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OIC OUTLOOK
REPORTS



People with Disabilities and Special Needs in OIC Countries

OIC Outlook Report

No: 2019/3





OIC OUTLOOK REPORTS

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Training Centre for Islamic Countries

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ABSTRACT

This report looks at the state of people with disabilities and special needs in OIC Countries in comparative perspective. It discusses global as well as regional trends and elaborates on the implications for OIC Countries. As a group, OIC Countries host millions of people with special needs. These people are in need of basic healthcare services, specialized rehabilitation services and other community services from transport to education. Due to underinvestment into social security systems, insufficient number of trained health professionals and rehabilitation units, many people with disabilities in OIC Countries cannot reach such services easily. Addressing diverse needs of people with disabilities require to develop a holistic approach and an action plan at the OIC level that can guide OIC Countries to deliver these services more effectively.



1. Introduction

More than one billion people experience some form of disability. In other words, 1 out of 7 persons has a disability worldwide. According to the estimates of the WHO, due to aging population and widespread chronic diseases, the global prevalence rate of disability increased from 10 per cent in 1970 to 15 per cent in 2011 (WHO and World Bank, 2011). Around 80 per cent of people with disabilities live in developing countries including OIC countries.

The term of “special needs” is being used in clinical diagnostic and functional development to describe individuals who require assistance for disabilities that may be physical or psychological. Types of special needs vary in severity and type. People with Autism, Down syndrome, and Alzheimer, for example, may be considered to have special needs. However, special needs can also include cleft lips and/or palates or missing limbs. On the other hand, people under conflicts or heavy-stress due to a natural disaster may have special needs especially in the form of psychological support.

The Article 1 of the United Nations Convention on the Rights of Persons with Disabilities (CRPD) states that ‘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’. Given these definitions, ‘people with special needs’ and ‘disabled people’ terms can be used interchangeably.¹

Disability and Its Implications on Individuals and Society

Persons with disabilities, on average as a group, are more likely to experience adverse socioeconomic outcomes than persons without disabilities, such as less education, worse health outcomes, less employment, and higher poverty rates.

Analysis of the World Health Survey shows that compared with people without disability, men and women with disabilities are twice as likely to find that health care facilities and providers’ skills are inadequate, three times more likely to be denied health care and four times more likely to be treated badly in the health care system. Of all persons with disabilities, half cannot afford required health care; people with disabilities are also 50 per cent more likely than those without disability to suffer catastrophic health expenditures (WHO and World Bank, 2011).

¹ This report follows this approach and uses both terms interchangeably.



Disability may also increase the risk of poverty especially through lack of employment and education opportunities, lower wages, and increased cost of living with a disability (Box 1). According to the United Nations (2015) Factsheet on Disability, having disability increases the cost of living by about a third of average income. On the other hand, poverty may increase the risk of disability through malnutrition, inadequate access to education and health care, unsafe working conditions, polluted environment, and lack of access to safe water and sanitation.

Box 1: Disadvantages Experienced by People with Disabilities

- a. Poor health outcomes: Depending on the group and setting, persons with disabilities may experience greater vulnerability to preventable secondary conditions and co-morbidities, untreated mental health condition
- b. Lower educational achievements: Children with disabilities are less likely to start school than their peers without disabilities. They also have lower rates of staying in school and of being promoted, as well as lower transition rates to post school education.
- c. Less economic activity: People with disabilities have lower employment rates than people without disabilities. Where people with disabilities are employed, they commonly earn less than their counterparts without disabilities.
- d. Higher rates of poverty: As a group and across settings, people with disabilities have worse living conditions and fewer assets. Poverty may lead to disability, through malnutrition, poor health care, and dangerous working or living conditions. Disability may lead to poverty through lost earnings, due to lack of employment or underemployment, and through the additional costs of living with disability, such as extra medical, housing, and transport costs.
- e. Limited independence: Reliance on institutional solutions, lack of community living, inaccessible transport and other public facilities, and negative attitudes leave people with disabilities dependent on others and isolated from mainstream social, cultural, and political opportunities.

Source: WHO & World Bank, 2011, p. 263

Key factors that cause disability can be grouped broadly under two categories: internal and external (environmental) factors. Internal factors include all biologically and genetically inherited factors (DNA codes) that a person does not have any power to control them. External factors cover all personal habits (e.g. eating and sleeping), living conditions (e.g. housing and sanitation, working conditions (e.g. work-related injuries, polluted work environment), and social conditions (e.g. natural disasters, wars, conflicts, in-house abuse and violence).

People usually become disabled as a result of combined effect of both internal and external factors. External factors affect the quality of life of people with special needs and may have significant impact on the severity of disability that a person suffers from. Moreover, a country's economic, legislative, physical, and social environment may create or maintain barriers to the participation of people with disabilities in economic, civic, and social life. Barriers include inaccessible buildings, transport, information, and communication technology; inadequate standards, lack of healthcare and rehabilitation services, and/or limited funding for those services; and too little data and analysis for evidence-based, efficient, and effective policies (WHO and World Bank, 2011). In this respect, policy-makers have responsibilities to improve the quality of life of people with special needs by devising and implementing effective policies.



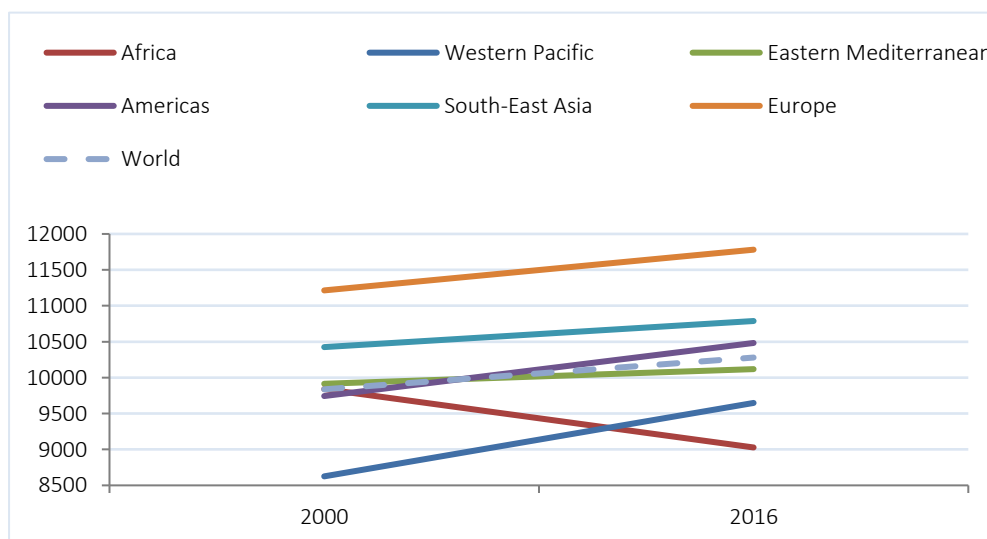


2. Global and Regional Trends on Disability

Burden on society stemming from disability is on the rise worldwide that a five per cent increase was observed in the global prevalence rate of disability between 1970 and 2011 (WHO and World Bank, 2011). Each year increasing number of people have been partially or fully becoming unable to fully utilize their physical and mental capacity to engage in daily social and economic activities.

When the burden is measured in terms of Years of Healthy Life Lost Due to Disability (YLDs) it becomes relatively easy to understand the scope of the burden. There is a clear positive trend in the world average YLDs that went up from 9,837 in 2000 to 10,279 in 2016 (per 100,000 people) (Figure 1). The increasing burden of non-communicable diseases on disabilities was among the main reasons that may explain the global positive trend. In line with the global positive trend, Western Pacific, Eastern Mediterranean, Americas, South-East Asia, and Europe regions registered increases in their average YLDs between 2000 and 2016. Only the Africa region saw a decline in the average YLDs in the same period thanks to both national and international efforts to strengthen the overall health systems.

Figure 1: Global and Regional Trends in Years of Healthy Life Lost Due to Disability (YLDs), (per 100 000 people), 2000-2016



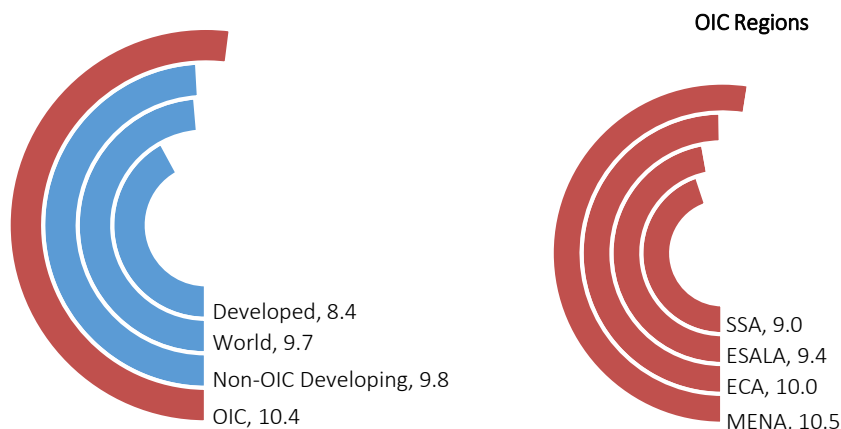
Source: WHO Data Repository, WHO Estimations



OIC Countries are not free from the consequences of disabilities. On average, OIC countries lost 10.4 years (per 100 people) where the world average was recorded at 9.7 in 2016 (Figure 2, left). Non-OIC developing countries, on average, lost 9.8 healthy life years (per 100 people) due to disability that was being relatively lower when compared to the OIC average. In terms of individual country performance, Somalia (15.0 years) was the most disability affected OIC countries in terms of YLDs in 2016. At the OIC regional-level, MENA (10.5) and ECA (10.0) regions, on average, had a relatively higher YLDs compared to the averages of ESALA (9.4) and SSA (9.0) regions in 2016 (Figure 2, right).

On the other hand, the developed countries group was a relatively less affected country group from disabilities when it is measured in terms of YLDs thanks to their well-functioning health systems and effective treatment methods including wide-range of rehabilitation mechanisms. On average, developed countries lost only 8.4 healthy life years per 100 people due to disability in 2016.

Figure 2: Years of Healthy Life Lost Due to Disability (YLDs) in the World (left) and OIC Regions (right); per 100 people, 2016



Source: WHO and World Bank.

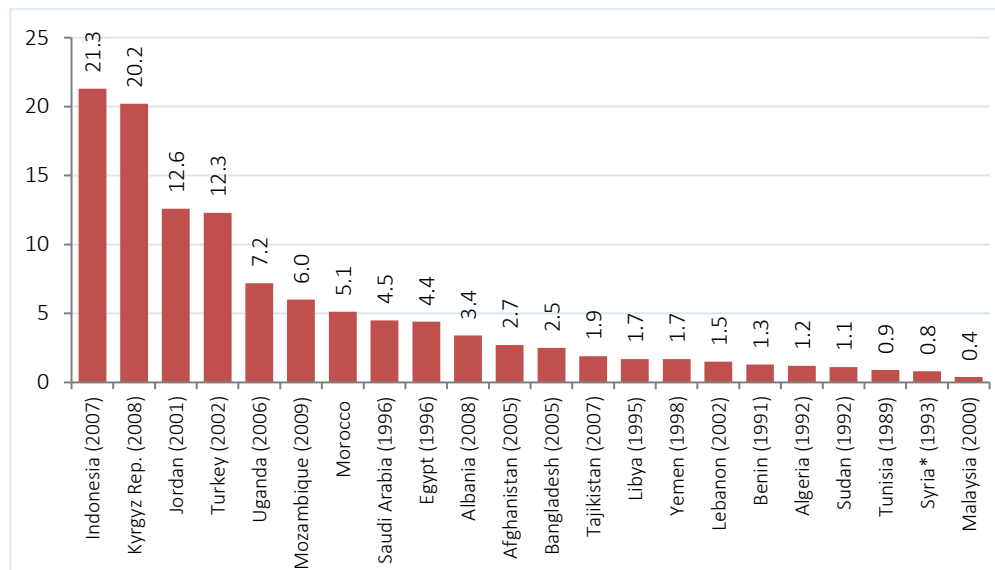
Note: SSA: Sub-Saharan Africa; ESALA: East and South East Asia and Latin America; ECA: Europe and Central Asia; MENA: Middle East and North Africa.

To provide the necessary services for disabled people effectively, countries need to know the exact number of disabled people. However, many countries have not been collecting and reporting disability data in a regular basis and standard way. Therefore, standardized data reported by international institutions have a special importance in cross-country analyses. WHO and World Bank (2011) provided the estimates of disability prevalence based on national surveys in 22 OIC countries. According to Figure 3, among data available OIC member countries, Indonesia had the highest disability prevalence rate that was measured at 21.3 per cent. Indonesia was followed by Kyrgyz Republic (20.2 per cent) and Jordan (12.6 per cent). On the other hand, among OIC member countries with available data, Malaysia recorded the lowest disability prevalence rate (0.4 per cent). This picture reveals that the prevalence rates of disability across OIC member



countries are away from being similar and ranges between 0.4 per cent and 21 per cent. In this regard, it is essential to design and implement some specific policies on disability and healthcare systems to address the needs of people with disabilities living in OIC member countries.

Figure 3: Estimates of Disability Prevalence (%) in OIC Member Countries



Source: World Bank, World Disability Report 2011

Learning and innovation may also take place in services and in some branches of agriculture, as they are becoming increasingly more capital intensive and knowledge based. However, it is again the manufacturing sector that produces a range of productive inputs for agriculture (e.g. chemicals, fertilisers, pesticides, and agricultural machinery) and services (e.g. transport equipment, computer technology, and mechanised warehouses) that help raise productivity in those sectors (UNECA, 2016).

Evidently, the services sector increasingly dominates the economic structure of many countries in terms of output, employment and value added. In many developing countries, the growth of services, rather than manufacturing, has become a core strategy to diversify away from dependence of primary commodities. However, it is important to note that many services that have grown rapidly in the last few decades are heavily dependent on manufacturing firms, such as communications, banking, insurance, transport, design and engineering. Moreover, most services are characterised with low tradability. This means that countries that rely on their services sector for economic growth will eventually struggle with trade balance constraints (UNECA, 2016). Although services account for two-thirds of output in most developed economies, they still represent only around 20%–25% of international trade (HSBC, 2015).



3. Mental Disorders and People with Special Needs

Mental health is an integral and essential component of health. It is defined as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to contribute to her or his community.

Although mental and psychological problems are a common place among all kind of people in the world, such complications occur more frequently among certain population because of their greater exposure and vulnerability to unfavorable social, economic, and environmental circumstances. The specific causes of psychological disorders are not known, yet it is obvious that such disorders have etiologies that are largely multi-factorial, involving complex interactions between biological, psychological and environmental factors.

Some mental disorders can be linked to biological factors such as chemical imbalance, genetic factors, prenatal damage, poor nutrition or exposure to toxins. Psychological factors that may contribute to mental and psychological disorders including severe psychological trauma, such as emotional, physical or sexual abuse or an important early loss of family members. Exposure to environmental stressors, such as natural disasters and man-made crises can also be among the leading causes of mental disorders that associate with an increase in the number of people with special needs.

A psychological disorder, also known as a mental disorder, is a pattern of behavioral or psychological symptoms that impact multiple life areas and create distress for the person experiencing these symptoms (Cherry, 2016). In other words, mental disorders negatively affect self-development, quality of life and ability to fully participate into socio-economic life. Moreover, high rates of suicide are usually associated with mental disorders such as depression schizophrenia and with alcohol and drug dependence (WHO, 2008). Poor mental conditions may also enhance the use of alcohol or substances that would trigger addictions.

3.1. Main Types of Mental Disorders

Mental health is a crucial part of human wellbeing meanwhile; mental disorders increase the risk of getting ill from other diseases such as HIV, cardiovascular disease, diabetes, and vice-versa.





There are different types of mental disorders with different causes and risk groups; in relation to age or gender. They include bipolar disorder, depression, psychotic breaks, dementia, schizophrenic manifestations, and intellectual or developmental handicaps or disorders as with autism.

Depression or unipolar depressive disorder is among the main causes of mental disability. According to the WHO estimations, around 300 million people worldwide are affected by the disorder.

Depression has basic symptoms that are naturally experienced by everyone at points of life as with feeling sad, guilty, lack of happiness and interest in life as well as low self-esteem. However, if not dealt with on time, it may have an impact on sleep, appetite, reduce concentration and result in unexplained tiredness. Sometimes it may lead to physical pain and complaints without any physical reasons. At its most severe, depression can lead to suicide (WHO, 2018a).

According to the WHO estimations, the bipolar affective disorder affects around 60 million people worldwide. This disorder can be characterized by having both periods of normal mood and mental conditions as with manic episodes. Manic episodes might be demonstrated by having over-activeness, over-irritability or high moods and inflated self-esteem, as well as a decreased need for rest and sleep (WHO, 2018a).

Schizophrenia is a severe mental disorder, affecting about 23 million people worldwide. Psychoses, including schizophrenia, are characterized by distortions in thinking, perception, emotion, language, sense of self and behavior. Common psychotic experiences include hallucinations (hearing, seeing or feeling things that are not there) and delusions (fixed false beliefs or suspicions that are firmly held even when there is evidence to the contrary). The disorder can make it difficult for affected people to work or study normally (WHO, 2018b). Countries with higher per capita income levels tend to suffer more from schizophrenia.

Dementia is a medical term for the group of diseases associated with decline in thinking and other mental capacities such as memory, ability to make arithmetic calculations, comprehension and others. The impairment may substantially reduce person's ability to perform simple daily activities. According to the WHO (2017), globally around 50 million people are suffering from dementia. The most common form of the dementia is Alzheimer disease followed by vascular dementia. The afflicted people usually have to suffer from the impairment through the remaining part of their life with progressive deterioration in their cognitive functions.

3.2. Mental Health Policies and Legislations

According to SESRIC (2016), in 58 per cent of OIC countries a mental health policy exists. This percentage is comparable to non-OIC developing countries (58.5 per cent) but it falls short from developed countries where 100 per cent of countries have a mental health policy. Similarly, mental health legislation is available in 51 per cent of OIC countries compared to 53.7 per cent in non-OIC developing countries and 100 per cent in developed countries. In terms of the



availability of a mental health plan, 72 per cent of OIC countries have a mental health plan compared to 65.3 per cent of non-OIC developing countries and 100 per cent of developed countries.

These figures imply that OIC countries have a large room to improve the state of people with special needs by developing effective policies, legislations, and plans. It is of importance for OIC countries to allocate more resources in order to have more mental health facilities, scale up the number of mental health professionals, and provide additional social services for people with special needs. In this picture, the OIC can play an important advocacy role in encouraging OIC countries without any mental health policy/legislation/plan to develop such instruments. And through improving cooperation among OIC countries, experience sharing and knowledge transfer programmes can also be developed in this domain.



4. Physical Disability and People with Special Needs

An estimated 15 per cent of the world's population experience some form of disability or impairment. Majority of these disabilities appear in the form physical disability where the physical health capacity of a person does not allow him/her to fully participate into daily socio-economic activities without any support. The number of people with disabilities has been increasing due to population growth, ageing, emergence of chronic diseases and medical advances that preserve and prolong life.

Persons with physical disabilities are diverse and heterogeneous, while stereotypical views of disability emphasize wheelchair users and a few other “classic” groups such as blind people and deaf people (WHO and World Bank, 2011). Disability encompasses the child born with a congenital condition such as cerebral palsy (a disorder that leads to permanent movement disability) or the young soldier who loses his leg to a land-mine, or the middle-aged woman. An elderly person can also be classified as a disabled person due to his chronic respiratory disease that hinders his full and effective participation in society on an equal basis with others.

The vast majority of disabled people, about 77 per cent, experience some form of physical disability mainly caused by 145 categories of diseases/disorders from cardiovascular diseases to sense organ impairments. Physical disabilities are mainly triggered by two factors in general: internal (i.e. genetic) and external (i.e. risk factors). However, as in the case of mental disorders, very frequently both of the factors play some role on the severity of physical disabilities (WHO and World Bank, 2011).

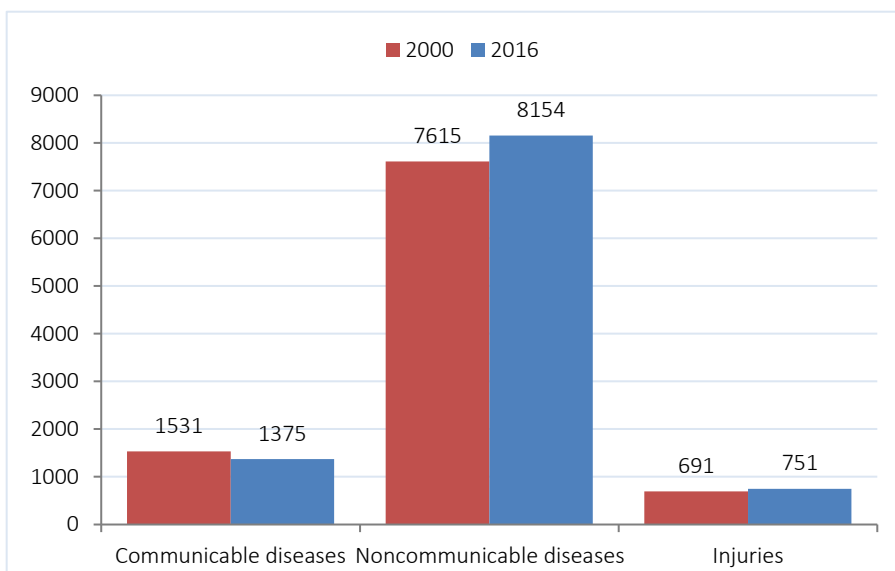
The most common external causes of physical impairment and disability include chronic diseases such as diabetes, cardiovascular disease and cancer; injuries such as those due to road traffic crashes, conflicts, falls, landmines, and other communicable diseases. Amongst others, no doubt, ageing is one of the key factors behind the increased prevalence of physical disabilities caused by both internal and external factors.

Figure 4 presents worldwide Years of Healthy Life Lost Due to Disability (YLDs) (per 100,000 people) by cause and age group. Both in 2000 and 2016, for all ages, non-communicable diseases were the main cause of YLDs worldwide. On average, non-communicable diseases were



responsible for 8,154 years of healthy life lost due to disability (per 100,000 people) in 2016. It is followed by communicable diseases (1,375 years) and injuries (751 years) in the same year. Over the period 2000-2016, on average, YLDs stemming from non-communicable diseases and injuries went up. On the other hand, thanks to the global, regional and national efforts to fight with major communicable diseases, the average YLDs stemming from communicable diseases decreased from 1,531 in 2000 to 1,375 (per 100,000 people) in 2016.

Figure 4: Years of Healthy Life Lost Due to Disability (YLDs) (per 100,000 people) in the World, by cause, 2000 and 2016



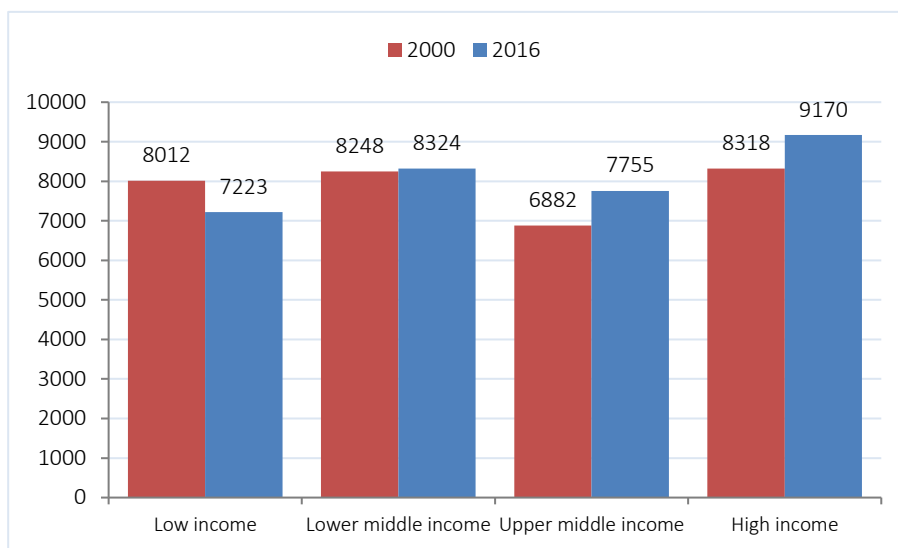
Source: WHO Data Repository

Nevertheless, it is important to note that different age groups are not affected at the same level from disabilities. For instance, for population over 60 or 70 years old, the effect of non-communicable diseases on YLDs tend to increase stemming from some chronic diseases that they experience. As different age-groups are being affected at varying degrees from disabilities in the world, the income level of a country (i.e. development level) is also an important determinant on YLDs. As poverty and disability reinforces each other, many disabled poor people fall into a vicious circle in developing countries including many OIC countries where they cannot fully integrate into society due to lack or limited coverage of social safety net mechanisms.

In this regard, Figure 5 presents YLDs across four-income group of countries caused by physical factors (diseases) in the world in 2000 and 2016. Lower-middle income countries suffered more from physical disabilities when compared to upper-middle income countries in 2016 in terms of YLDs. On the other hand, low-income countries achieved to reduce their YLDs from 8,012 in 2000 to 7,223 in 2016 (per 100,000 people). Lower-middle income countries experienced a slight increase (76-year) in their average YLDs in the same period.



Figure 5: Years of Healthy Life Lost Due to Disability (YLDs) caused by Physical Factors (Diseases) in the World, by income group (per 100,000 people), 2000 and 2016



Source: SESRIC Staff Calculation from WHO Data Repository

Note: Years of Healthy Life Lost Due to Disability (YLDs) caused by Physical Factors (Diseases) is calculated by deducting disabilities led by mental disorders from all causes of disabilities

Note 2: The World Bank's income group thresholds are used to group countries across the globe

National and international efforts as well as investments made to improve health care systems in developing countries might be some of the main reasons behind the negative trends seen in YLDs especially in low income countries. Moreover, detection of diseases and reporting mechanisms on the burden of diseases are comparatively less-advanced in some developing countries. In this regard, it is a fact that in some developing countries YLDs might be underestimated.

According to Figure 5, upper-middle-income and high-income countries lost healthier years due to physical disabilities in 2016 when compared with their averages in 2000. In 2016, the average YLDs (per 100,000 people) of upper-middle-income and high-income countries reached 7,755 years and 9,170 years, respectively. One of the underlying factors behind this picture seen in relatively richer countries is the “ageing population”. With increased life expectancy and lower fertility rates, population in these countries tend to live longer but with some disabilities mainly caused by physical factors especially chronic non-communicable diseases. Also increasing burden of risk factors such as limited physical activity and prevalence of obesity contributed to the positive trend seen in YLDs in relatively high income countries.

Overall, OIC member countries are in need of upscaling their health budgets in order to fully accommodate increasing number of demands from people with special needs thanks to improvements in medical technologies. As a result, the burden of physical disabilities on people and society (measured in terms of YLDs) would go down and people with special needs can better integrate into their respective societies.





5. Services for People with Disabilities and Special Needs

People with disabilities may require a range of services – from relatively minor and inexpensive interventions to complex and costly ones. These people have to overcome specific challenges to access to health care services (Box 2). Data on the needs – both met and unmet – are important to develop effective policy and programmes. In particular, unmet needs for support may relate to everyday activities – such as personal care, access to aids and equipment, participation in education, employment, and social activities, and modifications to the home or workplace.

Some studies revealed large gaps in service provision for people with disabilities. Unmet needs tend to be particularly high for welfare, rehabilitation, assistive devices, education, vocational training, and counselling services (WHO and World Bank, 2011). For instance, a national study on disability in Morocco estimated the expressed need for improved access to a range of services (Secretariat of Family, 2006). According to the findings, people with disabilities in the study expressed a strong need for better access to health care services (55.3 per cent), medications (21.3 per cent), and technical devices (17.5 per cent), and financial help for basic needs (52.5 per cent).

Policy-makers in OIC countries can benefit from rehabilitation and community-based rehabilitation services as well as assistive devices in order to improve the state of people with disabilities and encourage their participation into socio-economic life.

5.1. Rehabilitation

Rehabilitation is instrumental in enabling people with disabilities whose functions are limited to remain in or return to their home or community, live independently, and participate in education, the labor market and civic life. Access to rehabilitation can decrease the consequences of disease or injury, improve health and quality of life and reduce the use of health services. While global data on the need for rehabilitation, the type and quality of measures provided, and estimates of unmet need do not exist, national-level data reveal large gaps in the provision of and access to such services in many low-income and middle-income countries.



Box 2: Barriers to Health Care for People with Disabilities and Special Needs

People with disabilities usually encounter the following barriers when they attempt to access health care services including the rehabilitation and special care services:

- a) **Prohibitive costs:** Affordability of health services and transportation are two main reasons why people with disabilities do not receive needed health care in low-income countries - 32-33% of non-disabled people are unable to afford health care compared to 51-53% of people with disabilities.
- b) **Limited availability of services:** The lack of appropriate services for people with disabilities is a significant barrier to health care. For example, research in Uttar Pradesh and Tamil Nadu states of India found that after the cost, the lack of services in the area was the second most significant barrier to using health facilities.
- c) **Physical barriers:** Uneven access to buildings (hospitals, health centres), inaccessible medical equipment, poor signage, narrow doorways, internal steps, inadequate bathroom facilities, and inaccessible parking areas create barriers to health care facilities. For example, women with mobility difficulties are often unable to access breast and cervical cancer screening because examination tables are not height-adjustable and mammography equipment only accommodates women who are able to stand.
- d) **Inadequate skills and knowledge of health workers:** People with disabilities were more than twice as likely to report finding health care provider skills inadequate to meet their needs, four times more likely to report being treated badly and nearly three times more likely to report being denied care.

Source: Adapted from WHO (2018c) <http://www.who.int/mediacentre/factsheets/fs352/en/>

5.2. Community-based Rehabilitation

Community-based rehabilitation (CBR) was initiated by the WHO following the Declaration of Alma-Ata in 1978 in an effort to enhance the quality of life for people with disabilities and their families; meet their basic needs; and ensure their inclusion and participation. While initially a strategy to increase access to rehabilitation services in resource-constrained settings, CBR is a multi-sectoral approach working to improve the equalization of opportunities and social inclusion of people with disabilities while combating the perpetual cycle of poverty and disability. CBR is implemented through the combined efforts of people with disabilities, their families and communities, and relevant government and non-government health, education, vocational, social and other services. CBR has been practiced in more than 90 countries in the world.²

² However, there is no centralized database of CBR implementers and activities.





5.3. Assistive Devices

Assistive technology is the tool, and often the first step for any next steps to ensure people with disabilities are equal beneficiaries of, and contributors to any development process. As early as 1990, the UN Standard Rules identified access to assistive products as a precondition for equal rights and opportunities and urged countries across the globe to take affirmative actions to make these devices available at an affordable cost. The Convention on the Rights of Persons with Disabilities has recognized access to assistive technology as a human right and has called for international cooperation to improve its access (Article 32).

Despite all national and international efforts, only 5–15 per cent (approximately 1 in 10 persons) of the population in need has access to assistive products – e.g. wheelchairs, canes, prosthetic and orthotic devices, spectacles, low vision aids, hearing aids, and augmentative and alternative devices to cope with functional decline. Even production of important assistive products such as hearing aids barely meets 10 per cent of global need, and less than 3 per cent in developing countries (WHO, 2006). In developing countries, production quality is usually low and often of limited quality. Another problem that developing countries, including many OIC member countries, experience in this domain is the scarcity of personnel trained to manage the provision of such devices and technologies, especially at provincial and district levels. On the other hand, in many developing countries including OIC member countries, it is possible to access assistive devices but associated costs are prohibitive for people with special needs mainly stemming from ineffective social security systems.

The current gap in access to assistive products will be magnified in the future by the immense projected population growth, especially as the number of older people worldwide increases from 841 million in 2013 (11.7 per cent of the world's population) to more than 2 billion (21.1 per cent) by 2050. Therefore, in future the demand for assistive products is expected to go up remarkably.

In this regard, OIC countries need to take such demographic changes into consideration and change the way how assistive products or devices—collectively called assistive technology—traditionally perceived, designed, produced, manufactured, distributed, serviced and financed.



6. Global Initiatives on Improving the State of People with Disabilities and Special Needs

This section overviews selected global initiatives (e.g. action plans, strategies, projects) that aims to improve the state of people with disabilities and special needs.

6.1. The United Nations Convention on the Rights of Persons with Disabilities

The Convention on the Rights of Persons with Disabilities (CRPD) sets out the legal obligations on States to promote and protect the rights of persons with disabilities. It does not create new rights. According to the Article 1 of the Convention, 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.

The Convention outlines the civil, cultural, political, social and economic rights of people with disabilities. In other words, The Convention gives universal recognition to the dignity of persons with disabilities. The Convention marks a ‘paradigm shift’ in attitudes and approaches to persons with disabilities. In this regard, according to the Convention:

- a) Persons with disabilities are no longer an object to be fixed through medical treatment but a subject of rights with choices as to how he or she wants to live and what treatments, if any, he or she wishes to use;
- b) Persons with disabilities are no longer objects of charity or social welfare – a burden on society – but active members of society with something to contribute to society; and
- c) Persons with disabilities should have avenues to defend rights (complaints mechanisms, rights advocacy etc.) and to change society so that society becomes more capable.

The Convention on the Rights of Persons with Disabilities came into force on 3 May 2008. Countries which have signed the Convention agree to promote, protect and ensure the full and equal enjoyment of the human rights and fundamental freedoms of people with disabilities and prompt respect for their inherent dignity.

As of October 2018, 162 countries across the globe have signed the Convention (many of them completed the full ratification process). 40 OIC Member countries have completed both the signature and ratification processes of the Convention. 10 OIC countries, namely Afghanistan,





Djibouti, the Gambia, Iran, Iraq, Kuwait, Mauritania, Palestine, Saudi Arabia, and Turkmenistan have neither signed and nor ratified the Convention yet. However, these countries are in the accession process of the Convention on the Rights of Persons with Disabilities (see Annex).

During the implementation process of the Convention many countries across the globe including the OIC Members are in need for training, capacity building, and awareness raising, good practices collection and validation and knowledge management. They are also in need to mainstream disability in all development activities. It is also highly critical to include persons with disabilities as a stakeholder for the successful implementation of the Convention in its all stages.

6.2. Global Disability Action Plan 2014-2021

The 67th World Health Assembly adopted a resolution endorsing the WHO global disability action plan 2014–2021: Better health for all people with disability. The action plan provides a major boost to enhance the quality of life of the one billion people around the world with disabilities. The Global Disability Action Plan 2014-2021 is providing a universal guideline and framework to member states including OIC members on how to strengthen and extend rehabilitation, habilitation, assistive technology, assistance and support services and community-based rehabilitation.

The action plan is based on the recommendations of the WHO and World Bank World report on disability and aligns with the Convention on the Rights of Persons with Disabilities (CRPD). It was developed in consultation with member countries, United Nations organizations and national and international partners, including organizations of people with disabilities.

Across the world, more often than their non-disabled peers, people with disabilities do not receive the health care they need and have poorer health. People with disabilities are more than twice as likely to find healthcare providers' skills and facilities inadequate; nearly three times more likely to be denied health care; and four times more likely to be treated badly. The WHO global disability action plan 2014-2021 seeks to address these disparities.

The vision of the action plan is a world in which all persons with disabilities and their families live in dignity, with equal rights and opportunities, and are able to achieve their full potential. The overall goal is to contribute to achieving optimal health, functioning, well-being and human rights for all persons with disabilities. The action plan has three objectives:

- To remove barriers and improve access to health services and programmes;
- To strengthen and extend rehabilitation, habitation, assistive technology, assistance and support services, and community-based rehabilitation;
- To strengthen collection of relevant and internationally comparable data on disability and support research on disability and related services.

The indicators of success set for each objective can be used to help to monitor and measure progress towards attainment of the plan's goal.



The new resolution urges Member States to implement the proposed actions as adapted to national priorities and specific national circumstances. It invites international and national partners to take note of the action plan and its objectives, and requests the WHO Secretariat to provide guidance, training and technical support, and submit reports on the progress achieved in implementing the action plan (WHO, 2015).

6.3. Global Disability Conference and Charter

On 24 July 2018 some 700 leaders from organizations of people with disabilities, governments, donor agencies and technology companies convened in London for the first ever Global Disability Summit 2018. Hosted by the Government of the United Kingdom, and co-hosted by the International Disability Alliance and the Government of Kenya, the Summit aimed at:

- Raising global attention and focus on a neglected area;
- Bringing in new voices and approaches to broaden engagement;
- Mobilising new global and national commitments on disability; and,
- Showcasing best practice and evidence from across the world.

The ‘Charter for Change’ is the official legacy document of the [Global Disability Summit](#) on 24 July in London and aimed to ensure a global consensus to address a long-neglected issue, and support the rights of persons with disabilities around the world. The ‘Charter for Change’ was signed by a number of relevant official bodies and governments of OIC countries including Afghanistan, Cameroon, Bangladesh, Jordan, Mozambique, Somalia, Uganda, Iraq, Kyrgyz Republic, Lebanon, Nigeria, Pakistan, Palestine, Senegal, Sierra Leone, and Uganda.

6.4. Global Cooperation on Assistive Technology

Key stakeholders at a side event of the High-level meeting of the General Assembly on disability and development, New York, United States of America, 23 September 2013, requested WHO to develop and coordinate a global initiative to realize the obligations of the Convention on the Rights of Persons with Disabilities towards increasing access to assistive technology (article 32 in particular).

In response to this, WHO organized a key stakeholders meeting in Geneva on 3 and 4 July 2014 and established a global initiative: the Global Cooperation on Assistive Technology (GATE) in partnership with stakeholders who represent international organizations, donor agencies, professional organizations, academia, and user groups.

GATE would be instrumental to address the increasing need of people with special needs into these specific technologies and services. The vision of the GATE initiative is to have a world where every girl and boy, woman and man in need has access to high quality affordable assistive products to lead a healthy, productive and dignified life.





Box 3: Global Disability Summit Charter for Change

We gather here in London and across the world to achieve a common aim: to ensure the rights, freedoms, dignity and inclusion for all persons with disabilities.

Important progress has been made in the decade since the adoption of the United Nations Convention on the Rights of Persons with Disabilities (CRPD). But we must do more. We must strive for real change through the Convention's implementation and the delivery of the Sustainable Development Goals for persons with disabilities.

So today We commit to:

1. Catalyse political will and leadership to turn our promises into change; in long-term plans that we invest in, implement and review.
2. Promote the leadership and diverse representation of all persons with disabilities to be front and centre of change; as leaders, partners and advocates. This includes the active involvement and close consultation of persons with disabilities of all ages.
3. Eliminate stigma and discrimination through legislation and policies that make a difference, promoting meaningful leadership, and consistently challenging harmful attitudes and practices. All people deserve dignity and respect.
4. Progress and support actions that advance inclusive quality education for people with disabilities, with the necessary resources to put plans into practice: every child has the right to learn from birth.
5. Open up routes to economic empowerment and financial inclusion so that persons with disabilities can enjoy decent work and achieve financial independence. This will mean creating more and better jobs, providing social protection, ensuring the necessary skills training, making workplaces accessible and hiring people with disabilities.
6. Revolutionise the availability and affordability of appropriate assistive technology, including digital, which will enable persons with disabilities to fully participate and contribute to society.
7. Change practices to make all humanitarian action fully inclusive and accessible to persons with disabilities. We will mainstream inclusion across all Disaster Risk Reduction and humanitarian sectors, and implement our commitments in the Charter 'Inclusion of Persons with Disabilities in Humanitarian Action'.
8. 'Leave no one behind' and put the furthest behind first. We will champion the rights of the most underrepresented and marginalised persons with disabilities, of all ages, affected by any form of multiple discrimination, and notably women and girls with disabilities.
9. Gather and use better data and evidence to understand and address the scale, and nature, of challenges faced by persons with disabilities, using tested tools including the Washington Group Disability Question Sets.
10. Hold ourselves and others to account for the promises we have made here today. We agree that our individual commitments will be reviewed, assessed and published on a regular basis, with the results published on-line.



The GATE initiative has only one goal: to improve access to high-quality affordable assistive products globally. To achieve this, the GATE initiative will focus on four interlinked activities (4P):

1. **Policy:** National assistive technology policy framework (ATPF)
2. **Products:** Priority Assistive Products List (APL)
3. **Personnel:** Comprehensive assistive technology training programme (ATTP)
4. **Provision:** Single-window service provision model (ATSP)

GATE has the potential to open the doors for children with disabilities to access education and adults to earn a living, overcome poverty, participate in all societal activities, and live with dignity, which are some of the key objectives of the global development goals. Assistive Technology, Information and Communication Technology (ICT), Accessible Technology, Universal Design, Accessible or Enabling Environment are all interlinked and are preconditions for mainstreaming disability in development priorities. Investment in technology to make it available and affordable is definitely a practical step to establish the “Promise of Technology to Achieve Sustainable Development for All.”

6.5. Comprehensive Mental Health Action Plan 2013–2020

On May 27, 2013, the World Health Assembly adopted the Comprehensive Mental Health Action Plan 2013–2020. This action plan and the accompanying resolution—a first in the history of WHO—represent a formal recognition of the importance of mental health. It is also a commitment by member states of the WHO to take specified actions to improve mental health and to contribute to the attainment of a set of agreed global targets.

The vision of the action plan is to have “a world in which mental health is valued, promoted and protected, mental disorders are prevented and persons affected by these disorders are able to exercise the full range of human rights and to access high quality, culturally-appropriate health and social care in a timely way to promote recovery, all in order to attain the highest possible level of health and participate fully in society and at work free from stigmatisation and discrimination”.

Building upon earlier work, and based upon a consultation process that involved 135 member states, 60 WHO collaborating centres and academic centres, 76 non-governmental organisations (NGOs), and 17 other organisations and individual experts consensus was reached on the key actions to be taken with respect to each of the below listed four objectives:

Objective 1: Strengthen effective leadership and governance for mental health.

Global target 1.1: 80% of countries will have developed or updated their policies/plans for mental health in line with international and regional human rights instruments (by the year 2020).

Global target 1.2: 50% of countries will have developed or updated their laws for mental health in line with international and regional human rights instruments (by the year 2020).





Objective 2: Provide comprehensive, integrated and responsive mental health and social care services in community-based settings.

Global target 2: Service coverage for severe mental disorders will have increased by 20% by the year 2020.

Objective 3: Implement strategies for promotion and prevention in mental health.

Global target 3.1: 80% of countries will have at least two functioning national, multisectoral promotion and prevention programmes in mental health {by the year 2020}.

Global target 3.2: The rate of suicide in countries will be reduced by 10% (by the year 2020).

Objective 4: Strengthen information systems, evidence and research for mental health.

Global target 4: 80% of countries will be routinely collecting and reporting at least a core set of mental health indicators every two years through their national health and social information systems (by the year 2020).

Each of the four objectives has one or two specific targets, which provide the basis for measurable collective action and achievement of countries towards global goals. A set of core indicators relating to these targets as well as other actions have been developed and are being collected via the Mental Health Atlas project on a periodic basis. The relevant data on core indicators is expected to be collected from all countries to track national, regional, and global progress, to be reported back to the World Health Assembly in 2015, 2018, and 2021. According to the WHO, implementation of the action plan will face challenges; in particular, years or decades of inadequate investment into human and financial resources for mental health care need to be quickly reversed.

Implementation of the Action Plan will enable persons with mental disorders to:

- Find it easier to access mental health and social care services;
- Be offered treatment by appropriately skilled health workers in general health care settings; WHO's Mental Health Gap Action Programme (mhGAP) and its evidence-based tools can facilitate this process;
- Participate in the reorganization, delivery and evaluation of services so that care and treatment becomes more responsive to their needs; and
- Gain greater access to government disability benefits, housing and livelihood programmes, and better participate in work and community life and civic affairs.

6.6. Mental Health Gap Action Programme

Mental, neurological and substance use disorders are highly prevalent and burdensome globally. The gap between what is urgently needed and what is available to reduce the burden is very wide. There is a need for action to reduce the burden, and to enhance the capacity of countries



to respond to this growing challenge. Mental Health Gap Action Programme (mhGAP) is the WHO's action plan to scale up services for mental, neurological and substance use disorders for countries especially with low and lower middle incomes. The priority conditions addressed by mhGAP are: depression, schizophrenia and other psychotic disorders, suicide, epilepsy, dementia, disorders due to use of alcohol, disorders due to use of illicit drugs, and mental disorders in children. The mhGAP package consists of interventions for prevention and management for each of these priority conditions. Successful scaling up is the joint responsibility of governments, health professionals, civil society, communities, and families, with support from the international community. The essence of mhGAP is building partnerships for collective action (WHO, 2008).

6.7. Mental Health Atlas Project

Mental Health Atlas Project of the Department of Mental Health and Substance Abuse of the WHO is designed to collect, compile and disseminate data on mental health resources in the world. Resources include mental health policies, plans, financing, care delivery, human resources, medicines, and information systems. These resources are necessary to provide services and care for people with mental disorders.

The objectives of the project are to raise public and professional awareness of the inadequacies of existing mental health resources and services and the large inequities in their distribution at national and global level, and to provide useful information in planning for enhancement of mental health resources.

Mental Health Atlas project report was first published in 2001 and the information was updated in 2005, 2011 and 2014. In 2014, in total, 171 out of WHO's 194 Member States were able to at least partially complete the Atlas questionnaire, representing a participation rate of nearly 90%. According to the Mental Health Database of the WHO (2014), 15 OIC member countries (Cameroon, Chad, Comoros, Gabon, Guinea-Bissau, Kazakhstan, Kyrgyz Republic, Lebanon, Libya, Mauritania, Niger, Palestine, Tunisia, Turkey, and Uzbekistan) did not submit the Atlas questionnaire for 2014 to the WHO.





7. Concluding Remarks and Policy Implications

Disability is extremely diverse and it is estimated to affect every 1 in 7 persons across the globe. There is some evidence that disability disproportionately affects women, older people, and poor people. It is estimated that developing countries host 80 per cent of all disabled people in the world. Millions of people with special needs living in these countries cannot access and afford healthcare, rehabilitation services and assistive devices. For instance, in developing countries production of hearing aids only meet 3 per cent of needs of developing countries.

OIC member countries are not immune from these underlying facts and host millions of people with special needs who are in need of basic healthcare services, specialized rehabilitation services and other community services from transport to education. Despite not having standard comparable statistics on available services people with special needs, an overlook on selected indicators revealed there is underinvestment into health and social services in many OIC countries that directly affect the quality of life of people with special needs. For instance, in 2013, on average, the share of government health expenditures represented 7.9 per cent of total government expenditures in the OIC group where the world average was measured at 15.6 per cent in the same year. In this regard, it is fair to claim that for many people with disabilities living in the OIC region cannot meet their special needs for one reason or another (e.g. underinvestment into social security, insufficient number of trained health professional and rehabilitation units etc.).

In the light of above, OIC member countries should urgently address the needs of people with disabilities and special needs by:

Creating mechanisms to receive input from people with special needs: Successful removal of barriers and improvement in access to health services require input from persons with disabilities, who are most familiar with and affected by such barriers. Ensuring that health-related information is issued in an appropriately accessible format, and that modes of communication meet the requirements of persons with disabilities (such as sign language) is important. Some persons with disabilities may also require support to assert their right to health and equal access to health services.



Improving health outcomes: It is essential to invest into healthcare services designed for people with disabilities by improving access to quality, affordable health care services, which make the best use of available resources. In this regard, it is critical for OIC member countries to assess existing policies and services, identify priorities to reduce health inequalities and plan improvements for access and inclusion. It would be highly instrumental to make changes to comply with the United Nations Convention on the Rights of Persons with Disabilities (CRPD). It is important to make health care services affordable for disabled people to ensure that people with disabilities are fully covered by the social security systems that they no longer need to think on out-of-pocket payments. In order to improve accessibility of healthcare health care institutions it is essential to redesigning the physical layout of clinics and provide training health professionals to be more skilled on special needs of disabled people.

Collecting reliable information and data: Without reliable up-to-date data and statistics on people with disabilities in line with global standards, it is almost impossible to develop effective policies. In this context, collecting information and data on people with special needs would help OIC countries to make timely and effective policy interventions as well as improve monitoring capacities and enable needs assessment. To this end, OIC member countries need to pay a special attention on international guidelines on data collection, processing and reporting in order to develop evidence-based effective policies to address the special needs of people with disabilities.

Conducting more research: The lack of proper evidence and research on the needs, barriers, and health outcomes for people with disabilities limit capacities of policy-makers in developing policy solutions. Without having groundbreaking research and analytical analyses, it is not possible to find out drawbacks of existing policies, missing components and ineffective initiatives designed for people with special needs. In this regard, OIC member countries need to invest into research institutions, universities and specialized centres which are carrying out research activities and generate statistics on people with special needs.

Raising awareness: It is important to change the perception in the society about people with disabilities in order address some challenges faced by them and enhance their integration into socio-economic life.

Implementing training programmes: Designing training programmes and introducing courses into educational curriculums on people with special needs would help to eliminate any prejudices against people with special needs. Such programmes also would help to promote and protect their rights and dignity.





Reducing risk factors: Implementing policies with a view to reducing risk factors especially contributing to disabilities during pregnancy and childhood should be integral part of national strategies on disability. Such policies would be more important especially in the case of early and risky marriages where associated risks are relatively higher. Family counselling programmes including premarital testing for diseases such as anaemia and thalassemia might be effective to reduce the prevalence of disabilities. In this context, OIC member countries need to take the necessary steps to promote early intervention and identification of disability, especially during pregnancy and for children.

Encouraging community-based rehabilitation programmes: Promoting and encouraging community-based rehabilitation programmes would help members of any society to better understand people with special needs and assist them in their inclusion and integration into socio-economic life.

Developing assistive technology: OIC countries need to develop new mechanisms and review the existing ones to upscale the access of people with special needs to assistive technology including to prostheses, wheelchairs, driving aids and other devices.

Ensuring effective coordination: It is essential to ensure an effective coordination among all stakeholders in designing and implementing policies on disability. Such coordination would help to prevent duplications and improve policy effectiveness.

Looking through gender lens: OIC countries need to pay a special attention to gender equality and women with disabilities in developing all measures and policies targeting people with special needs. It is of importance where women in some countries are subject to social, cultural and economic disadvantages.

Developing national plans and strategies: Developing national plans and strategies by involving relevant ministries (e.g. health, women, family affairs, labour, transport and communication), private sector and civil society would help to improve the quality of life of persons with disabilities in OIC countries.

Developing an OIC Plan of Action: It is important for OIC member countries to actively involve and follow up other international initiatives on disability such as the WHO Global Disability Action Plan and SDGs that include several targets on people with special needs. Over the last decade, OIC also successfully developed the OIC Strategic Health Programme of Action 2014-2023 (OIC-SHPA) in the domain of health and OIC Plan of Action for the Advancement of Women (OPAAW) in the domain of gender equality and women rights with the involvement of member countries and other international stakeholders. In the light of international initiatives on disability and by considering SDGs, OIC Ten Year of Programme of Action: 2016-2025, and experiences of the OIC



in developing action plans (e.g. OPAAW, OIC-SHPA), it would be instrumental to develop an OIC Plan of Action on People with Special Needs. The OIC General Secretariat, relevant OIC Institutions and member countries need to develop such a plan in order to provide a proper guidance and list action points with a view to improving the well-being of people with special needs living in OIC member countries. While developing such an action plan, it is highly important to benefit from the experiences of international institutions (e.g. UN, WHO, World Bank), national-level initiatives of OIC member countries as well as civil society organizations working in this domain.





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Annex

Status of OIC Member Countries on the UN Convention on the Rights of Persons with Disabilities (CRPD)

Country	Date of Signature	Date of Ratification / Accession (a)
Afghanistan		18-09-12 (a)
Albania	22-12-09	11-02-13
Algeria	30-03-07	04-12-09
Azerbaijan	09-01-08	28-01-09
Bahrain	25-06-07	22-09-11
Bangladesh	09-05-07	30-11-07
Benin	08-02-08	05-07-12
Brunei Darussalam	18-12-07	11-04-16
Burkina Faso	23-05-07	23-07-09
Cameroon	01-10-08	
Chad	26-09-12	
Comoros	26-09-07	16-06-16
Côte d'Ivoire	07-06-07	10-01-14
Djibouti		18-06-12 (a)
Egypt	04-04-07	14-04-08
Gabon	30-03-07	01-10-07
Gambia		06-07-15 (a)
Guinea	16-05-07	08-02-08
Guinea-Bissau	24-09-13	24-09-14
Guyana	11-04-07	10-09-14
Indonesia	30-03-07	30-11-11
Iran		23-10-09 (a)
Iraq		20-03-13 (a)
Jordan	30-03-07	31-03-08
Kazakhstan	11-12-08	21-04-15
Kuwait		22-08-13 (a)
Kyrgyzstan	21-09-11	





Country	Date of Signature	Date of Ratification / Accession (a)
Lebanon	14-06-07	
Libya	01-05-08	13-02-18
Malaysia	08-04-08	19-07-10
Maldives	02-10-07	05-04-10
Mali	15-05-07	07-04-08
Mauritania		03-04-12 (a)
Morocco	30-03-07	08-04-09
Mozambique	30-03-07	30-01-12
Niger	30-03-07	24-06-08
Nigeria	30-03-07	24-09-10
Oman	17-03-08	06-01-09
Pakistan	25-09-08	05-07-11
Qatar	09-07-07	13-05-08
Saudi Arabia		24-06-08 (a)
Senegal	25-04-07	07-09-10
Sierra Leone	30-03-07	04-10-10
Somalia	02-10-18	
Palestine		02-04-14 (a)
Sudan	30-03-07	24-04-09
Suriname	30-03-07	29-03-17
Tajikistan	22-03-18	
Togo	23-09-08	01-03-11
Tunisia	30-03-07	02-04-08
Turkey	30-03-07	28-09-09
Turkmenistan		04-09-08 (a)
Uganda	30-03-07	25-09-08
United Arab Emirates	08-02-08	19-03-10
Uzbekistan	27-02-09	
Yemen	30-03-07	26-03-09

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