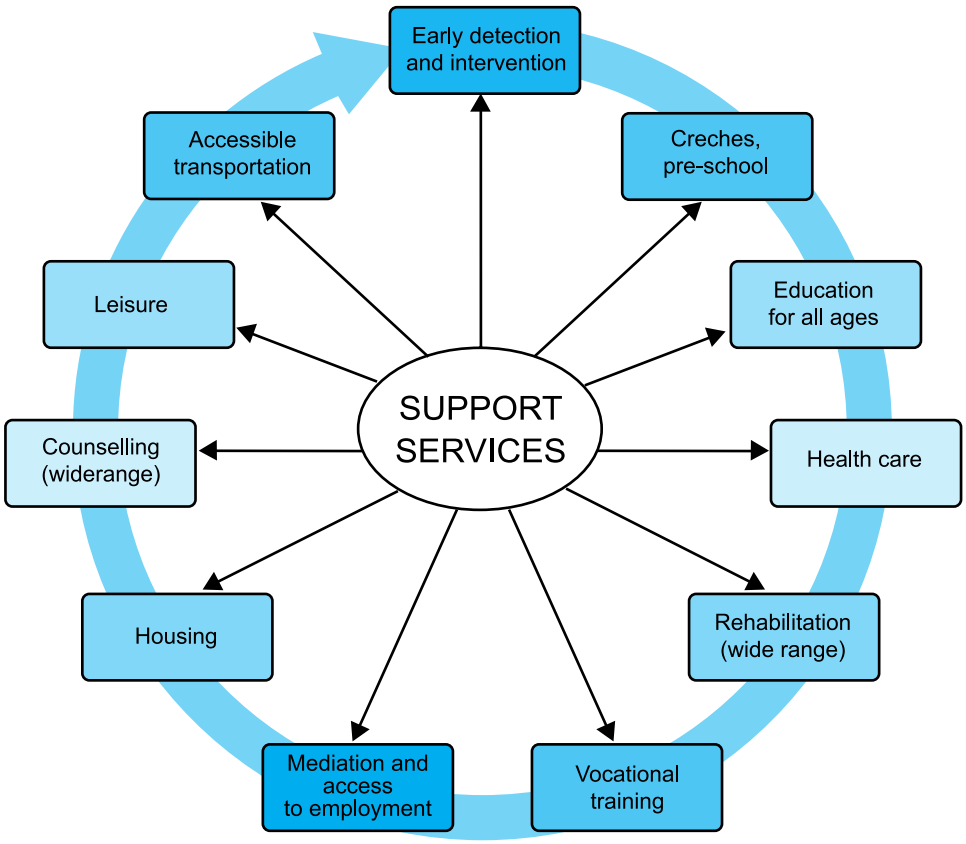
58 Ibid: p. 27.

Its main role is to support the access and active participation of persons with disabilities to various services and resources in the community and represent key elements to effectively mainstream disability. Examples include: provision of ortho-prosthetic and assistive devices, personal assistant schemes, support teachers for accessing education in schools, interpreters for persons with sensorial disabilities, accessible housing or home adaptations and in-home support for independent living.

As these services are somewhat similar to what is called **reasonable accommodation** in the CRPD, it is important to differentiate the two concepts. Personal support services involve face-to-face interaction akin to a service transaction while reasonable accommodation is a measure, a policy that ensures equal participation of all citizens in different activities such as employment or education. For example, reasonable accommodation in education is made for a child with visual impairment through the adaptation of examination processes and the provision of materials (i.e., textbooks) in Braille and ensuring that the school's physical environment facilitates his/her orientation of its premises. In this case, support services would come in the form of an adapted computer or a personal assistant.

More **specific disability services**, an extended category of social services are also needed to address the more complex needs of some persons with disabilities. These have to be provided in the community, based on a person-centred and inclusive approach, respecting the choices and interests of the users and their families. Some examples include: residential care in small family-like settings, respite care units, sheltered workshops, day care centres for persons with complex needs or a high level of dependency.

Scheme 4. Continuity of services needed at the community level for persons with disabilities[59]



59 Chiriacescu, D, 2008: p. 28.

Continuity of services refers to a specific requirement in the disability sector. Among all the services provided, strong functional and informational links have to be developed to allow the person to benefit from appropriate services during all stages of life. This is particularly important during the transition from one age cycle to another: from primary to secondary school; from childhood to adulthood; from the educational stage to employment; from employment to retirement; as well as when the person is in simultaneous need of different categories of services, as with education and rehabilitation; during this time, additional specific support services may be required. This unique nature of the disability service sector should be taken into consideration when a national system of regulatory procedures for social services is being drafted (this point is further elaborated in chapter 5 of this report).

The 4 A's criteria in looking at the efficiency and inclusiveness of social services

The final goal of providing any service to persons with disabilities is their active participation in social and economic life and be fully included in the community. Thus, these services often target activities related to social autonomy, personal development and individual well-being; they cannot always result in objective and measurable outcomes as with most economic or commercial activities. It is important that monitoring and evaluation, and funding of these services must also take this into account, as it is seldom the case among most disability services operating in the Middle East.[60]

For all these reasons, social services have to be **accessible** at the community level, **available** and **affordable** to all citizens, including persons with disabilities. They also have to be **accountable**, ensuring financial and organisational transparency and good governance; be provided with **good quality;** and organized in a way that reflects the choices and interests of persons with disabilities. Lastly, they have to enhance personal development and facilitate the progress of the person towards full participation in the social and as much as possible, economic life.

60 Training material developed by Handicap International Disability Services Coordinator, Darryl Barrett, for the MUSAWA training on Governance, Disability and Social Policy, Amman, July 2009.

Chapter 3. Advocating for inclusive social policies from a grassroots' perspective

Social policies are supposed to cover a large spectrum of social relations, considered to be necessary for the promotion of the human wellbeing, and entails systems by which this may be promoted; stated simply, it is concerned about the way daily lives of people are organised, facilitated or possibly challenged (i.e. if not inclusive policies). For people to develop their potential and capabilities, basic services, such as healthcare and education, or sources of livelihood are needed. All these things can be organised within various systems and through different entities, such as: government agencies and official bodies, businesses, social groups, charities, local associations, religious institutions or family members and neighbours. Moreover, it is important to point out that social policy is linked with more or less, the socially-sensitive strategic orientations and impacts of macro-economic policies and infrastructure investments.[61]

3.1 Brief overview on social policy and disability

The improvement in people's wellbeing and standard of living is dependent on the link between economic and social development, which the experiences of countless countries are testament to. Thus, a fundamental question that needs to be addressed through social policy is how **to equally distribute the benefits of economic growth and tackle poverty, disparities in income distribution, high levels of unemployment and under-employment and high living costs in relation to the income of the population.**[62] Social policy has to be in tandem with the objectives of economic policy and benefits of economic growth to ensure development that is socially sustainable and promotes social cohesion. They cannot be developed in a manner that will leave it to deal with social problems at a future date,[63] as has been the case in many countries. In this sense, social policy should be perceived as both a means and an end in any society; it is *"…a complex concept, which needs to be dealt with from an understanding and analysis of the economic, political and cultural components of a society in both its historical and modern dimensions".*[64]

Ensuring equal benefits of economic and social growth through inclusive policies

Another important aspect mentioned in UN's report on 'Integrated Social Policies in the Arab World' is that the development of social policies, or their reforms in the Middle East should emphasize inclusiveness and integration, close gender gaps, protect civil rights and take into account values of solidarity and justice. This implies that an improved system of public accountability should succeed implementation of social policies; this system has to be established or restructured in such a way that it applies equally to all agencies of government, including private groups in social service delivery (NGOs, charities or for-profit organisations),

61 Wiman, R., Voipio, T., and Ylönen, M. Comprehensive Social and Employment Policy for Development in a Globalizing World. Report based on an Experts' Meeting at Kellokoski, Finland, November 12006 ,3-. (Ministry of Foreign Affairs and Ministry of Social Affairs and Health and STAKES: Finland: 2007). www.stakes.fi/social-policies-for-development

62 ESCWA. Towards Integrated Social Policies in Arab Countries: Framework and Comparative Analysis, (United Nations: New York: 2005).

63 Mkandawire T. Social Policy in a Development Context, (UNRISD: Geneva: 2001).

64 Ministry of Planning - Palestine. National Report on Integrated Social Policy in Palestine, 19942008-, (Palestine Ministry of Planning: 2009): p 2. http://www.mop-gov.ps/web_files/conference_file/Executive %20Summary,%20Eng.pdf

such as education and healthcare.[65] In many countries, social policy development is a process involving a top-down approach, usually directed by the (political) elite, whose main motivation to undertake social initiatives or reforms is to gain votes and temporarily address instability.

Some countries in the Middle East with substantial economic resources are still faced with social volatility due to poverty and unemployment; while other nations in the region that are not as financially stable manage to provide better welfare for their citizens by combining economic with social policies.[66]

3.2 Advocating disability inclusive policies with grassroots organisations

With the adoption of the CRPD, an increased awareness on the importance of more participative policy processes, especially in the disability sector, is observed among activist and civil society groups in the countries included in this report.

In Jordan and Lebanon for example, several representatives of DPOs and a number of individuals with disabilities were involved in the drafting of new disability legislation, In Egypt, DPOs and NGOs, together with various governmental ministries and supported by the UNDP, will work together to revise the old legislation on Rehabilitation and Care of Persons with Disabilities. Through **more comprehensive and integrated social policies**, together with efforts that ensure access to social services for persons with disabilities, these can be radically improved. Existing good practices provide the necessary momentum to build on; it also served as an impetus for the development of the DMI-ME, in 2008, which was built on a multi-stakeholder partnership aimed to gather and disseminate information on disability in the region.[67]

Despite these efforts, social policies could still be more inclusive in accounting for the wellbeing of persons with disabilities, specifically in reducing the impact of disability. This can bring about improved living conditions and human development for the whole population. For this to happen, there is a need for **well-informed policy-makers** that have access to reliable data and statistics and **empowered and organised DPOs** working in alliance with other social movements to put the definition and implementation of social policies on the agenda of their respective governments.

At the national and local authority level, persons with disabilities have to be represented and are allowed to participate in the development of social policies that affect their lives. However, it is acknowledged that this is dependent on the authorities in a particular country and their position on civil society participation. One positive development in the Middle East in this area is the establishment of the different **National Disability Councils** set up in Lebanon, Jordan and Yemen. These councils are expected to influence policy development or revise other similar public initiatives that affect persons with disabilities. These bodies or organisations are not without their challenges: ensuring that they are truly representative of persons with disabilities and their DPOs, strengthening the capacity of the members for policy analysis and development by making available adequate and transparent information, and guaranteeing the presence of an independent media keen on depicting the plight of the marginalised and discriminated groups and promoting modern and progressive action undertaken by local or national authorities and different civil society groups to address social exclusion.

65 ESCWA, 2005: pp. 87, 89.
66 ESCWA, 2005.
67 More information on the Disability Monitor Initiative can be found in the Chapter 1 of the report.

A twin-track perspective in social policy development

A **twin-track approach could likewise be used to guide social policy development** in the perspective of disability in the Middle East; ensuring that all social policies are analysed from a perspective that incorporates disability, poverty and social exclusion whilst simultaneously guaranteeing that specific disability policies make available support services, cover extra costs of disability and protection for persons with disabilities with more complex and vulnerable impairments. Policies developed in the following social domains have to be inclusive of, among others, disability, while ensuring reasonable accommodation, accessibility, non-discrimination and support services for:

- **Policies that promote autonomy and self-determination** - ensure personal assistance or third person care;
- **Social security and social assistance** - including those persons with disabilities that cannot be integrated in the open labour market, taking into consideration extra costs related to disability for individuals and families (i.e., additional healthcare services, technical aids and adaptation devices, transport costs, clothing and the like.);
- **Employment measures** - installing mechanisms that promote inclusion into the mainstream labour market (e.g., imposing quotas, subventions for workplace adaptations, job coaching, raising awareness, or enhancing accessibility of employment offices). These also ensure that vocational training is inclusive, makes available the appropriate specialised support that are in accordance to market needs and is conducted in coordination with companies and employment offices;
- **Reintegration at work** of people who have become ill or have acquired a disability - involves rehabilitation such as occupational therapy, physiotherapy, re-training schemes, and the like;
- **Education policies** - inclusive policies where back-up or support teachers exist in mainstream schools and accessibility measures, curriculum adaptations, personal assistance in the school, technical aids and assistive technology, and specialized teaching within the conventional system are made available;
- **Health care policies** (including health-related rehabilitation) - ensure that mainstream healthcare is accessible to persons with disabilities; there is increased staff awareness; well-trained rehabilitation staff are available; and specialized rehabilitation centres are within reach when needed;
- **Public transportation policies** - aim to make ordinary transport systems accessible by purchasing new buses that can accommodate persons with disabilities, ensuring that bus stops and train stations contain adequate information, or providing fare discounts for person with disabilities;
- **Security and justice policies** - ensure sign language interpretation in courts and legal affairs offices are available, raise awareness of the police and rescue personnel on disability, especially on mental health and intellectual disabilities, make certain equality before the law, and provide other forms of legal support in an accessible manner;
- **Anti-discrimination policy** - ensures that the issue of disability is included in any anti-discrimination policy or law and establishes a monitoring body or ombudsman's office to guarantee its implementation; and

- **Participation in decision-making** - provides opportunities for persons with disabilities and their organisations to participate in local, regional and national decision-making processes, ensures that venues are physically accessible and include sign language interpretation and that DPOs are consulted in any local development plan.

Improved organisations among DPOs in the Middle East is needed to effectively influence and change policies

As aforementioned, to ensure **effective participation in policy development,** a precondition must be met: that the political context of a country is open to promote and legitimize participation in policy-making. This prerequisite varies among countries in the Middle East as some states use a centralised approach, thus restricting opportunities for civil movement and participation whilst others have a more open policy towards their functioning and involvement. It is worthwhile to note that civil society groups in all countries have some form or degree of organisation and it is imperative that persons with disabilities build up their capacity for networking and increasing their political abilities to influence development processes at various levels in their respective countries. Even in cases where decision- or policy-makers prove to be inaccessible, the empowerment of persons with disabilities and their respective organisations remain to be of utmost importance as there are other possibilities for them to improve their condition outside the political arena.

Together with other social movements, collectively, persons with disabilities can also advocate to their respective governments to take into account a person's right to participate by promoting more democratic institutions.

It is anticipated that through the active participation of the community and the presence of open and supportive authorities, the development of disability-inclusive social policies in the Middle East can become a reality. Though its wider societal implications will take time to become evident, the consequences of exclusion are noticeable today and indicate (the need for) prioritised attention.

Box 5. Musawa Project – strengthening self advocacy capacities[68]

Research and subsequent recommendations about building the demand side with regard to advocating for improved access to services and more inclusion of persons with disabilities requires more than presenting information in a report such as this. It requires complementary projects and programmes that address the real need for a stronger disability movement, more capable DPOs and more informed disability stakeholders. One such project being implemented between 2009 and 2011 by the AODP, the European Disability Forum and HI aims to address this grass-roots advocacy development is presented below:

Title: MUSAWA - "Strengthening self-advocacy capacities for rights and equal opportunities of people with disabilities in Middle East"

Specific objectives:

- Capacity building for Disabled People's Organizations (DPOs) at local, national and regional levels in the fields of human rights, anti-discrimination, public policy, social service delivery, networking and advocacy;

68 Written by Ms Ola Abu-Ghaib, Regional Project Coordinator (Musawa), Handicap International, Middle East.

- Build and improve the national and regional networks between the different DPOs;
- Enhance cooperation with national stakeholders and decision-makers as well as with the Arab League and other international organizations; and
- Increase the awareness of Government officials and staff so that they are more aware of disability issues and include such issues in their policy development.

Target groups: DPOs, persons with disabilities, public authorities and service providers.

Main activities:

- Development of a training curriculum on human rights, anti-discrimination, public policy, social services delivery, networking, advocacy and organisational development and train a team of trainer-of-trainers, 20 disability activists, to implement 125 training sessions across the region for 500 disability activists.
- Organisation of five regional workshops, on organisation of the movement, the UNCRPD and policy development, budget monitoring.
- Development and maintenance of two websites allowing discussion; e-learning; networking and follow-up of conferences; and collaborative work.
- Organization of a regional conference and two national meetings per year
- Support twelve local advocacy initiatives at a community level involving local authorities /countries.
- Publication of different reports, reviews and newsletters.
- Capacity building for representatives of relevant ministries and authorities.

PART B:

STAKEHOLDERS PARTICIPATION IN ENSURING ACCESS TO SOCIAL SERVICES

Chapter 4. Stakeholders' roles and responsibilities pertaining to social services

The provision of services for persons with disabilities at the community level usually involves a variety of actors. In the Middle East, these actors are still not well organised; often their lack of coordination and struggle to maintain their services has resulted in a range of scattered and often unsustainable initiatives, with the State having little or no control over quality of service or accountability of providers. To develop a coherent and comprehensive system of services for persons with disabilities and ensure that mainstream services become fully accessible to them, stakeholders, their roles and responsibilities and the mechanisms of ensuring their cooperation and coordination and legislative enforcement mechanisms need to be identified.

4.1 Roles and responsibilities of the actors in the social services sector in Middle East

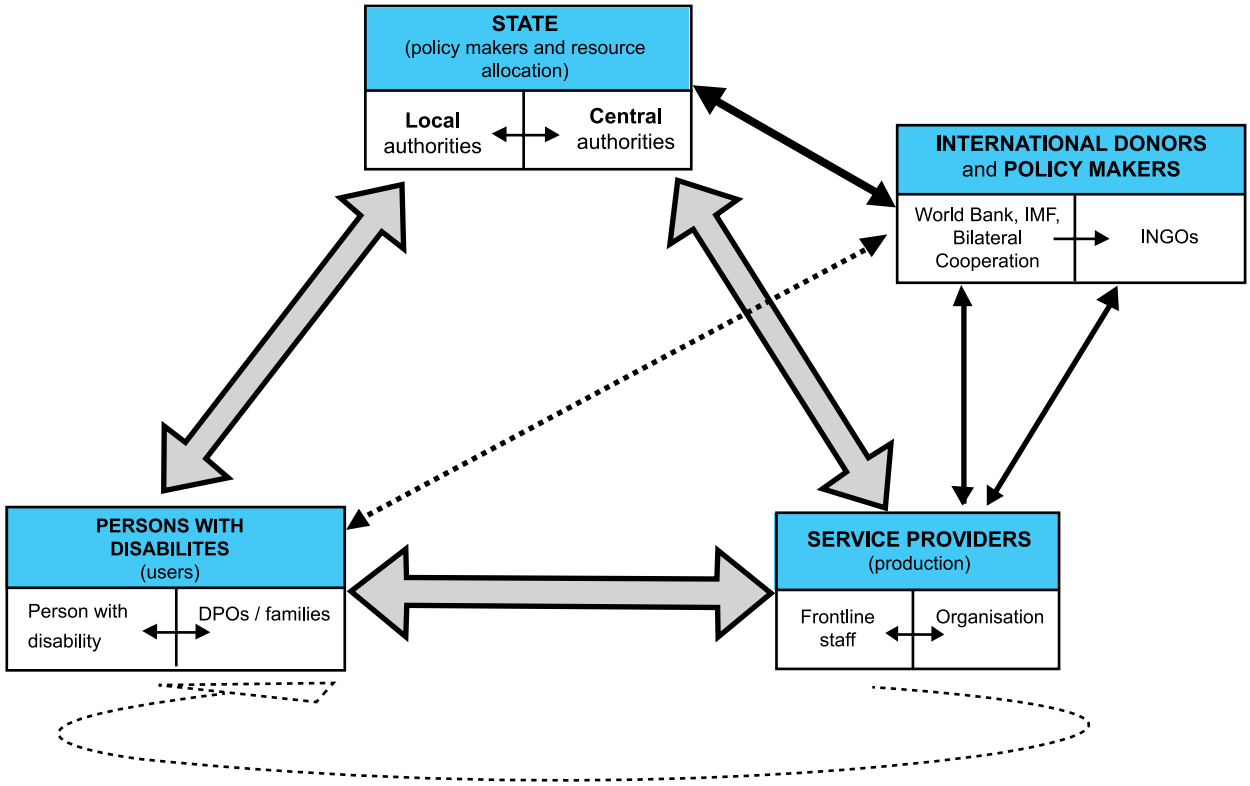
Three main stakeholders are usually identified in any system of services provision:

- the **State** with its national, regional and local institutions;
- the **service providers** (public, private for profit and non-profit, including religious organisations); and
- **the users** of the social services (persons with disabilities and their families and representatives, DPOs).

Within each group are varying interests and sub-actors, indicating that each sector cannot be considered wholly homogenous. In the Middle East, culture, religions, history and colonial past, traditional gender roles and the prevailing socio-economic situation are influences that affect the actors' roles and responsibilities.

Other actors that exert significant influence include: **international development institutions,** from governments of more developed countries through their bilateral aid agreements with the World Bank, International Monetary Fund (IMF) and World Trade Organisation (WTO); **religious charity organizations** and leaders of religious movements; and **international NGOs** who are extensively involved in supporting service delivery in developing countries, especially in the disability sector in the Middle East, (see Annex 6 for further information).

Scheme 5. Main actors of the social services system in the Middle East



All the actors, as illustrated in the figure above, contribute to the process of social service provision; however, three tend to stand out: **the State, the service providers and the users**, which in this case, are persons with disabilities and their representative organisations. These groups define and implement the regulatory system that governments, apart from their responsibility to provide sufficient funding, need to install for effective monitoring and control.

Service users and DPOs have a role of understanding and claiming their rights to the authorities and influencing policy-making. Moreover, active users should be allowed to participate in service provision, receive adequate information and raise complaints regarding the quality of the services made available to them, effectively permitting them to make **choices** about the kind of service provided. The involvement of DPOs as users should feed into the monitoring and evaluation process of state authorities, which does not always yield satisfactory results.

The State, through its central and local authorities, has the responsibility to assess the needs and demands of persons with disabilities for social services and ensure availability through adequate financial systems. Social services are made available through public service providers, typical in the education sector, or by delegating the responsibility to private NGOs or non-profit associations; this happens when private hospitals are allowed to operate or when social services are provided by civil society groups. In any case, the State should keep the responsibility with regard to the **regulatory role; define adequate policies for implementing legislation and comply with international conventions signed**. The State is also the **guarantor of the quality** of services by defining a monitoring system that involves the three main stakeholders.

Service providers are responsible for **providing quality services**, based on a person-centred and inclusive approach that adheres to defined quality principles and standards. They can be state, non-state, for-profit or not-for-profit agencies that make available to local and/or central authorities and users information about their services. They can also take part in tendering processes and at times may even be eligible to receive public funds. However, service providers should also recognise that users have the right to express their demands, take part in defining their needs and individual plans, and be involved in the phases of strategic planning for and monitoring and evaluation of effective service delivery.

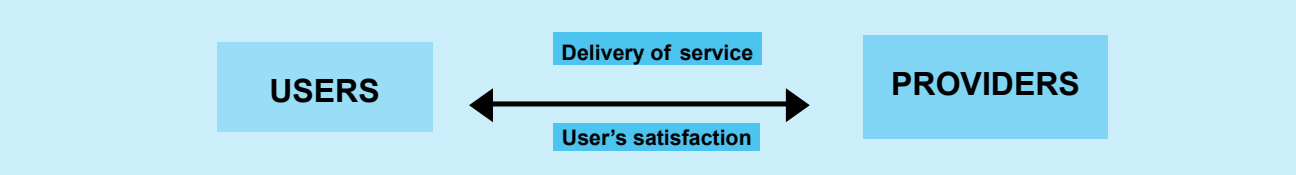
Within each group, one must keep in mind that members are not homogenous. For example, DPOs may not always effectively represent the specific needs of some service users or service users may not fully exemplify the purpose or aims of the organisation they belong to. More concretely, some providers may not be compelled to make available quality services at the individual level, even with support from the state and/or international community due to the lack of clear regulatory procedures regarding enforcement of monitoring mechanisms and quality standards.

Table 1. Summary of the roles and responsibilities of actors

ACTORS	ROLES AND RESPONSIBILITIES
STATE	
• Central authorities	• Ensuring fundamental rights • Regulating social services • Distributing resources and financing social services • Evaluating demands at macro level and planning of services (gate-keeping) • Monitoring quality • Ensuring availability and quality of professionals
• Local (regional) authorities	• Providing social services / delegating and contracting out • Assessing demands at local and regional levels (gate-keeping) • Coordinating local planning and ensuring compliance with national legislation, policies and strategies • Monitoring quality • Promoting participation of persons with disabilities • Financing (cash or in-kind)

SOCIAL SERVICE PROVIDERS • Public providers • Non-profit organisations • For-profit companies • Religious organisations • Informal providers (families and volunteers)	• Ensuring quality of services • Assessing individual demands • Providing services and adequate accessible information • Promoting positive images amongst the community • Adapting to users' needs • Ensuring the right of users participation
USERS OF SOCIAL SERVICES • DPOs • Persons with disabilities • Families and/or legal representatives of persons with disabilities.	• Rights-holders with responsibilities • Participate in service planning and provision, monitoring and evaluation • Represent users and advocate for their rights, including the creation of adequate services for persons with disabilities

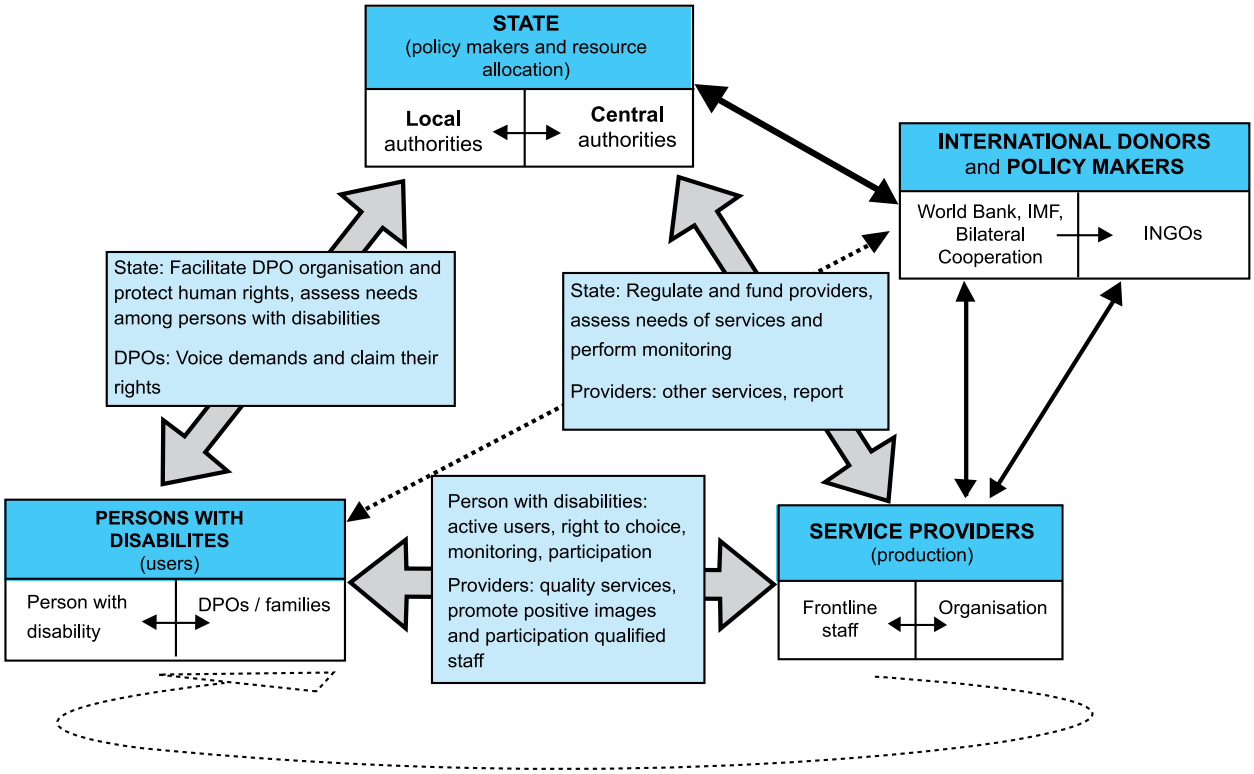
Market principles and social service provision



In general, the principles of the market economy dominate in the determination of the supply of and demand for commercial services. Providers make available the service needed or wanted by consumers at a price they are willing to pay for; essentially, this is the concept of self-regulation. In some countries, this self-regulating mechanism may even be applied to very necessary services such as electricity, water and telephone.

However, the provision of social services cannot, as defined in Chapter 2, be regulated by market mechanisms as most social services are the concern of a State and comprise the fundamental human rights of people. Because they are considered essential for human development, they have to be accessible to all, including persons with disabilities, who may not be able to afford them if regulated solely by the market. States then have the obligation to intervene and regulate this relationship and ensure that demand and supply are addressed consistently at the local and national levels, with the resources allocated properly to respond to the needs of the people. In this sense, **the State becomes the regulator of the supply of and the demand** for social services.

Scheme 6. Roles and responsibilities of main actors in ensuring social services for persons with disabilities in the Middle East



In countries where the State has limited resources, lack the political will to ensure basic services, or is in a situation of conflict or political instability, persons with disabilities may try to organise themselves to put pressure directly on service providers to make these services accessible and available to them; this is often the case with international NGOs or donors. This is true for example in the occupied Palestinian territories wherein the direct link between users and providers allow the former to demand the latter's accountability in service delivery.

4.2 Users' participation in service delivery and development

As aforementioned, the roles and responsibilities of persons with disabilities in the development of social policies and social services are essential. Previous studies and international research have put the focus on the involvement of users in the development of services or more specifically, the participation of the poor in development processes. This is based on the assumption that services that promote users' inclusion tend to result in more responsive and accountable providers and better quality of service.[69] Brian Munday (2004) discusses the development of user involvement in concrete social services and social policies in general within the European Union countries. He defines it as a complex issue, dependent on several factors; however, he identifies two important aspects expected to improve the participation of DPOs as representative organisations and individual users, in social service provision and planning:

- Pressure and advocacy from organised users, interests groups and DPOs; and,
- Willingness of service providers and policy-makers to institutionalise the right to participate.

69 Munday, B. User Involvement in Personal Social Services, University of Kent UK, with the assistance of the Group of Specialists on User Involvement in Social Services adopted by the European Committee for Social Cohesion (CDCS), (UK: 2004).

Some key principles that could provide a value basis for an effective system of user involvement, which may well be significant and useful in the Middle East context, are presented here:

- *Involvement as a right and responsibility - the right of people to participate in policy-making, and service provision that is often observed and asserted in a democratic setting. In this context, these rights must be enforceable and accessible and user participation helps ensure the relevance of the service and effectiveness of its delivery.*
- *A culture of user involvement - ensuring that persons with disabilities participate in planning and service delivery would require "…that public policy assists the growth of a national culture of user involvement, with unswerving commitment from different sectors of society."*
- *Persons with disabilities are recipients and actors - persons with disabilities should not be seen solely as passive recipients of social services as they have the right and responsibility to take an active role in its provision and contribute to the social care for other people. In turn, social service providers "…have a duty to support and enable users to contribute to social care."*
- *Taking account of the informal and formal networks of persons with disabilities - the participation of persons with disabilities in service planning and delivery should also take into account family members and other non-paid caregivers (i.e., friends) important to the individual user.*
- *Participation requires time and resources - an often overlooked issue is that participation in and advocacy for achieving the right to get involved takes time and resources from persons with disabilities. And not everyone can spare the time or afford to use their money on such activities; some live in rural areas, isolated from decision-makers."*[70]

In the Middle East, the realization of user participation in service provision is still in its initial phases as there is no clear institutionalisation of this right despite provisions in recent disability legislation in Lebanon and Jordan that provides for the participation of representatives of persons with disabilities through **National Disability Councils** and other similar structures. While there are a number of service providers that have initiated inclusion in making social services available, most still employ a top-down approach, presenting and perpetuating barriers to users' involvement. At the same time, users as well as DPO representatives need to develop an in-depth knowledge around services systems as well as social policy development. The right to participate brings also a responsibility to have the right tools and knowledge to bring an added value to the process.

One major obstacle seems to be the medical approach to service provision, wherein the professional staff decides the kind of service or intervention provided, based mainly on a diagnosis. Service provision, in this case, is aimed at rehabilitating or correcting the impairment, with the user as a passive beneficiary rather than an active partner.

Simultaneously, there are opportunities for persons with disabilities and service providers to work together to improve the situation. Jordan and Egypt have on-going programs that define general quality standards for health and rehabilitation services, which incorporate the DPOs' responsibility to lobby for users' right to participate. Egypt is well on its way to harmonising and producing quality standards in healthcare at the national level. Similarly, the ratification of the CRPD presents and rationalises user inclusion as it highlights in several articles, the right of persons with disabilities to participate in all public and political affairs, to be informed and to make their own decision about accessing services.[71]

70 Munday, B. 2004: p. 33. All the quotes are from the same report.

71 Article 19 Living independently and being included in the community states: "…community services and facilities for the general population are available on an equal basis to persons with disabilities and are responsive to their needs".
Article 25 Health states: d) "…provide care of the same quality to persons with disabilities as to others, including on the basis of free and informed consent…"
Article 29 Participation in political and public life states: "…to promote actively an environment in which persons with disabilities can effectively and fully participate in the conduct of public affairs, without discrimination and on an equal basis to the others…"

There is also another group that should be as important as users when it comes to the development of services and social policies, namely the professionals and professional associations of staff working in the services. They are well placed to propose improvements, increase quality of services, and are important actors in this sector. The existence of professional associations in the Middle East is still rather limited, but could be a force to count on in any reform process.

4.3 Disabled Peoples' Organisations in the Middle East – constructing a disability voice for improving access to social services

As described earlier (see Scheme 6), DPOs have an extremely important role in the service provision system because aside from being active users, they also have the capacity to affect the accountability of other major stakeholders. By being involved in monitoring the quality of services, identifying gaps in the service systems, and collectively advocating this to the relevant authorities and service providers, their voice and demands can be included to improve the situation. Another way of articulating their demands and lobbying for their rights is by coordinating their efforts with other social movements to more effectively challenge the status quo of certain injustices and the general condition of their access to basic services.

Across the Middle East, there are numerous organisations that either represent persons with disabilities or take on roles that assume their representation. Some nations in the region have established national bodies that promote changes to legislation and policies and community organisations that focus on local initiatives aimed at improving the situation for persons with disabilities. While these individuals and groups work towards increasing the participation in and improving the access of persons with disabilities to service provision, they also constitute the users and beneficiaries of the social services provided.

Roles and responsibilities of DPOs and suggestions as to how these could be improved were expressed in discussions in national workshops and interviews with persons with disabilities and/or their representatives.

Collective action

The formation of groups of persons with disabilities into DPOs, and the identification of real leaders, in particular, was a major task specified in the regional workshops. Stakeholders expressed a demand for more DPOs with greater organisational capacity and transparency to undertake activities aimed at promoting the inclusion of persons with disabilities in the region. It was explained that there is room for improvement for the current levels of collective action and the relatively low numbers of DPOs greatly hinder efforts to advance the disability movement in the region.

Doing advocacy work towards concerned government agencies, officials and other relevant stakeholders was also identified as a responsibility that DPOs should be more proficient at; it was also pointed out that advocacy is subject to political factors and dependent on the willingness of individuals to undertake them and the political support extended by governments. In the Middle East, political instability presents a major limiting factor in the organisation and implementation of activities of DPOs. For example, the efforts of DPOs in Lebanon to ensure the state's involvement in the elaboration of the CRPD were ceased due to the death of former Prime Minister Rafic Hariri, resulting in the exacerbation of political instability in the country.[72]

72 Disability Monitor Initiative – Middle East Journal. A view from the Middle East of the entry in force of the Convention on the rights of persons with disabilities, launching issue, 2008: p. 9. Interview with Ms. Sylvana Lakis about: "The Responsibility of the Disability Movement to Promote the Convention: the Limited Choices".

Despite this setback, DPOs in Lebanon continue to lobby for the implementation of the convention.[73] Similarly, the current state of political instability and violence in other countries like Iraq and the occupied Palestinian territories, limits the possibilities and opportunities for activists to advance the rights agenda of persons with disabilities. With priorities moving constantly between emergency and development issues, activists struggle to maintain the momentum on their progress regarding the implementation of their rights, reform legislation and the development of adequate policies.

Disability awareness-raising

The development of self-help groups, peer counselling and improvement in the self-esteem of persons with disabilities is paramount to modifications in their perspective within the community. Empowering individuals enables them to gain the confidence to challenge the status quo as a necessary precursor to the development of a viable disability movement; this is demonstrated by the presence of some inspiring activists at the helm of different disability organisations in the region.

Crucial disability awareness-raising activities include: media events, conferences, publication of disability information and opinions. These activities do not only help to raise awareness amongst stakeholders unfamiliar with the issue of disability, but these also help to show support to persons with disabilities - that they are not alone and that they share a common bond with millions of other people in the world. Dealing with the discrimination of persons with disabilities and addressing the public's negative perceptions is seen as a major function for DPOs and user groups to perform. Journalists, members of local authorities, students, health and social academics have been identified as important target groups for awareness-raising activities. The current shift towards the rights-based approach feeds into the momentum of the present effort to change viewpoints - from stereotypes to open acceptance; although, DPOs and user groups have expressed that there remains much to be done.

Provision of services

The matter of DPOs as service providers indicates and supports a general assumption that service delivery for persons with disabilities, particularly in rural areas in the region is lacking. When users or their representatives collectively recognize and express their need to provide themselves with certain services, assistive devices, rehabilitation, education or vocational training, or seek improved skills to manage their lifestyles, it is likely symptomatic of acknowledged gaps in service delivery and an apparent desire to fill these gaps. Moreover, the lack of quality of some services or those made available based on "traditional" principles that do not put the user at the centre of the service provision motivate activists and DPOs to introduce innovative practices and new types of services.

Consequently, this raises the issue of potential conflict between DPOs operating as service providers and other stakeholders such as funders and regulators. The DPOs that perform service provision functions could be considered as "hybrid" organisations as they make available certain types of services to persons with disabilities while concurrently representing them in policy and/or decision-making activities. Whilst there are obvious advantages for persons with disabilities being able to form an organisation that provides services for others, it can also present problems in terms of their relationship with state authorities and funders. It is very difficult for service organisations that demand or rely on money and support from the government to also be the same group that criticises the authorities and demand improved

73 Ibid: p. 9.

support from them. In resource-strapped regions such as the Middle East, it would likely only be an organisation with a strong capacity and integrity that could demand improved recognition of rights, highlight government deficiencies, and request for fund support for the social services it wants to provide.

Becoming their own disability experts

Disability activists have long recognised the power imbalance between persons with disabilities and those that are tasked to provide services or make laws and policies. With the dominance of the medical approach to disability in the region, persons with disabilities and their families are seen more as subjects and passive players, to be directed by so-called 'experts' in the disability field. Users and disability activists alike now recognise there is a definite role for them to play in becoming their own disability experts, advising authorities, service providers and other stakeholders on disability issues to more effectively address challenges in the field.

Box 6. Social services and persons with intellectual disabilities[74]

The inclusion of persons with intellectual disabilities and their families are confronted with additional difficulties compared to those with other types of disabilities. First of all, they tend to be more vulnerable and poorer than the others as the financial and social challenges of intellectual disability is more underestimated than the negative impacts of other disabilities. These challenges are not easily observable; it is a silent and longstanding factor that drains the well-being of persons with intellectual disabilities and their families. Persons with intellectual disabilities and their families are not always well-equipped with the required capabilities to face these lifelong obstacles; they are often excluded or overlooked in many disability policies or other related measures such as:

- Gaps in primary and maternity healthcare due to the lack of understanding of the needs of persons with intellectual and learning disabilities and their families;
- Limited availability of personal support services, outreach domestic services, family training, financial subsidies, respite care, household training and life skills development;
- Inadequate early detection and intervention services, which is one of the main steps towards access to education services;
- Inclusive education components for persons with intellectual disabilities require more than the simple removal of physical barriers; it is a right that should be provided based on non-discrimination and broader human rights principles and should include the provision of reasonable accommodation such as adapted curricula, smaller classes or specific support of personal assistants or support teachers within mainstream settings;
- Re-classification of services for persons with intellectual disabilities, instead of categorizing persons with intellectual disabilities as having mild, moderate, severe or profound impairments;
- Lack of or the limited livelihood opportunities are more challenging and serious for persons with intellectual disabilities who are often not included in the category of supported employment, which usually only targets persons with physical or sensorial disabilities; and

74 The textbox has been elaborated by Moussa Charafeddine, M.D., President of Friends of the Disabled, Lebanon. The authors have edited the text to fit within the report layout.

- The absence of support programs for persons with intellectual disabilities and their families who have had to deal with an important and often, overlooked challenge: the eventual loss of the parents of persons with intellectual disabilities. More often than not, they are left to fend for themselves while some are fortunate enough to have other family members who can assist in or attend to their care.

Many DPOs in the region do not routinely include persons with intellectual disabilities and their families; this of course can depend on the country they are in and on the skills they are equipped with and the extent of their influence on local authorities and officials. Persons with intellectual disabilities and their families are usually excluded from capacity building activities and support measures and sometimes even discriminated against by other DPOs. International funding agencies often invest their funds and direct their training projects by supporting DPOs of persons with visual impairments or physical disabilities while those with intellectual disabilities and hearing impairments and their respective families are often excluded from international support through DPO-related activities.

The most empowered DPOs working with and for persons with intellectual disabilities are located in Jordan, Lebanon and the occupied Palestinian territories while those Egypt and Syria seem to be less active, fewer and in need of support and exchange of experiences.

The impact of regional and international DPOs in the Middle East

Although not a supra-national governmental body like the European Union, the League of Arab States (LAS) is a forum that brings together governments of Arab nations to discuss issues specific to the region. It includes support to the disability movement in the region, through various mechanisms and funding arrangements. With the declaration of an **Arab Decade of Disabled People** at its 2004 meeting in Tunis, the goal of incorporating disability into the social and economic development of participating Arab states between 2004 and 2013 was set.[75] Several focus areas in the overall strategy were identified, which include: health, education and employment, with meetings and conferences held regularly to discuss issues affecting persons with disabilities. Because this multi-national government body is perceived as addressing issues confronting persons with disabilities in the region, it would be difficult to argue that more effective dialogue between LAS members and DPOs along with greater encouragement for the formation of DPOs across the region is somewhat overdue.

The **Arab Organisation of Disabled People** (AODP) is a coalition of DPOs in the Middle East; it is also a member of Disabled People International and the International Disability Alliance. Its main aim is to encourage the development of organisations of persons with disabilities across the Middle East, to promote equality, rights and freedoms. Though the disability movement in the region continues to move forward regarding these issues, one of the problems identified by the AODP is the lack of new leaders and democratic culture within organisations working for persons with disabilities.[76]

75 United Nations General Assembly Reporting Group. Fifth Quinquennial Review and Appraisal of the World Programme of Action concerning Disabled People, United Nations, July 2008.

76 Disability Monitor Initiative – Middle East Journal. A view from the Middle East of the entry in force of the Convention on the rights of persons with disabilities, launching issue, 2008: p. 12. Interview with Dr. Nawwaf Kabbara about:. "CRPD: A Regional Perspective".

Across the Middle East, the attention on improving human rights and disability rights in particular, requires a strong and committed civil society movement to bring about effective legislative and policy change. In the case of Lebanon, DPOs have been very active in enhancing the rights, lobbying for legislative changes at the national level, exerting significant influence in the development of Law 220/2000 through various advocacy initiatives and contributing to the development of the CRPD.[77] In other parts of the region, like in Yemen, DPOs proved to be instrumental in pushing their government forward to take part in the negotiations regarding the convention. They emphasised broader issues of empowerment and civic engagement of marginalised groups, helped raise awareness and build capacity to improve the situation for persons with disabilities.[78]

As the shift in perspective on disability from a medical to a rights-based one continues in the international arena, DPOs will be better able and more responsible to support the development of a strong and viable disability movement in the region, ultimately influencing other stakeholders to improve the rights and access to services of persons with disabilities in the Middle East.

4.4 Roles and responsibilities of social service providers

Service providers constitute a diverse and heterogeneous group in the field of social services; and thus may pursue different aims and objectives despite apparent similarities in initiatives. Mainstream health, education, employment or social protection services may not be inclusive of the specific needs of persons with disabilities; hence rendering the **CRPD a very important component of making inclusion operational**, and implemented and observed by service providers and their professional staff.

Service providers are expected to ensure the supply of high quality services, forms of assistance that promote participation of people, including persons with disabilities, uphold positive images and the concept of social inclusion. In abiding by the nationally defined quality criteria or standards (where present), the State has a responsibility to **ensure some form of sustainable funding mechanism to these providers**, to enable them to make available affordable, accessible and accountable services and ensure the supply of a range of services for persons with disabilities.

As previously discussed in this report, the equal access to social services is the **social responsibility of the State**, which means that determination of its supply cannot and should not be left to the mechanisms of the liberal market; a regulatory framework that ensures that affordable services are accessible to those who need them should be in place and adhered to by both public and private service providers.

Service providers in the Middle East, whether state or non-state, play an important role in the creation of inclusive environments and the promotion of the rights of persons with disabilities. This is due to their more frequent interaction with persons with disabilities compared to that of the authorities and their involvement in helping persons with disabilities manage their life roles and daily tasks. During the conduct of interviews and workshops across the region,

77 Disability Monitor Initiative – Middle East Journal. A view from the Middle East of the entry in force of the Convention on the rights of persons with disabilities, launching issue, 2008: p. 9. Interview with Ms. Sylvana Lakis about: “The Responsibility of the Disability Movement to Promote the Convention: the Limited Choices”.

78 Disability Monitor Initiative – Middle East Journal. A view from the Middle East of the entry in force of the Convention on the rights of persons with disabilities, launching issue, 2008: p. 11. Interview with Ms. Raja Al-Musaabi about: “Steps towards change, CRPD: Yemeni context”.

stakeholders, including government and non-government service providers, identified specific roles and responsibilities for this group with respect to access to social services for persons with disabilities in the Middle East.

Provision of quality social services

The basic role of providing quality social services was identified as the main task of service providers. It is imperative that this is acknowledged due to the growing interest of service providers to work on rights and advocacy-related work. Service delivery and advocacy are two different objectives that may result in potential problems with other stakeholders if the positions and interests of service users, providers and authorities are not clear and may be in contrast with one another. Though provision is a major task, service providers also have a role in supporting the **improvement of legislation on social services in general**; for example, developing quality standards, training of future staff or enlarging the range of services available. The development of professional standards and ethics, either through professional associations or by governmental authorities, is one, maybe easier way, to have a direct impact on the quality of services, while waiting for official quality standards to be implemented.

While provision is considered to be a central activity, stakeholders noted that services offered should also be accessible, of good quality, sustainable and available to users. A lack of a clear understanding of working with a twin-track approach and seeing points of similarities and comparison between mainstream, support and specific disability services was also evident amongst stakeholders in the region; this limits the providers' ability to plan for effective inclusion and mainstreaming and also curbs improvement of service delivery in recognised areas of need. For example, while there are a number of specialised disability services in the region and some mainstream services have integrated or included the needs of persons with disabilities in their activities, limited personal support services exist. Until an understanding of the link between the kinds of services and their interrelationship has been reached, it is anticipated that inclusion and service development would be ineffective for majority of persons with disabilities.

Despite the limited financial resources and current global economic crisis, service providers recognise the responsibility to **provide free or low cost services to persons with disabilities** as imperative. By becoming sensitive to the situation of poverty associated with disability and the limited social assistance made available to persons with disabilities in the region, some service providers take on the task of assisting poorer individuals with disabilities and their families access services they require, even when and especially if authorities are unable to do so.

Even though governments around the world provide social services, NGOs and religious charities quite often feature prominently in service provision for persons with disabilities in the Middle East. Despite this situation in the Middle East, governments remain responsible to ensure equal access to services for persons with disabilities, and are not able to relieve themselves of this duty. An overarching and perhaps, latent objective of NGOs making services available to persons with disabilities is to highlight the need for authorities to be more proactive in regulating service provision, distribution, resource allocation, funding and monitoring. While the efforts of public and private providers seem to be complementing each other, as aforementioned, these should be regulated within the same framework that ensures effective service provision for persons with disabilities.

Service providers and advocacy

Service providers, particularly NGOs in the region, are increasingly becoming interested in advocacy, creating a stronger link between disability and rights than what has existed in the past. Their stronger voice relative to that of DPOs in the region currently, shows that some NGO service providers are beginning to assume an activism function, promoting the rights of persons with disabilities. As noted earlier, whilst the promotion of disability rights by various stakeholders has positive impacts for the movement in general, there are issues related specifically to the relationship service providers have with authorities or funders and their ability to lobby for more resources whilst simultaneously pushing for reform. In addition, it is important that the slogan, **"Nothing about us without us"** is reiterated and the need for providers to base their advocacy on the voice of persons with disabilities is highlighted.

Raising awareness on disability is considered to be a key element of any organisation that makes services available and works with individuals and families. Educating families is important as persons with disabilities more often than not rely on familial relationships for their emotional, financial and other support. The role of service providers in this sense cannot be underestimated.

Moreover, service providers also have a significant responsibility to fulfil in the aspect of empowerment, as they are often, in the best position to assist a person with disability to understand their situation better so they can have the opportunity to build their self-esteem and manage their disability to take on activism functions on their own.

Whilst health promotion, early detection, monitoring of disabling factors and prevention are important components, this report, and associated DMI-ME activities did not address them significantly; it has remained focused on the promotion of rights, inclusion and positive changes for persons with disabilities without neglecting issues related to prevention of disability.

Coordination of disability stakeholders

Some service providers in the region, particularly NGOs that are national in scope, take on a leadership role in the coordination of different actors and activities related to the field of disability. For example, members of the DMI-ME Steering Committee are large organisations (DPOs, NGO service providers and two INGOs) that have strong and extensive networks which coordinate with one another to address issues at national and local levels. This is constructive as they can complement each other's work, which is especially crucial when the capacity of DPOs and/or authorities is still weak and developing.

Facilitating communication and coordination among stakeholders was considered a pivotal role for some NGO service providers, as the ability to link authorities with DPOs and help them arrive at a common understanding was identified in the workshops conducted.

Strategy building and lobbying for improved service provision

Service providers, especially NGOs, indicated that there was a strong need for improved laws, policies and strategies to enhance the situation of persons with disabilities across the region, specifically with respect to obtaining increased funding to make a wide range of services available. It has been observed that larger NGO service providers seem to be dependent on foreign aid, which smaller organisations have a harder time accessing. This limits the potential of small or local NGOs to develop and augment their resources as they only rely on local donations and fundraising. These larger NGO's found themselves a role in lobbying the

international community for further assistance and funding, particularly in countries where government support has been limited. The availability of funding from international agencies in the region translates to increased competition amongst some service providers, mainly in Lebanon, occupied Palestinian territories and parts of Egypt.

The work of developing and continuously improving the technical capacities of service providers was identified and is likely connected to the need to obtain funding by providing superior service and quality outcomes. Building the technical capacity of staff working with persons with disabilities in the region was also consistently mentioned, along with obtaining the latest technology and resources to complement or support effective service provision. While relying on international donors is not sustainable, stakeholders still have not placed considerable importance or confidence in their respective governments providing the requisite financial and technical support to enhance the sustainable capacities of service providers. Failing to emphasise the state authorities' obligation to provide support means that service providers will continue to compete for international and national donors' support, which by its very nature is unsustainable and difficult to regulate.

Research, statistics and technical capacity

Service providers asserted that it is important for them to be able to assess the demands and needs of persons with disabilities and obtain other relevant information that may assist them in their work. Some service providers in the region have large databases with information obtained from various surveys and needs assessments; an example of this is the large computerised database of persons with disabilities of the Regional Committee for Community Based Rehabilitation- Southern Region of West Bank. This has substantial value in making available vital information regarding the situation of persons with disabilities and the importance of sharing amongst relevant stakeholders is evident.

Box 7: College of Ability Development, Khan Younis (Gaza), occupied Palestinian territories – forming new professionals in disability sector[79]

In 1984 there was an opportunity within the Palestine Red Crescent Society (PRCS) to develop a rehabilitation centre for children with disabilities in a crowded, disadvantaged area of Cairo. As there were no other similar services in the area, it was important to structure the centre so that children with disabilities, regardless of the type of disability, could access the centre's services. There were no trained *generalist* rehabilitation workers available and the availability of specialists such as physiotherapists or speech therapists was limited. As a result of this unavailability, an in-service training program commenced which evolved into a structured two-year course, which later became an introduction of a follow-on two year advanced level course.

Ten years later, in 1995, the PRCS introduced the same program in their newly established Palestine Institute in Khan Younis, Gaza Strip, simultaneously done with the establishment of the centre for rehabilitation. In 1997, together with a committee from Al Quds University, Ramallah, the program was restructured into a four-year

79 Written by Dr Jean Calder, Consultant Rehabilitation and Training & Dean Ability Development College, Gaza, occupied Palestinian territories.

degree course. Accordingly, the name of the Institute was changed to *College of Ability Development.*

Then in 2008, at the request of the Palestine Ministry of Education and Higher Education, four minor specialist streams were introduced into the fourth year of the program, thus changing the name of the program to "*Special Education & Rehabilitation".*

The program had two main aims.
First, to prepare well-qualified professionals to work in the field of rehabilitation at a practical, grassroots level with persons with disabilities in a holistic and boundary-spanning manner; second, to advocate for inclusive policies in relation to persons with disabilities in their respective communities.

The anatomy of the Special Education and Rehabilitation Program
The subjects taught in the course relate to the concept of students obtaining knowledge and skills to enable them to interact in a variety of ways with persons with disabilities, with the 'person' always being in front of 'disability'. The program is multidisciplinary, as it consists of subjects drawn from biological science, social science, education and other fields related to culture, history and religion; further, information on general and specific aspects of disability is developed throughout the course.

Great importance is placed on practical experience; during each term, students are involved in field work relating to the area of disability being studied throughout that semester. At the completion of the fourth year, the students are required to do two months of continuous field work in the PRCS Rehabilitation Centre.

Post-program: opportunities for employment and career advancement
After completing the course, graduates are presented with a variety of options for their career paths: government and NGO inclusive education programs; NGO rehabilitation centres; rehabilitation hospitals; mental health departments; and community-based rehabilitation (CBR) programs. Reports from the different employment settings note the quality of the work of the graduates and the high value placed on them.

One of the positive aspects of the course is the development of professional personnel working with persons with disabilities and their families in a continuous manner, based on social-and rights-based models rather than on restrictive and segmented medical models.

Main roles graduates fill include:-

Teacher:
working with children with disabilities in inclusive education programs of regular schools, as a resource person in the classroom, or in rehabilitation centres.

Trainer:
developing and implementing comprehensive programs with children who have more complex disabilities and adults in rehabilitation centres or in their homes, either independently or in a team.

Instructor:
working with the youth and adults in vocational training settings, work placement programs, or production workshops.

Activity Leader:
in recreation and sports programs.

The graduate's involvement in awareness-raising activities, including lobbying for more accessibility is related to their main purpose of working directly with persons with disabilities and their families. He or she is not viewed exclusively as a healthcare professional as their role involves education, development, community integration and a boundary-spanning role between and with other professionals in different sectors of the area.

The relationship of the college graduate with other medical practitioners is one of sharing – obtaining specialist guidance in specific situations when needed; providing valuable information in team meetings and/or to individual specialists on progress or demands of a particular shared service user; such a role involves a vertical relationship with specialists in terms of providing inputs in programs and a horizontal relationship with other members of the professional teams.

The graduate is basically a *generalist* who can work with persons of different ages and disabilities in different situations, alone or as part of a team. When alone, he or she will seek from the advice of specialists as the need arises and working with a team, he or she will be acting holistically with the service user, incorporating various inputs made available by the range of professionals he or she is able to access and consult.

In addition to the direct benefit to students gaining skills and to persons with disabilities who stand to obtain more qualified personnel to provide services, another palpable advantage to the community is the increased recognition being given to the situation of persons with disabilities and the need for further promotion of inclusion and rights issues through the implementation of programs that highlight the potential and rights of persons with disabilities.

Challenges
Understanding the concept by the local administration and specialist-oriented personnel, and working with the diverse lecturing staff to integrate the information provided to students is one challenge implementers of the program face. Whilst the PRCS provides the basic funding of the College, there is a heavy dependence on obtaining fund support from outside sources. And this is turning out to be a recurrent difficulty as the PRCS has structured student fees at a minimum level in recognition of the particular economic hardship experienced by people in the Gaza Strip, thus, the ongoing effort to gain adequate financial support.

In the future, the College plans to continue improving the quality of the program and developing its facilities. It also intends to expand the Continuing Education Department in planning its programs and short courses outside the curriculum that address international developments and current needs, establish a research department and plan other courses outside the disability sector that likewise address the needs of the community, particularly for persons with disabilities.

4.5 How do authorities in the Middle East assume their responsibilities?

Some authors believe that in less-developed countries, governments are failing to ensure access to adequate public services; even when NGOs fill some of the gaps, states do not promote supportive environments for this action to develop.[80],[81] In the Middle East, many profit and non-profit private service providers either complement or substitute the state in providing basic services. Despite this prominent substitution by the non-governmental sector, governments still have the legal responsibility to ensure access to, and participation in, these services by users, particularly marginalised groups, such as persons with disabilities.[82]

Governments have the obligation to respond to challenges and market failures, though this is not often the case. Questions arise around the policy environment that is essential for effective partnerships, and the Middle East is a region in which effective policy development around social services remains void. Notwithstanding the fact that there is much room for improvement in this area, the ratification of the CRPD has triggered some government efforts to improve service provision for persons with disabilities in the region.

National governments are at various stages regarding the development, amendment and implementation of legislation and policy addressing disability. In the regional workshops and interviews conducted, various governmental representatives and civil society groups indicated their understanding of their roles and responsibilities but acknowledged that much remains to be done in terms of realistic implementation.

Authorities need to understand the situation of persons with disabilities

These days, it is rarely disputed that having reliable data and statistics on various issues is a central concern of most governments.[83] These statistics are used to inform policy design, planning and evaluation and assist in domestic comparisons of various indicators.[84] Many nations in the Middle East lack accurate and transparent statistics on disability attributed to a host of factors: the varying definitions of the concept of disability in legislation, the lack of comprehensive surveys on disability issues, lack of or limited availability of financial resources, and political instability and conflict coupled with the often inadequate technical capacity of governments to undertake an effective analysis of the situation.[85]

Related to surveys and data gathering is the issue of confidentiality; some progressive NGOs involved in the DMI-ME have indicated a degree of discretion with the information they have gathered on or from persons with disabilities and their families. However, there are no strong legislative frameworks enforcing respect for the confidentiality of service user information. In the face of these issues, surveys remain to be a necessary undertaking for service providers, governments and DPOs to acquaint themselves with the situation of persons with disabilities. Nevertheless, caution must be observed to avoid 'survey fatigue' that may exist due to the high and continuous demand for surveys, the completion of sporadic and uncoordinated efforts and the minimal advancement of the situation as a result of repeated and frequent data gathering.

80 Bately, R. Engaged or Divorced, Capacity.Org, Issue 30, March 2007.
81 Oxfam and Water Aid. In the Public Interest. Health, Education, and Water and Sanitation for All, (Oxfam International: Oxford: 2006).
82 United Nations Enable. http://www.un.org/disabilities/default.asp?navid=12&pid=150 as at 22 July 2009.
83 United Nations General Assembly Reporting Group, Fifth Quinquennial Review and Appraisal of the World Programme of Action concerning Disabled People, United Nations, July 2008.
84 Ibid.
85 Ibid.

Despite these foreseen drawbacks, some positive experiences are under way in the region; one of these is the Higher Council for the Affairs of People with Disabilities in Jordan that is planning on undertaking a national survey on persons with disabilities.[86] Based on the information that they will obtain, the Council hopes to be able to guide policies and strategies better and address issues facing Jordanians living with disabilities. However, it is important to point out that information collected or needs identified **have to be in relation to social functions and rights, in contrast to the traditional disability needs and medical classifications**.

Data gathered usually only pertains to physical or functional impairments and does not always cover the participation of, barriers to and facilitators in the daily lives of persons with disabilities. Information on the "numbers of persons with visual impairment" or the "percentage of unemployed women with disabilities" is somewhat easier to obtain than more qualitative data that may help identify obstacles that affect the opportunity of persons with disabilities to participate in various community activities such as; social stigma, physical and informational barriers, negative attitudes of employers and service providers towards persons with disabilities or limiting governmental policies.

Develop legislation and policy with persons with disabilities using a 'bottom-up' approach

Whilst disability legislation exists across the Middle East, it is clearly insufficient to address the different demands of persons with disabilities and their families; thus, understanding the concept of disability better and improving legislation to more effectively address the rights of persons with disabilities were identified as key responsibilities of authorities. Related to legislative development is the creation of policies and strategies in aid of legislation. In Yemen, Jordan and Lebanon there are different forms of national disability committees organised to assist their respective governments. In Yemen, inputs from a variety of structures (e.g., The Social Fund for Development, Social Welfare Fund and the Disability Fund) all promote a more comprehensive approach to effective legislation- and policy-making for persons with disabilities.

In the region, it is usually the Ministry of Social Affairs' responsibility to handle the "welfare" of persons with disabilities. It is also a well-known fact that these types of ministries typically have limited financial resources and are often on the lower rung of priorities for funding, compared to the other government agencies such as the Ministries of Finance, Labour or Health. Whilst it will always be convenient to charge ministries with the duty to deal with social welfare issues, disability is a cross-cutting issue that requires a **whole of government approach** to effectively tackle it. So while different ministries do work towards addressing disability, there is a need for consistent strategies among and prioritisation of issues within ministries.

86 Disability Monitor Initiative – Middle East Journal. A view from the Middle East of the entry in force of the Convention on the rights of persons with disabilities, launching issue, 2008: p. 5. Interview with Dr. Hmoud Olimat about: "Forestalling Initiative and Optimistic Future".

Box 8. Whole of Government approach

Governments in the region lack the change in perspective towards disability necessary to strategically put the issue **transversally**, across all its ministries and departments. This concept is not new and some countries (outside the Middle East) have taken or have started taking this perspective with not only disability, but also with other cross-cutting issues such as gender and ethnicity. One name for the concept is the "*whole of government"* approach.

This concept refers to government agencies working across a range of sectors (i.e., traditional ministry or department allocations such as Ministry of Finance, Department of Education etc.) to achieve a set of shared goals and vision through an integrated government response to issues, which could vary from policies, programs or service delivery.[87]

The concept in terms of disability refers to the inclusion of all government ministries and departments in addressing the issue within their scope of work. It may require departments to identify issues related to service provision for persons with disabilities, how these concerns will be dealt with and determine how the actions of a particular ministry or department complement that of others. For example, they could be looking at themes common to various ministries or departments such as policies and procedures; information and communication; attitudes and awareness of employees; physical access to buildings; recruitment and retention and complaints. Depending on the legislative framework, a "*whole of government*" approach can also require ministries or departments to develop disability service plans to show how individual government entities address disability issues. The monitoring and evaluation of the performance of each ministry or department is also a responsibility that they have to undertake under the approach, with outcomes published publicly.[88]

Despite the obvious benefits of working with a "*whole of government*" approach, authorities also need to be aware of the challenges it poses. These include: developing competence of working and supporting for the promotion of these skills among government employees; governance frameworks and budgetary considerations; maximising the information and communication methods; improving engagement between authorities and the public and developing the capacity to quickly respond to any crisis or emerging trends.[89]

Whilst the challenges confronting both persons with disabilities and their governments in the region continue to require innovative and persistent efforts, the latter could improve their ability to meet these challenges by having a more transversal and "*whole of government*" approach to disability issues in their respective countries. After all, issues that confront persons **without** disabilities (i.e. work, transport, health accommodation, education, etc) are also faced by, if not more so, by persons **with** disabilities.

87 http://www.apsc.gov.au/mac/connectinggovernment1.htm as at 21 September 2009.
88 http://www.disability.qld.gov.au/key-projects/disability-services-plan/documents/disability-service-plan.pdf as at 21 September 2009.
89 http://www.apsc.gov.au/mac/connectinggovernment1.htm as at 21 September 2009.

Ensure that services are sufficiently funded

Ensuring funding for service provision is a key role for authorities in the region. Despite the strong emphasis on this particular responsibility of the government, counterarguments were put forth by stakeholders from the public sector; pointing out the scarcity of resources, specifically of funds, in most countries in the Middle East and the region's consequent dependence on international funding. The existence of financial limitations is true for many regions, as in the Middle East and may negatively affect partnerships of civil society with government agencies and ultimately the access to services of persons with disabilities.

However, it is also because of this limitation in resources that the government and civil society organisations, instead of working together to complement each other's roles and support each other in different ways, can compete for the inadequate amount of resources available.[90] Even in countries with well-developed systems of service delivery for persons with disabilities, advocates continuously demand for more resources from their governments. Regardless of the quantity of both financial and technical resources, governments in the region could focus on the equitable distribution of their existing resources. In general, it would seem more convenient to rely on the "lack of resources argument", instead of directing efforts on the **distribution of resources and good governance processes to ensure maximum efficiency and achieve the greatest positive impact for persons with disabilities and their families.**

Raising awareness on disability

Promoting and facilitating the full inclusion of persons with disabilities in society was another task authorities across the Middle East are expected to perform, as clearly emphasised in the CRDP. In addition, the low levels of understanding of disability among governments in the region have also been identified. Government representatives consulted for this report recognise the need to change this perspective and assist DPOs in promoting more positive messages and opportunities for persons with disabilities in the region. However, in reality, this varies substantially, as some governments have a more restrictive attitude towards activism and civil society than others. In Jordan, the Higher Council on the Affairs of Persons with Disabilities undertakes awareness-raising activities on persons with disabilities in the country, including working with media on disability issues.[91]

Working with media, organising conferences, implementing community education programmes and conducting workshops for various stakeholders on disability issues were some of the identified activities expected to help promote a more positive message about persons with disabilities and address issues related to the lack of inclusion. The National Council for Childhood and Motherhood in Egypt for example, has been involved with organising conferences on disability for the media, acknowledging the extent of its influence in depicting a more constructive image of persons with disabilities.

Service provision

Along with the regulation of services, governments are usually one of the actors (public service providers) responsible for providing a variety of services, including hospitals, schools, social protection, water and sanitation facilities and public transport for their citizens. Whilst mainstream services do reach the majority of populations in the region, at least in urban areas, they remain inaccessible to more marginalised groups, among them persons with disabilities, albeit some exceptions for certain schools and healthcare centres. Similarly, in

90 Richard B. Engaged or Divorced, Capacity Org, Issue 30, March 2007: p 4.

91 Disability Monitor Initiative – Middle East Journal. A view from the Middle East of the entry in force of the Convention on the rights of persons with disabilities, launching issue, 2008: p. 5. Interview with Dr. Hmoud Olimat about: "Forestalling Initiative and Optimistic Future".

countries where services are much more developed and available in urban areas, it is the rural population that confront difficulties in accessing these services, sometimes even basic utilities such as potable water, electricity or proper sewage systems.

When stakeholders representing authorities in the region discussed service provision for persons with disabilities, most of them related services to those provided by specialised centres (e.g., rehabilitation centres, special schools, special vocational training centres). Rarely did they indicate that mainstream services, except for education and healthcare, needed to be more inclusive for persons with disabilities. Other services they identified include: orthotic and prosthetic, rehabilitation, vocational training, employment, recreation, culture, sports and justice services.

The Rights and Access Program in Lebanon, administered by the Ministry of Social Affairs, serves as a means of identifying persons with disabilities and providing them with a type of disability card that allows them to access free or subsidised services from both government and non-state providers, including assistive devices and medical aids. In Yemen, the Social Fund for Development, a semi-government body, supports disability-related initiatives and organisations that assist persons with disabilities. Whilst governments in the region are taking steps to provide some forms of specific disability service for persons with disabilities, much remains to be done in terms of macro (i.e., national) policies, enforcing regulations and ensuring that mainstream services are accessible.

Capacity building of service providers and other professionals working with persons with disabilities

Governments have likewise acknowledged their role in providing technical support and capacity building activities to professionals working with persons with disabilities. It is interesting to note however that some service providers, particularly the larger ones, indicated that governments actually gave very little technical support, if at all. The knowledge and skills of authorities regarding disability were considered to be inferior to that of some private service providers; also, it is very common for service providers to give the authorities training instead of the other way around.

Monitoring and regulation of laws and services

Whilst not strongly or always directly identified, the regulation of services to ensure quality and sustainability for users was indicated as a major role for authorities. It was particularly noted that the feedback of users about the services is crucial factor in this process of monitoring and improvement.

Monitoring is considered to be an important task for authorities to perform, despite their recognised limitations to do so. Stakeholders have indicated that monitoring of the implementation of laws and policies on disability issues is significantly missing in the region; this may be aggravated by the fact that authorities do not invest enough in regulating the system of service provision or enforcing the implementation of laws related to inclusive education and open employment.

Facilitating the development of DPOs to demand rights

Authorities have identified the need to provide support to persons with disabilities and facilitate the organisation of DPOs and self-help groups as part of their responsibility. The League of Arab States (LAS) supports the AODP in its efforts to improve the voice and capacity of national DPOs in the region; however, national governments are often not recognised for similar work at the local level, as the numbers and capacities of DPOs at a national level remain very poor in many Middle Eastern countries. Recently, LAS members pledged funding for the establishment of a monitoring unit to oversee the implementation of the CRPD in Arab States that have ratified the convention; hence, it would be logical to expect national governments that make up the LAS[92] provide similar support to DPO formation and capacity-building at national levels.

Box 9. The AODP seeks to implement the CRPD and the Arab Decade for Persons with Disabilities[93]

The relationship of the Arab disability movement in general and the Arab Organization of Disabled People (AODP) in particular, with the League of the Arab States (LAS) is about eleven years old, beginning in November of 1998 when the former Secretary General of the League, Mr. Ismat Abdul Majeed was asked to grant his patronage to a regional congregation of Arab disabled people and a number of disabled people's organizations (DPOs). This allowed the group to hold an inaugural meeting in the premises of LAS in Cairo to establish the AODP and lay the foundations of the movement's relationship with the League; consequently, this has also led to the coordination of the LAS' efforts and that of the disability movement to guarantee the progress of the rights-based approach, which seeks to include persons with disabilities in their respective communities, considered to be a basic and inalienable human right. However, this was not the first disability-related action of the LAS, as it had previously been active in other disability issues. The League promoted the medical approach to disability, evident in existing national laws pertaining to the affairs of persons with disabilities of many Arab countries as well as the manner in which Ministries of Social Affairs, Health and Education deal with the question of inclusion.

So far, the League has worked quite slowly and cautiously in promoting the rights-based approach, although the former and current secretary generals have advocated for the proposal of the Arab Decade for Persons with Disabilities and have it endorsed by the Arab Summit of Tunisia in 2004. However, the need to modify the perspective of the laws dealing with the affairs of persons with disabilities in the different LAS member countries was not heavily emphasized and though the League did try to be responsive to the suggestions of the AODP, efforts at the grassroots level remain unsatisfactory.

Currently, the LAS is committed to working for the promotion of the rights-based approach and seems partially willing to give priority to the social approach. The former and current secretary generals and other officials of the LAS have reiterated their willingness to act in a dedicated manner for adopting and implementing the Arab Decade for Persons with Disabilities. In the eleven years of AODP's operation, the LAS worked closely with the organisation to push forward the draft of the Arab Decade, with LAS officials helping the organisation gain an observer status in the Economic and Social Council of the LAS. While LAS officials seem interested in the implementation of the Arab Decade, one cannot help but wonder how efficient their actions are in lobbying for expediting the

92 The League of Arab States includes the target countries of the DMI-ME.
93 Ms Jahda Al Khalil, Executive Director of the Arab Organisation of Disabled People, Lebanon.

procedures to actually put the decade into effect. This is an important point as the Arab Decade is not particularly congruent with the CRPD and the former is currently being amended to make it more in-line with this international instrument.

Despite the many problems it faces, the relationship between AODP and the LAS appears sound, positive and is moving forward. It is reasonably realistic to expect the affiliation to develop and for two parties overcome a number of difficulties together.

It is the AODP's firm belief that the disability movement is a cause that deserves their full attention, understanding and commitment. However, working for such a worthwhile cause is time-consuming and requires unwavering dedication; and AODP has pledged to continue supporting the movement in its bumpy and arduous road, regardless of the obstacles.

Coordination

Government representatives have also identified coordination as an important role of the public sector, particularly with regard to international actors and local civil society organisations. The ability to collaborate is considered important in addressing the demands and rights of persons with disabilities, ensuring that priority issues were dealt with and avoiding unnecessary duplication of resources. As governments are ultimately responsible for the welfare of their populations, the coordination of service provision, involving many national and international actors is an obvious major responsibility.

In countries such as Jordan, for example, the government has recently initiated a decentralisation process, effectively dividing the nation into smaller administrative entities, the impact it will have on service provision is yet to be seen. However, it could be argued that having administrative bodies "closer" to the local population will more effectively facilitate the provision of basic services for socially excluded and groups such as persons with disabilities.

PART C:

REGULATION AND LEGAL IMPLICATIONS

Chapter 5. The need for a comprehensive regulatory system of social services in the Middle East

A set of comprehensive regulatory mechanisms allows public authorities to assess the needs of persons with disabilities and determine who are eligible for entitlements and support enshrined by laws. If designed and implemented well, these mechanisms contribute to the establishment of an effective support system to persons with disabilities, a good method of monitoring of the situation of persons with disabilities and the optimal allocation of resources. This chapter will introduce a regulatory framework that typically govern social services delivery and examine the current situation in the Middle East. There is a risk that, if not properly developed, these mechanisms could misinform the situational analysis of persons with disabilities and make way for an inequitable distribution of public support.

5.1 Regulatory frameworks in social service delivery – benefits and challenges

To ensure that the social needs and demands expressed by people and their organisations, including persons with disabilities, are met, each country has to define specific procedures to balance the demands for and supply of services. It is a State's responsibility to design transparent **regulatory mechanisms** for each type of relationship between and among actors identified in the previous chapter. In monitoring the demand for services, the State establishes **gate-keeping procedures** at the local or national level and in regulating the supply of services from service providers, States can develop **licensing procedures**, **quality standards, contracting and funding procedures and monitoring and evaluation procedures**. The CRPD likewise stipulates important principles and norms on how such a framework should be developed, taking into consideration the rights of persons with disabilities.

Box 10. Gate-keeping and regulatory frameworks for social services[94]

Gate-keeping has been described as one of the fundamental regulatory aspects of public social policies that aim to support persons with disabilities in their communities. In short, it has been described *"as the system of decision-making that guides effective and efficient targeting of services*" that should support persons with disabilities and other vulnerable groups .[95] Gate-keeping mechanisms operate at a macro or systems level, whether local or national, and at a micro level - individual or organisational - with three main functions:

- Develop an understanding of the demands and needs of persons and ensure that they benefit from the realisation of their rights and provision of the assistance they require;

94 Excerpt from The Disability Monitor Initiative – Middle East Journal, Gate Keeping: Urgent Need for Reform to Ensure Fair and Effective Access to Social Protection Entitlements, Alexandre Côte, February 2009, p. 18.

95 Bilson, A. and Harwin J. Gate-keeping Services for Vulnerable Children and Families, (Florence: UNICEF Innocenti Centre and World Bank: 2003): p.11.

- Aggregate the needs and demands of individuals to gain a territorial overview of the situation of persons with disabilities and support effective policy formulation in some areas of service delivery such as the types and diversity of services, availability and distribution of services; and

- Implement effective resource allocation from the central authorities to local agencies.

In the Middle East, gate-keeping mechanisms are limited and usually grounded on medical approaches (e.g., diagnosis, issuance of medical certificates), often occur outside of a clear framework such as the ICF or DCP classifications systems, have administratively complex structures (i.e., different governmental institutions determine eligibility or process applications) and have limited legislative bases. The gate-keeping mechanisms some governments have installed may be indicative of a certain level of demand in the country, but reality of the actual need may be quite different.

In addition, the lack of knowledge of persons with disabilities about their own rights limits their access to any form of support that may be available to them. However, regional examples of gate-keeping mechanisms that seek to address some of these issues are evident, as in the case of Lebanon, with the Rights and Access Programme (see Box 13) and in Syria, with its plan for the "Care and Rehabilitation of People with Disabilities", which aims to form a national commission to address community-related problems such as building codes, communication and public transport.[96]

The responsibility to regulate social service delivery falls primarily in the hands of authorities; specifically, to initiate and maintain macro-level gate-keeping and territorial mapping of demands and needs – activities considered vital for a regulatory framework to operate effectively. If information on the situation of persons with disabilities is gathered and analysed effectively, policy-makers would be in a better position to understand how services should be developed and distributed, quality and licensing measures defined and funding demands made for further implementation of social services activities, either by state or non-state providers.

However, one must note that this type of regulation also puts more pressure on governments to be more accountable to their populations. With the current limited systems in place, some persons with disabilities (e.g., those with intellectual disabilities and their families) are somewhat **invisible** as the system may be designed to more readily identify persons with physical disabilities. In connection to this, some governments may not be as willing to develop precise regulatory and gate-keeping mechanisms, for fear of opening "the floodgates" regarding eligibility of support and being held responsible to ensure services to a group in the population for which it has limited resources to provide.

Governments have to be accountable and open because addressing these issues stimulates the development of effective and comprehensive gate-keeping mechanisms and regulatory frameworks. The effective regulation of services not only benefits persons with disabilities, but also serves the wider population and supports efficient resource allocation for many governments operating on low social budgets and limited technical capacities.

96 Blal, T. Impact of Social Policies on the Situation of Persons with Disabilities in Terms of Equal Access to Work, the Effectiveness of the Policy of Employment Adopted by the State and Legislation Pertaining to Employment of Persons with Disabilities, Unpublished policy paper within the MUSAWA project, 2009.

Regulatory frameworks can vary from country to country; however, their overarching goal is to ensure that social services meet real needs and demands and the rights of the population are observed and respected, and that services are provided in an effective and efficient way. Each of the three main stakeholders – users, providers and the State - considered relevant in the process of social services provision plays different roles in this context.

Their roles are to regulate and coordinate: **the access of users** to the system of social services, keeping to their needs and demands; **the offer (supply)** of services responding to these needs; and the concrete **delivery of social services**, abiding by essential principles as accessibility, accountability, affordability and quality for all persons who might need them. Since social services cannot be governed solely by market mechanisms, the regulatory function must be ensured by a third actor - in this case, the central or local authorities.

The authorities thus become:

- *"The guarantor and responsible body ensuring the fundamental human and social rights of all citizens;*
- *The recipient of the expressed needs of the population; and*
- *The guarantor of a qualitative provision of social services through a regulatory frame that applies to both public and private service providers."* [97]

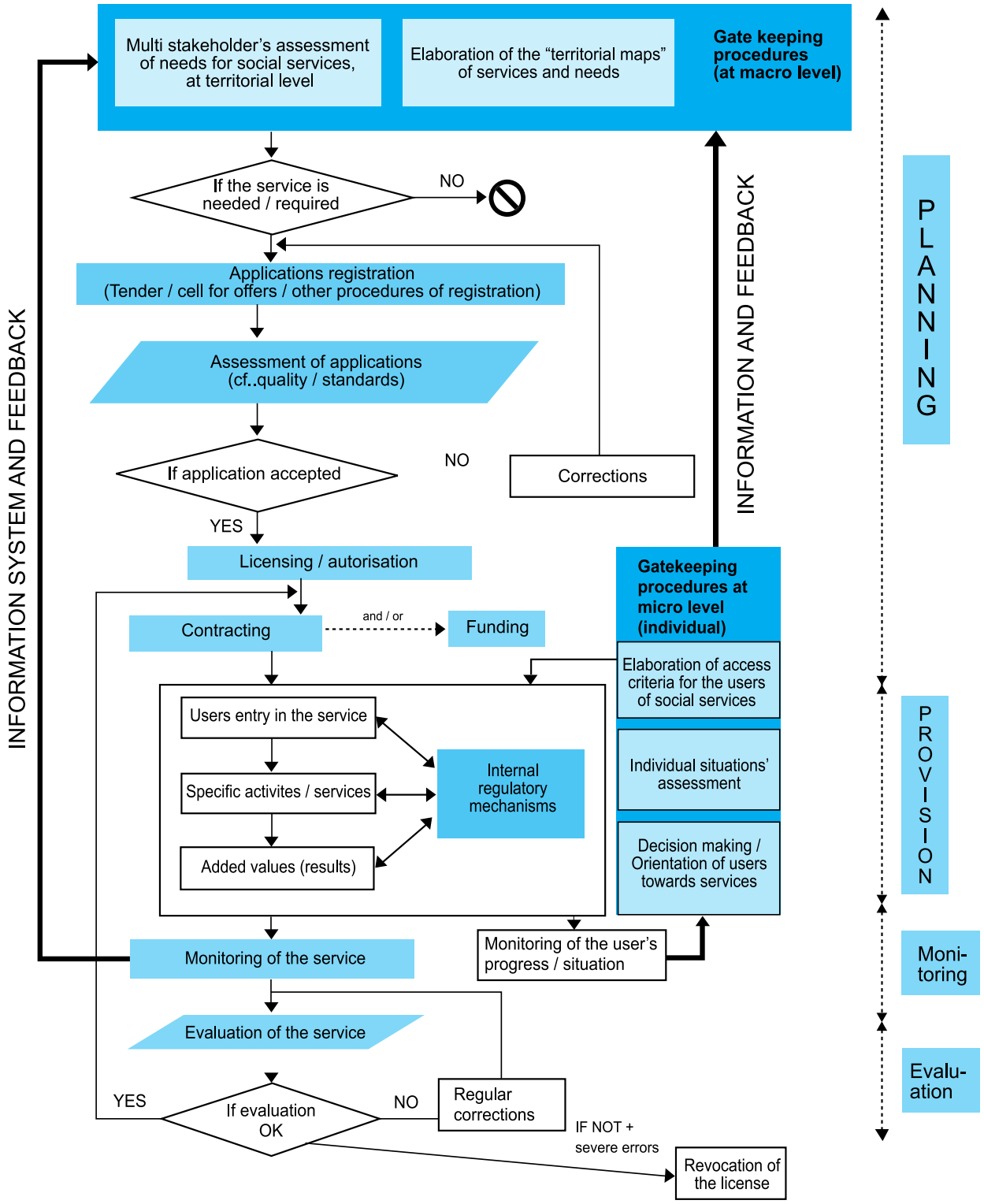
Regulatory framework example for social services[98]

This example (scheme 7) of a regulatory framework combines elements related to the previously discussed macro/micro level gate keeping; planning, monitoring and feedback systems in light of accreditation/licensing and contracting mechanisms.

Regulatory mechanisms have multiple functions and are not only about controlling the basic cycle of services provision - the access of users, actual service provision and the evaluation of the impact and results; they also include procedures that precede the concrete provision of services - planning of the needed service, licensing and the approval of service providers, contracting and financing. Moreover, there are also phases that take place parallel to this - monitoring, internal evaluation, renewal or non-renewal of the licence and contract, among others.[99]

97 Chiriacescu, D. Ensuring access of persons with disabilities to social services. The need for regulatory mechanisms of social services in South East Europe, Working paper no 3, Disability Monitor Initiative, (Handicap International South East Europe: Belgrade: 2006): p. 27.
98 Chiriacescu, D. Ensuring access of persons with disabilities to social services. The need for regulatory mechanisms of social services in South East Europe, Working paper no 3, Disability Monitor Initiative, (Handicap International South East Europe: Belgrade: 2006).
99 Ibid: p. 27

Scheme 7. Global understanding of social service provision



The responsibility of designing and implementing a regulatory system to guarantee the availability of and accessibility to social services is a reflection of political will. The choice of fundamental principles and the CRPD as one of the main references for the countries who have ratified it, which support a national regulatory system in the field of social services, is political in nature and requires a strong political mobilisation by governments. Legislative bodies have to be constructed together with a range of policies and implementation mechanisms (i.e., allocation of human and financial resources, concrete procedures for each regulatory stage, training assessors, evaluators and monitors), as these are the essential ingredients in putting a regulatory system in place.

Table 2. Main regulatory mechanisms in a social services system[100]

GATE-KEEPING MECHANISMS (Referral, information and direct access to social services)	At the level of the general system of social service (macro): • Assessing demand (which types of services are in demand and needed to ensure fulfilments of rights) • Elaboration of territorial maps of demands and services • Defining national access criteria to social services At the individual level (micro): • Assessment of the individual situation • Decision-making and orientation to community services
QUALITY-RELATED MECHANISMS (Quality principles and/or standards)	• General principles (rights-based, values and non-prescriptive standards) • "Technical" standards, taking into account more specific quality requirements for different categories of services
CONTRACTING AND FUNDING MECHANISMS	• Call for offers/tenders/project applications for social services at the local or national levels • Licensing/authorisation of social service providers • Purchasing and contracting of social services at the community level • Funding of social services at the community level

100 Chiriacescu, D., 2008: p. 33.

THE INTERNAL REGULATORY MECHANISMS (at the level of the service provider)	• Internal regulations (i.e., human resources, relations with users, or safety regulations) • Quality management and improvement procedures • Strategic planning procedures and follow-up • Internal and external communication procedures • Evidence-based decisions and measures • More generally, manuals of policies and procedures
MONITORING AND EVALUATION MECHANISMS	At the level of the system of social services (macro) • Monitoring of social service provision at the local level • Periodic evaluations and articulation of the gate-keeping system at the macro level At the level of service providers (micro) • Internal evaluation of service providers (self-evaluations) • External evaluations of the social service • Auditing and control procedures • Regular monitoring of service delivery
OVERALL SYSTEM OF INFORMATION AND FEEDBACK	• Data collection and flow of information that ensures the transparency of the system at all levels, and facilitation of decision-making and planning

Importance of regulating social services in the Middle East

As many governments in the Middle East have few or no experience in developing a regulatory system of social services, with some authorities left relatively weak due to previous or ongoing conflicts, as in the case of Lebanon, Iraq and the occupied Palestinian territories, there is a risk of relying too much on contracting out or delegating services to the private sector. The risk exists primarily due to some governments' inadequacy to effectively enforce mechanisms of control, quality and affordability.

In this report, specific attention has been given to this regulatory system due to the fact that some countries are lagging behind in this aspect and the current situation puts the responsibility of service provision to persons with disabilities in the hands of the private sector, mainly non-profit organisations or foundations, while mainstream public services systems remain largely inaccessible. This system is neither sustainable nor can it guarantee that the demands and needs of persons with disabilities are met. At the same time, some examples, such as the health care sector in Egypt and the Social Welfare Fund in Yemen, exist where projects that elaborate on some of the mechanisms of the regulatory systems have been initiated, usually beginning with the quality standards of services. However, it is important to consider the regulatory mechanisms in their **comprehensive and complementary approach**; it is not

enough to introduce high quality standards when services are often provided by civil society, working with scarce and unreliable funding from one year to the next. In the absence of at least a minimal set of tools for demands, needs assessments and information systems, it would also be difficult to define proper gate-keeping mechanisms.

Strengthening the capacity of all actors involved in the service provision process - the government, its ministries and de-concentrated bodies, service providers, users and their DPOs - is of utmost importance. Regulatory mechanisms are similar for any type of social service, including disability-specific ones, and could thus be developed within a comprehensive social policy reform. **Disabled Peoples' Organisations and services providers need to be included** in the process and be encouraged to participate so they can emphasise the additional needs some persons with disabilities may have to equally access with reasonable accommodation, universal design and support services as tools and advocate for a twin-track approach to service development. It is imperative that DPOs and service providers have the knowledge and understanding of social policy and social services.

Regulatory mechanisms can be perceived to be fulfilling three main functions:

a) **Normative** – *"it sets standards that must be respected by service providers, the decision-makers and donors. It offers concrete tools for guaranteeing a minimum set of conditions for the correct delivery of the social service; it fixes "the rules of the game" and makes sure that all relevant stakeholders in the process respect these rules."*[101] For services providers in the Middle East, often, non-profit organizations, such a system could strengthen their sustainability as they may become eligible for new funding schemes. Concurrently, it will bring additional administrative requirements and increased accountability and demands for better quality, which might threaten smaller organizations operating largely with volunteers or less serious providers.

b) **Corrective** - "*the regulatory system identifies the weaknesses in the provision of social services and requires corrections or adaptations."* [102]

c) **Promotion and continuous improvement of services delivery** -*"through specific procedures of evaluation, accreditation and therefore, valorisation of the "practices of excellence", the regulatory system is not only a correction tool, but also a means to modernise and innovate in the social service field."* [103]

Depending on the current (socio-political) situation, history, culture and present level of resources of each country, the development of a regulatory framework can take different shapes:

- In countries with very **limited resources**, or that are in, or emerging from, a major crisis (i.e., war, economic collapse) as in the case of Iraq and the occupied Palestinian territories, the implementation of a regulatory system that emphasises the high level of quality or a top-down control system is not very realistic. The normative function then ensures minimal coherence of the social intervention at the national level, guarantees the observation of minimal quality standards for all users and aims to ensure basic community services or coordinate the external flow of aid that can be the situation in such contexts.

101 Chiriacescu, D, 2008: p. 43.
102 Ibid: p. 43.
103 Ibid: p. 43.

- In countries that are in a **stage of developing social policies, and/or making reforms and 'transformation '**, the choice of a corrective function could play a more important role. It facilitates and promotes faster appropriation and implementation of new practices, paradigms or principles among the service providers, users and decision makers. Lebanon, Egypt and Yemen are countries where these processes have been initiated, while Jordan has developed a quality system for medical rehabilitation services.
- The function related to the continuous improvement of the quality of services has a more significant weight in the **well-developed systems of social services**. It can facilitate the modernisation of the sector, work towards innovation, promote excellence and benchmark among various providers.

Box 11. Cash Transfers and Persons with Disabilities in Practice: The Case of Yemen[104]

In the 1990s, the government of Yemen instituted a Social Safety Net Program to mitigate the economic reform program for people living in poverty; those that directly target persons with disabilities are the Social Fund for Development, the Disability Fund, and the Social Welfare Fund.

Fund mechanisms

The Social Fund for Development includes a wide range of community-based projects related to the provision of services, including disability services, capacity building of DPOs and NGOs and supporting the development of disability policies with the government. Whereas the Disability Fund and the Social Welfare Fund target persons with disabilities directly, the Social Fund for Development aims for all people living in poverty, including persons with disabilities.

The Disability Fund, established in 2002, aims to provide stable financial resources to support projects that provide medical rehabilitation for persons with disabilities. It has a coordinating function that channels financial resources to persons with disabilities in different ways:

- It supports DPOs and NGOs that provide services for persons with disabilities (e.g., physical rehabilitation, vocational training and special education).
- It directly purchases requirements for persons with disabilities such as assistive devices, health and educational assistance.

The fund is operational at a governorate level, and people can access assistance after they complete the necessary requirements, which is one of the limiting factors of the program as it restricts access for many of Yemen's rural population.

The Disability Fund provides financial assistance to persons with disabilities for health, education and assistive devices; this is also extended to DPOs and NGOs that support persons with disabilities. While the Social Welfare Fund (explained below) is the cash transfer mechanism for persons with disabilities the Disability Fund makes available 'in-kind' assistance.

104 Al Ahamadi, A. Excerpt from the article: Can cash transfers reduce inequalities for persons with disabilities, The Disability Monitor Initiative – Middle East Journal, February 2009: p 27.

The Social Welfare Fund, established in 1996, by making two types of assistance available, aims to provide cash grants to vulnerable groups of the population. Support could either be in the form of permanent or temporary relief, depending on whether people receive assistance from other sources. Currently, cash transfers are not conditional, so families and individuals have the freedom to use the money how they like; but reform processes are underway, including exploring Conditional Cash Transfers for the fund. Another key area of reform pertains to the challenge of providing social protection to many of Yemen's rural population; while many initiatives exist, these are concentrated in larger urban centres, limiting majority of Yemen's rural population from benefiting from these activities.

5.2 Disability Services – Legal provisions or welfare visions[105]

A central question related to the implementation of the CRPD and other international human rights treaties is determining the extent Middle Eastern countries attempt to harmonize their national legal situation and strategies related to social services with the general principles, obligations and other relevant provisions in the CRPD.

To shed some light on this question, it is necessary to first examine the current legal situation of social services in the region. Social services and its delivery system for persons with disabilities and society as a whole is not yet well-defined in the Middle East; this can be observed in national laws and policies that deal with social services as independent matters in terms of legal provisions, implementation and monitoring. Even though the Ministry of Labour may regulate access to employment, there are other relevant and essential factors that affect the employment sector (i.e., primary, secondary and higher education, vocational training, social traditions particularly for women and persons with disabilities and some environmental factors.

The present disability legislation in countries in the Middle East provides limited solutions for people regarding access to services. This limitation is attributed to the medical approach that still influences policies pertaining to disability, as explained earlier in this report). As this approach perceives persons with disabilities as 'patients' and passive recipients, related services are often designed in a similar manner - with the individual approach mainly dealing with urgent short-term needs.

Some kinds of national legislation have had direct or indirect reference and links to social services, particularly in terms of the status of implementation of the CRPD in the different countries (see Annex 2 for national legislation references).

The CRPD shadows on the disability situation in the Middle East

In 2002, the process of negotiations and drafting of the CRPD began, and along with it, initiatives were undertaken in different parts of the world, in preparation for the implementation of this unique instrument at the national level. This has resulted in pre-emptive schemes through which States attempt to prepare their national legislation for the anticipated amendments after the ratification. At that time, these moves were voluntarily made, but after entry into

105 This chapter is based on the contribution of Dr Muhannad Alazzeh, Regional Disability Rights and Advocacy Coordinator, Handicap International.

force of the CRPD and its ratification by various countries, these steps must be transformed into concrete actions fulfilling the general obligations stated in Article 4 of the convention.

The CRPD becomes binding at the international level due to provisions that include it in various countries' constitutions. These constitutional principles vary from country to country, but all generally acknowledge that an international treaty becomes part of the national legislation after it has been ratified and translated into domestic legislation.

Table 3. Status of ratification of the CRPD from Middle Eastern countries[106]

Country	CRPD Ratification	Optional Protocol Ratification
Jordan	Ratified on 31 March 2008	No ratification
Egypt	Ratified on 14 April 2008	No ratification
Yemen	Ratified on 26 March 2009	Ratified on 26 March 2009
Syria	Ratified on 10 July 2009	Ratified on 10 July 2009
Iraq	No ratification	No ratification
Lebanon	No ratification	No ratification
Occupied Palestinian territories	Not a State party - ineligible to ratify	Not a State party - ineligible to ratify

It is worth mentioning that the occupied Palestinian territories as observer member in the United Nations do not have the legal eligibility to sign or ratify international instruments. Nonetheless, the Palestinian Authority is obliged to respect and implement the human rights instruments according to the temporary Palestinian constitution, known as the Basic Law for the Palestinian National Authority.

Several national initiatives to amend disability legislation and policies in the region are currently taking place:

- **Egypt** - A three-year project aimed to adopt a new disability law conforming to the CRPD is being developed through the cooperation among the National Council for Childhood and Motherhood, the Ministry of Social Solidarity and the UNDP. Handicap International is involved in this process by facilitating activities and providing technical support.

- **Jordan** - The Higher Council of the Affairs of Disabled Persons in Jordan has formed a national team, including a legislative committee to amend Law # 31/2007 on the rights of persons with disabilities. These amendments were presented in a national conference aimed to review the disability strategy in November 2009.[107]

- **Iraq** - Persons with Disabilities and DPOs have just submitted a new draft law to the government. This draft law is now in the Consultative Council of the State for revision and approval before being presented to the parliament.[108]

106 As of 6 October 2009

107 Information provided by Ms. Mona Abdel Jawwad, Assistant Secretary General of the Higher Council of the Affairs of Disabled Persons in Jordan,

108 Information provided by Mr. Moaffaq Al-Khafaji, President of the Iraqi National Disability Forum and Vice President of the AODP)

- **Yemen** - The Ministry of Social Affairs, supported by the Social Fund for Development in Yemen and in cooperation with the Union of Disabled Persons, is working on drafting a comprehensive national disability strategy in accordance with the CRPD.[109]

- **At the regional level**, the League of Arab States, in cooperation with different stakeholders from the region, has initiated practical steps towards amending the Arab Decade of People with Disabilities in line with the CRPD and its advocacy. Although the Arab Decade of People with Disabilities is a very good initiative and there have been attempts to constitute it in a regional framework, producing revisions and amendments is urgent to reflect the social and human rights approach to disability and promote the general principles of the CRPD.[110]

109 Information provided by Mr. Hasan Ismail, Vice-President of the Yemeni Union of Disabled Persons

110 Alazzeh, M. The Arab Decade in the Balance: Critical Study of the Arab Decade of Disability, The Effectiveness Scope and Implementation Horizon, Presentation during the Arab symposium on laying down a regional Action plan to implement the Arab decade of persons with disabilities and the CRPD, Saudi Arabia, June 2009.

PART D:

TRENDS TO ADDRESS SERVICE PROVISION PRACTICE

Jordan

Chapter 6. Regional trends in the access of persons with disabilities to social services

The DMI-ME activities regarding access to services for persons with disabilities emphasise that as a starting point, providers could look at the 4A's (see 2.4.) and the criteria of quality, in relation to their service. These indicators or criteria can be used as references and are relevant options for providers to determine the effectiveness and inclusiveness of their service. This chapter will give a general picture on the situation in Middle East, based on information from stakeholders and actors who are active in the disability sector in Egypt, Iraq, Jordan, Lebanon, occupied Palestinian territories, Syria and Yemen.

Box. 12 DMI-ME Good Practice Tool Development, based on the 4 A's

The good practice awards conducted by the DMI-ME were a way of examining the service providers in terms of the 4 A's (**accessible** at community level, for all citizens, including persons with disabilities; **available** and **affordable** for these people; **accountable** and provided with **good quality**) and in light of the CRPD. Service providers were invited to submit applications, based on certain eligibility criteria (e.g., size of organisation, service provided and number of staff).

The decision to examine good practices in service provision across the Middle East was not a simple one, as the DMI-ME Steering Committee needed to determine the factors that made a practice "good" and indicators to measure it. Across the region there are many examples of what constitutes as ***good practice*** in service provision, however, in order to accurately measure these, the DMI-ME team decided to develop their own tools based largely on the principles of the CRPD as well as other service guidelines.

Understanding what makes a service excellent, good or even acceptable for a person with disability is a complex and contextual matter. Various factors need to be considered when looking at how good a service is, including, but not limited to, the technical skill of staff, types of services offered, resources available, target group identified, monitoring and evaluation. The DMI-ME tool that was developed with local level practitioners includes the criteria of availability, accessibility, affordability, accountability and quality.[111]

Different versions of the assessment tool were tested by different stakeholders and service providers over a three month period and the DMI-ME regional steering committee. The tool was modified to include a Lickert-type scale, with scores possible from 0 (non-existent), 1 (weak), 2 (good) and 3 (very good). Emphasis is placed, not on quantifying the information, but rather, the additional information it provides for data collection and comments. The tool was further developed into a 54-point assessment covering the above criteria.

111 The 4A's were first described by the European Association of Service Providers and since then has been extensively used in the social services sector www.easpd.eu

A **regional validation and testing** of different service providers was conducted to obtain an indication about the relevancy and validity of the DMI-ME tools and research activities. In testing the tool, different services were utilized, not only for the information it would yield and the improvement that would inevitably take place, but also for the goal of understanding the willingness of service providers to openly share knowledge about their services. Because in a region where information and knowledge can be equated to power and status, the readiness of some service providers to be transparent and open proved to be uncertain. The results of this award, applicants and winners are described in Annex 1.

6.1 Accessibility – social services can be reached and used by all people who need them

In the context of social service provision, accessibility has to be considered in a broad and multi-layered sense. In the Middle East, making community services accessible for persons with disabilities represents a major stake and challenge; this involves not only a transformation of the built environment but also a reform of the referral and information systems –**gate keeping mechanisms** –correct assessment of people's demands and needs, local evaluation and mapping of existing and required services, implementation of funding schemes and cost calculations per service.[112]

A service could be considered accessible if it…

- Has a physical and informational accessible environment for its target and for all;
- Is non-discriminatory on the basis of status: war veterans, work injured, disability, citizens/migrants, or refugees;
- Does not discriminate based on gender, religion and ethnicity; and
- Has reasonable transportation time and means from home to services or home-based services.

In the region, stakeholders indicated that mainstream services have generally remained inaccessible to persons with disabilities for a variety of reasons. However, accessibility must be considered not only from a physical perspective, for example - in relation to ramps or hand rails,- but also from a sensorial perspective, which pertains to communication. It was reported that in general, specific disability services were more physically accessible in the region, primarily owing to its disability focus; however, very few providers offer information in easy-to-read formats for persons with intellectual disability, have sign language interpreters or provide Braille formatted information for users.

112 Bilson, A. and Gotestam, R. Improving Standards of Child Protection Services - A Concept Paper, UNICEF Innocenti Centre (UNICEF and World Bank: Florence: 2003).
In this report, gate-keeping is defined as the system of decision-making that guides effective and efficient targeting of services for persons with disabilities or other vulnerable groups. The gate-keeping system could be a combination of assessments and decision-making procedures, realised at both the individual (micro) level, meaning at the level of the person in need of services, and the level of a community or region (assessment and planning at the macro level). Gate-keeping is elaborated in Chapter 5.

Stakeholders reported physical accessibility as an issue that is slowly being addressed in **schools** across the Middle East, for children with physical disabilities to attend either specialised or mainstream settings. Ramps, rails, adapted classrooms and bathrooms are being considered by families, schools, governments, and the international community as a first and essential step in having greater inclusion of children with disabilities in education settings, but less emphasis has been placed on communication and information accessibility for people with visual or hearing impairments, or learning disabilities.

Identification and assessment of needs of persons with disabilities

Linked to the issues identified with the medical model as a form of gate-keeping, some countries in the region use a disability card or some other form of "categorisation" for persons with disabilities. Generally, it refers to a medical report, certificate or identification card to distinguish and "classify" persons with disabilities. This system that is being utilised is grounded on a medical approach and terminology, in effect, negating legal obligations of the state to look at social barriers and thus can exclude some persons with disabilities.

In some countries, individuals apply for assistance directly from the government; however, without referrals, they still need some form of medical report when they avail of the services. **In Jordan for example**, persons with disabilities can submit their applications individually and obtain a document from the local council, neighbourhood chief or police station, verifying their eligibility to benefit from a special fund. Applications are assessed and analysed by the finance department of the directorate or governorate of the city. Administrative approval is sought and once the person is considered eligible, depending on the funding for that year, social assistance may be given on that year or delayed until the next year. Allocated funds are claimed in the post office or from city or municipal treasurers.

Some governments in the region are attempting to improve the regulation of social services and reach more vulnerable persons with disabilities. As aforementioned, the **Rights and Access centres in Lebanon** (see Box 13 below) exist to identify and assist persons with disabilities to receive benefits; in other countries, these are equivalent to special medical committees. Persons with disabilities seek the assistance of these committees after they have been ill or have been in an accident that has resulted in some form of disability. Referral mechanisms to these centres remain limited and rely mainly on social workers' or medical staff's recommendations; often, persons with disabilities and their families go through "self-referral" or as "walk-in" applicants.

Box 13. The Rights and Access Program - Lebanon[113]

The Rights and Access Programme in Lebanon is an example of gate-keeping mechanisms facilitating inclusion of persons with disabilities through the optimisation of available resources and collaboration between private and public sectors.

How was the Rights and Access Programme initiated?

The adoption of a disability law following a national disability seminar allowed for the creation of a National Committee for the Disabled (NCD) as a reference for disability issues in Lebanon, including policy-making and follow-up of implementation of ministerial actions.

113 Côte, A. Excerpt from: Gate -Keeping: Urgent Need for Reform to Ensure Fair and Effective Access to Social Protection Entitlements, The Disability Monitor Initiative – Middle East Journal, February 2009, p. 20.

The Rights and Access Programme is integrated in the agenda of the Ministry of Social Affairs in 1994 with the following goals:

- Ensuring all the rights of persons with disabilities in Lebanon;
- Facilitating access to these rights and all accompanying privileges; and
- Transforming relationships between the private and public sectors from one based on affiliations (i.e., to a community or party) to one on rights alone.

Main actors in the program

The NCD, a semi-government organisation comprised of eighteen representatives from the Ministry of Social Affairs, NGO service providers, DPOs and persons with disabilities, is one of the main actors.

The NCD has one representative from some of the main groups of persons with disabilities: physical, sensorial and intellectual disabilities, including hearing and visual impairments. Twelve members are elected by their representative organisations while the Minister of Social Affairs nominates two experts. The President of the Committee is the Minister of Social Affairs, the Vice-President is the General Director and two other members are the Head of the Disabled Service and the Director of Social Affairs.

Main programme components

There are currently six Rights and Access centres: Beirut, Baalbek, Hadath Taanayel, Tripoli and Sarafand with a seventh due to open soon, which provides the administrative interface between persons with disabilities and the Ministry of Social Affairs. These include physicians who diagnose the impairment, social workers and administrative staff who obtain socio-economic information about the service user. A disability card is issued to allow the person to obtain legal benefits such as technical services (rehabilitation), medical aids or equipment and tax exemptions. Current diagnosis of disability is based on the 1983 World Health Organisation classification system, which attracts some degree of criticism due to its limitations.

Procedures for granting entitlements in the programme

Persons register their details, including their medical files, identification and other form of documentation, at one of the programme's administrative centres. A specialised physician then examines the person while an administrative staff assists by completing the necessary documentation; after a person has been identified as having a "classified impairment", he or she is then issued a disability card. Around 68,000 disability cards have been issued to address the demands and facilitate the access to rights of persons with disabilities. Though there are no direct financial benefits obtained from the programme, the Disability Card provides a way and legitimacy for people to access services that they may have to pay for otherwise.

An example of macro level Gate-keeping

The Rights and Access Programme has been recognised as guaranteeing an administrative infrastructure that allows for the targeting of the needs of persons with disabilities and facilitates their access to services. It is an example of a macro level gate-keeping in a welfare system, which permits persons with disabilities better access to services.

Limitations to the system
As funding comes from the Ministry of Social Affairs, access to financial resources is usually a major issue. One of the major threats is that the provision of aids such as wheelchairs or incontinence aids will decrease as the budget decreases. Moreover, the classification system currently used by the programme, including the use of "specialised physicians", adopts a medical model that has limitations in addressing social, psychological or intellectual issues related to disability. As mentioned the programme has attracted criticism due to its adherence to a medical perspective and limitations on addressing some of the rights and social barriers related issues faced by persons with disabilities. It remains however an interesting example of an overall system and an attempt at regulating the demand with the offer of services for persons with disabilities in Lebanon.

For many stakeholders in the region, the failure to adapt **workplaces** in a manner that enables persons with disabilities to perform tasks on an equal basis as non-disabled persons is an issue that remains to be addressed. Nevertheless, some have also acknowledged that the attitude in the region towards accessibility is improving; at the least, people with mobility impairment may continue to see improved workplaces and opportunities.

Inaccessible transportation

Due to the large proportion of the population in the region living in the rural areas, **good transportation systems and infrastructure is crucial** for people to move freely and access their communities. Poor infrastructure, especially transport systems, can make it difficult for anyone to move around; it is even more difficult for persons with disabilities, who are often not considered when transport or infrastructure is planned and developed. With a disproportionate amount of service providers existing in large, urban centres relative to those in the rural areas (e.g., only about 20 percent of households in Yemen have access to hospitalisation services; this coverage increases to 61 percent in urban areas and decreases to 7.1 percent in the rural areas[114]), the importance of planning so persons with disabilities can access basic services is paramount.

Even when transport is available and persons with disabilities are able to pay, almost all of the **transport is inaccessible** to people who have visual impairments, use a wheelchair or have other disabilities that limit their independent mobility; information that is easy to read for persons with learning disabilities is also absent. Also, in areas where taxis, buses or microbuses are operating, stigma and discrimination preclude the use of these services by many persons with disabilities. The stigma attached to the limited physical accessibility of these facilities compounds the issue of excluding persons with disabilities from accessing these and other similar features in their respective communities or in other areas. Independent travel it seems, for persons with disabilities in the Middle East is extremely difficult and many times impossible.

Whilst this is clearly a problem, examples of promoting accessible transportation have been reported, as in the case of Jordan, wherein one of the larger national service providers and a government-affiliated sports association have started using adapted buses.[115] This modified means of transport has enabled persons who use wheelchairs to access their services, or on a fee-for-service basis the buses may be used to access other parts of the community.

114 Shugaaldeen, J. A report on the situation of disabled children in Yemen, (Social Fund for Development: 2008).
115 The Al Hussein Society for Rehabilitation / Habilitation of the Physically Challenged and the Al Hussein Sports Club.

Discrimination and negative attitudes

Some private and public schools in the Middle East can reportedly refuse to accept children with disabilities stating a lack of resources as the reason; whilst this may not be legally permissible, it has been reported to occur. Stakeholders elaborated that it was not unusual for school principals to refuse admission to a child with a disability, on the grounds of limited human and financial resources, lack of physical accessibility and teacher capacity.

Other problems include: failure of the government to implement laws and measures to secure education for all; most schools' refusal to accommodate children with physical disabilities or learning difficulties; and the inadequacy of the educational system in terms of school design, planning and tools required to educate students with disabilities. On the other hand, stakeholders have also noted some examples of both positive and negative discrimination; in that whilst curriculum and teaching tools were not always adapted for persons with disabilities, students were given support during examinations so that they could participate as their non-disabled peers, or provided assistance for notes-taking during class.

Moreover, the **work environment** is a place where discrimination on the grounds of disability can be a common occurrence; this is evident in the high levels of negative stereotyping that persons with disabilities are reportedly subjected to in the employment arena. Stakeholders generally believe that many employers maintain that persons with disabilities are not as productive and are less reliable than persons without a disability; therefore, costing them more money to provide work for. However, other stakeholders have indicated that where persons with disabilities are employed, the opposite can actually be observed; employers have positive attitudes reflected in the outcomes and outputs for members of the workforce with disabilities.

Access to social services in conflict or war-affected areas

The free movement of people in conflict and/or war-affected areas is significantly compromised due to infrastructure limitations and security hazards. Increased restrictions on the access to services during times of conflict and war impact an individual in one or more of the following: limitations on the choice of provider; increased demand for (a limited number of) providers; lack of material resources among providers (e.g., technical aids); compounded medical and/or psychological problems; and a reduced opportunity for persons with disabilities to determine their own service requirements.

For families, warfare can result in reduced capacity to work and pay for services required by a family member with a disability which brings increased stress on the entire family; and having to choose between healthcare, education services or other safety or basic life requirements such as food, electricity, clothing or shelter. For organisations and institutions working under prolonged situations of conflict, the reduced capacity to improve technical skills, share knowledge from experienced professionals outside of the conflict zone, to invest in service development or network for improved quality are all consequences that can negatively affect service provision to persons with disabilities. In Iraq for example, stakeholders have indicated that though new hospitals and health centres were being constructed, the political insecurity and increased mobility problems between regions keeps the demand for health services higher than what can be realistically delivered under the circumstances; moreover, there is an apparent gap in health services for rural populations and the lack of specialised staff for these health services due to the migration of Iraqis, many of which are health staff and professionals.

Considerations for improvement of the accessibility of social services in the Middle East

1. Reasonable accommodation[116] needs to be provided by service providers to ensure that persons with a diverse variety of disabilities can access the services they choose
2. Accessibility, whether physical, environmental, information or communication (i.e. limited information in Braille, sign interpreters or easy to comprehend information for users) should be addressed sufficiently at all levels of service provision, and adequate policies and regulations should be developed with incentives and penalties
3. Social policies should as well address the mainstreaming of disability within ordinary services, and promote the concept of inclusive services so that persons with disabilities are able to access these services if required
4. Antidiscrimination policies and regulations should be introduced and enforced, including the right to access services, ordinary as well as specialized ones
5. In accordance with existing legislation, or where needed new laws have to be developed, adequate regulations, incentives and support mechanisms should be developed to encourage public and private sector companies to adapt workplaces to allow for persons with disabilities to perform tasks on an equal basis to others
6. Financial as well as material support should be made available to services willing to introduce inclusive services so as to become models to be replicated and to serve as good practices (e.g. such as environmental adaptation or use of accessible communication methods)
7. Public transportation policies must aim to make ordinary transport systems accessible (e.g. all new buses that are bought to be accessible for example, bus and taxi stops to be accessible and with adequate information, discounts on transport for persons with disabilities). Improved infrastructure (i.e. transport), especially in rural areas should be prioritised to facilitate persons with disabilities being able to attend a service

6.2 Availability – social services exist and are available when needed

This parameter plays an important role in the Middle East as the region faces a significant lack of basic social services for persons with disabilities, both in terms of geographical coverage and typology. Making new services available at the community level is a priority, which involves, among others, technical and financial resources, as well as additional professional staff and related educational courses.

A service could be considered available if it…

- Answers to the diversity of needs for services (i.e., age, gender, type of impairment, or type of services);
- Contributes to a balanced geographic distribution;
- Develops mechanisms for sustainability; or
- Contributes to answering to the level of demand and needs.

116 Reasonable accommodation as defined in the CRPD "means necessary and appropriate modification and adjustments not imposing a disproportionate or undue burden, where needed in a particular case, to ensure to persons with disabilities the enjoyment or exercise on an equal basis with others of all human rights and fundamental freedoms"

The availability of services in the Middle East is an issue that directly impacts the lives of persons with disabilities and their families. Because these are tools that enable persons to participate more in society, the lack of specific types of services ultimately limits the chances of a person with a disability, negating their right to be included. In this report, availability refers to the range, type and number of services, including the professionals administering them that are obtainable by a person with a disability. If services are limited in type and number, this lack of options ultimately affects a person's freedom to make demands for a particular service, thus perpetuating the prevailing power balance in favour of service providers and re-enforcing outdated and negative stereotypes of persons with disabilities.

Health and medical services (including health-related rehabilitation)

The availability of a range of **health services** in the Middle East is variable depending on the country and its urban-rural context. There are large discrepancies within and between countries - from no or limited primary health clinics in some rural villages to very large tertiary hospitals with hundreds of employees in major cities. Even with the existence of these larger facilities or some rudimentary set of rural services, there is still a significant number of people in the region who are unable to obtain health services for a variety of reasons. It is estimated that in some parts of the region, less than 30 percent of the population receive health services as the availability of services is often concentrated in larger urban areas or governorates.[117]

Box 14. Health Services

Health is a basic and fundamental right that is applicable to everybody, including persons living with a disability.[118] Article 25 of the CRPD lists six basic provisions related to health and persons with disabilities; perhaps more importantly, the article explicitly states that, *"States Parties shall take all appropriate measures to* ***ensure access for persons with disabilities to health services****…"* For countries in the Middle East that have ratified the CRPD, there is a clear obligation for governments to work towards fulfilling this obligation and ensuring that persons with disabilities, whether living in rural or urban centres, regardless of disability or socio-economic status, have access to appropriate health services.

In discussing health, it is important to recognise that it encompasses more than the physical or psychological aspects of an individual's wellbeing. For persons with disabilities, health services are important not only in terms of their access to them, but also in terms of how they are often defined by them: impairment, condition, status or diagnosis. In the Middle East, as in many other parts of the world, persons with disabilities can more likely be categorised as having poor health due to their limited physical, mental and social wellbeing.

Whilst it is no longer acceptable to view disability from a health or medical perspective alone, persons with disabilities are still associated as having health problems requiring specialised health services, which can be adversely affected by a lack or inadequacy of it. Despite the fact that persons with disabilities in the Middle East have the right to health services, they are generally excluded from accessing most mainstream services and are subject to the lack of good, quality, disability-specific services such as medical rehabilitation, technical aids, diagnostic services, and the like.

117 Shugaaldeen, J. A report on the situation of disabled children in Yemen, (Social Fund for Development: 2008).
118 Article 25 United Nations Universal Declaration of Human rights and Article 25 United Nations Convention on the Rights of persons with Disabilities.

Stakeholders in the region tended to combine medical and specialised rehabilitation services when referring to healthcare services for persons with disabilities, indicating the insufficiency of specialised services in both rural and urban centres in the region. They noted that those providers in the rural areas required special attention as they are completely deficient in some of the services; people face difficulties of movement in and out of these parts; poor economic and employment conditions; no or very limited maternal and child health services; the absence of media awareness to these issues, illiteracy and environmental problems.[119]

Specialised health services (e.g., ortho-prosthetic centres, specialised diagnostic services or early intervention services) are categorised with rehabilitation services for persons with disabilities because stakeholders recognise that in some parts of the region, medical diagnostic services for persons with disabilities are often located in larger, specialised rehabilitation centres. To a large extent, these centres seem to be operated by NGOs and tend to be more readily available for some persons, such as those with physical or sensory impairments, compared with those having intellectual disabilities for example.

In Iraq, orthopaedic and physical rehabilitation services are in larger urban centres such as the Kurdistan Organisation for the Rehabilitation of the Disabled in Suleimaniyah. Persons living in central and southern Iraq have been known to travel great distances, often at their own personal risk, to receive services in these centres. The limited availability of similar services in these parts of Iraq continues to be an issue for persons requiring specialised services in their local areas. The poor security, insufficient availability of qualified professionals and the restricted functioning infrastructure in central and southern Iraq have contributed to the willingness of the people to travel north.

Box 15. Access to Medical Services for Women with Disabilities[120]

Women with disabilities in the Middle East continue to be underserved with respect to primary healthcare services appropriate to their needs. Women with disabilities share a number of important demographic characteristics that can impact their utilization of and ability to pay for healthcare. For example, it is known that more women with disabilities than those without live in poverty, with incomes below average levels for both women without disabilities and men with disabilities.

Another important issue limiting women with disabilities' access to health services is related to the geographic distribution of services; at least 40 percent of women with disabilities in the Middle East live in rural areas, where unemployment rates are higher than in urban areas and annual incomes of women with disabilities are lower on average than the incomes of women without disabilities.

Inaccessible public transportation and limited access to specialty care centres compound the healthcare challenges facing women with disabilities. Improving access to health services should be a priority because it is common for mainstream health service providers to neglect the specific needs of women with disabilities. Like all women, those with disabilities require routine preventive care, including regular medical and gynaecological checkups, mammograms, and reproductive care; however, their disabilities frequently result in the under utilization of the most routine preventive care

119 Ibid.
120 Written by Ms Ola Abu-Ghaib, Regional Project Coordinator (Musawa), Handicap International, Middle East.

services. The standard equipment made available for many routine exams is often not adequate for women with disabilities, who may need specially designed chairs or tables in order to be examined.

Women and girls with disabilities can and often do face multiple obstacles to participation in society due to two-fold discrimination: on grounds of both gender and disability. Although the general situation of persons with disabilities in the region has significantly improved, the benefits of such changes in society are not always equally distributed between women and men with disabilities.

The development and implementation of relevant policies and services should be designed in a manner that ensures a balance of opportunities between disabled men and women. The specific situation of women and girls with disabilities needs to be taken into account in the development of both disability and gender mainstream policies and programs at all levels: international, national, regional and local.

Livelihood and employment services

Employment opportunities and other means of livelihood were also found to be scarce in the region. In Jordan, stakeholders indicated that some good vocational training programmes that give people the chance to develop their skills that range from sewing to car maintenance, hair dressing to plumbing, are available.

Stakeholders stress that whilst the availability of similar programmes are limited to the general public, it is even more limited for persons with disabilities. The negative attitudes of staff at some centres in the region and the low expectations of what persons with disabilities could achieve, were also indicated as some of the barriers to the realisation of more inclusive livelihood services and employment opportunities for persons with disabilities.

In Egypt, legislative planning for persons with disabilities usually revolves around rehabilitation, financial assistance, vocational training and quotas and less around competitive open employment initiatives.[121] Whilst individual interventions such as rehabilitation and vocational training are important to assist a person with a disability obtain and maintain a minimum standard of living and access to employment opportunities, they fail to address system-wide factors such as market regulation, school-to-work transition and supported employment. The Ministry of Social Solidarity in Egypt is currently responsible for providing training services, such as:

- Monitoring mandatory enrolment of persons with disabilities into rehabilitation programs;
- Conducting social rehabilitation by rehabilitation offices;
- Sheltered workshops and rehabilitation centres; and,
- Maintaining a database of 'rehabilitated persons' in an employment office.[122]

121 Ghanem, A. Livelihood of Persons with Disabilities in Egypt, Unpublished report, 2009.
122 Ibid.

In Yemen, two new strategies have been defined recently to improve employment opportunity for persons with disabilities:

- The **Third Social and Economic Development Plan for the Reduction of Poverty 2006-2010** aimed at prioritising the employment of women and persons with disabilities and affirming a civil service strategy for improving employment opportunities.[123]

- The **National Strategy for Women's Work 2001-2011**, addresses issues for women, but unfortunately does not mention measures to include women with disabilities.[124]

Implementation of policies and laws remains a problem in the Middle East, including Yemen, where a mere 10,000 Yemini riyal fine is imposed (about US$50) on a company violating the rights of persons with disabilities with respect to employment.[125]

Education services

The increased demand for **special education services** for children with disabilities has been identified as necessary for skills development but as well a potential promoter of exclusion. In line with the twin-track approach, whilst it could be argued that some specialised schools will always be required by a minor part of the population, these should not be provided or promoted in an exclusionary manner. Special education has to be provided within the mainstream education system, with the same quality criteria and with a person-centred approach. As the availability of inclusive schools remain limited in the Middle East, stakeholders have reported that children with disabilities are increasingly attending some mainstream schools in small numbers.

Moreover, some education services have programs that work toward the inclusion of children with disabilities into mainstream schools. These preparatory settings have a curriculum designed to facilitate a child with a disability's transition into a mainstream education environment; in some cases, these centres collaborate with more than one ministry such as the Ministry of Social Affairs and Development or the Ministry of Education.

To support these efforts at inclusion, some specialised school services have developed policies and worked with local mainstream schools to address physical and educational barriers in schools; thus, making the shift for children more streamlined and less difficult. Also, through local level partnerships, the staff in special education centres can positively impact the transformation of these mainstream schools into more open centres where children with disabilities can attend.

In addition, some centres also work with parents to help them realise the advantages of having a child with a disability enter a mainstream school as early as possible and enable them to establish their independence at a young age. Some education facilities, such as the Al Khader Charitable Child Care Society in the occupied Palestinian territories, are available for both children with disabilities and those without. These types of settings counteract the notion that children with disabilities have to and can only learn from a different specialised school before they have to adjust to the new environment of the mainstream school. The shortage of these types of educational programs in the region was attributed to the unwillingness, capacity and financial resources of local schools, public or private, to be more inclusive, parental fears for their child and the lack of technical skills in mainstream educational settings to undertake successful inclusion.

123 Ismail, H. No Disability with the Access of Persons with Visual Disabilities to Livelihoods and the Right to Employment, Unpublished policy paper within the MUSAWA project, 2009.
124 Ibid.
125 Ibid.

Whilst access to places of **higher education** remains limited for persons with disabilities, stakeholders have indicated that this situation is improving in the region. More specifically, as educators become more aware of how they can improve physical accessibility for inclusion and introduce alternative learning methods, more people with mobility and visual impairments are reportedly being accommodated in universities on a more regular basis than a few decades ago.

Some universities, like the An-Najah National University and the Bethlehem University in the occupied Palestinian territories, have **disability support offices** that assist with the enrolment and inclusion of persons with disabilities. The disability office in An-Najah National University produces Braille-formatted documents for persons with visual impairments, is affiliated with special accommodation and transport services and is linked with community-based outreach services in the local area.

Box 16. Education services

Education is without a doubt one of the most important components of a person's life that will enable him or her to achieve their personal goals, maximise their choices or unfortunately in some cases, manage to survive each day. Article 24 of the CRPD, clearly articulates the right of persons with disabilities to access education, including compulsory and free primary education, general tertiary education, vocational training and adult education.[126]

Despite the significant implications of education on one's basic survival and prosperity, many children in the Middle East, specifically those with disabilities, are still unable to access education services. In Yemen, basic school enrolment for all children ages 6 to 15 years was reported to be only 59.3 percent, with girls making up a significantly lower proportion.[127] Children and youth with disabilities are even less likely to be enrolled in educational programs or schools, further placing them at a disadvantageous situation in a region where many barriers to livelihood opportunities already exist. The right of these children to be educated in inclusive settings to enhance their capacities to participate in social and economic activities in their respective societies should be recognised and addressed.

Funding of services to ensure availability, affordability and continuity

Securing adequate funding for many services, such as some specialised health or education services that are accessible also for persons with disabilities was described as tenuous, partly due to the heavy reliance on unsustainable support from international donors and the limited support from national governments. Stakeholders recognised the limitations of national governments to maintain effective and sustainable services for persons with disabilities or to undertake a re-allocation of resources; thus, leaving the alternatives for project funding to international organisations and other fundraising initiatives. This rather insecure source of funds places additional burden on service providers in trying to develop appropriate services for their target population. Moreover, services can be skewed towards the requirements of the donor than the needs of the service user, thereby causing another obstacle in the availability of various types of services for some persons with disabilities.

126 CRPD Article 24.
127 Shugaaldeen, J. A Report on the Situation of Disabled Children in Yemen, Social Fund for Development, 2008.

Considerations for improvement of the availability of social services in the Middle East

1. An increase in the diversity of types of services available, particularly in rural areas would contribute to greater access to services by persons with disabilities

2. Diversity of vocational training programmes should be encouraged to ensure greater choice and options for persons with disabilities to facilitate skills development (e.g. employment skills) that matches needs or demands (e.g. of the open labour market)

3. Increase the quantity and quality of the surveys and information gathering mechanisms to assist in more comprehensive planning for services, beyond medical model related interventions. Without waiting for time-consuming surveys in all cases, stakeholders should be encouraged to engage in other forms of information gathering such as participatory assessments or assessments based on Agenda 22[128] in defining local action plans for disability

4. Emphasis needs to shift to community based services that provide greater availability of services for persons living rurally, remotely, have difficulties with accessing transport or are otherwise unable to travel easily to attend centre based services

5. Programs should be developed to facilitate the transition from segregated specialised types of services to more inclusive ones in the mainstream sector, including both governmental and non-governmental service providers. Specialised and/ or support services should be located in mainstream settings (e.g. specialised educational support services within regular government schools)

6. Sustainable funding mechanisms for services need to be developed, as one very important procedure of the regulatory mechanisms based on the right to access services for all the population, including persons with disabilities. This would also ensure a better service development, maintenance and quality, as well as availability at community level, particularly for more vulnerable populations in rural and remote areas

7. With the twin-track approach to service development and social policy reforms, it is important to keep in mind that specific strategies and support need to be ensured for persons with disabilities that have higher dependency needs (e.g. students with complex intellectual disabilities, or children and adults with multiple physical and intellectual disabilities) to ensure they are protected as well as included in mainstream settings as much as possible

8. Essential social services have to be available to persons with disabilities during conflicts, war or political instability and all services being provided by international organisations as well as local ones, should take into account the additional needs persons with disabilities might have in order to access water, sanitation, health and education as well as shelter

128 Agenda 22 can be accessed at: www.hso.se

6.3 Affordability – social services should be provided for free, or at a reasonable price for all people who need them

This refers to all measures required to allow everyone, especially the marginalised and socially excluded populations, financial access to social services at the community level.

A service could be considered affordable if it…

- Is free-of-charge or only requires a nominal fee, based on a means test, for all users with a sliding scale to ensure realistic payment division;
- Develops mechanisms that will ensure long-term funding; and
- Accounts for the costs of transportation, meals or accommodation and family members accompanying the person, in the overall service provision.

Stakeholders indicated that despite the fact that some governments in the region have made many services such as health and education free, in some instances, persons with disabilities could still be required to supplement the costs of the service, medication or assistive devices associated with their impairment. Some non-governmental service providers, with better quality services, are reported to charge fees that at times are too steep for persons with disabilities to afford; thus, limiting their options to choose the most appropriate or best quality service for them.

The issue of cost is not just a matter of **how much** something is, but as noted earlier, it is also related to the assessment and identification of the needs and demands of persons with disabilities. If a person is determined as having a disability solely on the basis of a medical diagnosis, he or she stands to receive free or subsidised benefits (i.e., healthcare) regardless of their level of income or social situation. However, identifying disability on impairment alone is not the best method. To address this issue, some non-public and public providers examine and evaluate the socio-economic status of a person with a disability to determine if they should receive free or low-cost assistance; however, this system of means testing and "social study" requires further development to ensure a more appropriate use of resources and allocation of funds. Some stakeholders point out that as long as the medical model of disability is used to categorise disability, achievement of these goals will continue to be hampered.

Healthcare and health related rehabilitation services

In principle, legislation that states that healthcare services for persons with disabilities and their families are free, as covered **by health insurance supplied by governments** does exist in certain countries in the Middle East; in reality however, this is not always the case. In the occupied Palestinian territories, persons with disabilities can access public health services when their "disability percentage" exceeds 60 percent. This figure is criticised partly because it is based on a Jordanian law from 1951 and a new Palestinian law that varies from this has not been implemented due to financial constraints.[129]

Many countries in the region offer free or low-cost services such as primary health and basic hospitalisation and education that are supported by different government initiatives. The Disability Fund in Yemen provides finances to support provision of health services for persons with disabilities, though the implementation in rural areas is severely limited and the issue of the quality of the services provided has been raised. In Lebanon, persons with disabilities

129 Canawati, R. Health Insurance for Persons with Disabilities: Real Practices or Pure Wishes? Views from Public Officials, Jordan, and Civil society Palestine, Disability Monitor Initiative – Middle East Journal, February 2009: p. 30.

are entitled to full health coverage, with assistance from the Rights and Access Programme and on the condition of the issuance of its disability card. In Egypt, since 1998, universal healthcare is available to all children, including those with disabilities.

In general, the need for improved health insurance systems that are universal in nature has been put forward, as the current systems in place in some countries are insufficient to meet the demands of service users. Without free or subsidised health services and a geographically-balanced distribution, persons with disabilities will continue to struggle or be excluded from accessing the necessary health service they require.[130] In the occupied Palestinian territories, for example, it was estimated that only 55 percent of people had some form of health insurance[131] and considering that persons with disabilities often have limited social protection or experience difficulties in obtaining employment, the percentage of persons with disabilities without insurance will be higher and their capacity to pay for health services lower.

Educational services

With respect to education, there are different specialised **educational services** that have arrangements with the various ministries that ensure that some subsidies are given children with disabilities attending these special schools. For example, some specialised educational settings receive a small daily allowance from the government for each child with a disability enrolled. Many educational facilities are free or at a low cost, but as noted previously, extra costs associated with transport, assistive devices or educational materials often significantly increase the burden for families of children with disabilities. It is also not uncommon for some private educational institutions to charge extra, sometimes as much as double the tuition fees, for educating a person with a disability.

Financial assistance and exemptions

Laws related to tax and financial exemptions for persons with disabilities are also related to the charity approach, based on a medical classification of disability that do not always correlate with actual needs. In the Middle East, financial exemptions are sometimes evident in the following areas: free public transportation, free or subsidised costs for travel of personal assistants and customs exemptions on new vehicles. Whilst some stakeholders contend that these exemptions should be improved and increased, particularly those related to transport and accessibility, others believe that exemptions should be a function of income and activity. Because if a person has the means to pay for a service, then he or she must not be given an exemption as this should only apply where relevant. More specifically, customs exemptions for the purchase of new cars for persons with disabilities are not always given to people who wish to drive, but are available on the grounds of having a disability. Stakeholders also recognise that whilst some people consider this as unjust, it has also been referred to as a type of **compensation** for higher costs they incur in other areas where social protection should exist but is limited.

Cash transfer mechanisms, as a form of social protection and assistance to make services more affordable are quite limited in the Middle East and not adequately supported by legal or policy frameworks. There are some specific forms of financial support but cash transfer systems in general are deficient. In Yemen for example, families receive cash benefits that do not exceed 48,000 riyals (US$ 250 per year) in social assistance, which activists argue is insufficient for basic needs and does not consider the extra costs associated with living with a disability.[132]

130 World Bank. People with Disabilities in India: From Commitments to Outcomes, Human Development Unit South Asia Region (World Bank: 2007): p. 82.

131 UNICEF. The Situation Analysis of Palestinian Children, Young People and Women in the West Bank and Gaza Strip, (UNICEF: 2000).

132 Al Ahamadi, A. Can Cash Transfers Reduce Inequalities for Persons with Disabilities, The Disability Monitor Initiative – Middle East Journal, February 2009: p. 23.

Considerations for improvement of the affordability of social services in the Middle East

1. Essential services, considered as basic human rights, have to be part of a funding scheme from governmental levels in order to ensure their affordability to all persons, including persons with disabilities. This should be part of a comprehensive regulatory system as one very important aspect. Funding could be of financial character, in-kind support, tax-relief or other incentives
2. Costs of transport, accommodation, assistive devices and other ancillary costs must be considered as part of the overall service cost to the user. Social assistance for persons with disabilities must take into consideration the extra costs related to disability for the individual and the family (e.g. healthcare costs, technical aids or adaptations, transport and clothing etc.)
3. Review of the existing options of social insurance, particularly health insurance, to address the issue of limitations for persons with disabilities on their coverage, particularly related to insuring for pre-existing disabilities / medical conditions
4. Increase the type of social protection options to include better social assistance or social services schemes for persons with disabilities who are unable or find it difficult to be included in the open labour market

6.4 Accountability – social service providers' transparency in terms of financial management and organisation

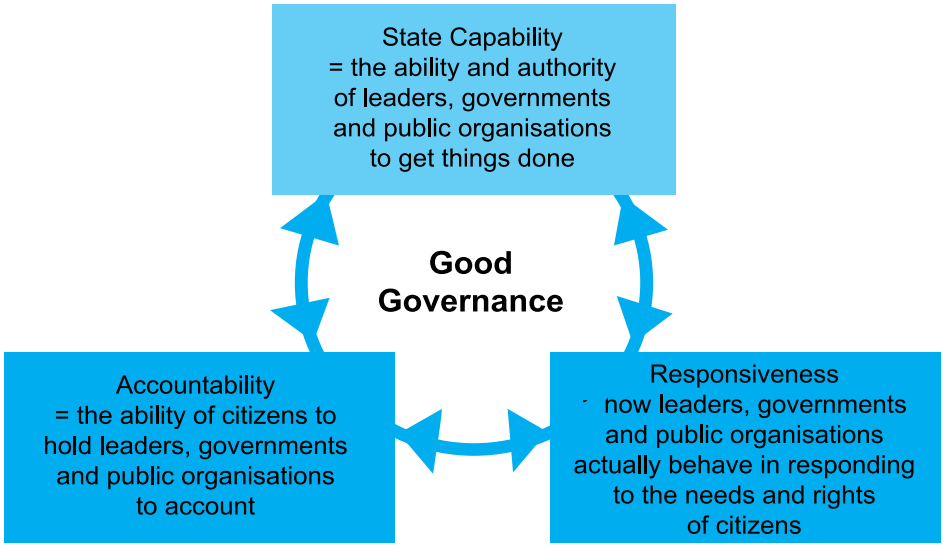
This parameter refers not only to the transparency of the financial management of the service (i.e., clear unit cost per service and user, an accurate accountability system at the level of the service, transparent flow of resources and expenditures), but also to the overall organisation of the service: clear manuals of policies and procedures, internal regulations, and a qualitative and transparent staff management system.

A service could be considered accountable if…

- It is person-centred and promotes rights and inclusion of persons with disabilities;
- It is results/outcome-oriented;
- There are good partnerships with the local community;
- A system for a continuum of services (before- and after-service) exists;
- The staff and the organisation development is adaptable to meet the demands and needs of the users;
- There are monitoring mechanisms in place;
- It produces and complies with standards, policies and procedures;
- It considers users and their families as actors in the development, delivery, management and monitoring services;
- A mechanism is in place ensuring financial and organisational transparency and allowing the user to access their information; and
- Users are involved in decisions that concern them, as a real stakeholder, not as an external consultant to "approve" plans.

The existence of good health service providers and the weak regulatory mechanisms that support them limit the effectiveness of the distribution of these services. Part of the requirement of a comprehensive system is the presence of referral mechanisms (as a main part of the gate-keeping system), which, if poorly developed can negatively impact a person's ability to choose a certain service over another or shift between services.[133] Stakeholders noted that an appropriate referral system to, from and between services for persons with disabilities is lacking in the region.

Scheme 8. Good governance relationships[134]



Referral systems for any type of service can exist between providers outside of a formal framework. Whilst many service providers in the region have informal mechanisms and ad hoc referral procedures that have become the "norm", problems with an informal referral system are not unanticipated and include:

- Lack of real user choice;
- Inability to provide a continuum of services;
- Gaps in service provision that may affect outcomes;
- Extra costs to users;
- Lack of knowledge of a demand for a particular service; and
- Limited opportunities for coordination and collaboration between stakeholders.

Monitoring and evaluation of social services

Stakeholders indicated that improved **monitoring and evaluation** of services is necessary to improve outcomes. As stakeholders struggle to determine coherent systems in the region, they note a variety of gaps in the regulation of services - from the identification of national priority areas, the assessment and eligibility criteria to contracting and collaboration with non-state providers. In countries with large rural populations like Yemen, the limited development of community-based services impacts the population's access to services whilst in states like Iraq and Lebanon, where political instability can be an issue, the capacity of ministries to plan and

133 World Bank. People with Disabilities in India: From Commitments to Outcomes, Human Development Unit South Asia Region (World Bank: 2007): p. 92.
134 DFID. Civil Society and Good Governance, A DFID Practice Paper, September 2007.

implement programs is ultimately affected by the functioning capacity of the authorities at the time. The lack of comprehensive systems of data collection and statistical analysis in most of the countries can further jeopardize transparency and accountability in the services domain.

Reforming some of the social service sectors is an important issue that is being addressed by governments in the region. In Egypt, the Ministry of Health, with different European and Egyptian organisations, is undertaking changes to its health system. Through the installation of a new system of registering the family in a network of health services at the local level, the group is anticipating positive changes to how health services are provided to Egyptians.[135] In Yemen, the Ministry of Health, along with other stakeholders, is initiating a plan to upgrade its health services, improve preventive and rehabilitation services and encourage personal and proactive attitudes to health amongst the population. The Yemen Disability Fund is included in this reform, through the establishment of a support system to persons with disabilities for such services as surgery, medication, therapy, medical aids, assistive devices, transportation and accessibility of health services outside Yemen.[136]

Stakeholders indicated that **coordination** amongst the different actors and service providers is vital for improved access and accountability to services for persons with disabilities as collaboration between state and non-state education providers across different education levels (pre-school/kindergarten, primary and secondary schools, vocational training centres and universities) remains limited. In the occupied Palestinian territories for example, kindergartens are managed mostly by the private sector and organisations, to which the Ministry of Education grants licences.[137] Primary schools are managed by a mixture of government, UNRWA and the private sector, with licences given by the Ministry of Education.[138] This mix of service providers presents many opportunities for collaboration and innovative service provision, however, if not effectively regulated and coordinated could result in duplication or exclusion. Other examples of inter-ministerial sharing of responsibilities exist in countries like Yemen, where the Ministries of Education, of Technical Education and Vocational Training and of Higher Education were all responsible for different aspects of the education services offered in Yemen.[139] Even without providers from the private sector, the amount of coordination between and within government bodies still warrants closer attention to determine effectiveness of currently operating regulatory mechanisms. If coordination mechanisms include aspects of transparency and good governance, their accountability to all stakeholders, but especially to persons with disabilities is likely to be acceptable.

Stakeholders indicated that **greater regulation of the services and systems** is required for services to become more accountable and inclusive. Monitoring, related not only to macro level coordination and licensing of organisations and services, but also at micro level collaboration, where service users and their families have more control and choice about their options for service provision. Social services require a system or framework that will ensure that they adequately reach the target population, achieve set goals, are organised for constant review and improvement and are flexible to meet the demands of users. Currently, social services in the Middle East lack such a system and an effective form of gate-keeping, as service provision is based on or is still related to medical diagnosis.

135 British Council, Health Sector Reform Programme, Egypt http://www.britishcouncil.org/ development-health-experience-egypt-hsrp.pdf as at 19 October 2009.
136 Al-Kabzari, H. Health Rehabilitation for Girls with Hearing Disabilities in Yemen. Unpublished policy paper within the MUSAWA project, 2009.
137 UNICEF, 2000.
138 Ibid.
139 Saleh Bin Shaeb, R. Inclusion of the Visually Disabled in Basic Education. Unpublished policy paper.within the MUSAWA project, 2009.

Legislative and policy deficiencies

Many stakeholders noted that as a starting point, legislative amendments are required to ensure that a more rights-focused approach is taken so accountability of all stakeholders in service provision is improved. A more systemic emphasis is also necessary for effective policy design, changing community attitudes to more positive and inclusive ones and mainstreaming disability issues with respect to such issues as open labour market interventions. The intervention and "management" of employment services for persons with disabilities by the Ministries of Social Solidarity / Welfare in the region, and not by the Ministry of Labour also reinforces the prevailing welfare approach to disability.

Stakeholders have stated that **clear policy guidelines on how to develop inclusive services and improve participation of persons with disabilities** in communities is missing. This, along with the wages of services staff (e.g., teachers, rehabilitation professionals, social workers, and health staff), a general lack of the numbers of technical staff and poor intra and inter ministerial coordination are considered major issues that the government needs to improve. The ability of governments to respond to demands for improving services systems is complex and is limited by state resources, willingness and capacity.

In 2008, the Jordanian Ministry of Labour launched a strategy and national action plan, the **National Employment Policy,** which include women with disabilities to promote social security and prevent social exclusion.[140] Yet Jordan remains to have no clear employment policy for persons with disabilities integrated into its national strategy or vision but it nevertheless has a legislative framework with provisions on minimum wages, employment contracts and social security, but does not include such things as unemployment insurance. [141]

Regulation is important not only for persons with disabilities as users of services, but for governments to ensure that they maintain the optimal use of financial, technical and human resources. This is linked to the development of quality standards, already evident in Egypt and Jordan for example. In July 2009, the Higher Council for the Affairs of Persons with Disabilities in Jordan, published the guide, *Accreditation Standards of Institutions and Programmes of Persons with Disabilities in Jordan*.[142] This set of standards aims to achieve quality improvements regarding the education of persons with disabilities that are in line with national and international laws.

Considerations for improvement of the accountability of social services in the Middle East

1. Identification and assessment of the disability situation should not be grounded in the medical approach (e.g. with a card referring to medical diagnosis) but should include abilities, social and exclusion issues and support from a rights based approach and obligations of the state. The state should take the lead by setting examples of how a disability is defined and guidelines for how social barriers to inclusion should be included in the assessment of disability, rather than strictly applying a medical diagnostic model

2. Monitoring and evaluation of services should include input from persons with disabilities to ensure that the programmes are meeting the demands of users.

140 Abed El-Matlab, A. Policy of Employment of Women with Disabilities in Jordan / Reality, Challenges and Aspirations, Unpublished policy paper within the MUSAWA project, 2009.
141 Ibid.
142 Higher Council for the Affairs of Persons with Disabilities Jordan www.hcd.gov.jo as at 26 October 2009.

Councils related to service provision either within a service provider or group of providers, or at a local/national governmental level should be created to help monitor and regulate how services operate and the standard with which they perform

3. Increased regulation of services will contribute to better accountability by ensuring that roles and responsibilities of all stakeholders are clearer. Currently in the Middle East there is very limited control of NGO provided services. Regulation by governments should ensure that service providers deliver as they intend to, that they have financial transparency and that the role of the state as monitoring and controlling these aspects is ensured

4. The implementation of capacity building for service provider organisations and for professionals specifically working with persons with disabilities to assist in recognising demands/needs should be a priority. Training for professionals would vary across the countries and services, however clear development of professional capacity (e.g. social work) and even the creation of new professionals (e.g. occupational therapy) in some countries should be encouraged by the state and by service provider organisations

6.5 Quality – services adhere to a minimum set of quality criteria or standards

The **quality of services provided to persons with disabilities** contributes to supporting a person to overcome and manage barriers to inclusion. For example, the quality of health systems and service providers in the Middle East vary greatly; however, stakeholders commented that services for persons with disabilities in the region are generally better in the urban areas and in private facilities, especially when they are paid for, than in the rural areas and some of those provided by the government. However, they also noted that there are great discrepancies across the region; even in comparing services in capital cities with those in rural Yemen and central Iraq.

Lack of qualified professionals

From the viewpoint of stakeholders, the quality of services available to persons with disabilities is directly related to the quantity and quality of health professionals working in the various services.[143] The inability of many service providers to employ a sufficient number of qualified staff was attributed to the lack of funding and organisational capacity and the actual availability of professionals knowledgeable about a certain type of disability (i.e., special education teachers to work with children with intellectual disabilities). More specifically, the lack of technical capacity and the high teacher-student ratio hinders the inclusion of children with disabilities in educational settings. If more teachers were trained on how to educate children with disabilities in an inclusive manner, this would improve the likelihood of more children with disabilities being able to attend and succeed in school. The use of **support teachers** in mainstream schools to assist the inclusion process was identified as a means to facilitate greater educational inclusion.

The lack of professionals who can facilitate persons with disabilities accessing the **open employment market** is also an issue that needs to be addressed as it reduces the ability for advising governments, educating service providers, sensitising employers and supporting persons with disabilities in obtaining employment and income.

143 World Bank, 2007: p. 90.

Mental health services

Generally speaking, the **specific issues faced by persons with mental health disabilities** are an important, but often overlooked aspect of service provision, not only in the Middle East, but also in many parts of the world. This is attributed to the low level of general development in many of the countries and the prevalence of conflicts in the region.

The degree of mental health disabilities brought about by conflict is difficult to determine but it could be assumed that significant psychological disorders would be common in Iraq and other conflict zones such as the 2008 Israeli War on Gaza or in Lebanon following the 2006 Israeli War and the armed conflict in the Palestine refugee camp, north Lebanon in 2007. In general, political instability, conflicts and wars in the Middle East are major factors to consider with respect to access to services. The conflicts mentioned above affect the ability of governments and non-state actors alike to provide all types of basic services and the ability for people to travel or attend centre-based services.[144]

Qualitative services support personal development

The promotion of self-esteem and personal development is increasingly recognised as an important aspect for service providers to consider, for successful outcomes and improved social participation of persons with disabilities to be realised. Some have started recognising this and attempts to improve the quality of their services by contributing to the empowerment of persons with disabilities are underway. Some special education centres, such as the Helen Keller Centre in Jerusalem or the Light and Hope NGO in Cairo, for girls with visual impairments, focus their efforts on empowering these girls and young women to fully develop their own potentials.

Curative and preventive approaches in disability

The DMI-ME stakeholders agreed that health systems across the region were strongly based on curative methodology, rather than on an approach that looks at prevention or health promotion. The curative approach is a more passive approach to dealing with health issues, and does not always promote pro-activeness in addressing health issues for persons with disabilities. Many service providers are engaged in health promotion and disability awareness, in varying degrees; however there are limited national health promotion strategies identified that particularly impact on the lives of persons with disabilities. Stakeholders are concerned with the limited amount of public health research and promotion campaigns, which if implemented, could positively impact disability prevention strategies and improvement in the quality of life for persons with disabilities.

Mismatch of market needs in employment

When it comes **to education, livelihood and employment services,** stakeholders noted that the acquired skills of persons with disabilities often do not appropriately fit the open labour market or even the personal choice of the user. This aspect of quality was noted as being related partly to programmes that do not provide training to persons with disabilities for skills that match labour market demands or projects that give therapeutic activities rather than technical know-how that could generate income on an equal basis with others.

Some innovative organisations that were providing users with more choices and matching skills and interests with market demands were identified. Centres in Jordan, such as the Al Jofeh Centre and in the occupied Palestinian territories, the Atfaluna Society, are vocational training centres that strive to fit the interests and skills of the person, particularly in tourism-related work.

144 Ibid.

In Jordan, with the assistance of foreign aid, the Ministry of Social Development and the Higher Council for the Affairs of Persons with Disabilities are collaborating to train young people with disabilities from Zarqa, Amman and Irbid in an attempt to improve their ability to find employment in the open labour market (*Maharat* programme).[145] However, in Egypt, as in most countries in the region, there remains limited supported employment to enable people to participate in the open labour market.[146] Even though several countries have specified a quota related to the employment of persons with disabilities, there is an overall lack of implementation of policies and incentives and sanctions for non-compliance to support the process of including persons with disabilities in the open labour market.

Quality of statistics and research

Statistics is important for states, service providers and DPOs to better **understand the social demands and needs of the population** and more effectively plan for **comprehensive and quality services**. Governments use statistics and data to plan services for the population, whilst service providers utilise similar information to tailor their services to specifically meet the demands of their users and make more choices available to them. Across the region, there is recognition of the gap in the production, sharing and use of reliable statistics for health or disability purposes.

Public, private and international organisations conduct surveys and gather statistics periodically; it is the sharing of this knowledge and information that is unfortunately limited. As Article 31 of the CRPD states, governments have clear responsibilities with respect to statistics and data collection, which need to be undertaken to fully understand the situation and challenges faced by persons with disabilities. Stakeholders agree that the criteria to determine and "measure" disability vary across the region, primarily based on the medical approach, which tend to put a stigma on disability within a community; objectifying persons with disabilities instead of empowering them, limiting service options to medical interventions and allowing some persons with disabilities to "fall through the gaps."

Medical approach

Whilst the definition of disability differs among countries in terms of accessing social services, there are some common denominators, one of which is utilising the medical approach to disability. In some instances, a person who may have lost part of a finger may be eligible for significant levels of support (e.g., cash benefits) despite no limitation on their ability to work or participate in society. This is in contrast with parents of children with disabilities who do not always receive adequate support for the extra costs they incur from raising a child with disability.

Quality of education

In 2007, the Egyptian government launched a **six-year National Strategic Plan for the Reform of Pre-University Education,** which includes references to persons with disabilities, specifically in at least two of their principles.[147] In the strategy, reference is made to the *"… faith in the ability of all children to achieve high quality education"* and the creation of *"… social environments that are supportive to learners and teachers."* These two aspects of the strategy reflect an aim to improve inclusive education, though it remains very much focused on special or integrated education; nevertheless, overall, this is encouraging for a country with the largest population in the Middle East region.

145 Jordan Times 10 November 2008, www.jordantimes.com .

146 Ghanem, A. Livelihood of persons with Disabilities in Egypt. Unpublished report, 2009.

147 The National Strategic Plan for Pre-University Education Reform in Egypt 20072011- can be accessed at: http://knowledge.moe.gov.eg/NR/rdonlyres/8CD0AE2228-C56-8226-4844-E5CEA46842810511// strategicplan_main.pdf

Across the Middle East, **special education centres** that include health clinics and early diagnostic/intervention services exist, such as those for hearing and communication impairments or orthotic and prosthetic requirements. Some of the larger centres have the technical capacity to diagnose children's impairments in order to recommend particular educational programs. However, stakeholders note that the number of these centres is insufficient to meet current and future needs. There are two opposing points with regard to this:

- The inherent need for special education settings and providing skills for children with disabilities is essential as there are many children with disabilities who currently are not able to access any form of education;
- Conversely, it is expected that the increase in the number of special education centres would lead to a decline in demand for inclusion into mainstream settings.

Considerations for improvement of the quality of social services in the Middle East

1. Mainstream service providers should have access to training about disability and increase the awareness among the staff. This would improve inclusion and quality of the service.
2. Service provider organisations should support the development of clear policy guidelines by their organisations on how to promote inclusive services for users, human rights, and person-centred approaches and should initiate the setting up of quality management system
3. Staff should improve their communication skills to be able to address persons with disabilities with dignity and mutual respect
4. Comprehensive and multi-disciplinary approaches for service provision should be encouraged
5. Encouraging the personal development of individuals with disabilities, especially children, is one of the major elements that should be addressed to ensure successful service provision outcomes through building of confidence, self-esteem and self-worth that aid in countering the negative community attitudes that are experienced by many persons with disabilities
6. Health promotion and early detection of disability is required to ensure better quality outcomes for persons with a disability requiring rehabilitation or educational services
7. Examples of good practices for mainstream and specialised services that have inclusive practices must be shared and reinforced in the region

Chapter 7. Recommendations

Stakeholders who participated in the various DMI-ME activities made recommendations with respect to ***improving access to services***, some of which have been summarised as follows:

7.1 Recommendations for Disabled People's Organisations and Service Users

1. DPOs need to establish stronger alliances among one another and build their own capacities to improve their work on rights and empowerment of persons with disabilities and emphasise the "*Nothing about us without us"* slogan. Also they could collaborate with other social and human rights movements as there are overarching issues shared by all: poverty, social inclusion, and equal distribution of resources in society.

2. DPOs need to be more inclusive of women with disabilities and persons with intellectual and hearing disabilities; giving them more space and encouraging the development of stronger capacities within these specific groups as well as within the wider disability movement. Having better availability and accessibility of DPOs with respect to rural or remote populations would also increase the effectiveness of work done in larger towns or urban areas.

3. In improving sustainability, DPOs can encourage the development of a wider grassroots level disability movement, supporting the building of a new generation of disability activists and leaders to ensure continued action of and within the disability movement.

4. Establish a code of conduct and demand better organisational capacities of DPOs so that current and future organisations operate based on a minimal set of standards that ensure transparency, accountability, inclusiveness and good governance within their organisations and for them to become better counterparts to policy-makers and other stakeholders.

5. DPOs must learn to build their own capacities for different types of work (e.g., knowledge on rights, social policy development etc.) and relations (e.g., having greater links with authorities) without having to rely on other stakeholders (e.g., international NGOs) to provide the means for them to develop their capabilities. The dependence on improved legislation may limit the development of a disability movement in the Middle East and DPOs need to be confident enough to demonstrate to each other and to other stakeholders, how to effectively promote the inclusion of persons with disabilities without waiting for the better legislation.

6. Conduct media campaigns, conferences and publish information on disability to promote a change in attitude on the issue amongst persons with disabilities themselves and the wider community.

7. DPOs should not confuse their main roles with that of service providers, whether state or private. They could provide models or initiate pilot projects of innovative services and evaluate, monitor and report on the performance of service providers and authorities.

8. DPOs need to take a more proactive approach in the training of persons with disabilities and their families regarding advocacy and campaigns for rights such as those related to the CRPD. They must demand to be included in the development of legislation and public policies and work conducted by national and international NGOs and the lobbying for more inclusive services should be encouraged and made a priority of DPOs.

7.2 Recommendations for Central and Local Authorities

1. Governments must ensure that they uphold their legal responsibility to guarantee access to social services for all groups of their population, including persons with disabilities through the promotion and protection of human rights. Policy-makers should not just consider disability a health or social problem; central bodies within the government should be established to ascertain effective coordination among stakeholders, including approaching disability from a 'whole of government' perspective and dealing with disability transversally across different ministries.

2. The implementation of and/or pending amendment to existing laws for ensuring the rights of persons with disabilities needs to be addressed by most governments in the region – including addressing negative terminologies related to disability. Ratification of the CRPD and optional protocols should be a priority for those governments that have not already done so and serve as a guide in policy development.

3. All levels of government need to contribute to the undertaking of "territorial mapping" of the demands and needs of persons with disabilities; and level of fulfilment of rights affecting persons with disabilities, developing adequate regulatory mechanisms for a social services systems that can match these demands.

4. National governments need to create sustainable funding mechanisms (e.g., from taxes and donations) for an effective and responsive social services system, including the support for quality education and livelihood opportunities for persons with disabilities.

5. National governments should take the lead in the development of regulatory mechanisms to support effective distribution of services, particularly related to geographic distribution and disability type, but also ensure that mainstream services are inclusive of the demands and needs of persons with disabilities. Standards and quality criteria need to be set by governments to make sure that service providers maintain an acceptable standard of service.

6. External monitoring and evaluation of the laws and social services need to be supported by government bodies, but conducted by third parties. Persons with disabilities and their families should be considered in setting up evaluation commissions or committees as well as in defining quality criteria and standards.

7. Development of a system incorporating a neutral entity such as the system of an *ombudsman*, to oversee monitoring effectiveness and report on breaches or complaints related to service provision (e.g., quality, discrimination or accessibility).

8. Through multi-stakeholder involvement, governments need to improve the provision of services for persons with disabilities, especially those living in rural or remote areas.

9. Authorities should develop a positive environment for interest groups as well as professional associations in general, and DPOs in particular to develop. They should facilitate for persons with disabilities to form groups that can develop into advocacy-oriented DPOs.

10. Authorities need to ensure that mainstream social services do not discriminate against persons with disabilities and facilitate the inclusion of persons with disabilities. This can be done through capacity building of staff, reasonable accommodation, provision of technical aids or support staff and addressing the negative attitudes and culture surrounding the inclusion of persons with disabilities.

7.3 Recommendations for Service Providers (public and non-public)

1. Service providers of all types should be reviewed periodically, in terms of the 4A's: accessibility, availability, affordability, accountability and quality or any other aspect of their service. An external party could do this with regular intervals and could be combined with self-review processes internally by the service provider itself.

2. Clarify the differences between mainstream, support and specific disability services amongst stakeholders in the Middle East to prioritise and more effectively develop inclusive services.

3. Improvements are needed in the ability for providers to survey the target population to better identify demands/needs of service users or potential users and link with authorities' territorial mapping of issues related to persons with disabilities.

4. Service providers should base their work on a rights-based approach and help raise awareness in full coordination with persons with disabilities about disability rights at a community level.

5. DPOs and disability experts should be consulted by service providers on disability issues, particularly in relation to strategic planning, development and monitoring of services – allowing for the real participation of service users and families in strategic decisions.

6. Up-to-date technology / methods should be considered when developing and planning service provision.

7. Service providers should coordinate more comprehensively with other stakeholders to ensure greater availability and continuity of services, smoother provision of services for persons with disabilities and minimise duplication.

8. If service providers assisted DPOs and other stakeholders in lobbying the government for better rights, policies and strategies on disability, this would support the disability movement in the region; more specifically, service providers should increase the coordination of their efforts with DPOs and build alliances / networks with such organisations.

9. Service providers should encourage the development of greater and more formal regulation of services to ensure diversity and availability of services to meet the demands of neglected and discriminated persons within the population.

10. Access to information regarding aspects of services such as costs, eligibility and complaints is a rights issue and should be available to persons with disabilities attending or considering a service.

11. Service providers are in a strong position to increase their advocacy for new types of professions to be established where they are deficient, or professional standards to be developed and implemented or even for entirely new types of services to be initiated.

7.4 Recommendations for Other Stakeholders

1. Media awareness campaigns and other forms of awareness-raising activities should be undertaken to address negative attitudes and stereotypes related to disability and success stories about persons with disabilities included in workplaces should be disseminated to encourage others to follow suit. Training on how to provide positive messages about persons with disabilities should be provided for journalists and influential opinion-makers to help change community attitudes (e.g., through arts, drama and television). Other forms of media could be used to reach persons with disabilities in remote or isolated areas to build their knowledge on their rights.

2. International NGOs working to support persons with disabilities need to be more inclusive and more sensitive to cultural specificities in addressing disability issues. The international community should be more involved in promoting sustainable funding and technical assistance to disability stakeholders – with particular attention to capacity building in less-developed areas (e.g., rural areas) or currently under-served populations (e.g., some persons with specific disabilities that are not receiving a basic level of service). International NGOs should continually evaluate the impact of projects and services funded for or about persons with disabilities. International NGOs should develop more transparent assessment tools and understanding of disability issues prior to developing or funding a project.

3. Article 32 of the CRPD highlights the need for international cooperation, specifically for development programmes, to include disability in all aspects of their work, sharing of information and supporting national efforts with respect to the CRPD, which would ensure greater participation at all levels of persons with disabilities. Facilitation of cooperative measures between various actors at national and international levels is not only appropriate and necessary; it is also legally binding at international law along with other provisions in the CRPD.

Bibliography

ADAMS, L., AXELSSON, C., and GRANIER, P. *Beyond De-institutionalization: The Unsteady Transition towards an Enabling System in South East Europe*, Handicap International South East Europe, Belgrade, 2004.

ALBERT, B., DUBE, A.K., and RIIS-HANSEN, T.C. *Has Disability been Mainstreamed into Development Cooperation?* UK: Disability KaR Programme, 2005.

AXELSSON, C., and SHARKAWY, G. *Taking a Step Forward. Views From Stakeholders on Disability Policies and Services in Egypt, Jordan and Lebanon*, Working paper, Handicap International-Middle East, 2006.

AXELSSON, C. *Ensuring the Access to Quality Social Services for People with Disabilities in Middle-income Development Countries*, Working Paper, Handicap International, 2007.

AXELSSON, C. *A Guidance Paper for an Inclusive Local Development Policy*, Handicap International, SHIA and HSO, Lyon, 2008.

BATLEY, R. *Engaged or Divorced*, Capacity.org, Issue 30, March 2007.

BAYAT, A. *Social Movement, Activism and Social Development in the Middle East,* Civil Society and Social Development Programme paper no. 3, UNRISD, 2000.

BERRY C., FORDER A., SULTAN S., and MORENO-TORRES, M. *Approaches to Improving the Delivery of Social Services in Challenging Environments,* PRDE Working Paper 3, DFID, October 2004.

BILSON, A., and GOTESTAM, R. *Improving Standards of Child Protection Services - A Concept Paper*, UNICEF Innocenti Centre and World Bank, Florence, 2003.

BILSON, A., and HARWIN, J. *Gate-Keeping Services for Vulnerable Children and Families*, UNICEF Innocenti Centre and the World Bank, Florence, 2003.

CBM. Make Development Inclusive. *How to Include the Perspectives of Persons with Disabilities in the Project Cycle Management Guidelines of the EC,* Mainstreaming Disability in Development Cooperation, CBM, Brussels, 2007.

CHIRIACESCU, D. *Ensuring Access of People with Disabilities to Social Services: The Need for Regulatory Mechanisms in South East Europe,* Working Paper, Disability Monitor Initiative, Handicap International South East Europe, Belgrade, 2006 .

CHIRIACESCU, D. *Shifting the Paradigm in Social Service Provision, Making Quality Social Services Accessible for People with Disabilities in South East Europe,* Disability Monitor Initiative no. 3, Handicap International South East Europe, Belgrade, 2008.

CHPI and SAFCD. *The Child Health Policy institute and the South African Federal Council on Disability,* 2001.

CLARK, J. *Social Movement Theory and Patron-Clientelism: Islamic Social Institutions and the Middle Class in Egypt, Jordan and Yemen,* Vol.37, No.8, 941-968 (2004).

COLERIDGE, P. *The Social Fund for Development Yemen. Disability Programme Strategy 2004-8.*

DFID. *Disability, Poverty and Development,* DFID, UK, 2000.

DFID. *Civil Society and Good Governance.* A DFID Practice Paper, September 2007.

DISABILITY MONITOR INITIATIVE – MIDDLE EAST JOURNAL. A view from the Middle East of the entry in force of the Convention on the rights of persons with disabilities, launching issue, 2008.

- *CRPD. A Regional Perspective*: Interview with Dr. Nawwaf Kabarra, President of Arab Organisation of Disabled People, Lebanon.
- *The Responsibility of the Disability Movement to Promote the Convention; the Limited Choices*: Interview with Ms. Sylvana Lakis, President of Lebanese Physical Handicapped Union, Lebanon.
- *Forestalling Initiative and Optimistic Future*: Interview with Dr. Hmoud Olimat, Secretary general of the Higher Council for the Affairs of persons with disabilities, Jordan.
- *CRPD Yemini Context*: Interview with Ms Raja Al-Musabi, Chairwoman of the Arab Human Rights Foundation, Yemen.
- *Towards the ratification, constitutional barriers and gaps to be bridged:* Interview with Ms Corinne Azar, Director of the Disability Directorate in the Ministry of Social Affairs, Lebanon.

DISABILITY MONITOR INITIATIVE – MIDDLE EAST JOURNAL. Social protection and persons with disabilities in the Middle East: issues, challenges and debates, Issue 1, February 2009.

- CANAWATI, R. *Health Insurance for Persons with Disabilities: Real Practices or Pure wishes? Views from Public Official, Jordan, and Civil Society Palestine*.
- AL-AHAMADI, A. *Can Cash Transfers Reduce Inequalities for Persons with Disabilities*.
- CÔTE, A. *Gate-Keeping: Urgent Need for Reform to Ensure Fair and Effective Access to Social Protection Entitlements.*

DISABILITY RIGHTS COMMISSION, Changing Britain for Good of Public Policy, <http://83.137.212.42/sitearchive/drc/pdf/focus21pdf.pdf> as at 20 July 2009.

ELWAN, A. *Poverty and Disability: A Survey of the Literature*, Social Protections Discussion paper Series, World Bank, Washington, 1999.

ESCWA. *Towards Integrated Social Policies in Arab Countries:* Framework and Comparative Analysis, United Nations, New York, 2005.

EUROPEAN COMMISSION:

- *Draft Joint Report on Social Inclusion; Part I – The European Union*,Commission of the European Communities, COM(2001) 565 final, 2001.
- The Green Paper on Services of General Interest, COM(2003) 270 Final, 2003
- *Implementing the Community Lisbon Programme*, Social Services of General Interest in the European Union, COM(2006) 177 Final, 2006.
- Services of General Interest, Including Social Services of General Interest: a New European Commitment, COM(2007) 725 Final, 2007.
- Disability High Level Group. *Quality of Social Services of General Interest* (SSGI), Disability High Level Group Position Paper, 2007.

EUROPEAN UNION. *Guidance Note on Disability and Development for EU Delegations and Services ,* 2004.

FOUGEYROLLAS, P., CLOUTIES, R., BERGERON, H., COTÈ, J., and ST MICHEL, G. *Quebec Classification: Disability Creation Process*. International Network on the Disability Creation Process. http://www.ripph.qc.ca/

GRAMMENOS, S. *Illness, Disability and Social Inclusion*, European Foundation for the improvement of working and living conditions, Dublin, 2003.

GRUT, L. and INGSTAD, B. *This is my life – Living with a Disability in Yemen.* A qualitative study for the World Bank, SINTEF Health Research, Trondheim, 2006.

GUERNSEY, K., MARCO NICOLI, M. and NINIO, A. Making Inclusion Operational. Legal and Institutional Resources for World Bank Staff on the Inclusion of Disability Issues in Investment Projects, World Bank, Washington DC, 2006.

MKANDAWIRE, T. *Social Policy in a Development Context*, UNRISD, Geneva, 2001.

MINISTRY OF PLANNING PALESTINE. National report on integrated social policy in Palestine 1994-2008, 2009. http://www.mop-gov.ps/web_files/ conference_file/Executive%20Summary,%20Eng.pdf

MUNDAY, B. *User-Involvement in Personal Social Services*, University of Kent UK, with the assistance of the Group of Specialists on User Involvement in Social Services adopted by the European Committee for Social Cohesion (CDCS), UK, 2004.

MUNDAY, B. *Integrated Social Services in Europe*. A report prepared for the Council of Europe, September 2007.
OXFAM and WATER AID. In the Public Interest. Health, Education, and Water and Sanitation for All, Oxfam International, Oxford, 2006.

PARIS DECLARATION ON AID EFFECTIVENESS, 2005. www.oecd.org/dataoecd/11/41/34428351.pdf

SHUGAALDEEN, J. *A Report on the Situation of Disabled Children in Yemen*, Social Fund for Development, 2008.

SOCIAL WATCH, *Rights is the Answer*, Social Watch Report 2008, Montevideo, 2008.

THEISOHN, T. *Using Accountability relationships to support capacity,* Capacity.org, April 2009.

UNICEF. The Situation Analysis of Palestinian Children, Young People and Women in the West Bank and Gaza Strip, August 2000.

UNDP. *International Cooperation at a crossroads: Aid,* trade and security in an unequal world. World Development Report 2005, New York. 2005.

UNDP. *Challenges to Human Security in the Arab Countries*, Arab Human Development report 2009, Beirut, 2009.

UN CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES, http://www.un.org/disabilities

UN DEPARTMENT OF ECONOMIC AND SOCIAL AFFAIRS, *United Nations Millennium Development Goals Report 2008*, United Nations, August 2008.

UN ENABLE, RIGHTS AND DIGNITIES FOR PERSONS WITH DISABILITIES, http://www.un.org/ disabilities/ as at 30 July 2009.

UN GENERAL ASSEMBLY REPORTING GROUP, *Fifth Quinquennial Review and Appraisal of the World Programme of Action Concerning Disabled People*, United Nations, July 2008.

UN OFFICE FOR THE COORDINATION OF HUMANITARIAN AFFAIRS. *Review of the Humanitarian Situation in the occupied Palestinian territory for 2004*. OCHA occupied Palestinian territories, 2004.

UN SOCIAL AND ECONOMIC COUNCIL. *Enhancing Social Protection and Reducing Vulnerability in a Globalizing World.* Report of the Secretary General, E/CN.5/2001/2, Geneva, 2001.

UN Standard Rules on the Equalization of Opportunities for people with disabilities, http://www.un.org/esa/socdev/enable/dissre00.htm

UNRWA. Health Report, 2008.

UN World Programme of Action Concerning Disabled Persons, http://www.un.org/documents/ga/res/37/a37r052.htm

WIMAN, R., VOIPIO, T., and YLÖNEN, M. *Comprehensive Social and Employment Policy for Development in a Globalizing World*. Report based on an Experts' Meeting at Kellokoski, Finland, November 1-3, 2006, Ministry of Foreign Affairs and Ministry of Social Affairs and Health and STAKES, Finland, 2007. www.stakes.fi/social-policies-for-development

WHO, *International Classification of Functioning, Disability and Health*, http://www.who.int/classifications/icf/en/

WORLD BANK. *Better Governance for Development in the Middle East and North Africa: Enhancing Inclusiveness and Accountability,* World Bank, 2003.

WORLD BANK, *Disability and Development and the World Bank*. A Briefing Summary on February 2, 2005.

WORLD BANK. *Making Services Work for Poor People,* World Bank and Oxford University Press, 2003.

WORLD BANK, *People with Disabilities in India: From Commitments to Outcomes*, Human Development Unit South Asia Region, World Bank, 2007.

WORLD BANK. *A Note on Disability Issues in the Middle East and North Africa,* Human Development Department Middle East and North Africa Region, World Bank: 2005.

YEO, R. *Chronic Poverty and Disability.* Chronic Poverty Research Centre, Background paper no. 4, Action on Disability and Development (ADD), UK, 2001.

YEO, R. *Disaiblity, Poverty and the New Development Agenda,* Disability KaR programme, UK, 2005.

POLICY PAPERS DEVELOPED WITHIN THE MUSAWA PROJECT, Handicap International, 2009:

- BLAL, T. *Impact of Social policies on the Situation of Persons with Disabilities in terms of Equal Access to Work, the Effectiveness of the Policy of Employment Adopted by the State and Legislation Pertaining to Employment of Persons with Disabilities,* Unpublished policy paper, 2009.
- SALEH BIN SHAEB, R. *Inclusion of the Visually Disabled in Basic Education*. Unpublished policy paper, 2009.
- AL-KABZARI, H. Health Rehabilitation for Girls with Hearing Disabilities in Yemen. Unpublished policy paper, 2009.
- ISMAIL, H. *No Disability with the Access of Persons with Visual Disabilities to Livelihoods and the Right to Employment*, Unpublished policy paper, 2009.
- ABED EL-MATLAB, A. *Policy of Employment of Women with Disabilities in Jordan / Reality, Challenges and Aspirations*, Unpublished policy paper, 2009.

ANNEXES

ANNEX 1. The DMI-ME Good Practice Award

Disability is increasingly being recognised as a human rights issue rather than a medical one. Disabled persons and organisations who represent them have been the primary advocates for this shifting paradigm, culminating with the taking effect of the Convention on the Rights of Persons with Disabilities (CRPD) at the international level.[148] With 140 signatories and 62 ratifications[149], the CRPD now places on national governments the responsibility to implement policies that support the full participation of persons with disabilities in society as well as their equal access to quality, inclusive services. Whilst this obligation is evident, policy formulation is complex, with competing interests, limited resources and politics influencing or impeding the process. Particularly in developing countries, it is recognised that policy formulation often occurs too far from the intended point of impact, excluding the very people who can ultimately effect positive social change at the community level.[150]

The situation for many persons with disabilities, particularly those living in some countries in the Middle East,[151] will not improve significantly unless changes are made to the policies and services affecting their lives.[152]

There are major gaps between the standards set by the CRPD and the reality on the ground for persons with disabilities. Many governments lack quality, evidence-based information about what actually works at the community level and this is a major barrier to creating policies that will foster inclusive, accessible services and improve the quality of life of persons with disabilities. Even persons with disabilities who belong to a Disabled Person's Organisation (DPOs) often do not possess the needed expertise to develop and undertake constructive advocacy with governments; thus, rarely, becoming effective and relevant actors in the policy-making process. The Middle East is not immune to these obstacles of top-down policy-making and limited political engagement of civil society.

The activities of the Disability Monitor Initiative-Middle East (DMI-ME) aim to address these issues from the bottom-up, bringing together experts and service users from the community level to capture and exchange good practices, serving as an instrument to influence policy change. Through this initiative of sharing knowledge of good practices, disability activists will be given more opportunities to engage in constructive dialogue with policy makers on initiatives and efforts that are effective in improving their situation.

Social Services in the Middle East

The provision of basic services has been identified as a central task in poverty reduction and the achievement of the Millennium Development Goals.[153] The United Kingdom Department for International Development (DFID) defines service delivery as the relationship between policy makers, service providers and poor people.[154] The concept of social services can also be viewed in terms of a narrow or broad perspective - with the former relating to personal

148 United Nations Enable, Rights and Dignities for Persons with Disabilities, see: http://www.un.org/ disabilities/default.asp?id=1423 24 July 2009.
149 United Nations Enable, Rights and Dignities for Persons with Disabilities, see: http://www.un.org/ disabilities/ 30 July 2009.
150 Theisohn, Thomas, Using Accountability relationships to support capacity, Capacity.org, April 2009.
151 The World Bank, http://web.worldbank.org/WBSITE/EXTERNAL/DATASTATISTICS/ 0,,contentMDK:204204 58~ menuPK:64133156 ~pagePK:64133150~piPK:64133175~theSite PK:239419,00.html as at 21 July 2009
152 Disability Rights Commission, Changing Britain for Good of Public Policy, <http://83.137.212.42/ sitearchive/drc/pdf/focus21pdf.pdf> as at 20 July 2009 and Berry, C., Forder, A., Sultan, S., and Moreno-Torres, M., Approaches to improving the delivery of social services in challenging environments, PRDE Working Paper 3, DFID, October 2004.
153 Berry, C., Forder, A., Sultan, S., and Moreno-Torres, M., Approaches to improving the delivery of social services in challenging environments, PRDE Working Paper 3, DFID, October 2004.
154 Ibid.

domains such as social security and personal care assistance and the latter pertaining to health and education, which have additional functions related to social cohesion.[155]

The Middle East is a diverse landscape with an equally diverse political and social matrix that influences the way people interact with each other and their governments. Although there are some similarities in the situation for persons with disabilities across the region, there are also marked differences due to the multiplicity of cultures and political structures. In some countries for example, the unstable political situation limits the ability for long-term strategic planning with regard to inclusive legislation and policy planning. In others, the large rural population creates very specific issues that need to be addressed at the community level rather than by a centralised government located in the capital city. Whilst in other countries still, there is a real need for DPOs to develop a **strong voice** in order to effectively influence change from a bottom-up perspective.

DMI-ME Research on Good Practices: The Competition

To facilitate the collection of research on good practices, the DMI-ME team decided to conduct a regional competition, which the Steering Committee deemed would provide significant momentum to the project. Also, it was a way to engage disability stakeholders on the importance of sharing knowledge and good practices. More importantly, it would increase the likelihood of participating service providers to be open to discussion and suggestions.

Moreover, the prize from the contest was expected to serve as a material incentive for service providers to participate in the project. Winning organisations stand to gain a 1,500euro contribution to their cause, significant media coverage and free airfare to and accommodation at a Regional Disability Conference.

Conducted in the years 2008 and 2009, the contest was held in only five of the seven countries involved in the DMI-ME project, these are: Jordan, Lebanon, Yemen, the occupied Palestinian territories and Egypt, which were chosen mainly with the limited resources available to the project taken into consideration. Service providers for persons with disabilities in the fields of health, education, livelihood opportunities and social protection were invited to submit applications that demonstrate their good practices. The DMI-ME received almost 30 applications from across the region; the number was shortlisted to 23 service providers eligible to join the competition. Short listing was done on the basis of the eligibility criteria set by the DMI-ME Steering Committee regarding the size of the organisation (personnel and financial capacity) and the sector of social services provision (health, education, livelihood opportunities and social protection).

After a shortlist was drawn, visits were made to observe the selected service providers to obtain documentation about their facilities, observe good practices and meet with some of the users. The team of assessors consisted mostly of persons from the Middle East involved in service provision for persons with disabilities. Each assessor performed at least one evaluation with the DMI-ME Project Coordinator to ensure consistency in fieldwork research and appropriate interaction with the service providers.

Upon completion of their assessments of service providers across five countries, the assessors met with a panel of regional experts to present their recommendations and discuss the findings. Members of the expert panel, with their extensive experience as service users

155 Chiriacescu, Diana, *Ensuring Access of People with Disabilities to Social Services: The need for regulatory mechanisms in South East Europe,* Working Paper, May 2006, Disability Monitor Initiative South East Europe.

or providers/managers in the region, decided on the winners of the Good Practice Awards. Their decision was based on the assessors' evaluations, recommendations and validation provided by the DMI-ME Steering Committee.

Some difficulties were encountered in validating the judges' decisions, as it became clear that identifying good practices in service provision for persons with disabilities in the region is not just about recognising who has the most qualified staff, resources or capacity, it is also about philosophy, transparency and the ability of the providers to acknowledge the need to put the service user at the centre of the process, modify their services for them and address their demands. This last set of criteria, though a little more complicated to define, is equally important as the service provider's resource use and technical capacity.

Eventually, seven winners from across the region were selected. All applicants that were assessed, including the winners, were given formal feedback on how to improve their practices to make them more acceptable for persons with disabilities. Award ceremonies attended by local and national dignitaries took place in each participating country. Many stakeholders indicated great interest and willingness to continue to develop activities that aimed to improve service delivery to persons with disabilities, in line with principles of the CRPD.

Future plans

There are plans to further refine the good practice tool and engage service providers at the national and local levels so they can have information on ways to improve their service in line with the CRPD and allow greater participation of and choice for persons with disabilities. As the DMI-ME activities continue, tools developed and feedback gathered from their users will contribute to efforts of the disability movement in the region. It is anticipated that it will be much easier for activists in the Middle East to lobby successfully about good practices in the region, than to try and advocate that governments adopt service provision practices or even policies from more distant countries in Europe, Asia and the Americas.

DMI-ME Good Practice Award Winners

Name of Organisation	**Palestinian Red Crescent Society (PRCS) Rehabilitation Centre, Khan Younis** Headquarters – Al-Bireh, West Bank Tel: 02-9986515,6,7 Fax:02-9986518
Country	Gaza, Palestinian Occupied Territories
General services provided	Generally, the PRCS is well-known for its medical and health services, which impact positively on the lives of thousands of persons with disabilities. More extensive services offered by the PRCS include rehabilitation, education, vocational training, recreation, medical and other social programs for persons with disabilities or people with injuries.

Good practice area submitted	There are four units of the Rehabilitation Centre at the PRCS Al-Amal that were submitted for judgment in the competition: • Parent and Baby Program – offers early intervention and skills for parents to manage at home and facilitate the development of their child with a disability • Special kindergarten – includes a program for children who can be enrolled in mainstream school settings and a program for children who are unlikely to attend a mainstream education setting in Gaza. The kindergarten is registered with the Ministry of Education and other units are likewise certified by the Ministry of Social Affairs. • Special training programs for children with multiple and severe disabilities – home visits or centre-based activities are provided in the areas of life skills and activities of daily living. • Vocational training – centre-based activities with links to community training, skills for writing, money management and daily living
Good practices	• Availability Good availability for children; with good, sustainable institutional support from the larger PRCS and additional project funding from other donors; outreach service to make assistance available to more isolated areas of the southern Gaza strip for users that would otherwise be unable to travel to the centre; good referral links with other organisations • Affordability No fees for the services and only nominal fees are charged to users of physiotherapy or speech therapy services and a bus service to the centre • Accessibility Good physical accessibility with ramps, elevators and adapted toilets; a high proportion of teachers use sign language, volunteers with disabilities were present and sign language interpreters were available; over 10 percent of the staff in these units had some form of disability; general policy of PRCS of non-discrimination, equality and fairness; no policy on non-discrimination or employment of staff with disabilities but practice evident
Good practices	• Accountability Good involvement in the community with various social activities organised with service users, their families and the wider community; the community, users and their families are consulted regarding the services, but not with a strategic approach to service development or implementation

	• Quality The centre developed a good technical level for their units, especially considering the isolation experienced in Gaza; there is a comprehensive training course for rehabilitation workers, which reportedly "fills the gap" in having outreach disability staff for persons with disabilities unable to access centre-based professional services • General – overall comments The outreach program and existence of a comprehensive set of services based in the centre is a very positive aspect for this service in southern Gaza, one of the most challenging environments for a person with a disability in the Middle East to be in; an openness to changing the practices / writing more policies and procedures, with closer consultation with users were demonstrated

Name of Organisation	**The Regional Committee for Community Based Rehabilitation (CBR) – Southern Region of West Bank (Bethlehem and Hebron Districts)** CBR Office Beit Jala Palestine TEL.FAX: 02-2767796 Email :cbrsouth@palnet.com
Country	West Bank, Occupied Palestinian Territories
General services provided	This service is under a legal umbrella of a coalition of non-government organisations comprised of the Bethlehem Arab Society for Rehabilitation (BASR), Palestinian Red Crescent (PRCS) and Health Work Committees (HWC). The range of activities undertaken include home visits for persons with disabilities; facilitation of the integration into vocational training centres and mainstream schools for children with disabilities; adapting schools and houses for physical accessibility; provision of technical aids and referral to various health and rehabilitation services.
Good practice area submitted	Outreach rehabilitation services
Good practices	• Availability Selection of target group is flexible, depending on project funding, resources and local demand; statistics and information about the target population were put to good use; surveys conducted prior to starting work to set priorities; ensured limited overlap with other service providers because of the corresponding services in Central and Northern Palestine; offers subsidised transport to large referral centres if required and rural services are continually being developed; psychiatric referrals exist (however there is limited expertise in this area) with improving knowledge of autism/learning disability; secured commitment from larger supporting organisations to continue CBR if funding becomes restricted

	• Affordability No cost for services; minimal cost for summer camps or other special events; subsidised transport available for some users if needing referral to larger centres; no equipment rental scheme for users but they must wait for equipment from larger centres • Accessibility Some municipal offices are reportedly accessible, but most services are home-based, not centre-based; some volunteers have a disability while most of the staff employed do not; mix of religious denominations in the office, with no gender/religion discrimination demonstrated
Good practices	• Accountability Demonstrated good file management and financial/accounting processes; limited strategic input from service users/community members • Quality Treatment plans are developed with family and professionals; good networks with other disability stakeholders and complementary service providers; good input in regional networks and training activities • General – overall comments The CBR service is a good model for service delivery in the occupied Palestinian Territories due to the limitations of people accessing services; restricted transportation; and the political implications on infrastructure and the rural population. The backing of the three larger institutions ensures a good degree of sustainability of activities and that the service would be improved with increased user-involvement and linking with DPOs.

Name of Organisation	**Community-Based rehabilitation Association (CBRA)** Al-Badawi - Al-Jabal - facing the northern entrance of the camp northcbr@yahoo.com
Country	Lebanon
General services provided	The organisation is now located at Al Badawia camp; it started in 1991 at Naher Elbared Camp as a rehabilitation and training centre, providing social and academic training. In 1997, CBR projects started and the CBR committee established. In 2006, it was legally registered as Lebanese association with License no. 440\Ed working on: • Academic and vocational integration program • Advocacy, awareness and training • CBR • Special education program • Physical, occupational and speech therapies • Geriatrics and stroke rehabilitation • Psychosocial support

	• Supporting groups • Referral system • Relief work
Good practice area submitted	• Academic and vocational integration program • Advocacy groups and training • CBR • Special education program • Advocacy, awareness and training • Physical, occupational and speech therapies • Referral system
Good practices	• Availability The association has clearly defined a target population and geographical areas; it strives to keep an updated database of all persons with disabilities in the area; simple outreach services depend on funding sources, with good ability to efficiently allocate resources and promote itself in the local community. They have developed partnerships with complementary service providers and the semi-public sector. • Affordability The association presents good affordability measures with minimal sliding- scale fees, rental scheme and simple outreach services • Accessibility The association participates in awareness-raising initiatives to reduce the physical barriers for persons with disabilities in the community. As much as 10 percent of employees have disabilities, though there is no policy for PWD employment. The association tries to develop a philosophy of non-discrimination. • Accountability Has a working supervisory board, which includes persons with disabilities; listed legally as a Lebanese Association and there are audits (i.e., financial audit) by Lebanese authorities in relation to this • Quality The association participates in a network of stakeholders in the disability field; has a good file management system with a fair users-centred approach; there is a good staff performance system and it tries to ensure the safety and protection of vulnerable persons from abuse • General – overall comments The association possesses the good ability to reform itself after its destruction; and to cope and exist in camp circumstances; they have a good outreach service and the capacity to meet the demands of users, especially after the disaster (i.e., camp destruction); psychosocial support services were designed to meet the demands of the community it served

Name of Organisation	**Egyptian Centre for Knowledge Building and Creative Child** 142 Jalal Al-Dessouki, Waboor El-Mayyah - Bab Sharq - Alexandria m_ebed@yahoo.com Tel: 0123992044
Country	Egypt
General services provided	The centre was founded in 2000 and it took on many distinct and successful educational services and projects to raise the awareness of the society on education issues of children with disabilities and learning difficulties. • Rehabilitation services for children with learning difficulties • Support services for mainstreaming children with learning difficulties in public schools • Counselling services for families • Training courses to staff in other centres and schools • Awareness-raising campaigns in the field of education
Good practice area submitted	• Rehabilitation services for children with learning difficulties • Support services for mainstreaming children with learning difficulties in public schools • Counselling services for families • Awareness-raising campaigns in field of education
Good practices	• Availability The association has a clearly defined target group but not geographical areas. Its ability to maintain sustainable funding and resources from grants and income from services is quite good. Services are provided to a group within the population that is known to be under-served (i.e., children with learning difficulties); with good ability to promote themselves and forge partnerships with others • Accountability Working procedures are documented to act as accountability and evaluation references • Quality The association participates in a network of stakeholders in the disability field and has a good file management system with a fair users-centred approach. They have a good staff performance system and try to ensure the safety and protection of students from abuse. • General – overall comments The organization is a good example of working on inclusion of persons with disabilities through the provision of special services and support services for mainstreaming. From a professional perspective, they network with other service providers for cooperation and capacity building.

Name of Organisation	**Arab Episcopal School – Irbid** Al-Barha Street, Irbid, Jordan Tel. 02 / 7275572 www.aeschool.org
Country	Jordan
General services provided	• Kindergarten • School for children until the sixth grade • Mainstreaming program for children with visual impairments in kindergarten and schools
Good practice area submitted	• The Church provides social services to teach and integrate the blind and visually-impaired children and address issues related to isolation. It supports opportunities to teach and include children within the local community.
Good practices	• Availability The target population is very clearly defined; they are well-known to provide educational opportunities for blind children between the age of four (4) and thirteen (13). Transportation is offered for free to most blind students except the ones living in very far areas outside Irbid. They are the only school in the whole area that includes blind children in regular classrooms. • Affordability The school fees for blind students are supported by the church and partially from the Al Dia Charity Association. Blind students do not have to pay any fees for educational services. • Accessibility The school is quite accessible for blind children; there are Braille signs, special floors at the steps' edges, Braille books, some screen readers and other similar devices; there are safety rails, but it is not accessible to wheelchair users in all the facilities; all the educational materials are in Braille format for the children; the work environment is suitable for blind employees; currently, they have five (5) teachers who are blind and are capable to use the facilities efficiently • Accountability They have an anonymous complaints system; there is a form where families can fill and put in a box at the school • Quality The school's inclusion program is a good example of the inclusion of children with disabilities in regular schools. They build students' plans based on consultations with families, medical teams and other national NGOs working in the same sector. A variety of innovative

	and required services are present in this high demand environment. There is a very good security of information and filing system. Capacity building for teachers are conducted regularly • General – overall comments The practice of the school is a good model for the mainstreaming of children with disabilities in schools; many lessons can be gleaned from their experience; their case is a strong advocacy tool to prove that implementation of inclusive policies is not difficult if there is a will to do it and commitment to see it through

Name of Organisation	**Yemen Association for Landmine and UXO Survivors** Sana'a, Jarraf neighborhood, next to the Al Thawra Stadium, P.O. Box 25143 Telefax: + 967-1-336862 Email: saleh0096@hotmail.com
Country	Yemen
General services provided	A DPO and a service provider with all of its members, survivors of landmine and associated injuries. Services provided are: • Vocational training • Rehabilitation • Income-generating projects • Inclusive education
Good practice area submitted	Inclusion of landmine victims and survivors, young males and females alike, in public schools and universities
Good practices	• Availability Good database on relevant factors on the issues (i.e., locations of landmines and survivors) with a well defined target group • Affordability Free services due to good financial support of the government • Accessibility A facility of one main centre in Sana with six other satellite centres in different districts, all with physical accessibility features • Accountability Policy and procedures are documented and demonstrated • Quality There is a committee for inspection and follow-up, composed of three members who are not in the board of the organisation

	• General – overall comments It is an innovative and inspirational organisation that addresses a critical problem in Yemen. The organization has effective networking with the concerned local authority and the international bodies and efficiently utilises its financial resources.

Name of Organisation	**Abu Jihad Al-Wazir Institution for the rehabilitation of the disabled**
Country	Lebanon
General services provided	The organisation located at Tyre/Al-Rashidieh camp started in 1989 as a committee for Palestinian refugees with disabilities, which was supported by UNICEF, UNRWA and the PLO. The rehabilitation institution was eventually established and was expected to provide: • Educational support services for children with mental disabilities ages 3-6 years in the kindergartens and UNRWA schools • Educational special services for children with mental and visual disabilities ages 4 to 15 years old • Vocational courses for persons with disabilities ages 15 and above o Woodcrafts and handicrafts o Maintenance of wheelchairs and prosthetic devices o Sewing wool, mirror carving, canvas embroidery o Electronics (radio and TV) sessions • Cultural and recreational services for all ages • Assistive devices loan program • Social research services
Good practice area submitted	• Educational support services for children with mental disabilities ages of 3-6 years in the kindergartens and UNRWA schools • Educational special services for children with mental & visual disabilities ages 4 to 15 years old • Vocational services for persons with disabilities ages 15 and above • Assistive devices loan program • Social research services
Good practices	• Availability The association has a clearly defined target population and geographical areas; it has established a social research centre to keep an updated database of disability issues in the area; offers free transportation, and promotes itself in the local community. They have developed partnerships with complementary service providers and the semi-public sector.

	• Affordability The association presents good affordability mechanisms, with minimal fees and a sliding scale to determine costs, rental schemes and free accessible transportation • Accessibility The association has worked on its accessibility in terms of information, physical infrastructure and location (i.e., the centre's availability to users); they provide accessible transportation; as much as 75 percent of its workforce are persons with disabilities, though there is no policy for persons with disabilities and employment. The association tries to develop a philosophy of non-discrimination • Quality The association participates in a network of stakeholders in the disability field and has a good file management system • General – overall comments The association managed by persons with disabilities possess a positive attitude and motivation; although they have a high and complex security context, the service provided is strong and stable, particularly the outreach service and the program of involving persons with disabilities in the society; they do have weak resources but try to cover most of the users within their means

The Remaining Good Practice Award Applicants

Country	Organisation	Service	Address
Egypt	The Egyptian Association for the Care and Rehabilitation of the Deaf, Blind and Other Disabled Persons	Rehabilitation for people who are deaf, blind, and other disabilities	24 S. Abdel Rahman Mohamed El Ishrin, Faisal, El Giza, Egypt Deafblind.partner@gmail.com
	KAYAN Society for Persons with Special Needs	Rehabilitation of children	12 Mohammad Shalabi Street – Egypt & Sudan Al-Qubbah Gardens, Cairo www.kayanegypt.com
	NAS Association For Persons with Disabilities,	Education, advocacy for rights of persons with disabilities, family counselling, rehabilitation, and organization of conferences	22 Al Abour Buildings, Salah Salem Street, 13th Floor, Apt. #6, Cairo, Egypt Tel: 202 – 24049029, 202-24027057 Fax: 202-24027047 Email: nascenter@hotmail.com

	Social Care Institution	Care, education and rehabilitation of persons with multiple disabilities. It is also a centre for physiotherapy.	3 Um Al-Abtal Street, Al-Talibiyyah, Al-Haram, Al-Jeezah Nadia_Mona64@yahoo.com
	Menara Centre for Special Needs - Menouf	Training and Rehabilitation Centre	Al Madaress Street, Menouf, Menoufiya, Egypt menaracenter@yahoo.com
	NIDA Society for Rehabilitation of Deaf and Partially-Deaf Children	Education and rehabilitation	30 Omar Zafan Street, Branched from Al-Tayaran Street Nasr City – Cairo, Egypt nidasociety@hotmail.com
	St. Anasimon Society for Social Services	Vocational training, computer courses, languages and employment	9 Hassan Bahgat Street - Khulusi Duran Shubra, Cairo Street_ anasemoncenter@yahoo.com
	True Light Society for the Blind and Visually-impaired	Teaching Braille method, health, community-based rehabilitation (CBR), community awareness	Crossroad of the Al Oubour and Al Khoulafaa Streets, Ard Sultan, Minya, Arab Republic of Egypt POB: 31 Minya provinceTel & Fax: 0020862334939 mrattalla@yahoo.com
Country	**Organisation**	**Service**	**Address**
Jordan	Al-Dia Charity Association for Teaching and Educating Children with Visual Impairments	Education and Rehabilitation	The Hashemite Kingdom of Jordan – Amman – El Jawza› Street – Apt. 12B – PO Box 961357 – Zip Code: 11196
	Jofeh Community Rehabilitation Center "Saleem Inn"	Early intervention and early special education Societal awareness and family guidance Care and rehabilitation Professional training and employment Treatment services	PO Box 15, 19110, Jordan Tel: 05-3591575 Mobile : 079-5523022 Fax : 05-3591576 yousefrizik@wanadoo.jo

Country	Organisation	Service	Address
Lebanon	Al Karamah Association For Palestinian Disabled in Lebanon	Rehabilitation, education, treatment, cultural and social assistance	Saida Ain el-Hilweh Camp, Upper Street, Jabal El Halib, Lebanon karamah_dis2000@hotmail.com
Country	**Organisation**	**Service**	**Address**
Palestine	Al Khader Charitable Child Care Society	Education, rehabilitation, recreation, awareness	Al Khader City Old Town, Al Madariss Street, Bethlehem alkhadersociety@yahoo.com
	An-Najah National University	Education	Omar Bin A-lkhattab Street, Nablus, Palestine Tel. 0097292394960 Fax 0097292345982 info@najah.edu
	Jasmine Charitable Society for Care of Children with Special Needs	Services of care, rehabilitation and treatment of children with special needs (i.e., mental disability)	Palestine, Ramallah Al-Bira, Al-Shurfah Main Jerusalem Street, Opposite Effel Sweets jasminesociety@palnet.com infor@jasmine.ps www.jasmine.ps
	Local Committee for Rehabilitation of the Disabled	Basic education, health and social services, rehabilitation of private and public utilities, free assistive devices, winter and summer camps, as well as awareness services	Bethlehem – Deheishe refugee camp, near the Relief International Agency Tel./fax: 02.2765033 Local_Committee1988@hotmail.com
Country	**Organisation**	**Service**	**Address**
Yemen	Attahadi (Facing Challenges) Association for the Rehabilitation of Yemenite Girls with Disabilities	Providing education, training and rehabilitation for women with disabilities	Sanaa-Baghdad Street, near Amal Bank Tel: 00967445270 Fax: 009671445433 Mobile: 00967733772983 P.O. Box: Sanaa 1116 Tahadi1998@gmail.com

ANNEX 2. International legal instruments and disability in the Middle East[156]

International legal instruments and disability in the Middle East

In the last two decades, the disability arena has witnessed various changes regarding the concepts and approaches that influence disability issues. The World Health Organization has taken an initiative to classify disability according to more inclusive means that account for environmental barriers as the main factors that create a disabling situation. This work has resulted in the International Classification of Functioning, Disability and Health (ICF)[157]; since its adoption, there have been attempts to minimize the medical factors or at least to strike a balance among environmental, social and attitudinal barriers have taken place at the international level.

The development of the United Nations Standard Rules on the Equalization of Opportunities for Persons with Disabilities was another step aimed at constituting a better understanding of disability based on rights and participation. Hence, we may argue that "according to this instrument" social services represent one of the manifestations of enjoying the related basic rights and fundamental freedoms and exercising them on an equal basis with others.[158] This definition can be extrapolated from the provisions that refer to ensuring equal opportunities and equality of rights through an accessible environment, free from any type of barrier or obstacle.

Though the UN Standard Rules have global characteristics, there is a serious flaw that makes this international instrument rather inefficient: its non-binding status. These rules are not more than recommendations issued by the General Assembly to advise national decision-makers on how to draft disability policies and action plans; but because of this limitation, they have been trivialized as nothing more than simple suggestions, its significance and urgency lost. In response to this flaw, the global disability movement, together with some UN member-states, mobilized their efforts to persuade the international community to adopt an internationally binding treaty in which the rights of persons with disabilities were respected. It is apparent that the CRPD has rewarded the efforts of the international community by enhancing the enjoyment of the basic rights of persons with disabilities on equal bases with others.

Middle Eastern countries are not far from all these developments; specifically the radical shift from the medical approach to a rights-based one, in addition to the increasing participation of stakeholders in decision-making processes pertaining to their welfare. One of the strange paradoxes is that while the non-binding status of the UN standard rules is a real challenge for this instrument as explained above, it seems that the binding characteristic of the CRPD is a critical point for Middle Eastern countries as it tends to assume full compliance with the principles and detailed provisions of the convention. This imposes on States Parties significant amendments in their legislation and serious adoption of inclusive policies in which disability social services are embedded and mainstreamed.

The following table provides examples of national legislation from different sectors in the region.

156 The text has been written by Dr Muhannad Al Azzeh, Regional Disability Rights and Advocacy Coordinator, Handicap International.
157 (http://www.who.int/classifications/icf/en)
158 (http://www.un.org/esa/socdev/enable/dissre00.htm)

EMPLOYMENT

Current Provisions

The main measure to promote employment for persons with disabilities is the quota.

Law number 31/2007 on the Rights of Disabled Persons in Jordan states that four percent of the workforce in public and private sectors should be comprised of persons with disabilities. In the private sector, employers with from 25 to 50 employees have to hire at least one worker with a disability; when staff count is above 50, quota should be 4 percent.

Law # 39/1975 on Rehabilitation of the Disabled: Egypt sets the quota to five percent for both the public and private sectors.

Articles 7/8 from this law and Articles 11/14 from the Unified Labour Law # 12/2003 organize specific provisions related to rehabilitation certificates and related records. This certificate can be considered as a gate-keeping tool because one of the legal requirements for persons with disabilities is to be hired or employed, with some exceptions. It is through these exceptions that employers can accept job applications apart from labour offices' records and notifications. In all cases, employers are obliged to notify the Labour Office about the workers with disabilities they have hired.

Law # 61/1999 on the Welfare and Rehabilitation of Disabled People, Yemen states that the quota is five percent in the public and private sectors (Articles 18/19). This law contains provisions on a rehabilitation certificate and which persons with disabilities access employment (Articles 15/17). Article 14 contains provisions that give preference to persons with disabilities in micro-enterprises, loans and promotion of marketing of their products.

Law 220/2000 on the Rights of Disabled Persons, Lebanon states that the quota is three (3) percent in the public and private sectors. In the private sector, the minimum personnel threshold of an employer requiring them to hire one worker with a disability is between 30 to 60 (Articles 73/74).[159]

Conformity with the CRPD

Quotas are recognized indirectly in the CRPD in Article 5 Paragraph 4, which states that, "Specific measures which are necessary to accelerate or achieve de facto equality of persons with disabilities shall not be considered discrimination under the terms of the present Convention."

There are legal provisions in Arab disability laws restricting the implementation of the quotas; this provision provides that the disability or "impairment must suit with the nature of work." Nothing in the current laws pinpoints how this provision must be applied and who is to monitor it; therefore, employers usually reject job applications of persons with disabilities relying on this restriction.[160]

Law 39/1975 of Egypt Article 12 and Law 61/1999 of Yemen Article 15, state that a person with a disability who holds a rehabilitation certificate are considered to be physically fit legally. Nonetheless, these laws reaffirm that the disability type must be commensurate with the nature of work.

159 Arab Disability laws are available on the Landmines Network Jordan: http://www.musawa.org/new2/ documents.asp
160 Article 4/C/4 Law # 31/ 2007 Jordan, articles 18/ 19 Law # 61 /1999 Yemen; the Lebanese law does not have this restriction

EDUCATION

Current Provisions

The right to education of Persons with Disabilities is recognized in the Middle East through clear provisions. Special education forms the main feature of the educational system in the region.[161] In higher education, persons with disabilities benefit from some exemptions, discounts or exceptions. In Jordan, the Board of Trustees of each official university has discretion to accept a specific number of students with disabilities and exempt them from the admission condition related to the minimum general grade in high school so that they may access these institutions.[162] Undergraduate students with a 40 percent ratio of disability "impairment" and above, according to the social security schedules are eligible to benefit from significant discounts from tuition fees as they only pay 10 percent of the total amount. Meanwhile, post-graduate students with the same ratio of disability "impairment" benefit a from 50 percent discount from the tuition fees. However, these provisions are only for official Universities.[163]

Law # 4/1999 on the Rights of Disabled in Palestine states in Article 15 that related ministries shall provide accessible environments for Persons with Disabilities in schools, colleges and universities.

Conformity with the CRPD

Article 24 of the CRPD states that States Parties shall ensure equal opportunities and measures that direct to full inclusion. The convention does not include direct and firm obligations for the States parties to turn their educational systems to mainstreaming or full inclusion due to practical and fiscal difficulties. However, the current legal provisions in this regard are still focused on special education. Having said that, some good provisions can be read in the Lebanese law Article 60 which states that persons with disabilities shall not be excluded from their right to education on the basis of their disability and any clause provided that the applicant must be free of disability/handicaps or that she/he must be physically fit as a requirement to be admitted in any educational institution, whether public or private, shall be void.

Although the Palestinian law # 4/1999 states in Article 2 that persons with disabilities shall enjoy their rights and access to services on equal bases with others without any form of discrimination on the bases of disability; the same article in its second clause states, "in accordance with their capacities." The prevailing medical approach in these laws, reflected in such restrictions (i.e., "in accordance with their capacities", "in accordance with the nature of the disability", and the like), create legal and empirical conflict between the anti-discrimination perspective embedded in some good provisions and these limiting provisions. Current laws regarding rights to education have some valid bases to build on, but the inclusion does not represent a strategic trend in these laws.

161 Article 10 clause 3, Law # 4/ 1999 on the Rights of Disabled, Palestine http://www.dft.gov.ps/index.php? option=com_dataentry&pid=12&leg_id=%20284 ; Article 9 of Law #34 /2004, Syria; Article 5 of law 39/ 1975 Egypt.

162 See the admission bases of official Universities in Jordan, http://www.moe.gov.jo/mhane/ass2008.doc

163 See: decree # 320/ 2007 of the Higher Education council, http://www.mohe.gov.jo; See also: Law# 34/ 2004 of Syria Article 9 Sec2 Para 36/

HEALTHCARE

Current Provisions

The legal provisions in Arab disability laws ensure free access to medical services.[164] Some laws contain provisions on specific services or programs such as providing and production of orthotics and prosthetics,[165] physiotherapy services,[166] health care for woman with disabilities during pregnancy and after childbirth.[167]

Conformity with the CRPD

Article 25 of the CRPD contains general provisions on the right to health, which reaffirm non-discrimination in access to health services. This article imposes on States parties to ensure equal access to these services through specific measures including amongst other things gender sensitivity, affordability, accessibility and informed consent. The CRPD does not contain provisions on prevention. Some may argue that Para (B) of this Article highlights preventive points;[168] however, these services are clearly specified as being needed by persons with disabilities specifically because of their impairments. This means that early detection and intervention as well as preventive measures, should aim to minimize the existing disability and prevent further injuries or impairments.

In Arab disability laws, the clearest provisions regarding the right to health are those related to prevention of the occurrence of disabilities in society.[169] Some of these laws clearly state that related departments shall provide medical tests for the spouses before marriage in order to prevent or reduce potential disabilities.[170] The preventive provisions or programmes shall not take place in laws that are aimed to ensure full enjoyment and exercise of the basic rights and fundamental freedoms of persons with disabilities on equal bases with others. Such provisions must be included in the public health law or any other relevant legislation. Once again, the welfare and medical approach has its impact on the legal provisions that organize the right to health of persons with disabilities.

This obviously emerges in the lack of reflection of several general fundamental principles (i.e., equality between men and women, disability as natural diversity, equal opportunities, freedom of choice, and non-discrimination). Under these principles, accessibility, availability, affordability and informed consent are basic prerequisites to access to social services and must be embedded in health policies and disability laws; these prerequisites are missing, or at least very weak in the present laws in the Middle East.

164 Article 9/A/1 law 34 /2004 Syria, Article 4/A/4 law 31 /2007 Jordan
165 Article 13 law 61/ 1999 Yemen;
166 Article 9/A/2 law 34 /2004 Syria
167 Article 4/A/5 law 31 /2007 Jordan
168 Provide those health services needed by persons with disabilities specifically because of their disabilities, including early identification and intervention as appropriate, and services designed to minimize and prevent further disabilities, including among children and older persons.
169 Law 4/ 1999 Palestine article 10 the second clause
170 Article 9/A/4 law 34/ 2004 Syria

ANNEX 3. Access to Social Services in the Palestine Refugee camps in Lebanon[171]

Historical background:

Lebanon is host to a population of 422,188 Palestine refugees.[172] There are twelve official camps in Lebanon and 39 unofficial Palestine refugee gatherings.

Both camps and gatherings are frequently assessed by humanitarian actors, with results including: overcrowding, poor infrastructure, politically motivated violence, poor health, low education standards, poor environmental health conditions caused by out of date drainage and sewage systems, limited access to a clean and safe water sources, unsecured shelters, poor status of roads and alleys, minimum levels of electricity and inadequate water resources. Moreover, Lebanese law is applied and observed in gatherings but is not applicable in the camps.

Palestine refugee camps in Lebanon have faced war and destruction over the years. Each time, destruction was followed by rapid rehabilitation and reconstruction to allow the inhabitants to return to the camps as soon as possible. However, the reconstruction plan often failed to meet the refugees' needs or demands and to include the issues of persons with disabilities in a comprehensive and sustainable process.

As early as September 2007, Nahr el-Bared Camp in North Lebanon was destroyed after three months of conflict between Fatah al-Islam and the Lebanese Armed Forces. A number of buildings in the area bordering the official camp boundaries were also destroyed in addition to non-governmental organisations (NGOs) and community-based organisations' offices and centres in the area. This affected their ability to provide services and activities, particularly for children, women and persons with disabilities.

Persons living with disabilities in the Middle East are up against a rather difficult state of affairs when it comes to effecting change in their respective countries, especially with regard to their national governments. A particular instance is when persons with disabilities have to live beyond the normal range of protection by and reach of policies of the governments in the countries they reside. The significant number of refugees and internally displaced people all over the Middle East indicates the parallel challenges they face, regardless of their country of origin. This situation is illustrated by the plight of Palestinian refugees in Lebanon, where the lack of mechanisms or policies to mainstream them in (Lebanese) society exacerbate their current deplorable state. This is aggravated by the fact that these displaced groups are considered stateless, thus, rendering them incapable to focus their claim of fulfilling their basic human right to any legal entity.

Social services in Palestine refugee camps in Lebanon

Palestinian refugees in Lebanon are highly dependent on the United Nations Relief and Works Agency for Palestine Refugees in the Middle East (UNRWA) as their core provider of social services such as education, healthcare and social protection. In addition, there are also a number of Palestinian as well as international NGOs that make available temporary or permanent services for Palestinian refugees; however, only a few of them are active in the disability sector.

171 This text has been written by Ms Loubna Abu Chakra, Disability Technical Advisor, Handicap International Lebanon
172 http://www.un.org/unrwa/refugees/lebanon.html

Moreover, most of the UNRWA's premises are not accessible to persons with disabilities or equipped to provide them with basic services while other forms of assistance made available by other NGOs in the camps are also limited; thus, many of their demands and needs remain unmet.

The following table briefly shows the availability and quality of services for persons with disabilities in the Palestine camps in Lebanon:

Disability Type	Good services	Poor services	Possible reasons
Physical disability (adults and children)	Though the number of existing rehabilitation centres is limited, the quality is reportedly good	Very poor availability of rehabilitation services – for example, there are only two or three in each area (there have five areas in Lebanon). There is a total of fifteen centres that are unevenly distributed; there are not enough technical staff in the existing ones to meet the demand.	Lack of funding and lack of paramedics or therapy professionals in the Palestine community and Palestinian doctors are working through UNRWA clinics only. NGOs provide rehabilitation services but they lack professionals especially paramedical and therapeutic disciplines
Hearing impairment	There is one specialised centre providing audiogram and rehabilitation for children with hearing impairment		Limited number of persons with hearing impairment. Majority do not need specialized institutions.
Visual impairment		UNRWA is providing social services with specialized equipment for education and work on school inclusion for a limited number of students.	Lack of adequate equipment and materials and when they are available, are often unaffordable. There is also a lack of a comprehensive strategy to work with persons with visual impairments in the Palestinian community in Lebanon.

Psychological Disability Psychological Disability		Though the quality of the service is good, it has very poor availability; there are a lot of persons with psychological disabilities that are not included in the community. There is a lack of hospitalisation and medication services, psychologists and follow-up activities on the situation of persons with psychological disabilities. While some NGOs provide some services to children, they cannot cover all the demands and needs; many of them are on the waiting list and there are times that they are asked to pay for the service.	Lack of funding and lack of psychologists in the Palestinian community.

Access to healthcare and rehabilitation services

The UNRWA provides preventive and curative healthcare to Palestinian refugees through the health centres it has situated in all the camps. They can also make available secondary and tertiary hospital care through a network of contracted hospitals. Primary healthcare services include medical care, family health planning, disease control and prevention, and health education supplied to refugees registered at the UNRWA at no cost. However, Palestinian refugees are obliged to share costs for secondary care, tertiary care, prostheses and specialised life-saving treatments.[173]

Persons with disabilities have very limited access to specific health services such as early intervention, specialised diagnostic or medical rehabilitation as these are not provided by the UNRWA nor by the Palestine Red Crescent Society, another main healthcare provider, but can only be obtained from Lebanese hospitals and clinics, often at a very high cost.

173 UNRWA. Health Report 2008.

In sum, the following challenges have been described by persons with disabilities and their representatives in Lebanon:

- The main medical service providers in the camps, the Palestine Red Crescent Society and the UNRWA, are restricted to short-term and acute care, with limited or almost no services for rehabilitation, chronic illness, disability, counselling and social support. Persons with disabilities and the elderly who are ill often have to depend on their families for care, with female members of the household commonly having to share the responsibility.
- The provision of mental health services in the UNRWA centres is also limited and the profile of mental health medications available at UNRWA dispensary is restricted.
- Several stakeholders complained that they are not properly treated in external hospitals contracted by the UNRWA: people diagnosed with cancer are not fully covered; there is only partial recovery for open heart surgery patients; and no coverage is offered for cardiac catheterization and chronic renal failure requiring haemodialysis.
- Palestine Red Crescent Society hospitals still lack some modern equipment required by some persons with disabilities; thus, those who are in need of specialized services are obliged to consult private Lebanese hospitals, often at a higher price they could not afford.
- UNRWA clinics have an insufficient number of health staff that health centres are often congested and crowded and patients are met with and treated within a limited period of time.
- UNRWA clinics are not accessible to persons using wheelchairs or with reduced mobility.
- Moreover, these medical services offer limited or no accessible modes of communication for persons with visual or hearing impairments and attending staff often have inadequate training to effectively converse with persons who have learning disabilities.

Despite these challenges, there are examples of innovative programs and initiatives being implemented among the Palestinian population in Lebanon:

- Community Based Rehabilitation (CBR) services are implemented in three areas: in the North, in and around Beirut and Tyre and are supported by international funding;
- UNRWA is following a similar CBR concept and are providing some rehabilitation services in all of the camps; and
- Rehabilitation services for physical and sensory disabilities are made available through 17 small NGOs in the camps; and although their efforts are not enough to meet all the needs of persons with disabilities, it ensures them of some form of initial access to services they require.

Access to education services

Due to the limited access of Palestine refugees to public education in Lebanon and the high cost of private secondary schooling, it is not surprising that UNRWA's education program is the largest of all its programs. Children who are registered refugees have access to free elementary and preparatory education in more than 80 schools throughout the country, including a number of secondary schools, and some that offer special education for children with learning difficulties.

Most of the students find themselves unable to pursue their higher studies in the universities due to the low income levels of their families. The UNRWA recently established a new program that provides scholarships to a limited number of students; unfortunately, it does not specify requirements to allow students with disabilities to avail its benefits on an equal basis with others. Moreover, the agency runs two vocational training centres (one in the North area and one in the South), which offer vocational and semi-professional courses but does not provide inclusive or specialised courses to persons with disabilities.

Majority of UNRWA school buildings are rented, with a number of them in need of repair. In addition, most of the schools' premises such as classrooms or bathrooms in the first or second floors are inaccessible to children with physical disabilities because of the lack of elevators in school buildings; also, there is a general insufficiency of sign language interpreters or aids for students with hearing impairment.

According to the accounts of parents and children with disabilities, UNRWA schools and educational systems must change to develop into supportive educational communities where the right to education for all children are met. For this to happen, some reforms and modifications need to take place:

- Teachers, schools and the education system need to adapt to better accommodate the diverse needs of the pupils and ensure their inclusion in all aspects of school-life.
- Identifying barriers within and around the school that hinder learning and participation, and striving to remove or reduce these obstacles.
- Undertake changes and adjustments in the curriculum as most of the schools' programs have not been updated for several years and as such, do not address the needs and rights of children with disabilities, specifically those with intellectual disabilities or learning problems.
- Implementation of modifications in UNRWA's educational policies and administrative structures, specifically in the manner teachers educate, the method students learn, the means by which pupils can access educational facilities information and effective ways of communication.
- The significant number of kindergartens in the camps should be made accessible to children with disabilities and undertake such measures to ensure that these follow standard kindergarten curriculum as well as safety and security norms.
- Recently, two early interventions units were established in the South - one in Tyre and another one in the Saida. Both units provide specialised rehabilitation services for children with disabilities from 0 to 6 years old through a multidisciplinary approach. These types of initiatives need to be replicated to assist in the improvement of services for children.

Shelter and Protection

The vertical expansions of the camps and the hazardous construction of houses are major causes of the refugees' poor health and their sub-standard living conditions (e.g., asthma due to humidity and osteoporosis due to deficient sun light and high temperature inside the shelters). The risk of collapse of some shelters also constitutes a threat to the public safety of people inside the camp.

The current state of the physical infrastructure of the camps is inadequate to accommodate the increasing number of residents. It suffers from many severe problems, such as: minimal levels of electricity, inadequate water resources and sewage systems, poor roads/alleys, and unsecured shelters[174] that do not meet the minimum standards of security and safety.

Referring to the focus groups with a large number of persons with disabilities, their parents and some community members, the actual situation affects their lives and limits their freedom of movement. Physical barriers inside and outside the home can be a major cause of isolation and discrimination in the Palestinian camps. Moreover children with disabilities cannot get their right to play safely and join other children their age because of the lack of accessible playgrounds or parks. This contributes to the segregation of persons with disabilities and prohibits them from developing their capacities and participating in social activities, which makes them unable to have equal rights.

In response, currently, some NGOs as well as UNRWA engineers and construction service office are implementing home and schools adaptation and rehabilitation projects for persons with disabilities. Others are working on advocacy and human rights activities to raise awareness and give the opportunity for persons with disabilities to have full participation and inclusion in their communities. Many community actors are involved especially the Palestinian Disability Forum who plays an essential coordination role and sometimes is taking the lead in these matters.

Access to livelihood and employment services

The UNRWA's relief and social services programme, initially known as the welfare programme, concentrates its efforts on the poor, supporting them with food aid, shelter, and selective cash assistance for families registered as having hardships. The first Social Services Policy documents produced in April 2008 marked important milestones in the life of the programme covering issues such as women, disability, children, youth and the micro-credit support programmes.[175] The disability programme aims to promote, rehabilitate and equalise opportunities for persons with disabilities and their inclusion into the community utilising the community-based rehabilitation approach, following the principles of the UN Convention on the Rights of Persons with disabilities (CRPD).

Based on the information gathered from the focus groups discussions, majority of Palestine refugees work as daily paid labourers without any medical insurance or social security; and there remain a large number of unemployed refugees living in the camps. This is due to the Lebanese employment law imposing restrictions on Palestinians in 70 different trades.[176] Due to the limited work opportunities for Palestine refugees in Lebanon, most of the men and women work within or on the peripheries of the camps, mostly in private sectors.

Men work mainly in the construction, transport and agriculture industries, with women working for the NGOs sector or the UNRWA. Persons with disabilities are also affected by this situation and they are mostly working inside the camps in small businesses such as shops, bakeries, handicrafts or artisanal work, through a microcredit programme. Moreover, the disability program in UNRWA is trying to improve the economic independence of persons with disabilities; however, it is noted that very few persons with disabilities are recruited by the agency.

174 Such as shelter without doors or windows, a dark, humid room or a zinc roof half-destroyed.
175 Social Services Policy and Guidelines, April 2008.
176 UNRWA. www.unrwa-lebanon.org

The UNRWA provides cash assistance and food parcel rations to Palestine refugees registered as experiencing special or unique hardships; however, it was reported that the assistance does not fully cover the family's needs.

People that are not registered as being "in hardship" and the non-registered refugees do not receive these services from UNRWA and are at a greater risk of falling below the poverty line. The microcredit programme at the UNRWA Relief and Social Service Department provides small business grants to registered Palestine refugees who wish to open their own commerce in the camps; however, sometimes, the profit is less than the interest rate that they have to pay to close their loan. Some international NGOs provide microcredit services to a limited number of persons with disabilities who have the capacity to manage a business; while some of them succeed and are now running their own shops, others are unable to do so due to many major obstacles in the camps.

Coordination of the support to Palestine refugees with disabilities

The UNRWA is a member of the Palestinian Disability Forum, a gathering of all organisations involved in the disability sector for Palestine refugees in Lebanon. These two groups collaborate to collect data on persons with disabilities while the Palestinian Disability Forum has undertaken the responsibility of issuing disability cards that is supposed to provide them some benefits from their member-organisations. However, any kind of assistance has remained limited and seems to be made available mainly to collect information and statistics.

In general, one may observe that this system is still a work in progress; there is still no reliable source of data on the exact number of persons with disabilities, especially regarding persons with mental health or intellectual disabilities. Plans for improvement and reform are dependent on NGO projects, donor policies and priorities, which do not often meet the needs of refugees. Local NGOs in Palestine camps work with international NGOs funded by large organisations, such as the World Bank, foreign government funds, the European Union and other UN organisations. While other local NGOs, especially those who are well-established, gets direct fund support from embassies to cover their operating costs and to support their activities.

ANNEX 4. Main recommendations of the report: Taking a Step Forward – A Stakeholder Review, 2005

The main recommendations of the 2005 HI report (*Taking A Step Forward – A Stakeholder Review*) are:

1. Review the **existing legislation** to be in-line with the developing CRPD in all three countries. Initiate a discussion around mainstreaming disability into general social policies. Advocate for an anti-discrimination legislation.
2. **Health care and rehabilitation** – increase the coverage of healthcare services and medical rehabilitation to also cover rural areas, improve the information system and introduce quality standards based on a modern and rights based concept. Ensure that services are affordable to everybody that needs them. Improve the coordination between the government and the private sector when it comes to service provision.
3. **Education** – improve accessibility in mainstream education, both in terms of physical access and pedagogy. Improve the quality of education in general but specifically for persons with disabilities to enhance possibilities for higher education and employment. Define proper educational strategies where disability is included.
4. **Sustainable livelihood** (employment/vocational training and social protection) –enforce existing legislation, especially the quota mechanism that existed in all countries. In all the three countries, recommendations to upgrade the quality as well as the availability of vocational training programs were mentioned, with regard to geographical distribution. An urgent recommendation was to adequately include persons with disabilities in the development of social protection policies as well as to define specific disability policies in this area.
5. **General recommendations** – improve the coordination and cooperation among DPOs at national and regional levels and to find common actions for advocacy. Provide capacity building opportunities for DPOs and the creation of new DPOs, especially around topics such as legislation and policy-making, campaigning techniques and how to work with the media.

ANNEX 5. Steps towards social and economic inclusion - The LPHU's relentless struggle to secure decent work for persons with disabilities in Lebanon[177]

In 2004, the Lebanese Physical Handicapped Union (LPHU) developed a five-year plan, which focused on the "bread-and-butter" issues of education and labour. Even though Law 220/2000 on the rights of people with disabilities remained largely unimplemented, the LPHU built its plan on a solid foundation of scientific research and field surveys, more particularly in the poorest and highly marginalized Lebanese regions. Capitalizing on these studies, LPHU designed a series of programmes with people with disabilities, who account for more than ten percent of the population, their families, the private sector, technical institutes, universities and civil society groups for the Bekaa governorate. This effectively opened communication channels between persons with disabilities and society to promote their economic and social inclusion.

The groundwork

Between 2005 and 2008, projects such as "Unlocking Potential Job Opportunities for Persons with Disabilities", opening the employment office in Central Bekaa, the "Social and Economic Inclusion," and "Youth and the Labour Market" constituted a unique phenomenon and a driving force to bridge the wide chasm separating two social categories that were, until then, "alien to each other".

At the social level, foundations were laid down for the establishment of the body composed of experts, advisors, representatives of private sector companies and the chambers of commerce, industry and agriculture that supports diversity in the workplace. The concept of "diversity in the workplace" was introduced and disseminated to members of the media, advocating decent work for all. In support thereof, the LPHU Information Unit released the Diversity at the Workplace Guide distributed daily along with the widely circulated Al Nahar.

The Economic and Social Inclusion Project

With its economic and social inclusion project for persons with disabilities, LPHU takes advanced steps to emulate this unique experience in Lebanon and the Middle East. Its efforts are not solely confined to rehabilitating and preparing people of all types of disabilities to join the labour market, it encompasses sensitising and advising employers and making the workplace physically accessible to all.

Launched in cooperation with Christian Aid - UK, the project

- was designed to introduce sustainable improvements to the means of economic inclusion of persons with disabilities
- to facilitate the access of people with disabilities to the labour market
- cooperates with the private sector, persons with disabilities and their families, the local community, technical institutes, universities, civil society organizations, and public institutions at the local and national levels
- encourages concerned stakeholders from the public sector it collaborates with -- municipalities, mayors, ministries, the National Employment Office, the chambers of commerce, industry and agriculture -- to embrace diversity in the workplace;

177 Writen by Mr. Lmadeddine Raef, I., Media officer, The Lebanese Physically Handicapped Union, Lebanon.

- it also sets the example for private institutions and companies to make use of the potential of persons with disabilities.

In addition, the project intends to deepen the knowledge of private institutions on vocational training for people with disabilities through the following activities:

  - networking and introducing the project to these companies,
  - conducting in-house employee-oriented awareness-raising seminars and
  - training sessions for employees and managers to promote the concept of diversity in the workplace, altering old notions on the potentials of persons with disabilities.

- conducts vocational training sessions on multiple specializations/disciplines including illiteracy, computer and the English language
- the project provides them with vocational guidance and counselling oriented to market needs to groom them for inclusion and give them in-house training, according to his own specialization
- secures job opportunities for this segment of society,
- ensures post-employment follow-up and interaction with families;
- it offers advice on setting up small ventures in cooperation with concerned parties.

Recruitment and Contribution

The project adopts one of the most advanced hiring mechanisms. Recruitment offices receive and thoroughly assess job applications from people with disabilities and a specialized team searches for the available employment opportunities in the labour market. The workplace is then examined; the job opportunity described in details then matched with received job applications. After a successful match and hiring, the team follows up on the conditions of the employed people with disabilities, suggests adaptive changes as needed. The project engages organizations, companies and individuals and allows them to join the diversity-supportive body, host in-house training sessions and awareness-raising seminars, provide training and job opportunities for people with disabilities, secure funding, offer consultancy services and participate in one of LPHU programs or project sections.

ANNEX 6: Combined Agendas: Paradox of International Donors' And NGOs' Approach In Supporting Access Of People with Disabilities to Social Services in Middle East[178]

For international agencies, the social services situation in the Middle East is somewhat challenging as their level of social development and governance does not match the middle income nations' economic indicators; in some countries in the region, political instability constantly generates humanitarian crises regarding long-term conflict or sporadic crisis or refugees' issues.[179] This challenge is reflected in the number of approaches international donors and NGOs have taken with regard to the access of persons with disabilities to social services in the Middle East. Whilst disability is not a key issue for donors in the Middle East (none of the major donors mention it as such in any country or regional assistance strategy), concrete practice of international NGOs and donors could be clustered to two main trends. *Firstly*, the persistent charity and welfare approach and the humanitarian assistance (which emphasizes a project-based method with NGOs taking the lead in service delivery) are predominant and relevant in the region. *Secondly*, the paradigm shift towards a human rights approach to disability, together with the good governance agenda, which emphasizes local policy-maker ownership[180], therefore increasing accountability towards citizens notably with regards to service delivery.[181]

The persistent charity and welfare approach and humanitarian assistance: sustaining existing services but weakening further policy development

In general, regional donors who are heavily involved in the Middle East are inclined to finance direct service provision following a medical and welfare approach to disability. This approach to supporting local NGOs is very much related to the donors' own national approach and legislation which are in most cases, welfare-oriented rather than rights-based.[182] It also reflects the religious practice of donation for the vulnerable members of society, related to either Islamic or Christian religions. The presence of regional donors is significant as a sustainability factor for many service providers that rely on external charity funding to maintain and develop their services.

While these funds do support service delivery, it also weakens to some extent the real investment of the State in ensuring access of persons with disabilities to services, as it still considers this a form of charity or an issue for NGOs to address.[183] Moreover, support to NGOs service delivery is also very much related to the humanitarian response. Indeed, the unstable political situation in the region, with the conflict in Iraq and the tension and resulting crises in Palestine and Lebanon as well as in Yemen, generate significant response from donors.

In humanitarian relief, depending on the type of project, international and local NGOs are either partnering, complementing or competing to directly provide services to persons with disabilities in substitution of State provision, funding or regulation. In most of these cases however, coordination between donors and NGOs is very poor as the flow of funds channeled to service providers often engages them in a growth that does not always fit their absorption capacity and ability to manage the complexities of projects and proposals from an organizational

178 Written by Mr Alexandre Cote, Consultant, S.I.E.M.P.R.E..
179 As an example of this paradox see "DFID Palestinian team strategic interim plan" DFID, 2008
180 Paris Declaration on Aid Effectiveness, 2005. www.oecd.org/dataoecd/ 11 / 41 /34428351.pdf
181 World Bank. *Making Services Work for Poor People,* (World Bank and Oxford University Press: Washington: 2003).
182 Axelsson, C., and Sharkawy, G. Taking a Step Forward. Views From Stakeholders on Disability Policies and Services in Egypt, Jordan and Lebanon, Working Paper, Handicap International-Middle East, 2006.
183 See Egypt Human Development Report, 2008 in which NGOs are called to invest more in social services provision especially for vulnerable groups such as persons with disabilities

perspective. Also the withdrawal of donors after a crisis can prevent the consolidation of gained operational capacities and may lead to serious organizational issues. The political instability in some parts of the Middle East generates a paradoxical situation in which the funds are more or less constantly available but in a stop-and-go manner which limits the opportunity to plan on a long-term basis. This situation simply encourages the concentration of services in with a few providers who have been successful in combining emergency relief, development funding and charity donations. The situation of Palestine camps in Lebanon is quite illustrative as services that are funded through a humanitarian assistance scheme for decades do not include a strategy or plan that will ensure sustainable access to services.

However, humanitarian assistance is only one aspect of donor's policies in the region. Compared to other regions, the Middle East shows a clear governance gap.[184] Donors identify the promotion of good governance and/or institution building, which directly impacts social service delivery, as key to supporting social and economical development.

The shift of paradigm towards a right-based approach to the disability and good governance agendas: the quest for accountability mechanisms

From a perspective that was very much oriented in creating adequate medical rehabilitation at both primary and secondary levels or community based rehabilitation, the disability agenda of international donors has expanded to become inclusive, built on a rights-based approach and broad poverty reduction principles. The advocacy of disabled peoples' organizations (DPOs) and NGOs for better national legal frameworks and the CRPD, have pushed major donors to acknowledge disability as a key human rights issue intrinsically linked to poverty reduction. Many of them have adopted policy papers or guidance notes[185] to mainstream disability that has been more or less enforced.[186] Indeed, disability inclusion is still supported by specific projects rather than included in major mainstream programs. In the Middle East, many field staff of major donors (e.g. USAID, European Commission) are not aware of the disability policy guidelines of their own organizations[187] and therefore fail to mainstream disability in key programs such as strengthening social inclusion, education and health care systems or post conflict reconstruction.[188]

The human rights approach to disability, emphasizing empowerment, participation, non-discrimination and accountability as reflected in the CRPD, makes a strong case for support to self-advocacy of persons with disabilities towards policy-makers and service providers. This echoes strongly with the good governance agenda of major international donors and agencies. In line with the Paris declaration on aid effectiveness[189] and the accountability framework approach to service delivery[190] promoted by the World Bank and other major international donors and agencies, support of access to services for persons with disabilities would be a combination of national strategies, public-private partnership mechanisms and strengthening of the demand side.[191]

184 World Bank. Better Governance for Development in the Middle East and North Africa: Enhancing Inclusiveness and Accountability. (World Bank: Washington: 2003)..
185 USAID Disability Policy Paper ,1997.
DFID. Disability, Poverty and Development. 2000.
European Commission, Guidance Note on Disability and Development. 2004.
186 Albert, B., Dube, A.K., and Riis-Hansen, T.C. Has Disability Been Mainstreamed into Development Cooperation? (Disability KaR programme: UK: 2005).
187 Interviews with USAID And EC staff by the author in Egypt, Palestine, and Lebanon 2007- 2008.
188 LPHU. Assessment of Accessibility in Post-2006 War Reconstruction in South Lebanon. 2008.
189 Paris Declaration on Aid Effectiveness. 2005.
190 World Bank. Making Services Work for Poor People, (World Bank and Oxford University Press: Washington: 2003).
Berry, C., Forder, A., Sultan, S., and Moreno-Torres, M. Approaches to Improving the Delivery of Social Services in Challenging Environments, PRDE Working Paper 3, (DFID: UK: 2004).
191 World Bank. A Note on Disability Issues in the Middle East and North Africa, Human Development Department Middle East and North Africa Region, (World Bank: 2005).

Acknowledging both the dictum of the international disability movement, "*Nothing about us without us"* and the significant weakness of the disability movement in the region, international donors and NGOs are strongly engaged in sustained support to the self-advocacy of persons with disabilities at local, national and regional levels. This is in cooperation with the support provided by such bodies as the European Commission, USAID, Open Society Institute, Mercy Corps, CBM Handicap International and Diakonia. In general, civil society participation and advocacy is generally not strongly established in the region as typically patron-client relations,[192] poor authorities' responsiveness or possible repression encourage a quiet encroachment of self-help strategies of communities.[193] However, field practice shows that local authorities are quite sensitive to the emergence of structured demands from parents of children with disabilities and adult with disabilities and there is growing acknowledgement of the lack of services and accessibility by national authorities.

To reflect the paradigm shift, international agencies and NGOs also support civil society and innovative government service provision initiatives in inclusive education, employment and community based rehabilitation. However, it is worthwhile to note that support services are not strongly developed because there is a lack of demand from local service providers who do not identify those services as a priority and similarly for donors and international NGOs. This shows that if the paradigm shift is on-going, its complete translation in the field of service provision is far from being achieved as the availability of support services is key to the inclusion of persons with disabilities, as stated in Article 19 of CRPD. Another important issue met in most projects is the failure to scale-up those initiatives to policy levels. There have been few significant exceptions: the Rights and Access Program in Lebanon supported by Arc en Ciel and the Inclusive Education Project led by Caritas Seti in Egypt, both having directly contributed to changes in national policy.

To fill this gap, donors also invest in policy-making activities such as the support to the Lebanese Rights and Access Program by the European Commission in the past; more recently, to the Jordanian Higher Council on the Affairs of Persons with Disabilities by USAID in Jordan and the new joint UN agencies program of support to the Ministry of Social Affairs in Egypt for the implementation of the CRPD.

If, as mentioned, access to services for persons with disabilities in the Middle East is not a key issue, it is also not completely ignored either. Certainly, donors and international NGOs could do more with consistent mainstreaming of disability in their humanitarian and development activities, longer-term funding and better coordination, but until a stronger demand side builds capacities, not much progress will be achieved. Despite the CRPD, ensuring the access of persons with disabilities to social services is not a vital issue in a troubled and unstable Middle East: as in many regions ***"this low priority can be explained*** by the ***political weakness of disabled*** persons and by the ***high perceived economic costs*** and ***low perceived political benefits".***[194] ***Only a combination between a stronger disability movement and more aware donors can raise the political cost of doing nothing to a higher level than the cost of doing something.***

192 Clark, J. Social Movement Theory and Patron-Clientelism: Islamic Social Institutions and the Middle Class in Egypt, Jordan and Yemen, Comparative Political Studies, Vol.37, No.8, 941- 968 (2004).
193 Bayat, A. Social Movement, Activism and Social Development in the Middle East, Civil Society and Social Development Programme Paper no. 3, (UNRISD: 2000).
194 Yeo, R. Disability, Poverty and the New Development Agenda, (Disability KaR programme: UK: 2005).

ANNEX 7.
Country Profile: Egypt

COUNTRY INDICATORS

Country name
Arab Republic of Egypt[195]

Population
64,824,466 M (1997 estimate)[196]
80,335,036 M (2007 survey)[197]

Population growth rate
1.7 percent[198]

Capital
Cairo

Constitution
Amendments ratified on 22May1980 referendum[199]

Political system
The political system of the Arab Republic of Egypt is a **multiparty** one, based on the basic elements and principles of the Egyptian society as stipulated in the Constitution (Political parties are regulated by law). – *Article 5, Egyptian Constitution*[200]

HDI Ranking
116th out of 179 countries, (HDI = 0.716)[201]

Total GDP
USD 78,422 (in million constant 1995 USD)[202]

Inequality ranking (GINI)
29 (0=perfect equality, 100 = perfect inequality)
71 – ranking among countries (2004), HDI = 34.4[203]

Gender
9 percent of legislators, senior officials & managers are women (1999-2005)
1956: year women received the right to vote and stand for election
1957: year first woman elected to parliament
5.9 percent of women in government at ministerial level (%age of total)
2 percent of seats in lower house were held by women, 2007 (down from 3.9 percent in 1990)
6.8 percent of seats in upper house or Senate were held by women, 2007

GDP real growth rate
7.1 percent (2007 est.)[204]

195 http://www.arab.de/arabinfo/egypt.htm
196 Ibid.
197 http://www.mapsofworld.com/egypt/population.html
198 ibid.
199 http://aceproject.org/ero-en/regions/mideast/EG/Egyptian%20Constitution%20-%20english.pdf/view
200 Ibid.
201 http://hdrstats.undp.org/countries/country_fact_sheets/cty_fs_EGY.html
202 http://earthtrends.wri.org/pdf_library/country_profiles/eco_cou_818.pdf
203 http://www.photius.com/rankings/economy/distribution_of_family_income_gini_index_ 2004_0.html
204 http://www.indexmundi.com/egypt/gdp_real_growth_rate.html

GDP per capita

USD 4,337 (PPP, 2005)

Unemployment rate

9.9 percent – 2003
10.9 percent – 2004
9.5 percent – 2005
10.3 percent – 2006[205]

Population below poverty line

22.9 percent (national poverty rate)
3.1 percent (percent of population living on less than $1 a day)
52.7 percent (percent of population living on less than $2 a day)

BCI level

89[206]

Persons with disabilities stats

1,060,536 – total number of PWDs, 1996
151,510 – visually impaired
90,906 – hearing impaired
1,515,100 – mentally disabled
303,020 – mobility impaired[207]
183,391 males and 101,484 females per 100 population (1996)[208]

MDG

See table below

Literacy rate (15+)

71.4 percent
66.1 percent (males), 1999
42.8 percent (females), 1999

Public spending on social services

2.2 percent of total GDP went to health (2005)[209]
4.8 percent of total GDP went to education (1997)[210]
23.6 percent of total *public sector expenditure* went to social welfare[211]

205 http://www.economywatch.com/unemployment/countries/egypt.html
206 http://www.socialwatch.org/node/237
207 http://siteresources.worldbank.org/DISABILITY/Resources/Regions/MENA/JICA_Egypt.pdf
208 http://www.escwa.un.org/divisions/sdd/events/21mar/egypt-e.pdf; http://hdrstats.undp.org/en/indicators/100.html
209 http://hdrstats.undp.org/en/countries/data_sheets/cty_ds_EGY.html
210 ibid.
211 ibid.

Achievement of MDGs[212]

Millennium Development Goals	2000	2007
Goal 1. Eradicate extreme poverty and hunger		
Employment to population ratio, 15+ total (%)	62	61
Employment to population ratio, ages 15-24, total (%)	47	45
GDP per person employed (annual % growth)	3	3
Malnutrition prevalence, weight for age (% of children under 5)	-	23.2
Prevalence of undernourishment (% of population)	-	14.2
Goal 2. Achieve universal primary education		
Literacy rate (youth, female) (% of females ages 15-24)	84	87
Literacy rate (youth, male) (% of males ages 15-24)	90	91
Primary completion rate, total (% of relevant age group)	83	85
Total enrollment, primary (% net)	85	89
Goal 3. Promote gender equality and empower women		
Proportion of seats held by women in national parliaments (%)	14	18
Ratio of female to male enrolments in tertiary education	96	106
Ratio of female to male primary enrolment	92	95
Ratio of female to male secondary enrolment	93	95
Share of women employed in the non-agricultural sector ((% of total non-agricultural employment)	93 36.3	95 -
Goal 4. Reduce child mortality		
Immunization, measles (% of children ages 12-23 months)	73	82
Mortality rate, infant (per 1,000 live births)	55	47
Mortality rate, under-5 (per 1,000)	83	68
Goal 5. Improve maternal health		
Adolescent fertility rate (births per 1,000 ages 15-19)		52
Births attended by skilled health staff (% of total)		65
Contraceptive prevalence (% of woman ages 15-49)	60	60
Maternal mortality ratio (modelled estimate, per 100,000 live births)		400
Pregnant women receiving prenatal care (%)		81
Goal 6. Combat HIV/AIDS, malaria and other diseases		
Incidence of tuberculosis (per 100,000 people)	136	139
Prevalence of HIV, female (% ages 15-24)		0.7
Prevalence of HIV, male (% ages 15-24)		0
Prevalence of HIV, total (% of population ages 15-49)		0.8
Tuberculosis cases detected under DOTS (%)	30	63

212 w World Development Indicators Database, see: http://ddp-ext.worldbank.org/ext/ddpreports/ViewSharedReport ?REPORT_ID=1336&REQUEST_TYPE=VIEWADVANCED

Country Profile: Iraq

COUNTRY INDICATORS

Country name
Republic of Iraq

Population
30M[213]
29,492,000[214]

Population growth rate
Data not available

Capital
Baghdad

Constitution
Approved through public referendum in October 2005[215]

Political system
Parliamentary democracy
Constitutional government appointed in May 2006

HDI Ranking
**No ranking; unclassified; data not available*

Total GDP
25.86 B (current US $), 2000[216]
94.1 B (at 2005 US$ PPP), 2008[217]

Inequality ranking (GINI)
42[218]

Gender
25.5 percent : women in parliament (percentage of the total number of representatives in the lower house), 2008[219]
18.8 percent: women in government at ministerial level (%of total), 2005
25.5: seats in lower or single house (% held by women), 2007
0.19: ratio of estimated female to male earned income[220]
1980: year women received the right to vote and stand for election
1980: year the first woman was elected in parliament[221]

213 http://web.worldbank.org/WBSITE/EXTERNAL/COUNTRIES/MENAEXT/IRAQEXTN/0,,contentMDK:20206699~menuPK:313113~pagePK:141137~piPK:141127~theSitePK:313105,00.html
214 http://www.socialwatch.org/en/fichasPais/100.html
215 http://go.worldbank.org/45E7BO8KQ0
216 World Development Indicators database, April 2009. See: http://ddp-ext.worldbank.org/ ext/ddpreports/ViewSharedReport?&CF=1&REPORT_ID=9147&REQUEST_TYPE=VIEWADVANCED&HF=N&WSP=N
217 http://www.visionofhumanity.org/gpi/results/iraq/2008/
218 ibid.
219 ibid.
220 http://hdrstats.undp.org/en/countries/data_sheets/cty_ds_IRQ.html
221 ibid.

GDP real growth rate

-4.3 percent (2000)[222]
1.5 percent (2007)[223]

GDP per capita

$1,480[224]

Unemployment rate

Overall: 11.7 percent (2007)[225]; 26.8 percent (2008)[226]
Men: 16.9 percent
Women: 35.7 percent

Population below poverty line

Data not available

BCI level

79[227]

Persons with disabilities statsMDG

See table below

Literacy rate (15+)

74 percent (2008)[228]

Public spending on social services

4.3 percent (% of GDP, current spending on education), 2008

Achievement of MDGs[229]

Millennium Development Goals	1995	2000
Goal 1. Eradicate extreme poverty and hunger		
Employment to population ratio, 15+ total (%)	35	35
Employment to population ratio, ages 15-24, total (%)	22	21
GDP per person employed (annual % growth)	-	-
Malnutrition prevalence, weight for age (% of children under 5)	-	-
Prevalence of undernourishment (% of population)	-	-
Goal 2. Achieve universal primary education		
Literacy rate (youth, female) (% of females ages 15-24)	-	-
Literacy rate (youth, male) (% of males ages 15-24)	-	-
Primary completion rate, total (% of relevant age group)	-	54
Total enrolment, primary (% net)	-	85

222 World Development Indicators database, April 2009. See: http://ddp-ext.worldbank.org/ ext/ddpreports/ViewSharedReport?&CF=1&REPORT_ID=9147&REQUEST_TYPE=VIEWADVANCED&HF=N&WSP=N
223 http://go.worldbank.org/45E7BO8KQ0
224 http://www.visionofhumanity.org/gpi/results/iraq/2008/
225 World Bank Iraq Country Brief 2009, see: http://go.worldbank.org/45E7BO8KQ0
226 http://www.visionofhumanity.org/gpi/results/iraq/2008/
227 http://www.socialwatch.org/en/informesNacionales/533.html
228 http://www.visionofhumanity.org/gpi/results/iraq/2008/
229 http://ddp-ext.worldbank.org/ext/ddpreports/ViewSharedReport?&CF=1& REPORT_ID=1336&REQUEST_TYPE=VIEWADVANCED&HF=N

Goal 3. Promote gender equality and empower women		
Proportion of seats held by women in national parliaments (%)	-	6
Ratio of female to male enrolments in tertiary education	-	54
Ratio of female to male primary enrolment	85	82
Ratio of female to male secondary enrolment	-	63
Share of women employed in the non-agricultural sector ((% of total non-agricultural employment)	-	-
Goal 4. Reduce child mortality		
Immunization, measles (% of children ages 12-23 months)	80	90
Mortality rate, infant (per 1,000 live births)	39	-
Mortality rate, under-5 (per 1,000)	48	-
Goal 5. Improve maternal health		
Adolescent fertility rate (births per 1,000 ages 15-19)	46	-
Births attended by skilled health staff (% of total)	-	-
Contraceptive prevalence (% of woman ages 15-49)	-	-
Maternal mortality ratio (modelled estimate, per 100,000 live births)	-	-
Pregnant women receiving prenatal care (%)	78	-
Goal 6. Combat HIV/AIDS, malaria and other diseases		
Incidence of tuberculosis (per 100,000 people)	-	56
Prevalence of HIV, female (% ages 15-24)	-	-
Prevalence of HIV, male (% ages 15-24)	-	-
Prevalence of HIV, total (% of population ages 15-49)	-	-
Tuberculosis cases detected under DOTS (%)	-	51

Country Profile: Jordan

COUNTRY INDICATORS

Country name
Hashemite Kingdom of Jordan

Population
5.7 M, 2007[230]

Population growth rate
3.2 percent – 2007[231]
2.5 percent – average annual population growth, 2008[232]

Capital
Amman

Constitution
The Constitution revised by King Abdullah in 1950 was liberalized and ratified by King Talal in 1952.
1950 was the year that King Abdullah merged West Bank with Transjordan.[233]

Political system
Unitary constitutional hereditary monarchy

HDI Ranking
96 – HDI rank, 2007
0.77 – HDI value, 2007[234]

Total GDP
USD 15.8 billion, 2007[235]

Inequality ranking (GINI)
37.7 (1992-2007)[236]

Gender
Gender Development Index (GDI)[237] value: 0.743, rank: 87 (2007)[238]
8 – seats in parliament (% held by women), 2008
15 – women in ministerial positions (% of positions), 2008
1974 – year women received the right to vote and stand for election

GDP real growth rate
6 percent – GDP growth[239]

230 http://siteresources.worldbank.org/INTJORDAN/Resources/AAG-JOAM09.pdf
231 ibid.
232 http://web.worldbank.org/WBSITE/EXTERNAL/COUNTRIES/MENAEXT/JORDANEXTN/0,,menu PK:315156~pagePK:141132~piPK:141109~theSitePK:315130,00.html
233 FEMISE Coordinators. 2005. Jordan Country Profile: The Road Ahead for Jordan. Cairo: Print Right Adv.
234 http://hdrstats.undp.org/en/countries/country_fact_sheets/cty_fs_JOR.html
235 ibid.
236 ibid.
237 Gender Development Index (GDI) was introduced in the 1995 Human Development Report to measure achievements in the same dimensions as the HDI indicators but captures inequalities in achievement between men and women. It is HDI adjusted downward for gender inequality. The greater the gender disparity in basic human development, the lower the country's GDI relative to its HDI.
238 http://hdrstats.undp.org/en/countries/country_fact_sheets/cty_fs_JOR.html
239 http://siteresources.worldbank.org/INTJORDAN/Resources/AAG-JOAM09.pdf

GDP per capita

USD 2,769 (2007)[240]

Unemployment rate

--

Population below poverty line BCI level

97.3[241]

Persons with disabilities statsMDG

See Table 2 below

Literacy rate (15+)

91 percent – adult literacy rate, 2007[242]
95 percent – male adult literacy, 2007
87 percent – female adult literacy, 2007

Public spending on social services

USD 257 – government expenditure on health per capita, 2006
9.5 – government expenditure on health as a percentage of total government expenditure[243]

Achievement of MDGs

Millennium Development Goals	2005	2008
Goal 1. Eradicate extreme poverty and hunger		
Employment to population ratio, 15+ total (%)	39	39
Employment to population ratio, ages 15-24, total (%)	20	19
GDP per person employed (annual % growth)	2	2
Malnutrition prevalence, weight for age (% of children under 5)	-	-
Prevalence of undernourishment (% of population)	5	-
Goal 2. Achieve universal primary education		
Literacy rate (youth, female) (% of females ages 15-24)	99	99
Literacy rate (youth, male) (% of males ages 15-24)	99	98
Primary completion rate, total (% of relevant age group)	100	82
Total enrolment, primary (% net)	95	84
Goal 3. Promote gender equality and empower women		
Proportion of seats held by women in national parliaments (%)	6	6
Ratio of female to male enrolments in tertiary education	105	110
Ratio of female to male primary enrolment	100	102
Ratio of female to male secondary enrolment	102	103
Share of women employed in the non-agricultural sector ((% of total non-agricultural employment)	25.9	-

240 http://hdrstats.undp.org/en/countries/country_fact_sheets/cty_fs_JOR.html
241 http://www.socialwatch.org/node/9242
242 http://hdrstats.undp.org/en/countries/country_fact_sheets/cty_fs_JOR.html
243 ibid.

Goal 4. Reduce child mortality		
Immunization, measles (% of children ages 12-23 months)	95	95
Mortality rate, infant (per 1,000 live births)	22	21
Mortality rate, under-5 (per 1,000)	26	24
Goal 5. Improve maternal health		
Adolescent fertility rate (births per 1,000 ages 15-19)	26	25
Births attended by skilled health staff (% of total)	99	99
Contraceptive prevalence (% of woman ages 15-49)	57	57
Maternal mortality ratio (modelled estimate, per 100,000 live births)	62	-
Pregnant women receiving prenatal care (%)	99	99
Goal 6. Combat HIV/AIDS, malaria and other diseases		
Incidence of tuberculosis (per 100,000 people)	8	7
Prevalence of HIV, female (% ages 15-24)	-	-
Prevalence of HIV, male (% ages 15-24)	-	-
Prevalence of HIV, total (% of population ages 15-49)	-	-
Tuberculosis cases detected under DOTS (%)	66	81

Country Profile: Lebanon

COUNTRY INDICATORS

Country name

Republic of Lebanon

Population

3.7 M, 2000
4.01 M, 2005
4.10 M, 2007[@]
No population census has been conducted since 1932

Population growth rate

1.2 percent (2000)
1.1 percent (2005 & 2006)
1.0 percent (2007)[@]

Capital

Beirut

Constitution

Adopted on 23May1926
Amended for the Charter of Lebanese National Reconciliation (Ta'if Accord) in October1989**

Political system

Parliamentary republic with a President and a unicameral national assembly**

HDI Ranking

88 (2005)
HDI value: 0.772[H]

Total GDP

(current) USD 16.2 billion, 2000
USD 21.56 billion, 2005
USD 24.35 billion, 2007[@]

Inequality ranking (GINI)

Lebanon's country ranking in the GINI index is the same as those considered to exhibit perfect inequality or those nations, which the index is not applicable *(2007 CIA World Factbook)*

Gender

Gender Development Index (GDI)[244] value: 0.759, rank: 80 [H] (2005)
Ratio of estimated female to male earned income: 0.31[G]
1952: year women received right to vote & stand for election
1991: year first woman elected or appointed to parliament
6.9 % - women in government at ministerial level (as % of total), 2005
4.7% - Seats in lower house or single house (% held by women), 2007[GL]

244 Gender Development Index (GDI) was introduced in the 1995 Human Development Report to measure achievements in the same dimensions as the HDI indicators but captures inequalities in achievement between men and women. It is HDI adjusted downward for gender inequality. The greater the gender disparity in basic human development, the lower the country's GDI relative to its HDI.

GDP real growth rate

1.4 percent (2000)
4.0 percent (2005)
5.0 percent (2007)@

GDP per capital

6.0 PPP USD 5,584 (2005)H

Unemployment rate

7.0 18 percent

Population below poverty line

Around ¼ of families (approx 894,509 people) are subsisting on less than USD 620 per year

BCI level

96[245]

Persons with disabilities stats MDG

See Table 2 below

Literacy rate (15+)

100 % (2005)H
However, in a UNESCO 2007/2008 Human Development Report, data on national literacy estimates for the period 1995 and 2005 for the country was unavailable

Public spending on social services

Public expenditure on health (% of GDP) – 3.2 % (2005)
Public expenditure on education (% of GDP) – 2.6 (2001-'05)
Public expenditure on education (% of total government exp.) – 11 (2002-'05)
Current public exp on education, pre-primary & primary (% of all levels) – 33 (2002-'05) L

* UN Human Development Report 2000
@ World Development Indicators Database, April 2009 see: http://ddp-ext.worldbank.org/ext/ddpreports/ViewSharedReport?&CF=1& REPORT_ ID=9147&REQUEST_ TYPE=VIEWADVANCED&HF=N&WSP=N
H http://hdrstats.undp.org/en/countries/country_fact_sheets/cty_fs_LBN.html
** http://en.wikipedia.org/wiki/Constitution_of_Lebanon
L http://hdrstats.undp.org/en/indicators/50.html
G http://hdrstats.undp.org/en/indicators/281.html
GL http://hdrstats.undp.org/en/countries/data_sheets/cty_ds_LBN.html

Other web references:
For the English translation of the Lebanese constitution:
http://www.servat.unibe.ch/law/icl/le00000_.html
http://www.clhrf/com/unresagreements/Lebanese constituti.pdf

General country profile:
http://nationsencyclopedia.com
http://www/atlas.iienetwork.org/?p=48096

245 http://www.socialwatch.org/node/343

Achievement of MDGs[246]

Millennium Development Goals	2000	2007
Goal 1. Eradicate extreme poverty and hunger		
Employment to population ratio, 15+ total (%)	46	46
Employment to population ratio, ages 15-24, total (%)	29	28
GDP per person employed (annual % growth)	0	0
Malnutrition prevalence, weight for age (% of children under 5)		
Prevalence of undernourishment (% of population)	-	5
Goal 2. Achieve universal primary education		
Literacy rate (youth, female) (% of females ages 15-24)	-	99
Literacy rate (youth, male) (% of males ages 15-24)	-	98
Primary completion rate, total (% of relevant age group)	91	82
Total enrolment, primary (% net)	89	84
Goal 3. Promote gender equality and empower women		
Proportion of seats held by women in national parliaments (%)	2	5
Ratio of female to male enrolments in tertiary education	105	120
Ratio of female to male primary enrolment	95	97
Ratio of female to male secondary enrolment	108	112
Share of women employed in the non-agricultural sector ((% of total non-agricultural employment)	-	-
Goal 4. Reduce child mortality		
Immunization, measles (% of children ages 12-23 months)	79	53
Mortality rate, infant (per 1,000 live births)	28	26
Mortality rate, under-5 (per 1,000)	32	29
Goal 5. Improve maternal health		
Adolescent fertility rate (births per 1,000 ages 15-19)	29	25
Births attended by skilled health staff (% of total)	93	-
Contraceptive prevalence (% of woman ages 15-49)	63	-
Maternal mortality ratio (modelled estimate, per 100,000 live births)	-	150
Pregnant women receiving prenatal care (%)	96	-
Goal 6. Combat HIV/AIDS, malaria and other diseases		
Incidence of tuberculosis (per 100,000 people)		19
Prevalence of HIV, female (% ages 15-24)		0.1
Prevalence of HIV, male (% ages 15-24)	27	0
Prevalence of HIV, total (% of population ages 15-49)		0.1
Tuberculosis cases detected under DOTS (%)		62

246 World Development Indicators Database, see: http://ddp-ext.worldbank.org/ext/ ddpreports/ViewSharedReport?&CF=1&REPORT_ID=1336&REQUEST_TYPE=VIEWADVANCED&HF=N

Country Profile: Syria

COUNTRY INDICATORS

Country name

Syrian Arab Republic

Population

20.50 M (2007)
21.23 M (2008)[247]

Population growth rate

3.5 percent (2007 and 2008)[248]

Capital

Damascus

Constitution

Adopted on 13March1971[249]

Political system

Parliamentary Republic
Since 1963, Emergency Law has been in effect, suspending most constitutional protections for Syrians[250]

HDI Ranking

HDI Rank: 107 out of 182 countries
HDI value: 0.742 (2007)[251]

Total GDP

In current US $: 40.55 B (2007)
55.20 B (2008)[252]

Inequality ranking (GINI)

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Gender

GDI rank (2007): 98
GDI value (2007): 0.715
12 percent of seats in parliament held by women, 2007
6 percent of women in ministerial positions, 2008
1949, 1953: year women received the right to vote
1953: year women received the right to stand for election[253]

247 World Development Indicators Database, April 2009: http://ddp-ext.worldbank.org/ext/ddpreports/ViewSharedReport?&CF=1&REPORT_ID=9147&REQUEST_TYPE=VIEWADVANCED&HF=N&WSP=N
248 World Development Indicators Database, April 2009 (see link above)
249 http://en.wikipedia.org/wiki/Syria#cite_note-const-45
250 http://en.wikipedia.org/wiki/Politics_of_Syria
251 http://hdrstats.undp.org/en/countries/data_sheets/cty_ds_SYR.html
252 World Development Indicators Database, April 2009 (see link in Footnote 1)
253 http://hdrstats.undp.org/en/countries/data_sheets/cty_ds_SYR.html

GDP real growth rate

4.2 percent (2007 annual growth rate)
5.2 percent (2008 annual growth rate)[254]

GDP per capita

PPP USD 4,511 (2007)[255]

Unemployment rate

8.6 percent (2008 est.)[256]

Population below poverty line

Data unavailable

BCI level

Data unavailable

Persons with disabilities stats

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Literacy rate (15+)

83.1 percent (2007)
Female adult literacy, 1997-2007: 76.5 percent
Male adult literacy, 1997-2007: 89.7 percent[257]

Public spending on social services

Government expenditure on health per capita (PPP US$), 2006: 52
Public current expenditure on primary education per pupil (PPP US$): 611
Percentage of total aid allocated to social sectors (gross disbursements), 2007: 79.6[258]

Achievement of MDGs[259]

Millennium Development Goals	2005	2008
Goal 1. Eradicate extreme poverty and hunger		
Employment to population ratio, 15+ total (%)	45	45
Employment to population ratio, ages 15-24, total (%)	33	33
GDP per person employed (annual % growth)	0	2
Malnutrition prevalence, weight for age (% of children under 5)	-	-
Prevalence of undernourishment (% of population)	-	-
Goal 2. Achieve universal primary education		
Literacy rate (youth, female) (% of females ages 15-24)	90	92
Literacy rate (youth, male) (% of males ages 15-24)	95	95
Primary completion rate, total (% of relevant age group)	92	95
Total enrolment, primary (% net)	-	-

254 World Development Indicators Database, April 2009 (see link in Footnote 1)
255 http://hdrstats.undp.org/en/countries/data_sheets/cty_ds_SYR.html
256 http://www.indexmundi.com/syria/unemployment_rate.html
257 http://hdrstats.undp.org/en/countries/data_sheets/cty_ds_SYR.html
258 http://hdrstats.undp.org/en/countries/data_sheets/cty_ds_SYR.html
259 World Development Indicators Database, see: http://ddp-ext.worldbank.org/ext/ddpreports/ViewSharedReport? &CF=1&REPORT_ID=1336& REQUEST_TYPE=VIEWADVANCED&HF=N

Goal 3. Promote gender equality and empower women		
Proportion of seats held by women in national parliaments (%)	12	12
Ratio of female to male enrolments in tertiary education	-	-
Ratio of female to male primary enrolment	95	96
Ratio of female to male secondary enrolment	94	97
Share of women employed in the non-agricultural sector ((% of total non-agricultural employment)	10.3	-
Goal 4. Reduce child mortality		
Immunization, measles (% of children ages 12-23 months)	98	98
Mortality rate, infant (per 1,000 live births)	16	15
Mortality rate, under-5 (per 1,000)	18	17
Goal 5. Improve maternal health		
Adolescent fertility rate (births per 1,000 ages 15-19)	67	61
Births attended by skilled health staff (% of total)	93	93
Contraceptive prevalence (% of woman ages 15-49)	58	58
Maternal mortality ratio (modeled estimate, per 100,000 live births)	130	-
Pregnant women receiving prenatal care (%)	84	84
Goal 6. Combat HIV/AIDS, malaria and other diseases		
Incidence of tuberculosis (per 100,000 people)	-	-
Prevalence of HIV, female (% ages 15-24)	-	-
Prevalence of HIV, male (% ages 15-24)	-	-
Prevalence of HIV, total (% of population ages 15-49)	-	-
Tuberculosis cases detected under DOTS (%)	89	80

Country Profile: Yemen

COUNTRY INDICATORS

Country name
Republic of Yemen

Population
22.4 M (2007) [260]

Population growth rate
3.0 percent (2001-2007)[261]

Capital
Sana'a

Constitution
Amended in 1994 after the war; 52 clauses were amended, 29 clauses added and one (1) deleted. Changes were approved by parliament on 29September1994.[262]
A controversial change was made to Article 3, which made the Islamic Shariah the source of all legislation, when previously; it was only "the main source".

Political system
Presidential Republic with a bicameral legislature

HDI Ranking
140th out of 182 countries (HDI = 0.575)[263]

Total GDP
$22.5 billion (2007)[264]

Inequality ranking (GINI)
32 (1998) [265]
33.4 (2009)[266]

Gender
1: Seats in parliament (% held by women), 2008
1967, 1970: Year women received the right to vote and stand for election
6: women in ministerial positions (% of positions), 2008

GDP real growth rate
3.6 percent (2007)
0.6 percent (2007, GDP per capita)[267]

260 http://web.worldbank.org/WBSITE/EXTERNAL/COUNTRIES/MENAEXT/YEMENEXTN/0,, menuPK:310170~pagePK:141159~piPK:141110~theSitePK:310165,00.html
261 http://devdata.worldbank.org/AAG/yem_aag.pdf (which can also be accessed through the link in footnote 1)
262 http://www.al-bab.com/yemen/gov/con94a.htm
263 http://hdrstats.undp.org/en/countries/country_fact_sheets/cty_fs_YEM.html
264 http://web.worldbank.org/WBSITE/EXTERNAL/COUNTRIES/MENAEXT/YEMENEXTN/0,,menuPK:310170~ pagePK:141159~piPK:141110~theSitePK:310165,00.html
265 Chemingui, Mohamed Abdelbasset. 2007. Public Spending and Poverty Reduction in an Oil-Based Economy: The Case of Yemen. International Food Policy Research Institute Working Paper No. 00701.
266 http://www.visionofhumanity.org/gpi/results/yemen/2009/
267 http://devdata.worldbank.org/AAG/yem_aag.pdf

GDP per capita

$465 (2000) [268]
$2,335 (2007), GDP per capita, PPP[269]
$970 (2009)[270]

Unemployment rate

11.5 percent[271]

Population below poverty line

42 percent[272]

BCI level

59[273]

Persons with disabilities stats

MDG

See table below

Literacy rate (15+)

58.9 percent[274]

Public spending on social services

9.6 percent: current education spending (% of GDP)[275]
32.8 percent: public expenditure on education as a percentage of total government expenditure, 2000-2007
38 percent: government expenditure on health per capita (PPP US$), 2006
5.6 percent: government expenditure on health as a percentage of total government expenditure[276]

Achievement of MDGs[277]

Millennium Development Goals	2005	2008
Goal 1. Eradicate extreme poverty and hunger		
Employment to population ratio, 15+ total (%)	39	39
Employment to population ratio, ages 15-24, total (%)	22	22
GDP per person employed (annual % growth)	1	0
Malnutrition prevalence, weight for age (% of children under 5)	-	-
Prevalence of undernourishment (% of population)	32	-

268 Kabbani, Nader and Wehelie, Yassin.. Measuring Hunger and Food Insecurity in Yemen. Working Paper 0419.
269 http://hdrstats.undp.org/en/countries/country_fact_sheets/cty_fs_YEM.html
270 http://www.visionofhumanity.org/gpi/results/yemen/2009/
271 ibid.
272 http://www.socialwatch.org/node/567
273 ibid.
274 http://www.visionofhumanity.org/gpi/results/yemen/2009/
275 ibid.
276 http://hdrstats.undp.org/en/countries/data_sheets/cty_ds_YEM.html
277 http://ddp-ext.worldbank.org/ext/ddpreports/ViewSharedReport?&CF=1& REPORT_ID=1336&REQUEST_TYPE=VIEWADVANCED&HF=N

Goal 2. Achieve universal primary education		
Literacy rate (youth, female) (% of females ages 15-24)	59	67
Literacy rate (youth, male) (% of males ages 15-24)	91	93
Primary completion rate, total (% of relevant age group)	60	-
Total enrolment, primary (% net)	75	-
Goal 3. Promote gender equality and empower women		
Proportion of seats held by women in national parliaments (%)	0	0
Ratio of female to male enrolments in tertiary education	37	37
Ratio of female to male primary enrolment	74	-
Ratio of female to male secondary enrolment	49	-
Share of women employed in the non-agricultural sector ((% of total non-agricultural employment)	-	-
Goal 4. Reduce child mortality		
Immunization, measles (% of children ages 12-23 months)	76	74
Mortality rate, infant (per 1,000 live births)	59	55
Mortality rate, under-5 (per 1,000)	79	73
Goal 5. Improve maternal health		
Adolescent fertility rate (births per 1,000 ages 15-19)	72	68
Births attended by skilled health staff (% of total)	36	36
Contraceptive prevalence (% of woman ages 15-49)	28	28
Maternal mortality ratio (modelled estimate, per 100,000 live births)	430	-
Pregnant women receiving prenatal care (%)	41	-
Goal 6. Combat HIV/AIDS, malaria and other diseases		
Incidence of tuberculosis (per 100,000 people)	82	76
Prevalence of HIV, female (% ages 15-24)	-	-
Prevalence of HIV, male (% ages 15-24)	-	-
Prevalence of HIV, total (% of population ages 15-49)	-	-
Tuberculosis cases detected under DOTS (%)	41	46

Country Profile: Occupied Palestinian territories

COUNTRY INDICATORS

Country name

Palestine, West Bank and the Gaza Strip or Occupied Palestinian territories

In a petition made by the Palestinian National Authority, the US granted its request for the West Bank and Gaza as a country or a legitimate political entity. However, the World Bank does not recognize it as a sovereign state, effectively disqualifying it from applying for membership in the World Bank Group and consequently, accessing sources of financing available to its member states[278].

Population

3.71 M (2007)
3.84 M (2008)[279]

Population growth rate

3.4 percent

Capital

Jerusalem is the capital of Palestine, which includes the regions of West Bank and Gaza; however, it is only in the Social Watch report that Palestine is even categorized as a country. (*See www.socialwatch.org/node/457)*

All other relevant websites and research materials only refer to West Bank and the Gaza Strip but are still not recognized as independent states; the UN refers to these areas/ states/countries as "Occupied Palestinian territories", indicating the nature of its non-independence.

Constitution

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Political system

The **Israel-PLO Declaration of Principles on Interim Self-Government Arrangements** (**DOP** or the **Oslo Accords**) signed in 13September1993 provides a 5-year transition period of Palestinian interim self-government in sections of the Gaza Strip and the West Bank.

The agreement obliges Israel to recognize the West Bank and the Gaza Strip as a single territorial unit, governed by the Palestinian Authority.

HDI Ranking

110[280]

0.737 – HDI value, 2007[281]

278 http://web.worldbank.org/WBSITE/EXTERNAL/COUNTRIES/MENAEXT/WESTBANKGAZAEXTN/0,,menuPK: 294372~pagePK:141132~piPK:141121~theSitePK:294365,00.html
279 http://ddp-ext.worldbank.org/ext/ddpreports/ViewSharedReport?&CF=1&REPORT_ID=9147&REQUEST_TYPE=VIEWADVANCED&HF=N&WSP=N
280 http://hdrstats.undp.org/en/countries/data_sheets/cty_ds_PSE.html
281 http://hdrstats.undp.org/en/countries/data_sheets/cty_ds_PSE.html

Total GDP

4.02 B, in current US$, 2005[282]

Inequality ranking (GINI)

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Gender

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GDP real growth rate

6.3 percent – GDP annual growth, 2005[283]

GDP per capita

USD 1,129 (2006)[284]

Unemployment rate

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Population below poverty line

58 percent – Palestinians living below the poverty line, half of these (30 percent) are in extreme poverty.[285]
71 percent – number of poor households in Gaza Strip, August 2007
51 percent – number of poor households in West Bank, August 2007
A UNDP study in May 2007was cited by the Social Watch Organization.

BCI level

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Persons with disabilities stats

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MDG

See below

Literacy rate (15+)

93.8 percent, 2007[286]
90.3 percent – female adult literacy rate, 1997- 2007
97.2 percent – male adult literacy rate, 1997 -2007

Public spending on social services

58.4 percent – percentage of total aid allocated to social sectors (gross disbursements), 2007[287]

282 http://ddp-ext.worldbank.org/ext/ddpreports/ViewSharedReport?&CF=1&REPORT_ID= 9147&REQUEST_TYPE=VIEWADVANCED&HF=N&WSP=N
283 http://ddp-ext.worldbank.org/ext/ddpreports/ViewSharedReport?&CF=1&REPORT_ID=9147& REQUEST_TYPE=VIEWADVANCED&HF=N&WSP=N
284 http://www.socialwatch.org/node/457
285 ibid.
286 http://hdrstats.undp.org/en/countries/data_sheets/cty_ds_PSE.html
287 ibid.

Achievement of Millennium Development Goals

Millennium Development Goals (MDGs)	2005	2008
Goal 1. Eradicate extreme poverty and hunger		
Employment to population ratio, 15+ total (%)	31	32
Employment to population ratio, ages 15 - 24, total (%)	17	16
GDP per person employed (annual % growth)	-	-
Malnutrition prevalence, weight for age (% of children under 5)	-	-
Prevalence of under nourishment (% of population)	-	-
Goal 2. Achieve universal primary education		
Literacy rate (youth, female) (% of females ages 15 - 24)	99	99
Literacy rate (youth, male) (% of males ages 15 - 24)	99	99
Primary completion rate, total (% of relevant age group)	95	83
Total enrolment, primary (% net)	82	77
Goal 3. Promote gender equality and empower women		
Proportion of seats held by women in national parliaments (%)	-	-
Ratio of female to male enrolments in tertiary education	103	122
Ratio of female to male primary enrolment	99	100
Ratio of female to male secondary enrolment	105	106
Share of women employed in the non-agricultural sector (% of total non-agricultural employment)	16.1	17.1
Goal 4. Reduce child mortality		
Immunization, measles (% of children ages 12 - 23 months)	-	-
Mortality rate, infant (per 1,000 live births)	24	24
Mortality rate, under -5 (per 1,000)	28	27
Goal 5. Improve maternal health		
Adolescent fertility rate (births per 1,000 ages 15 - 19)	85	79
Births attended by skilled health staff (% of total)	97	99
Contraceptive prevalence (% of woman ages 15 - 49)	50	50
Maternal mortality ratio (modelled estimate, per 100,000 live births)	-	-
Pregnant women receiving prenatal care (%)	99	99
Goal 6. Combat HIV/AIDS, malaria and other diseases		
Incidence of tuberculosis (per 100,000 people)	-	-
Prevalence of HIV, female (% ages 15 - 24)	-	-
Prevalence of HIV, male (% ages 15 - 24)	-	-
Prevalence of HIV, total (% of population ages 15 - 49)	-	-
Tuberculosis cases detected under DOTS (%)	3	5

Reference:
World Development Indicators Database, see: http://ddp-ext.worldbank.org/ext/ddpreports/ViewSharedReport?&CF=1&REPORT_ID=1336&REQUEST_TYPE=VIEWADVANCED&HF=N

A word from CBM and Handicap International

Although significant progress has been witnessed over the last decade towards the universal recognition of Persons with Disabilities as rights holders on an equal basis with others, insufficient changes are reported in their daily life. The signature and the ratification of the United Nations Convention on the Rights of Persons with Disabilities (CRPD) by an increasing number of countries definitely create a momentum where this recognition is supposed to be transformed into reality.

However, many factors like the inappropriate allocation of resources, the lack of knowledge on disability, the lack of coordination between stakeholders and the lack of an accurate understanding of the comprehensive issues in relation to the needs and demands of persons with disabilities affects this process.

In the Middle East, the situation follows this global trend with two major factors jeopardizing a strong movement of change: Firstly, the lack of understanding of the situation and of evidence of good practices and; secondly, the weakness of the disability movement which does not currently have the capacity to be acknowledged as a strong and reliable counterpart by Duty Bearers or as being in a position to influence them.

The Disability Monitor Initiative - Middle East (DMI-ME) is a civil society initiative which was built by a coalition of six organisations with the aim of contributing to fill these gaps. This report on "Access to Social Services for Persons with Disabilities in the Middle East" proposes to show the importance of ensuring the access to services as a necessary means to guarantee that persons with disabilities can enjoy their fundamental rights; it introduces mechanisms related to Access to Services, reflecting on the roles and responsibilities of each main stakeholder and the implication in terms of regulatory mechanisms, with recommendations for them. It highlights good practices of service provision collected throughout the region via workshops, field visits and exchanges with a vast range of stakeholders, providing recommendations with respect to improving access to services for persons with disabilities.

This report is part of a collection of resources the DMI-ME has been producing and will continue to produce, including a regional legislative review looking at implementation of disability related laws in the Middle East; periodic journals focusing on very specific issues (e.g. the CRPD, Social Protection and Education have been already addressed); and a web-based information resource including an on-line library. It intends to contribute to building the capacities of Middle Eastern civil society organisations by developing its expertise and its influence for Duty Bearers towards the improvement of the conditions of living for persons with disabilities.

The path for a sustainable change in the daily life of persons with disabilities is long but civil society organisations of the Middle East have started to move.

Produced by
Handicap International and CBM

Funded by

In cooperation with