# Equal Basis 2014:
## Access and Rights in 33 Countries

**Disability in Challenging Environments –**

**Armed Conflict**

**Post Conflict**

**Political & Economic Transition**

# Table of Contents

# Acknowledgements

The report was written by Megan Burke and Loren Persi Vicentic, Thematic Editors for the Monitor.

Thanks to Research Specialist Clémence Caraux-Pelletan and country profile researchers: Margaret Arech Orech, Marija Breber, Shushira Chonhenchob, Denise Coghlan, Geoffrey Duke, Mamady Gassama, Bekele Gonfa, Ania Kudarewska, Carlos Lujan Andrade, Jesus Martinez, Rahmatullah Merzayee, Francky Miantuala, Muteber Ogreten, Aisha Saeed, Camilo Serna Villegas, Ayman Sorour, and Jelena Vicentic.

Thanks also to those experts who reviewed the report and provided valuable feedback: Sheree Bailey, Disability Advisor, Elke Hottentot, Handicap International, Sebastian Kasack, Consultant in Mine Action and in Conflict Transformation, Marianne Schulze, Expert Human Rights Consultant, and Claude Tardif, ICRC. We thank Lisa Adams (Handicap International), Amelie Chayer (ICBL-CMC), and Marianne Schulze for their input during the research development process. These experts have responded in their individual capacity. Their input has been invaluable. The thematic editors are solely responsible for any errors or omissions.



**Photo Credits: (Loren Persi Vicentic/ICBL-CMC, unless otherwise noted)**

**Adequate Healthcare:** Emergency medical services call center number, Thailand

**Rehabilitation:** Rehabilitation center, Tajikistan

**Enabling Environments:** Steep ramp at the beach, El Salvador (Credit: © Foundation Network of Survivors and Persons with Disabilities)

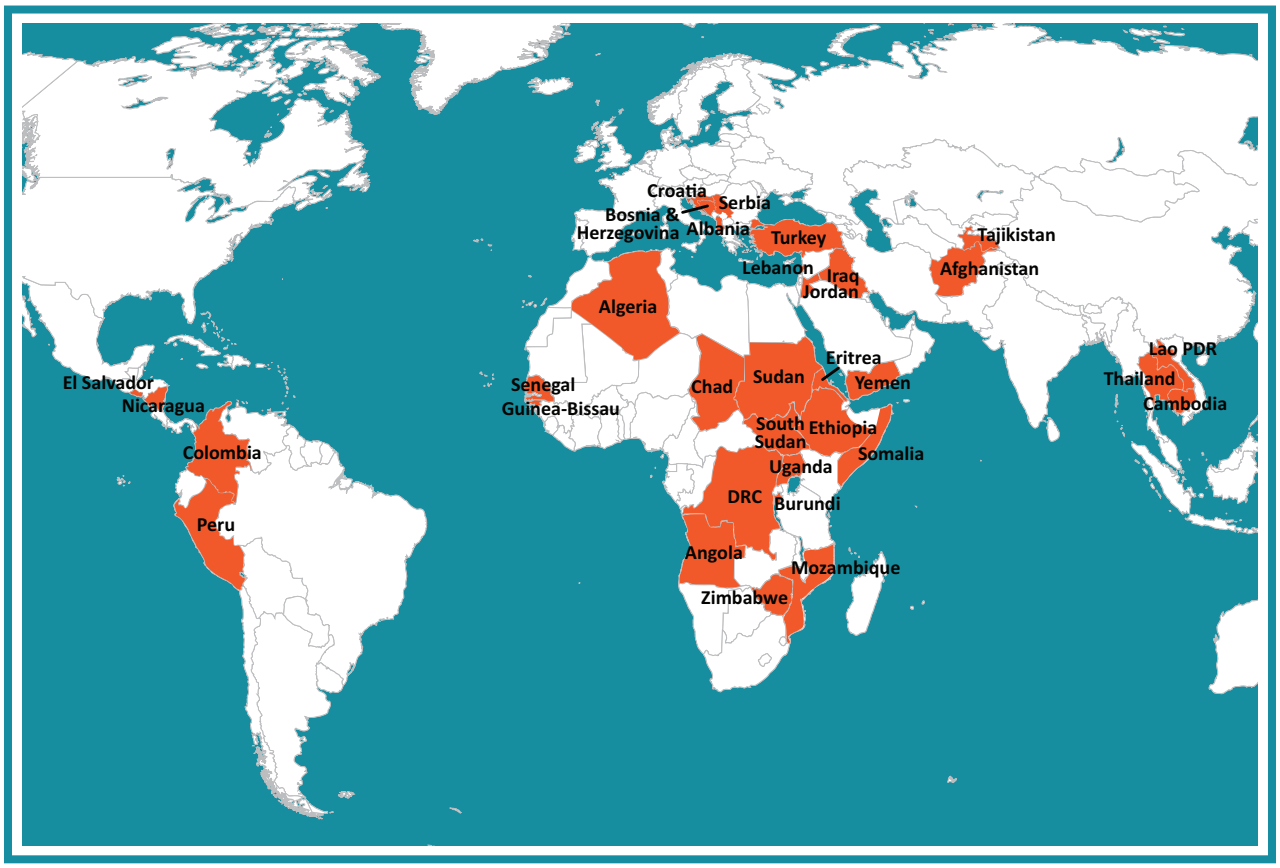
**Work and Employment:** Small business owner, Ethiopia

# Synopsis

This overview provides up-to-date information on efforts to fulfill responsibilities in promoting the rights of persons with disabilities—including the survivors of landmines, cluster munitions, and other explosive remnants of war—as well as in providing assistance for activities that address the needs of survivors and other persons with disabilities with similar needs. All of the 33 countries reviewed in this report have obligations and commitments to enforce those rights. The annual findings in this report can contribute to the work of a range of actors in the fields of disability issues, humanitarian relief, development, and human rights, and can also contribute to strengthening linkages among the actors in these fields.

By providing an overview of annual progress and challenges in the access to and the availability of healthcare, rehabilitation, and work and employment in these countries, this report shows that, in the face of vast challenges and numerous setbacks, there have been measurable improvements in services and activities that are available to both survivors and other persons with disabilities who have similar needs. Such improvements, even in the space of a year, allow for analysis of good practices. Particularly relevant are activities in development and post-conflict settings that increased the accessibility of environments and made progress in ensuring the inclusion and full participation of persons with disabilities, including survivors, in their societies on an equal basis with others.

## 33 Countries reviewed in this report




The designations employed and the presentation of the material on this map do not imply the expression of any opinion whatsoever concerning the legal status of any country, territory, or area or of its authorities, or concerning the delimitation of its frontiers or boundaries.

# Executive Summary

This report presents country-specific findings on changes in services, programs, and policies in 2013 in the areas of healthcare, rehabilitation, accessibility and enabling environments,[1] and work and employment that impact persons with disabilities in 33 countries whose populations have been affected by armed conflict and violence. It makes available annual research findings that will be useful to a wide range of actors working to promote the goal of societies accessible for and inclusive of persons with disabilities, including government representatives, NGOs, and service providers working in humanitarian relief, development, and human rights.

In the area of general healthcare including emergency health response, there were serious gaps in most countries in ongoing medical care and psychological healthcare services. However, responses to emergency health needs were provided in situations of armed conflict. While transport to health services was lacking in many countries, some made special efforts to increase the capacity of transport to healthcare using innovation in the face of limited resources. Others reached out to offer healthcare in communities and homes. Healthcare cost and equal access to healthcare remained significant challenges for persons with disabilities, especially in the area of specialized health services that persons with disabilities needed at a higher rate than the general population. To address these gaps, a number of countries extended national healthcare coverage or assisted persons with disabilities to register for health insurance.

Consistency and sustainability of rehabilitation programs and services were often not sufficient due to shortages of funding and trained staff. Progress was made in several countries with the construction of new rehabilitation centers, the reinvigoration of centers that had ceased to function, or through the introduction or expansion of outreach programs. Capacity-support including staff training by international organizations remained crucial to many rehabilitation programs. The withdrawal of some international programs or the reduction in their financial support, as well as political changes, hampered or stopped the work of a number of rehabilitation centers. As with healthcare more generally, sustainable financial coverage of services was an important measure to avoid creating financial hardship for persons with disabilities as users of these services. This coverage improved through concerted efforts in a few states. Equality and non-discrimination were essential to reaching all those in need, although there was work to do in many countries to ensure equal access among persons with disabilities.

Many of these countries had accessibility policies in place in 2013, in an effort to create an enabling environment for persons with disabilities. In addition, in some cases there was measurable progress in advancing accessibility. Such progress provided good practices to consider for other contexts. However, overall the implementation of policies and accompanying standards and enforcement measures were mostly missing or extremely limited, especially outside of urban areas. Partial compliance with physical accessibility regulations was common, but this did little to improve the situation for persons with disabilities who often faced barriers after initially being able to access a space. Transforming public attitudes towards the importance of accessibility was found to be a vital component in successfully expanding accessible spaces, as was the active participation of persons with disabilities in the process.

Persons with disabilities continued to be excluded from gaining meaningful work and employment in all the countries outlined in this report. The lack of inclusion was often exacerbated by poor economic conditions in these low-income and post-conflict economic environments. In several countries, access to vocational training for persons with disabilities increased, but funding for business start-ups, such as micro-credit loans, remained less available to persons with disabilities than for the rest of the population. Some programs targeted persons with disabilities to address this unequal access, but generally these projects were time-limited and did not reach the most vulnerable people. Projects to raise awareness among employers were carried out to counter discrimination against persons with disabilities in hiring practices. In at least one case, a government took steps to adjust pension policies that created disincentives for persons with disabilities to seek work.

# Background and Methodology

Research findings are presented in the framework of the Convention on the Rights of Persons with Disabilities[2] (CRPD, 2006) and as relevant to the World Health Organization's (WHO) *World Report on Disability* (2011).[3] The *World Report on Disability* is a unique global report on the situation of persons with disabilities, the obstacles they face, and practices to overcome barriers to healthcare, rehabilitation, education, employment, and support services as well as practices to create the environments which enable persons with disabilities to live on an equal basis with others. *Equal Basis 2014*, like the *World Report on Disability*, places current challenges in the context of programs and actions that aim to overcome these very challenges.

This research on disability issues has been carried out as an integral part of monitoring the implementation of provisions of what has been termed in humanitarian disarmament conventions as "victim assistance."[4] In purpose and in practice, such assistance encompasses responses to the needs of persons with disabilities, who face similar barriers and impairments (acquired through other causes or at birth) as those faced by survivors[5] of landmines, cluster munitions, explosive remnants of war (ERW), and other weapons.[6] The provisions arise within the work of humanitarian disarmament conventions, particularly the Mine Ban Treaty (1997) and its subsequent five-year action plans, and the Convention on Cluster Munitions (2008). States Parties to these treaties have agreed to provide adequate age- and gender-appropriate medical care and rehabilitation (including psychological support) as well as to provide for social and economic inclusion, in accordance with applicable international human rights law, based solely on needs and without discrimination as to the cause of impairments.

For more than a decade, the Landmine Monitor (which later became the Landmine and Cluster Munition Monitor), a civil society initiative providing research for the Nobel Peace Prize co-laureate International Campaign to Ban Landmines (ICBL) and later for its partner campaign the Cluster Munition Coalition (CMC), has been the *de facto* monitoring regime for these conventions. In this role, the Monitor has tracked the availability and accessibility of services and programs for persons with disabilities, as well as laws and policies to uphold their rights. The launch of this initiative in 1999 marked the first time that NGOs came together in a coordinated, systematic, and sustained way to monitor a humanitarian law or disarmament treaty, and to continue annually documenting the progress and problems.

## Geographic coverage and context of research

This report focuses on 33 countries that have reported substantial numbers of survivors of landmines or other indiscriminate effects of weapons. Most of these states have also recognized that these survivors, many of whom are persons with disabilities, have significant needs for which they, as the state, have made a commitment to address.

While much of the data gathered addresses the situation of persons with disabilities in the country as a whole, some information is specific to the situation in particular regions of a country, namely those that are most impacted by indiscriminate weapons and the indiscriminant effects of ERW.[7] These regions tend to be rural and remote areas; thus the research provides particular insight into the needs of persons with disabilities who live far from most urban-centered services and into programs and responses that have been developed to address their needs.

# States reviewed in this report

| STATE | CRPD | MBT | CCM |
|---|---|---|---|
| Afghanistan | Yes | Yes | Yes |
| Albania | Yes | Yes | Yes |
| Algeria | Yes | Yes | No |
| Angola | Yes | Yes | Signatory |
| Bosnia & Herzegovina | Yes | Yes | Yes |
| Burundi | Yes | Yes | Yes |
| Cambodia | Yes | Yes | No |
| Chad | Signatory | Yes | Yes |
| Colombia | Yes | Yes | Signatory |
| DRC | No | Yes | Signatory |
| Croatia | Yes | Yes | Yes |
| El Salvador | Yes | Yes | Yes |
| Eritrea | No | Yes | No |
| Ethiopia | Yes | Yes | No |
| Guinea-Bissau | Yes | Yes | Yes |
| Iraq | Yes | Yes | Yes |
| Jordan | Yes | Yes | No |
| Lao PDR | Yes | No | Yes |
| Lebanon | Signatory | No | Yes |
| Mozambique | Yes | Yes | Yes |
| Nicaragua | Yes | Yes | Yes |
| Peru | Yes | Yes | Yes |
| Senegal | Yes | Yes | Yes |
| Serbia | Yes | Yes | No |
| Somalia | No | Yes | Signatory |
| South Sudan | No | Yes | No |
| Sudan | Yes | Yes | No |
| Tajikistan | No | Yes | No |
| Thailand | Yes | Yes | No |
| Turkey | Yes | Yes | No |
| Uganda | Yes | Yes | Signatory |
| Yemen | Yes | Yes | No |
| Zimbabwe | Yes | Yes | No |

Yes
No
Signatory

**CRPD:** Convention on the Rights of Persons with Disabilities
**MBT:** Mine Ban Treaty
**CCM:** Convention on Cluster Munitions

All 33 states have experienced armed conflict, violence, or violent transitions. In eight states—Afghanistan, Colombia, Democratic Republic of Congo (DRC), Iraq, Somalia, South Sudan, Sudan, and Yemen—armed conflict was reported to have affected the availability of, or access to, services and programs for persons with disabilities in 2013. The other 25 states have experienced armed conflict or violence in the past. In addition to leaving people in these countries impacted by landmines, cluster munitions, or other deadly debris, violent events often damaged or destroyed health and rehabilitation infrastructure resulting in increased numbers of people with impairments and created additional barriers that prevent the full participation of persons with disabilities. In many cases, these countries have required extensive post-conflict reconstruction programs.

Among the 33 states covered by this report, 16 ranked "low" on the UN Development Programme's (UNDP) Inequality-Adjusted Human Development Index (IHDI), indicating comparatively low human development achievements in the areas of health, education, and income.[8] Lower levels of development tend to limit the availability of services and programs for all members of the population and to particularly exacerbate barriers to services and programs for persons with disabilities.[9] Another 11 states included in this report were ranked as "high" or "very high" on the IHDI, thereby also providing perspectives on the situation of persons with disabilities in more developed countries.[10]

## Research methodology

This research was collected through interviews and questionnaires from a broad range of sources that included government representatives from national councils on disability, ministries of health, ministries of social affairs, mine action centers, representatives of disabled persons' organizations (DPOs) including mine/ERW survivor networks,[11] international and national NGOs, UN staff, and many other service providers. This unique information is supplemented with publicly available reports, statements, and publications. The editorial team for this report worked with 17 researchers, more than a quarter of whom are persons with disabilities. They carried out research among the 33 states. Periodic field missions by report editors to those countries without researchers served to verify information collected through desk research and through interviews with disability experts and others at international meetings.

Since 1999, the Monitor has produced country-specific profiles detailing findings on the situation of services for persons with disabilities, including survivors, in approximately 50–100 countries annually. Detailed annual country profiles for 2013[12] and previous years are available online.

## Disability rights and humanitarian disarmament frameworks

During 2013 and the first half of 2014, the international community took concrete steps to advance the rights of persons with disabilities by linking related efforts undertaken in multiple disability, development, and humanitarian-disarmament frameworks. These initiatives emerged from actors working on addressing the needs and on promoting the rights of mine/ERW survivors within the context of disarmament treaties. It is generally accepted that the CRPD is relevant to survivors.[13] Recalling the words of Ron McCallum in 2010, then chair of the Committee on the Rights of Persons with Disabilities, landmine survivors are persons with disabilities and they are covered by the CRPD.[14] Similarly, over time it has become more widely recognized that, just as efforts to respond to the needs of survivors should indiscriminately benefit all persons with similar needs including other persons with disabilities, so should the rights of survivors be considered by disability rights actors.[15]

The needs and rights of people with disabilities including survivors are generally indistinguishable on the ground, as are the responses at the programmatic level. There has been an increase in the interweaving of humanitarian-based responses and broader right-based disability initiatives at the national and international policy levels. In 2013 and into 2014, relevant stakeholders came together at the country level in a series of national meetings in Peru, Ethiopia, and Tajikistan.[16] The meetings intentionally included representatives of both survivor networks and DPOs, along with representatives of government and of NGOs, and sought to develop collaborative efforts to advance disability programs, plans, and policies in conformity with the CRPD in these countries.[17]

A global conference held in Colombia in April 2014 discussed assistance to persons with disabilities, including survivors of landmines and ERW, in broader contexts.[18] It revealed commonalities between landmine survivors and others with similar needs, and recognized contributions made by the mine ban community to promote the rights of persons with disabilities as well as the contribution of the CRPD to strengthening legal frameworks to promote the rights of survivors.[19] Subsequent follow-up meetings held in Geneva and Maputo reinforced these conclusions and forged additional relationships among individuals working primarily on disability, development, or assistance to survivors from rights-based and humanitarian perspectives.

Other regional gatherings in Africa and Latin America, hosted by key actors such as the African Union, the ICRC, Handicap International, and the ICBL, carried these global conversations forward, outlining concrete measures to foster collaboration for the benefit of all persons with disabilities.

### Participation and inclusion

A core principle and obligation of the CRPD is the "full and effective participation and inclusion in society" for all persons with disabilities and that states in particular "closely consult with and actively involve" persons with disabilities in relevant decision-making processes.[20] For several years, the Monitor has tracked the participation of survivors and other persons with disabilities in decision-making and in the design, implementation, and monitoring of programs and services.[21] In this report, participation is highlighted in the section on enabling environments.

Without a doubt, the participation of a diversity of persons with disabilities, including men and women, people with different types of impairments, and people from rural and urban areas, in all decisions that impact their lives and as active members of their communities, their countries, and at the international level, is essential. It is a principle that cuts across all four thematic areas covered in this report and one that warrants future consideration and analysis.

In this report, the Monitor contributes to these recent efforts by reporting on the challenges faced by all persons with disabilities who have similar needs to survivors, and on solutions to overcoming barriers, in 33 countries in four thematic areas:

- Adequate healthcare;
- Rehabilitation;
- Enabling environments; and
- Work and employment.

## Endnotes

[1] Enabling environments are those that are accessible and enable the participation and inclusion of persons with impairments.
[2] Convention on the Rights of Persons with Disabilities, www.un.org/disabilities/convention/conventionfull.shtml.
[3] Dr. Tom Shakespeare of the WHO presented the *World Report on Disability* to the Standing Committee on Victim Assistance and Socio-Economic Reintegration of the Mine Ban Treaty on 23 June 2011. "Achieving the aims of the Cartagena Action Plan: The Phnom Penh Progress Report 2010–2011," 2 December 2011, p. 118.
[4] To date, victim assistance efforts have mainly been limited to the enhancement of programs and policies for persons with disabilities including survivors. The definition of "victim" in humanitarian disarmament treaties relates to the violation of human rights and humanitarian norms and includes all persons who have been killed or physically or psychologically injured, or suffered economic loss, social marginalization, or substantial impairment of the realization of their rights caused by the use of the prohibited weapon. This includes those persons directly impacted as well as their affected families and communities including persons with disabilities.
[5] A survivor is a person who was injured by any of these weapons and lived.
[6] Please see the *Landmine Monitor Report 2014* for more information about these weapons.
[7] An indiscriminate weapon is a weapon that cannot be directed at a military objective or whose effects cannot be limited as required by international humanitarian law. Weapon Law Encyclopedia, "Indiscriminant weapon," last updated 23 June 2014, www.weaponslaw.org/glossary/indiscriminate-weapon; and ICRC, "Rule 71. Weapons That Are by Nature Indiscriminate," undated, www.icrc.org/customary-ihl/eng/docs/v1_cha_chapter20_rule71. The Convention on Conventional Weapons recalls "the general principle of the protection of the civilian population against the effects of hostilities."
[8] Afghanistan, Angola, Burundi, Chad, DRC, Eritrea, Ethiopia, Guinea-Bissau, Mozambique, Senegal, Somalia (unranked), South Sudan (unranked), Sudan, Uganda, Yemen, and Zimbabwe. UNDP, Inequality-Adjusted Human Development Index, 2013, hdr.undp.org/en/content/inequality-adjusted-human-development-index-ihdi.
[9] There appears to be a relationship between a country's Human Development Index (HDI) ranking and the provision of emergency and continuing medical care. States Parties with higher HDI rankings tend to have better emergency and continuing medical care, while countries that are underdeveloped continue to struggle to meet the basic needs of the population as a whole, including people with disabilities and, among them, landmine survivors. ICBL, *Landmine Victim Assistance in 2006: Overview of the Situation in 24 States Parties*, published by Standing Tall on behalf of the ICBL Working Group on Victim Assistance, 3rd Edition, April 2007, p. 12, victimassistance.files.wordpress.com/2014/06/ landminevic2006.pdf. It should also be noted that according to the *World Report on Disability*, "Longitudinal data sets to establish the causal relation between disability and poverty are seldom available, even in developed countries." WHO, *World Report on Disability,* Geneva, 2011, p. 39.
[10] Albania, Algeria, BiH, Colombia, Croatia (very high), Jordan, Lebanon, Peru, Serbia, Thailand, and Turkey. The remaining six states were ranked as "medium": Cambodia, El Salvador, Iraq, Lao PDR, Nicaragua, and Tajikistan.
[11] "Mine/ERW survivor networks" are networks of people who have been impacted by landmines, cluster munitions, and ERW and often also include other victims of armed conflict and other persons with disabilities.
[12] All country-specific examples included in this report are also available, with references to original sources, in full country profiles available on the Monitor website, www.the-monitor.org/cp.
[13] Landmine survivors can also include people who recover from their injuries.
[14] ICBL, International Standing Committee Meetings, 21–25 June 2010—Summary, 20 July 2010, www.icbl.org/en-gb/news-and-events/news/2010/intersessional-standing-committee-meetings,-21-25.aspx.
[15] For example, see Mine Ban Treaty Implementation Support Unit, "Assisting Landmine and other ERW Survivors in the Context of Disarmament, Disability and Development," Geneva, 2011.
[16] The meetings were sponsored by the European Union and supported by the Mine Ban Treaty's Implementation Support Unit (ISU).
[17] Mine Ban Treaty ISU, "Tajikistan takes stock of the wellbeing of landmine survivors in the context of broader disability efforts," 17 March 2014, www.apminebanconvention.org/fileadmin/APMBC/press-releases/PressRelease-VA_workshop_in_Tajikistan-17March2014-en.pdf; and ICBL, "ICBL Participates in Peru Victim Assistance Meeting," 25 April 2013, www.icbl.org/index.php//Library/News/2013-Peru-VA-Meeting.
[18] "Bridges between Worlds," Medellin, Colombia, April 2014. Mine Ban Treaty ISU, Bridges between Worlds, undated, www.apminebanconvention.org/eu-council-decision/bridges-between-worlds/.
[19] Chairperson's Summary, "Bridges between Worlds: Global Conference on Assisting Landmine and other Explosive Remnants of War Victims and Survivors in the Context of Disability Rights and other Domains," Medellin, 3–4 March 2014, www.apminebanconvention.org/fileadmin/APMBC/bridges-between-worlds/Bridges-Worlds-Summary-Apr2014.pdf.
[20] CRPD, Articles 3.c. and 4. paragraph 3.
[21] See sections on participation and inclusion in individual country profiles published since 2009 and in Victim Assistance overviews in the Landmine Monitor and the Cluster Munition Monitor on the Monitor website, www.the-monitor.org.


# Adequate Healthcare

**Article 25 of the CRPD: "persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability. States Parties shall take all appropriate measures to ensure access for persons with disabilities to health services that are gender-sensitive, including health-related rehabilitation."**

The right to the highest attainable standard of healthcare, first articulated in the WHO Constitution (1946), is found in a number of human rights instruments.[22] In 2011, the *World Report on Disability* concluded that persons with disabilities do not have equal access to healthcare and have greater unmet health needs in comparison to the general population. Efforts are needed in all countries to remove barriers and to make existing healthcare systems more inclusive of and accessible to persons with disabilities. In 2013, this remained true across the 33 states under review here. In fact, particularly among states in the midst of armed conflict and developing states, there was a lack of even basic healthcare available for or accessible to persons with disabilities, especially those living in remote and rural areas.

## Conflict

In Afghanistan, Somalia, and South Sudan, where there was already a lack of basic healthcare outside of major cities, attacks on medical personnel and facilities in 2013 decreased the availability of healthcare for the whole population. Such attacks on medical facilities and threats to medical workers[23] forced organizations, such as the ICRC and Médecins Sans Frontières (Doctors Without Borders, MSF), to limit their geographic coverage. This left some areas with no emergency or other healthcare despite increased demand for such care by those wounded in the armed conflict. Ongoing armed conflict in parts of Afghanistan, Colombia, DRC, Iraq, Somalia, South Sudan, Sudan, and Yemen prevented many people from traveling to needed services due to the security risks.

Armed conflict in neighboring countries also impacted the ability of some states to provide healthcare for persons with disabilities in 2013. In Iraq, Jordan, and Lebanon, the influx of Syrian refugees, many of whom were wounded due to the conflict there, added additional pressure to services that were already struggling to meet demand. Refugees from Syria who fled to Turkey also required significant healthcare assistance. In Iraq and Lebanon, the ICRC, with local Red Cross/Red Crescent societies, expanded efforts to support humanitarian medical responses. The ICRC also supported a new five-year strategy (2013–2017) to improve medical services throughout Lebanon by upgrading Lebanese Red Cross emergency medical services, equipping them with computers and communication equipment, and providing logistics support and training for volunteers.

## Transport

Poor infrastructure and a lack of affordable transportation prevented many people from accessing healthcare in developing countries and a lack of accessible transport exacerbates this problem for persons with disabilities.[24] This was reported as an obstacle to accessing healthcare for persons with disabilities in Cambodia, Guinea-Bissau, Lao PDR, Mozambique, Nicaragua, Peru, and Senegal.

In 2012 and 2013, Angola invested in road reconstruction and began a new initiative to enlist the aid of the police and fire department to increase the speed of emergency medical responses. Peru's national transportation development plan (2012–2016) includes actions to increase the availability of accessible transport. Among other impacts, this should enable persons with disabilities to access healthcare services that are mainly centralized in Lima. In Nicaragua, in 2010 the government launched a program to provide home-based basic medical care to persons with disabilities; medical teams had reached thousands of people by 2013. However, people with more serious health needs were referred to regional hospitals and it was not reported if they were supported to reach these hospitals.

## Financial cost of care

In developing countries, the cost of healthcare is the primary reason that persons with disabilities do not receive medical attention when they need it.[25] The inability to afford care was reported as an obstacle in many countries, such as Afghanistan, Burundi, Cambodia, DRC, and even in countries with more developed healthcare systems, such as Iraq. For example, it was found in Afghanistan that the costs of specialized medical care, something that persons with disabilities tend to require more of than the general population,[26] forced many to borrow money—creating cycles of unmanageable debt and exacerbating poverty.

In Mozambique, while basic healthcare was free, more specialized care was not, and most healthcare workers in local health centers indicated that they were not trained to work with persons with disabilities. Specialized care was also difficult to obtain in Serbia where bureaucratic obstacles prevented persons with disabilities from receiving assistance through the national system. In Sudan, the national health insurance system failed to cover a number of disability-related healthcare interventions; the national disability plan (2012–2016) sought to amend coverage limitations to increase access to care.

In Colombia, as part of the implementation of a national law,[27] the government and many NGOs worked with people affected by armed conflict, including those with disabilities, to ensure that they were covered by the national health insurance system and thus not prevented from accessing care due to cost. In 2012, Algeria extended coverage of national health insurance to include persons with disabilities and their families and worked to register those who qualified through 2013. Peru and Senegal also assisted persons with disabilities to register for national health insurance.

Thailand improved funding mechanisms for emergency medical services in 2013 so that emergency patients would be sent to the nearest hospital without first being asked about their healthcare eligibility. Expenses are also to be covered up-front without patients having to pay out-of-pocket fees first and then await reimbursement. These changes have the potential to make a significant difference to persons with disabilities in remote and rural areas who may not have documentation with them at the time of medical need.

## Replacing international services with national capacity

The transition from international funding and/or management to national resourcing and management of healthcare programs can have a significant impact on the availability of healthcare. This must be carried out properly, as an ineffective transition can especially affect people with limited financial resources and those living in rural areas, including persons with disabilities.

In Chad, with the improved security situation following the ending of armed conflict in 2013, the ICRC ended its support to the Abeche hospital where it had been supporting emergency healthcare and surgical capacities. Despite having taken measures to work with national authorities before finishing its support, the ICRC found that the ongoing capacity of the hospital could not be guaranteed.

In Uganda, many international organizations that had supported the provision of healthcare, particularly in northern Uganda, began closing their programs in 2008 following a significant reduction in armed conflict in 2006. As a result, the availability of quality healthcare declined significantly. In 2013, Uganda's Ministry of Health worked to fill those gaps with a program to train village health teams in emergency first aid and through its ongoing (but underfunded) Health Sector Strategic Investment Plan III 2012–2015.

## Mental health care

In all 33 states, there was a lack of mental health care able to address the specific needs of persons with disabilities, including those survivors of armed conflict and mines/ERW who suffered psychological trauma as well as physical injury. In El Salvador, in 2013 the national mental health unit included just 10 professionals, including both psychiatrists and psychologists, to cover the entire country. In Mozambique, less than 20% of persons with disabilities living outside the capital reported having received mental health care despite most reporting symptoms that indicated unmet needs.

### Definition: Peer support in a mental health care context

"Peer support is a system of giving and receiving help founded on key principles of respect, shared responsibility, and mutual agreement of what is helpful. It is about understanding another's situation empathically through the shared experience of emotional and psychological pain."[29]

Even among more developed states, where physical healthcare was mostly available, mental health care systems, where they existed, failed to meet needs. For example, in Croatia the government operated centers for psychosocial assistance for persons with disabilities, located throughout the country. However, the centers were reported to be understaffed, underfinanced, and needing repairs; some seemed to exist mainly on paper only.

In Colombia, in implementing the national law to assist people affected by armed conflict,[28] the government launched several initiatives to increase the availability of mental health care throughout the country. The programs mainly targeted armed conflict victims, including victims with disabilities, but they also included training in mental health care for thousands of health professionals, including healthcare workers in remote areas who received the training virtually over the internet. This training was intended to increase access to appropriate mental health care for all persons with disabilities.

### Peer support[30]

In many countries, NGOs attempted to fill gaps in the availability of professional mental health care by developing programs to respond to the psychological needs of persons with disabilities. One model that was shown to be particularly successful for survivors with disabilities was the provision of peer-to-peer support—either through individual therapy or group support. DPOs, including networks of survivors, offered peer psychosocial support in more than two-thirds of the 33 states that were monitored, although often the availability in any given country was insufficient to meet the full needs there. Networks providing this support are led by persons with disabilities ensuring that peer support programs are designed and implemented by persons with disabilities for other persons with disabilities.

Peer support is not intended to take the place of professional mental health care. It can complement it by referring persons with disabilities to psychological and psychiatric services in cases where these services exist and their needs could not be met through peer support. For example, a DPO in El Salvador worked with local primary healthcare services to both refer people to the hospital and to be available to provide peer support counselors when hospital staff recognized a person with a need to talk with someone with a similar impairment and life experience.

Peer support is not just about psychological well-being; it is also about promoting social inclusion by encouraging persons who have newly acquired impairments to access ways to become involved in their communities through such things as employment, civic engagement, and recreational activities, for the full realization of their rights.

## Healthcare: recommendations based on annual findings

- Simplify processes for persons with disability to access their right to health, especially as guaranteed under the law.
- Facilitate access to care to avoid delays.
- Ensure that out-of-pocket costs for services are covered within insurance systems, where they exist for persons with disabilities with scarce resources.
- Ensure equal access to all healthcare for both females and males and provide gender-differentiated services including gender-appropriate staff.
- Dedicate funding to ensure the availability of mental health services for the population as a whole, including persons with disabilities.
- Expand psychological services to rural and remote areas and improve accessibility to any existing services in those areas.

## Endnotes

[22] Article 12 of the International Covenant on Economic, Social and Cultural Rights (1966) establishes the right to the highest attainable standard of healthcare, which is expanded in the context of Article 25 CRPD to be accessible for and inclusive of persons with disabilities. This is also found in Article 24 of the Convention on the Rights of the Child.

[23] For more information on these issues, please refer to "Health Care in Danger," an ICRC-led project of the Red Cross and Red Crescent Movement aimed at improving the efficiency and delivery of effective and impartial healthcare in armed conflict and other emergencies. ICRC, Health Care in Danger: A Sixteen Country Study, July 2011, www.icrc.org/eng/resources/documents/report/hcid-report-2011-08-10.htm.

[24] *World Report on Disability*, p. 72.

[25] *World Report on Disability*, p. 66.

[26] As found in 2011 as well by the *World Report on Disability*, p. 59.

[27] Law 1448 (2011) on Victims and Restitution of Land, which addresses issues of reparations for human rights violations.

[28] Ibid.

[29] "Peer support: A theoretical perspective," Shery Mead, David Hilton, Laurie Curtis, *Psychiatric Rehabilitation Journal*, Vol. 25(2), 2001, pp. 134–141.

[30] Article 26.1 of the CRPD on rehabilitation and habilitation includes a strong reference to peer support, requiring "effective and appropriate measures, including through peer support, to enable persons with disabilities to attain and maintain maximum independence, full physical, mental, social and vocational ability, and full inclusion and participation in all aspects of life."

# Rehabilitation

**Article 26 of the CRPD: obliges states to "take effective and appropriate measures to enable persons with disabilities to gain maintain maximum independence, full physical, mental, social and vocational ability, and full inclusion and participation in all aspects of life through improved comprehensive habilitation and rehabilitation services."**

**Article 20 of the CRPD: obliges states to "take effective measures to ensure personal mobility with the greatest possible independence for persons with disabilities," including by facilitating personal mobility in the manner and at the time of individual choice, and at affordable cost; by facilitating access to quality mobility aids, devices, and assistive technologies available at affordable cost; and by training in mobility skills.**

The *World Report on Disability* notes that rehabilitation "has long lacked a unifying conceptual framework" and that the availability of rehabilitation services in different settings varies within and across states and regions.[31] Among its conclusions is the priority to ensure access to appropriate, timely, affordable, and high-quality rehabilitation interventions, consistent with the CRPD, for all those who need them.

Since 1999, the Monitor has tracked progress and challenges in the availability of physical rehabilitation programs, especially orthopedic services and assistive devices, with a focus on meeting the rehabilitation needs of people in rural and remote areas and of those who are economically vulnerable. In 2013, the key challenges and solutions reported were in the reliable continuity of services and adequacy of funding mechanisms for affordable services. Challenges also included long distances to rehabilitation centers, high cost of travel, and the impact of conflict and violence. Similarly, unequal availability of rehabilitation due to discrimination or a lack of age- and gender-appropriate services continued to be a barrier to overcome in many countries.

## Physical and functional rehabilitation

Physical rehabilitation involves the provision of services in rehabilitation and physiotherapy and the supply of assistive devices such as prostheses, orthoses, walking aids, and wheelchairs to promote the physical wellbeing of persons with disabilities including survivors. Physical rehabilitation is focused on helping a person regain or improve the capacities of his/her body, with physical mobility as the primary goal. Functional rehabilitation includes all measures taken to lead a person with disability to be able to engage in activities or fulfill roles that she/he considers important, useful, or necessary.

> "Rehabilitation services should apply a multidisciplinary approach involving a team working together including a medical doctor, a physiotherapist, a prosthetic/orthotic professional, an occupational therapist, a social worker and other relevant specialists. The person with disability and his/her family have an important role in this team."[32]

## Fluctuating availability of services

In 2013, there was no country among the 33 where the demand for rehabilitation was fully met. To address this, numerous efforts were underway to improve availability of rehabilitation by building new centers, restarting programs that had ceased to operate, and training rehabilitation staff to develop more sustainable human resources.

A newly constructed physical rehabilitation facility, built with state funding, was inaugurated in El Salvador in 2013. In Peru, a newly built national rehabilitation center offered services, including prosthetics, occupational therapy, and psychological support. However, the new center, located in the capital, remained inaccessible to most survivors and other persons with disabilities living in rural and remote areas. Ethiopia lacked enough physical rehabilitation facilities to meet demand but three new centers were being developed to increase availability.

In contrast, plans to build a new rehabilitation center in Yemen, originally scheduled for 2011, remained stalled through the end of 2013 due to armed conflict. Construction of a new rehabilitation center in Faizabad, Afghanistan was suspended owing to technical problems.

Where rehabilitation centers exist in post conflict and vulnerable countries[33] but have ceased functioning or are not operating adequately, the renewal of rehabilitation efforts can increase the availability of services. In at least two of the 33 countries, such improvements occurred with the potential to benefit persons with disabilities in 2013. Following several years of declining prosthetics production in Angola's 11 rehabilitation centers, a nationally funded physical rehabilitation project was initiated to improve the quality of services in five provinces. Basic physiotherapy and rehabilitation services were also introduced in several referral hospitals. In Mozambique, production of prosthetic devices resumed in 2013, after a significant decline in production in 2012 due to a lack of raw materials; the backlog created a longer wait-list for prosthetic devices. Somali orthopedic centers continued "against all odds"[34] to provide services for persons with disabilities.

Conversely, some programs ceased to function or saw significant disruptions in services. No new prosthetics were produced in the conflict-affected Casamance region of Senegal in 2013 as the only public provider of rehabilitation services in the region was not functioning pending a renewed commitment from the authorities to replace staff. The availability of physical rehabilitation in Uganda decreased following the closure of international programs. The sudden and unforeseen creation of a new ministry that was given responsibility for the rehabilitation sector in Tajikistan delayed the reopening of a satellite rehabilitation center.

Training of rehabilitation staff is a primary measure to ensure the consistent availability of rehabilitation services through existing programs. Training was offered in most countries covered by this report in 2013. In areas where the shortage of trained staff was most severe, such as in south and central Iraq, the Casamance region of Senegal, and some areas of Sudan and Tajikistan, there were long wait-lists for services and some centers stopped functioning completely in 2013.

As part of the Disability Rights Initiative Cambodia, a joint program launched in 2014, the WHO is supporting the development of the government's ability to manage the rehabilitation sector by building the capacity of key rehabilitation sector stakeholders, increasing government involvement and rehabilitation sector leadership, and establishing a coordination mechanism.

### ICRC: Actively addressing rehabilitation in many states

ICRC activities address challenges related to ensuring the provision of physical rehabilitation to persons with disabilities in countries which have been affected by conflict. These challenges include insufficient and unequal availability, unaffordable costs of services, and obstacles to reaching rehabilitation centers. Projects assisted by the ICRC offer services to all those in need. Assistance is given to both the national system and to users of its services in more than half of the countries included in this report. The training component within ICRC-assisted projects is important for many programs to increase the number of trained and qualified professionals and also to increase the sustainability of rehabilitation facilities in the long term.

In 2013, the ICRC Physical Rehabilitation Programme provided assistance for rehabilitation in 12 of the 33 countries monitored in this report.[35] In Afghanistan, Cambodia, Chad, Colombia, DRC, Ethiopia, Iraq, South Sudan, Sudan, and Yemen, the ICRC continued to be the main international organization providing and assisting in the provision of physical rehabilitation services.[36]

The ICRC Special Fund for the Disabled (SFD) strengthens national capacity for accessible and quality physical rehabilitation services in less-resourced countries to remove barriers faced by persons with physical disabilities. Of the countries included in this report, in 2013 the SFD supported rehabilitation programs in seven: El Salvador, Lao PDR, Nicaragua, Peru, Somalia, Tajikistan, and Zimbabwe.

The SFD's support to prosthetics and orthotics schools and centers, its training component, and its provision of raw materials and technical support are aligned with Article 4 of the CRPD concerning the need for continuous development of professionals and staff working in rehabilitation services.

## Paying for rehabilitation

In most low-income countries, people pay a high proportion of the costs of health and rehabilitation services out of their own pockets. According to the WHO, the goal of universal health coverage is to ensure that all people can obtain the health services they need without suffering financial hardship when paying for them.[37] As discussed in the previous section, healthcare is not affordable for the majority of persons with disabilities in the 33 researched countries. As a specialized service that has a relatively high cost, the same is true or even more so for rehabilitative care.

In 2013, efforts to ensure coverage of rehabilitation-related costs were reported.[38] Lebanon was in the process of reviewing the eligibility requirements for persons with disabilities, including survivors, to receive "disability cards" to entitle them to some free health services including prosthetics and rehabilitation. Sudan's ongoing 2012–2016 disability plan seeks to address the failure of the National Health Insurance System to cover a number of disability-related claims, including rehabilitation services. The National Office for Rehabilitation of Persons with Disabilities and the National Employee Social Insurance Fund of Algeria signed an agreement to include coverage of all orthopedic equipment for

persons with disabilities within the role of the fund. National health coverage in Colombia was found to have significant gaps in rehabilitative assistance for hearing and sight impairments, gaps that would have to be addressed to ensure access to this assistance.

Thailand provided for rehabilitation through universal health coverage from national insurance funds as well as other insurance measures and continued to allocate these resources to improve physical rehabilitation services in consultation with local groups of persons with disabilities and feedback from community-based health and disability volunteers.

Bureaucratic delays for the funding of services were barriers to rehabilitation in some countries where services existed. In Colombia, it could take up to a year to register for benefits that allowed persons with disabilities to receive rehabilitation services; it could be up to six months between an initial consultation and the approval of an application for the provision of a prosthetic. In Serbia, there were delays of more than six months to receive even a response acknowledging applications for replacement prosthetics when requesting state funding.

Several other countries had no available funding to subsidize the cost of rehabilitation. In Burundi, Chad, and Uganda, for example, persons with disabilities continued to lack assistance to pay the costs of rehabilitation, placing it out of reach for many people with scarce resources.

### Community-based rehabilitation[39]

Research has shown that community-based rehabilitation (CBR) programs have positive results in many of the countries reviewed in this report.[40] In 2013, CBR programs assisted persons with disabilities in rural and remote areas (including urban areas which are isolated from existing infrastructure and social support institutions) with particular examples reported in Afghanistan, Cambodia, Colombia, DRC, Ethiopia, Eritrea, Thailand, and Uganda. CBR in these countries was often partial and fragmented, yet it offered access to rehabilitation services that would otherwise be unavailable or out of reach to persons with disabilities, including survivors, living in rural and remote areas.

In September 2013, the WHO launched a project to support government development of a national rehabilitation program in Tajikistan. The project's development focused on promoting CBR and on human resource development in the field of physical rehabilitation. While the services were intended to support all persons with disabilities, including survivors, one of the main target groups for the program is children affected by polio (Post Polio Residual Paralysis) in an outbreak in 2010.

## Equity and equality in coverage

In countries that have large numbers of persons with disabilities as a result of armed conflict, there are often favorable social security provisions, such as welfare payments associated with rehabilitation and additional healthcare benefits for veterans with disabilities and/or civilian conflict survivors. In many cases, these provisions are not made available to all persons with disabilities with similar needs, creating inequalities that must be addressed. Landmine survivors' organizations and mine action coordination centers were at the forefront of the fight to equalize coverage. At the sessions of the Committee of the Rights of Persons with Disabilities[41] in 2013, representatives of a mine survivors' organization in El Salvador joined DPOs to call for broader equality reforms in that country.

In an effort to address the disparity in services available to military versus civilian survivors in Jordan, the National Committee for Demining and Rehabilitation advocated for the provision of equitable medical

and rehabilitation services for both civilian and military survivors and strengthened the capacity of a rehabilitation center that serves civilian mine/ERW survivors and other persons with disabilities.

In many countries, there were few or no new reported approaches to ensuring equal access to gender- and age-sensitive rehabilitation services. In an effort to make services available equally to females, one-third to half of the local technicians and physiotherapists sponsored by the ICRC to improve their professional skills were women. In Yemen, the construction of a designated physiotherapy building for females and children aimed to overcome obstacles women and children had faced in accessing services. Efforts were made in Burundi to increase access to corrective devices for children by providing free lodging and meals at a rehabilitation center.

### Refugees and rehabilitation

Among the most vulnerable groups in need of rehabilitation are refugees and internally displaced persons.[42] In 2013, specific rehabilitation programs for refugees with disabilities, including survivors of mines/ERW and armed conflict, operated in states including Ethiopia, Iraq, Jordan, Thailand, and Lebanon.

## Serious obstacles and solutions to reaching services

In several countries, including Afghanistan, DRC, Iraq, Yemen, Sudan (Darfur and the southern states), South Sudan, and Somalia, the combined challenges of long distances to travel to reach services, a lack of public transport, high financial costs of attaining services, as well as increased insecurity or conflict in some areas remained among the greatest obstacles to reaching physical rehabilitation services, especially for people in rural areas.

Outreach programs provided one way to overcome these obstacles and increased the reach of rehabilitation services in several countries. In Guinea Bissau and Sudan, monthly outreach services were started for people living in rural areas. In Lao PDR, the outreach program continued to train networks to identify and refer people in need for assessment. However, not all changes in this area were positive. In Yemen, the rehabilitation center in Aden was forced to suspend its outreach services in 2011 due to security risks, which had still not resumed through 2013. In Albania, in the absence of a functional national prosthetics center in the capital, outreach activities by the survivors' organization referred amputees from throughout the country to the regional prosthetic workshop that had originally been established to address the needs of mine/ERW survivors.

Decentralization of services provided another means of bringing rehabilitation services into reach of people who needed them. Following efforts to decentralize physical rehabilitation services in Nicaragua through the opening of a new center in an underserved region in 2011 and a new outreach service in 2012, the ICRC SFD continued to sustain these programs plus three pre-existing centers based in major cities through 2013.

## Rehabilitation: recommendations based on annual findings

- Expand access to physical rehabilitation services, particularly in regions/provinces lacking services, or where traveling to reach rehabilitation services is difficult for persons with disabilities.
- Improve facilities and professional capacity in the rehabilitation sector, and ensure that governments are committed to sustain capacity.
- Create a sustainable funding strategy for the physical rehabilitation sector, including international and national funding, as appropriate to the national context.
- Make regional and rural rehabilitation and prosthetics opportunities sustainable, including through outreach services.
- Replicate experience in providing affordable rehabilitation services in regions where services are lacking.
- Ensure that all persons with disabilities have equal access to programs and services.

## Endnotes

[31] *World Report on Disability*, p. 101.

[32] Recommendations on Implementing the Cartagena Action Plan 2010–2014, Presented to the Second Review Conference of the States Parties to Mine Ban Treaty by Belgium and Thailand, Cartagena de Indias, Colombia, 30 November 2009, www.cartagenasummit.org/fileadmin/APMBC-RC2/monday/2RC-Item9a-30Nov2009-Co-Chairs.pdf.

[33] Vulnerable according to indicators such as economic decline, inequality, demographic pressures, armed conflict, and corruption. For example, see The Fragile States Index, "The Indicators," undated, ffp.statesindex.org/indicators.

[34] ICRC SFD, "Annual Report 2013," Geneva, May 2014, p. 18.

[35] Including Burundi and Guinea-Bissau in addition to the 10 countries where the ICRC was the main international organization providing or assisting with rehabilitation services.

[36] The entire global ICRC-assisted network of centers (comprised of 99 projects in 27 countries and one territory in 2013) ensured access to physiotherapy treatment for 134,742 people and provided 22,119 prostheses and 68,077 orthoses in 2013. This included 12,519 physiotherapy treatments for mine/ERW survivors and 7,681 prostheses and 1,997 orthoses provided to survivors.

[37] WHO, Questions and Answers on Universal Health Coverage, undated, www.who.int/healthsystems/topics/financing/uhc_qa/en/.

[38] In addition to or combined with the efforts underway to expand the availability of affordable healthcare for persons with disabilities as discussed in the section on healthcare.

[39] The WHO community-based rehabilitation guidelines provide guidance on how to develop and strengthen CBR programs; promote CBR as a strategy for community-based development involving people with disabilities; support stakeholders to meet the basic needs and enhance the quality of life of people with disabilities and their families; and encourage the empowerment of people with disabilities and their families. WHO, Community-based rehabilitation guidelines, undated, www.who.int/disabilities/cbr/guidelines/en/.

[40] Following the Geneva launch of the WHO community-based rehabilitation guidelines, government and civil society experts also discussed national approaches to CBR in relation to fulfilling the rights of survivors and other persons with similar needs in November/December 2012, www.apminebanconvention.org/meetings-of-the-states-parties/10msp/what-happened/parallel-programmefor- victim-assistance-experts.

[41] The Committee on the Rights of Persons with Disabilities is the body of independent experts which monitors implementation of the Convention by the States Parties. OHCHR, Committee on the Rights of Persons with Disabilities, undated, www.ohchr.org/en/hrbodies/crpd/pages/crpdindex.aspx.

[42] Landmine and Cluster Munition Monitor, "Landmines and Refugees: The Risks and the Responsibilities to Protect and Assist Victims," 20 June 2013, www.the-monitor.org/index.php/content/view/full/25018.

# Enabling Environments

**Article 9 of the CRPD: "To enable persons with disabilities to live independently and participate fully in all aspects of life, States Parties shall take appropriate measures to ensure to persons with disabilities access, on an equal basis with others, to the physical environment, to transportation, to information and communications, including information and communications technologies and systems, and to other facilities and services open or provided to the public, both in urban and in rural areas."**

The *World Report on Disability* highlights that access to public accommodations, infrastructure (such as buildings and roads), and utilities is a critical first step to access healthcare, rehabilitation services, government offices, education/training, and work and employment. It also enables participation in many aspects of community life, such as houses of worship, polling stations, parks, and playgrounds. Barriers to access, whether they are physical or attitudinal, exclude persons with disabilities or make their participation dependent on assistance from others.[43] Transportation that is accessible for persons with disabilities allows for independent access to jobs, markets, training centers, hospitals, and recreational activities.

**Definition: Accessibility[46]**
In common language, the ability to reach, understand, or approach something or someone. In laws and standards on accessibility, it refers to what the law requires for compliance.

**Definition: Public accommodations**
Buildings open to and provided for the public, whether publicly owned (such as courts, hospitals, and schools) or privately owned (such as shops, restaurants, and sports stadia) as well as public roads.

In the absence of more recent information, the *World Report on Disability* cited a 2005 UN Survey of 114 countries that found that while many had policies in place, few had made significant progress in advancing accessibility.[44] *The World Report* also found that the absence of appropriate accessibility standards and limited compliance was especially common in developing countries.[45]

Research for the Monitor's country profiles found that, in 2013, inaccessibility remained a major obstacle to services and to the ability to participate fully in communities for persons with disabilities in all countries. In line with the 2005 UN Survey, many countries had physical accessibility policies in place in 2013 (at least 19 of 33), but implementation of standards and enforcement measures were extremely limited, especially in rural areas. However, research also revealed an increasing number of good practices, even if partially implemented in many cases, which demonstrates progress towards the creation of a "culture of accessibility."[47]

### Attitudinal barriers

Developing an accessible environment can be aided by creating a "culture of accessibility," a culture where incremental changes to the environment are coupled with awareness-raising efforts so that the concept of accessibility in all of its dimensions becomes ingrained in a community.[48] In the absence of effective action by the government, in 2011 a group of NGOs came together in Afghanistan to form the Physical Accessibility Consortium for Afghanistan (PACA) with the idea of contributing to the development of such a culture. The consortium developed an accessibility awareness curriculum for local partners with modules on disability and identity; religious practice and the Koran; and the rights-based approach while including more technical guidance on improving physical accessibility. In 2013, such organizations continued to work in some communities to make adaptations to public accommodations.

## Existing laws and standards

Nearly two-thirds of the countries examined for this report had some kind of policy in place regarding accessibility standards or requirements. Efforts were underway to create standards in more countries. Quite consistently, the countries lacking such policies, such as Burundi, Chad, Guinea-Bissau, South Sudan, and Yemen, tended to also have the least developed economies and/or be in the midst of armed conflict. However, progress was identified in some countries facing significant development challenges. As of June 2014, legislation on physical accessibility had been drafted in Angola and was awaiting approval. The National Disability Council in Sudan designed a draft building code to improve physical accessibility for persons with disabilities and, as of April 2014, the code was under review by a technical committee before being approved as law. In Uganda, the Building Control Law was passed in December 2013, making obligatory the accessibility standards that were launched in 2010.[49]

## Lack of compliance and partial implementation

In many countries, a lack of compliance with existing policies and regulations was reported as a barrier for the inclusion of persons with disabilities. For example, in Afghanistan, accessibility codes were not respected in the construction of commercial markets, which impeded persons with disabilities from establishing their own small businesses in recognized market areas. In Croatia, there was strong legislation on building construction in place requiring accessible adaptation of buildings for persons with disabilities, but relevant supervisory bodies did not enforce penalties in cases of violations. In an effort to improve compliance with regulations on accessibility, in November 2013 Colombia's judiciary system (State Council) ordered all public offices to make their facilities accessible and to include requirements for accessibility when granting licenses for construction and occupancy. The State Council also called on all municipal governments to do the same as a means to remove barriers outside of urban centers.

Even in some countries where initial efforts were made to implement accessibility guidelines, such as the construction of ramps, persons with disabilities often still found it impossible to gain equal access to actual services. In Mozambique, where some ramps were constructed to enter health centers, not all consulting rooms or toilets were accessible for persons with disabilities. In Ethiopia, some health centers did not have any accessible stretchers or beds for persons with physical disabilities. In Nicaragua, the

city government in Managua took the important step of training bus drivers on accessible transportation but the impact was extremely limited since few of the buses available had the technical capacity to be accessible. In Turkey, a national workshop was organized on transport services for people with reduced mobility; however, access to most transport services and public buildings remained problematic.

In El Salvador, significant progress towards accessibility was made by removing physical barriers to access for persons with disabilities in an estimated one-third of public buildings by the end of 2013. However, this was primarily limited to urban areas. In 2013, the Committee on the Rights of Persons with Disabilities recommended that El Salvador develop a monitoring mechanism for compliance with accessibility standards and bolster efforts to increase accessibility in rural areas. Recognizing the specific accessibility challenges facing rural and mountainous communities, Peru's "Accessible Tumbes" pilot program, launched in 2012 and still underway in 2013, worked to identify regional disability policies with accessibility guidelines appropriate for those communities.

## Participation in promoting accessibility

In addition to being a fundamental principle and a right clearly expressed in the CRPD, the importance of the participation of persons with disabilities specifically in the development, enforcement, and promotion of accessibility policies is widely recognized.[50] The Physical Accessibility Consortium for Afghanistan found that the involvement of persons with disabilities from the community in planning specific accessibility adaptations led to the identification of other areas of the community from which persons with disabilities were excluded due to environmental barriers.

In Serbia, a parallel accessibility audit by a national DPO umbrella organization highlighted accessibility adaptations that might not serve persons with disabilities despite seeming to comply with existing guidelines. Although a government audit in 2013 of some public buildings in Belgrade found that 14 of the 21 examined were accessible, the DPO-led audit of those public facilities that are most likely to be used by persons with disabilities resulted in different findings. At least two of the buildings found to be accessible in the government audit could not be accessed by its members, including the government office working with veterans with disabilities and other persons impacted by armed conflict.

In Ethiopia, DPOs observed an increase in physical accessibility, but found some adaptations to be unusable due to the lack of specific regulations defining accessibility standards; for example, some wheelchair ramps could not be used because they were steep and slippery. To promote physical accessibility, the Ethiopian Center for Disability and Development carried out a two-year project through the end of 2013 collecting and processing accessibility survey information. The project provided accessibility information to government officials, business and building owners, and local architects and contractors, resulting in the publication of the "Guide to Accessible Ethiopia" covering the capital and 12 other towns.[51]

## Enabling environments: recommendations based on annual findings

- Act immediately to remove physical barriers, particularly for services and for government buildings, as a gateway to promote rights and access across a range of areas.
- Ensure timely and progressive implementation of national accessibility plans, with special attention to make sure that all regions and rural areas are included.
- Develop or improve existing means to monitor the implementation of accessibility standards to ensure widespread compliance, including in rural areas.
- Commit the necessary resources for the implementation of laws and policies that will eliminate barriers to access for all persons with disabilities.

## Endnotes

[43] In addition to physical and attitudinal barriers, barriers to information and communication also exclude persons with disabilities but are beyond the scope of this report.
[44] *World Report on Disability*, p. 172.
[45] Ibid., pp. 173–174, and 178.
[46] *World Report on Disability*, p. 170.
[47] Ibid., p. 169.
[48] Anti-discrimination legislation is also critical to combat discriminatory behavior and practices towards persons with disabilities but is the beyond the scope of this report.
[49] The development of the accessibility standards and the passage of the Building Control Law was the direct result of the work of a national DPO to provide technical support to the government in developing the standards and advocate for the law's passage.
[50] *World Report on Disability*, pp. 173–174.
[51] This work was also highlighted by the Zero Project among the selected "Innovative Practices 2014 on Accessibility," zeroproject.org/practice/guidebook-on-an-accessible-ethiopia.

# Work and Employment

**Article 27 of the CRPD: recognizes "the right of persons with disabilities to work, on an equal basis with others; this includes the opportunity to gain a living by work freely chosen or accepted in a labour market and work environment that is open, inclusive and accessible to persons with disabilities."**

The *World Report on Disability* found that persons with disabilities had "much higher unemployment rates" than persons without disabilities and that this exclusion from the labor market was linked to higher rates of poverty among persons with disabilities.[52] This was clearly evident among the 33 states reviewed in this report, with very low participation by persons with disabilities in the official labor market and large numbers of persons with disabilities lacking livelihood opportunities through either work in the informal economy or formal employment.[53]

Barriers to work and employment for persons with disabilities including mine/ERW survivors as identified by the Monitor were similar to those listed in the *World Report on Disability*,[54] although with a greater emphasis on exclusion from informal employment, such as through a lack of support to start micro-enterprises. This can be explained by the fact that most of the states reviewed lacked a robust formal labor market due to the economic impacts of conflict and often due to an overall lack of economic development. It is also likely influenced by the fact that DPOs and service providers reporting to the Monitor were often focused on populations based in remote and rural areas where formal employment was even scarcer than in urban centers. For example, in Mozambique, a survey in 2013[55] found that the majority of persons with disabilities in central provinces received no economic benefits (such as a pension), had received no funding or training to begin income-generating projects, and were unable to participate as effectively as other members of the population in the primarily agrarian economy.

Barriers to work for persons with disabilities most often reported to the Monitor in 2013 included:

- Insufficient access to education and training, preventing them from acquiring the skills needed for successful management of a small business;
- A lack of access to funding to start a business due to discrimination and a lack of eligibility; and
- Discrimination in hiring practices within the formal labor market.

In many countries, physical barriers or the lack of affordable, accessible transport also prevented persons with disabilities from traveling to jobs on a daily basis, as discussed in the previous section on enabling environments. In just a few cases, disincentives to participate in the labor market created by a reliance on social protection programs were found to be a significant factor in preventing the inclusion of persons with disabilities in the workforce.[56] Generally, these occurred in those countries with higher recorded levels of economic development.[57] Lack of reasonable accommodation practices carried out by employers for employees with disabilities were likely not found among the key barriers to employment reported in this research because other barriers and forms of discrimination prevented access to employment within a formal workplace altogether. Many respondents were focused on programs for the self-employed or those looking for self-employment or similar work.

## Access to training

In several of the 33 countries, it was found that mainstream vocational training programs were not accessible for or adapted to the needs of persons with disabilities. Recognizing this gap, various programs run by international and national NGOs and some governments developed training courses targeting persons with disabilities, and some worked to promote the inclusion of persons with disabilities in mainstream vocational training programs.

For example, in Ethiopia there were few government-run vocational training centers that were accessible to persons with physical disabilities, preventing their inclusion in these programs. In response, the Ethiopian Center for Disability and Development offered basic business skills training specifically for persons with disabilities. Angola's National Institute for Employment and Vocational Training (INEFOP) targeted persons with disabilities to include them in mainstream training courses in two provinces heavily affected by armed conflict. Starting in 2011 and continuing through 2013, the Academic Center for Educational and Professional Orientation in the Casamance region of Senegal provided educational and career advice adapted to the needs of persons with disabilities. In Peru, in 2013 an international NGO provided a regional employment center with equipment, tools, and materials for vocational training courses, as well as training to adapt their courses and occupational counseling for persons with disabilities.

## Income-generating opportunities

In many countries, there were reports of income-generating programs that had a *de facto* exclusion of persons with disabilities or some subset of this group due to the requirements for application.[58] For example, associations of veterans with disabilities in Serbia reported that their members faced obstacles in securing loans through mainstream financial institutions. In Colombia, organizations of survivors (persons with disabilities) or those working with survivors reported a lack of assistance from the government in gaining employment or starting income-generating projects and identified programs that were open to survivors but for which no survivors were successful in securing support.

Recognizing the unequal access to credit for persons with disabilities, in 2013 the National Bank of Ethiopia began requiring micro-finance institutions to incorporate disability-disaggregated data in their reports to ensure the inclusion of persons with disabilities in their service provision.

In nearly all 33 of the states reviewed here, various state and civil society programs, including programs designed and implemented by DPOs, offered micro-credit or grants targeting persons with disabilities to start small businesses. These programs aimed to address the lack of access to opportunities for persons with disabilities in mainstream economic inclusion projects. In order to overcome the barriers preventing access to mainstream income-generating projects, DPOs also reported providing support to persons with disabilities in preparing their applications in Bosnia and Herzegovina, El Salvador, Ethiopia, Uganda, and Yemen, among others.

In both Ethiopia and Uganda, NGOs worked to organize persons with disabilities into collectives and to register these collectives to increase their eligibility to apply for small grants and loans to start small businesses. In Uganda, the Ministry of Gender, Labour and Social Development also revised the guidelines for its special grants for persons with disabilities, as a result of advocacy by Ugandan DPOs, when it was seen that grants were not equally accessible for all persons with disabilities. In Algeria, Handicap International worked with the government to set up economic inclusion micro-projects adapted to the specific needs of persons with disabilities, as determined by a needs assessment. Some projects, for example a project run by a national organization in Burundi, specifically targeted women with disabilities, recognizing that they faced multiple forms of discrimination both as a person with disabilities and as a woman which obstructed opportunities for their participation in mainstream programs.

However, such programs tended to be limited in their reach and unable to meet the full demand. They were also often dependent on unstable funding sources that were not guaranteed from one year to the next. In South Sudan, several economic inclusion programs for persons with disabilities run by local NGOs were closed in 2013 when funding via the UN Mine Action Service (UNMAS) ended. The same occurred in DRC when mine action center funding ended. Similarly, in Sudan in 2013 funding channeled through the national mine action center for economic inclusion programs targeting persons with disabilities was further reduced, resulting in the closure of the two programs remaining from the six that had been operating in 2010. In Cambodia, several programs that provided micro-credit for persons with disabilities closed as international support for post-conflict reconstruction decreased. As of 2013, poverty among persons with disabilities in Cambodia remained widespread; the need for these programs remained and had not been addressed by the expansion of mainstream government or NGO programs.

### Multiple forms of discrimination: disability and gender

Research for the country profiles used in this report found that in many states women with disabilities experienced greater levels of poverty and exclusion than persons without impairments or when compared with other persons with disabilities, or others living in similarly remote or rural areas.

In 1995, governments meeting in Beijing for the Fourth World Conference on Women expressed their determination to "Intensify efforts to ensure equal enjoyment of all human rights and fundamental freedoms for all women and girls who face multiple barriers to their empowerment and advancement because of such factors as their race, age, language, ethnicity, culture, religion, or disability, or because they are indigenous people."[59]

In writing the CRPD, governments reinforced the need to address multiple forms of discrimination faced by persons with disabilities who are women and/or of another marginalized group.[60]

In 2004, having reviewed the work of the Mine Ban Treaty, states agreed that in all their efforts to provide rights-based assistance to survivors and other person with disabilities, they would ensure that emphasis is given to age and gender considerations and to survivors who are subject to multiple forms of discrimination.[61]

## Discrimination in hiring practices

In some of the states, particularly those with more developed formal employment sectors such as Bosnia and Herzegovina, Croatia, El Salvador, Jordan, and Serbia, it was reported that there was discrimination in hiring persons with disabilities.

In Bosnia and Herzegovina and El Salvador, the Monitor identified continuing efforts in 2013 to overcome discrimination and educate employers about the benefits of hiring persons with disabilities and providing them with reasonable accommodations. In El Salvador, workshops were convened by a national DPO in cooperation with the Ministry of Labor. The national DPO followed-up workshops with job placement assistance that connected persons with disabilities with interested employers.

## Disincentives to employment

Disincentives to enter waged employment due to the potential loss of state assistance payments for persons with disabilities were identified in Croatia and Serbia.[62] In Croatia, one of the higher-income countries included in Monitor research, the law had required persons with disabilities to forgo any form of education and employment in order to continue to receive a pension. Amendments made to the Pension Insurance Act in 2013 by the Ministry of Labor created the opportunity for persons with disabilities to maintain a family pension upon finding employment and to regain the right to benefits in case of job loss.

## Work and employment: recommendations based on annual findings

- Create economic inclusion opportunities for all persons with disabilities, in physically accessible facilities.
- Respond to the specific needs of women with disabilities who, as a group, tend to face greater financial hardship than both the population as a whole and men with disabilities.
- Sustain programs that support income-generating projects for persons with disabilities, using national resources.
- Find ways to address the extensive barriers to economic inclusion for persons with disabilities in the least-developed economies by providing meaningful work and training opportunities that would allow for an adequate standard of living.
- Adapt mainstream economic inclusion programs to include persons with disabilities and expand programs in line with significant unmet needs.

## Endnotes

[52] *World Report on Disability*, p. 235.

[53] "The 'formal economy' is regulated by the government and includes employment in the public and private sectors where workers are hired on contracts, and with a salary and benefits, such as pension schemes and health insurance. The 'informal economy' is the unregulated part of a country's economy. It includes small-scale agriculture, petty trading, home-based enterprises, small businesses employing a few workers, and other similar activities." *World Report on Disability*, p. 236.

[54] *World Report on Disability*, pp. 235–240.

[55] Rede para Assistência às Vítimas de Minas (the Assistance Network for Landmine Victims, RAVIM) and Handicap International, "Shattered Dreams: Living conditions, needs and capacities of mines and Explosive Remnants of War survivors in Mozambique," October 2013, www.hiproweb.org/uploads/tx_hidrtdocs/ShatteredDreams.pdf.

[56] See Disincentives to Employment section below.

[57] The *World Report on Disability* also found that the disincentive to work for persons with disabilities because of a loss of benefits and healthcare coverage was more of an issue in higher income countries where disability allowances tended to be more generous. *World Report on Disability*, p. 237.

[58] This pattern has also been identified in other reporting. For example, see Handicap International, "Good practices for the economic inclusion of people with disabilities in developing countries: funding mechanisms for self-employment," 2006, www.handicap-international.org/uploads/media/goodpractices-GB-2coul.PDF.

[59] Fourth World Conference on Women: Beijing Declaration, September 1995, Article 32, www.un.org/womenwatch/daw/beijing/platform/declar.htm.

[60] CRPD, Preamble.

[61] "The Nairobi Action Plan, 2005-2009," Nairobi, November 29–December 3, APLC/CONF/2004/2005, www.apminebanconvention.org/fileadmin/APMBC/MSP/6MSP/Nairobi_Action_Plan.pdf.

[62] It is likely that the risk of losing benefits prevented some persons with disabilities from participating in paid work in some other countries researched by the Monitor but that this issue was not considered to be the greatest barrier to accessing work and employment and thus was not mentioned in research questionnaires.

# Conclusion

In 2013, persons with disabilities around the world continued to face significant challenges in accessing their rights. In many countries transitioning after conflict, or those that are economically vulnerable, or facing the immediate impacts of conflict and armed violence, these challenges were exacerbated. While not seeking to be a comprehensive global review, much could be gleaned on the current situation of persons with disabilities living in challenging environments from the examples found in these 33 countries.

Evidence-based recommendations found at the end of each chapter drawn from profiles on the 33 countries studied for this report will also be applicable for many other countries in similar situations. All were identified as issues to be addressed in 2013, and swift action taken to implement these recommendations would go a long way to advance the rights of persons with disabilities. Such action would also correspond to the principles of the obligations and commitments that these and other states have under relevant instruments of international humanitarian and human rights law.

December 2014

This report was prepared by the Landmine and Cluster Munition Monitor, the unprecedented civil society initiative providing research and monitoring for the International Campaign to Ban Landmines and the Cluster Munition Coalition.

Layout and Design: The Tenth Planet Graphic Design

International Campaign to Ban Landmines

Cluster Munition Coalition

Landmine & Cluster Munition Monitor