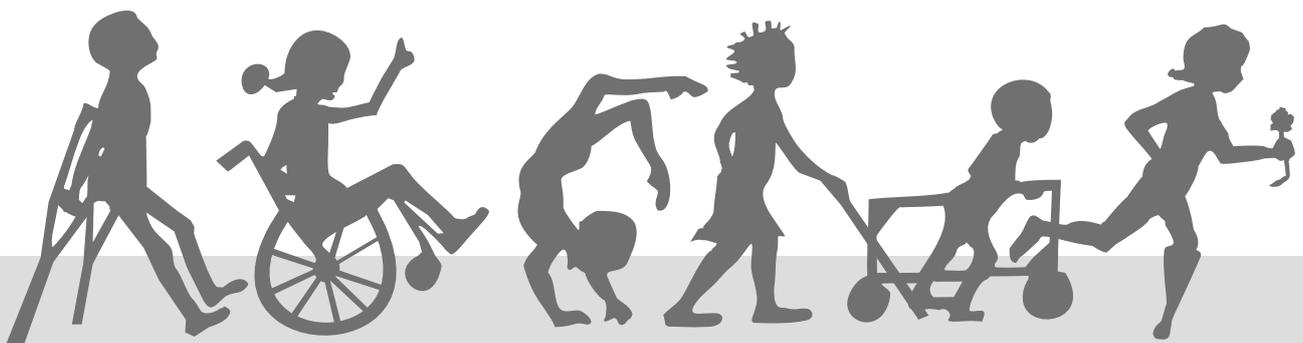


Behinderung und internationale Entwicklung

Disability and International Development





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Editorial

Liebe Leserinnen und Leser,

in diesem Jahr hat der Prozess der Entwicklung einer Nachfolge-Agenda der Millenniumsentwicklungsziele (MDG) intensiv begonnen. Auf der Ebene der Vereinten Nationen sind bereits mehrere Berichte von hochrangigen Gremien und Expertennetzwerken (u.a. vom High Level Panel of Eminent Persons) veröffentlicht worden, die Vorschläge vorgelegt haben, wie eine Entwicklungsagenda aussehen kann, die Fragen der sozialen, ökologischen und ökonomischen Entwicklung gleichermaßen berücksichtigt. Gleichzeitig wurde auf einem hochrangigen Treffen zu den MDGs bekräftigt, alle Anstrengungen zu unternehmen, um diese noch bis zum Jahre 2015 zu erreichen.

Bekanntermaßen werden Menschen mit Behinderung in den MDGs nicht explizit erwähnt. Umso bedeutender war das ebenfalls hochrangige High Level Meeting on Disability and Development im Rahmen der UN-Generalversammlung am 23.09.2013, bei dem nicht nur bekräftigt wurde, dass Menschen mit Behinderung bei der Erreichung der MDGs berücksichtigt werden müssen, sondern ebenso in der neuen Entwicklungsagenda, die es nach dem Auslaufen der MDGs 2015 geben wird.

Mit der vorliegenden Ausgabe greifen wir Fragestellungen und Herausforderungen auf, die für die Umsetzung von inklusiven Entwicklungsvorhaben von Bedeutung sind. Im ersten Beitrag wird anhand eines Beispiels aus der deutschen staatlichen Entwicklungszusammenarbeit aufgezeigt, wie ein inklusives Vorhaben im Gesundheitsbereich angegangen werden kann. Weitere Artikel beschäftigen sich mit dem Zusammenhang zwischen dem Bildungsstand von Müttern und Behinderung sowie der Inklusion von gehörlosen Menschen in das Gesundheitssystem in Kamerun.

Wir wünschen Ihnen eine anregende Lektüre und ein glückliches neues Jahr!

Ihr Redaktionsteam

Dear Reader,

this year, an intensive start was made in the process of developing a post-2015 agenda for the Millennium Development Goals (MDGs). At the level of the United Nations, several reports from high-level committees and networks of experts (including the High Level Panel of Eminent Persons) were published, presenting proposals on how a development agenda that considers social, ecological, and economic development in equal measure might be organised.

At the same time, a high-level meeting on the MDGs affirmed that all efforts would be undertaken to achieve these goals by 2015. As is known, persons with disability are not explicitly mentioned in the MDGs. All the more important therefore was the High-Level Meeting on Disability and Development within the framework of the UN General Assembly on 23.09.2013, which not only affirmed that persons with disability have to be considered in the process of attaining the MDGs, but also in the new development agenda that will come into effect post-2015.

In this issue, we will be taking up questions and challenges that are of importance for the realisation of inclusion development programs. The first article, taking one example from German governmental development cooperation, will show how an inclusiv program in the health sector can be implemented. Further articles focus on the link between the educational background of mothers and disability, as well as the inclusion of deaf people in the health care system in Cameroon.

We wish you an inspiring read and a Happy New Year.

Your editorial board



Towards Inclusive Health Services in Cambodia - A Promising Approach

Deborah Looser-Konczalla/Adam Huebner/Esther Sommer

During government to government consultations in 2011, the Royal Government of Cambodia and the German government decided to cooperate on including persons with disabilities in joint development cooperation. As a consequence, first measures have been implemented enhancing the inclusion of persons with disabilities in the health sector.

Regarding the Cambodian-German Technical Cooperation, this political commitment has been translated into practice by different state and non-governmental actors such as the Cambodian Ministry of Health, the Deutsche Gesellschaft für Internationale Zusammenarbeit operating on behalf of the German Federal Ministry for Economic Cooperation and Development, Handicap International as well as various local civil society organisations including Disabled People's Organisations. The partners progressively integrated aspects of the inclusion of persons with disabilities into the design and the activities of the Cambodian-German Social Health Protection Project. The activities ranged from awareness raising workshops over trainings to community health centre services more accessible to clients with disabilities. Disabled People's Organisations have been involved both in planning and in implementation, thus playing a key role in the process.

With this article, the authors aim to give an overview on first steps on the way to mainstreaming the inclusion of persons with disabilities in the Cambodian health sector. Besides information on the specific situation of persons with disabilities in Cambodia related to health services, the article highlights key elements and success factors of the mainstreaming process.

Introduction

More than one billion people across the world live with some form of disability, a large majority of whom live in developing countries. Poverty and disability are often interrelated. The United Nations Convention on the Rights of Persons with Disabilities (CRPD) represented a major step towards making disability a human rights issue, and became an important framework for disability-inclusive development cooperation. The CRPD, ratified by Germany in 2009, encouraged and influenced development cooperation partners in their efforts to ensure greater inclusion of persons with disabilities in programmes and policies. Following its ratification, Germany developed a National Action Plan on the Inclusion of Persons with Disabilities and the Federal Ministry for Economic Cooperation and Development (BMZ) elaborated its own Action Plan for the Inclusion of Persons with Disabilities (2013), which aimed to ensure systematic mainstreaming of the inclusion of persons with disabilities in German development policy. It outlined several strategic objectives and measures to be incorporated into development cooperation. One measure is the inclusion of persons with disabilities within the health sector in Cambodia, building on the existing partnership with the Cambodian Government in this area.

Cambodia ratified the Convention in 2012, committing itself to promoting the equality of

persons with disabilities in all spheres of society. In 2011, the Royal Government of Cambodia and the German Government agreed during its cooperation meetings to develop ideas about how to mainstream the inclusion of persons with disabilities in current and future cooperation activities to ensure that one of the most vulnerable groups of Cambodian society could increasingly participate in and benefit from poverty reduction programmes and development initiatives. Based on this decision, Germany provided additional resources for the priority area Health (Social Health Protection Programme) of Cambodian-German bilateral development cooperation. They were allocated in June 2012 to the Technical Cooperation (TC) project implemented by the Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ), operating on behalf of BMZ to enhance the inclusion of persons with or vulnerable to disabilities.

With this article, the authors aim to show how the political commitment to include persons with disabilities and other groups such as older persons has been translated into practice in the Cambodian health sector. Based on the principles laid out in BMZ Action Plan for the Inclusion of Persons with Disabilities, the authors present key developments and lessons learned from the inclusion of persons with disabilities in the Social Health Protection Project, which is part of the Cambodian-German Social Health



Protection Programme. The first section provides a brief overview of disability prevalence and different forms of disability as well as main challenges persons with disabilities face in relation to health care access in Cambodia. In the second section, the authors describe the process of mainstreaming the inclusion of persons with disabilities in the health sector, outlining key elements of this work and factors influencing success.

Identifying Barriers for Inclusion in the Health Sector

In Cambodia, thirty years of civil conflict have left the country littered with 10 million unexploded land mines, and thus caused a high number of victims disabled by these remnants. The war and genocide not only destroyed the social fabric but also destructed health care facilities and social support structures within the country (GIZ LiPortal). The lack of social and health care services also shapes the current prevalence of disability within the country. Although injuries still dominate the image of disability in people's minds, data from the Cambodia Socio-Economic Survey (CSES) reveals a different picture. Today, the most common impairments in Cambodia are related to vision, hearing and mobility. The number of persons with intellectual disabilities is likely to be underestimated in Cambodia like in many other developing countries. A secondary survey on disability following on the 2004

CSES found the most common self-identified causes of disability to be old age, various diseases, accidents and congenital conditions (CSES 2004). The overall prevalence of disabilities is estimated between 4 % (CSES 2009) and 15 % (ADB 2000). As in other countries the disability prevalence rate in general and by type in Cambodia varies widely from one survey to another depending on the methodology and the sensitivity of the particular research tool in use. From 2011 to 2012, the Cambodian Ministry of Education supported by Handicap International (HI) conducted the first medical assessment of impairment

and disability amongst children. The research was carried out in seven provinces and involved a two-phase assessment of 20,000 children aged 2-9 years. The results show that 1 of 10 children is affected by a type of disability with a majority related to learning skills, followed by difficulties related to hearing and oral-motor speech problems (Handicap International 2011/12). Thus, noting that disability prevalence increases with age, it can be deduced, that the actual disability prevalence rate amongst Cambodian adults is significantly higher than the official rate. In accessing qualified social and health services, Cambodians with disabilities most often face institutional, attitudinal and financial barriers (Kleinitz et al. 2012). While the overall capacity of the Cambodian health structure has improved vastly in the last decade, specialised health services provided by the government and non-government organisations (NGOs) are only available in more populated urban areas. Available specialised therapeutic and rehabilitation health services mostly focus on visual and physical impairments and are often reported to be of insufficient quality. One of the greatest challenges is a lack of transportation accessible for persons with disabilities or elderly. Without appropriate transportation urban health facilities cannot be reached by all rural residents. Physical barriers in addition create severe challenges for persons with disabilities to access health care services. Most common barriers are for example missing

During focus group interviews and workshops in Cambodia, persons with disabilities stated the following topics as most important factors influencing their access to health care services (HI/GIZ):

- Lack of transportation and other physical barriers are major challenges to reach and access health service facilities.
- Fees for health services despite existing regulations exempting persons with disabilities from payment.
- Limited specialised services at community and provincial levels.
- Since livelihood is the most urgent concern, health and disability often receive less attention.
- Seeking out health services is prompted by having money rather than need for health services.
- *ID Poor Cards* (which identify poor people and make them eligible to receive free health care services) and health equity funds (which are used to cover the medical costs for the poor) do not benefit persons with disabilities because specialised services are not offered or referral to available services in other provinces is not covered.
- Private healthcare providers often offer better services and show less discriminating attitudes towards persons with disabilities because they are directly financed by clients.
- Persons with disabilities often face discrimination from other villagers and officials; sometimes they are called by their disability instead of their name.



wheel chair ramps, narrow doors and toilet facilities, small lettering on written and posted documents and signs, minimal lighting and no institutional means of communicating for deaf and mute (Annear 2006).

Studies showed that many Cambodians attribute mild and moderate difficulties in function to aging or simply as a fact of life and might therefore not relate it to disability. Associated stigma and belief in bad karma as major cause of disability also make revealing impairments and disability less likely (Trani/Van Leit 2010). The lack of information on available health services and possible health related prevention measures leads to a weak service seeking behaviour of affected families (Van Leit/Ti-ty/Channa 2007). Therefore, a number of impairments that could be treated or mitigated with appropriate care are left untreated, causing permanent impairments.

Addressing the Inclusion of Persons with Disabilities in Health Services

GIZ has been implementing the Social Health Protection Project in Cambodia since 2009. From the beginning of the implementation, its efforts have focused on the challenges faced by vulnerable groups and persons living in poverty in accessing and benefiting from health care services with high quality. Several developments have helped to shift the focus towards even greater inclusion of vulnerable groups such as persons with disabilities, who are not only proportionally more likely to be confronted with poverty but also face particular barriers as far as access to health care services and social protection are concerned – as was outlined in the first section of this article.

Work in Progress: Steps Towards Mainstreaming in the Social Health Protection Project

The ratification of the CRPD in Germany in 2009 created a momentum for a greater inclusion of persons with disabilities also in development cooperation programmes, such as those implemented on behalf of BMZ in its partner countries. As described above, both the Royal Government of Cambodia and the German Government have

agreed to focus on corresponding measures within the Cambodian health sector.

Already in 2009 both governments' delegations agreed to conduct a study on how to improve access of persons with disabilities and the elderly to quality health services. Commissioned by GIZ on behalf of BMZ the study entitled *Healthcare for Vulnerable Groups in Cambodia* was conducted by the non-governmental organisation HelpAge International with support from Handicap International and several local organisations (GIZ 2010). Cooperation partners from civil society and local organisations provided information on which obstacles are perceived by persons with disabilities as being the most significant factors in their exclusion from health care services. The findings were submitted to the Ministry of Health in Cambodia and other partners and also served as a basis for further reflecting on the inclusion of persons with disabilities with different stakeholders.

Aspects of the inclusion of persons with disabilities and elderly were progressively integrated into the project's design and activities. Moreover, one indicator explicitly states that persons with disabilities and older persons' needs are taken into consideration in all components. This reflects the principles of BMZ Action Plan for the Inclusion of Persons with Disabilities also based upon the CRPD, adopting a rights-based focus and following a *twin-track* approach. The twin-track concept combines specific measures aimed at persons with or vulnerable to disabilities and their relatives with mainstreaming measures for greater inclusion of persons with disabilities into general pro-

The Cambodian-German Social Health Protection Programme supports the Royal Government of Cambodia in improving the quality of and access to health services, in particular for people living in poverty and for vulnerable groups. It is composed of two Technical and one Financial Cooperation (TC / FC) modules. In this article only the TC-Social Health Protection Project is considered.

In line with the Ministry of Health's Strategic Plan, GIZ provides assistance in the achievement of national targets in the areas of health care financing, health service delivery and health systems governance. At national level, measures include the development and application of national quality standards for public and private health facilities, quality improvement and capacity building for health personnel. GIZ focuses on the implementation of the national strategy at sub-national level, in particular in the provinces of Kampot and Kampong Thom. The project team and partners seek to enhance accountability in health service provision and increase access to and quality of services. Vulnerable groups, including persons with disabilities and older persons, are explicitly targeted. BMZ has provided additional resources to support the extension of the target group.



grammes or policies.

As of this year, the Cambodian Ministry of Health, the Provincial Health Departments, Handicap International, GIZ and several national NGOs have cooperated on implementing the objectives outlined in the project. Several steps have been taken to develop specific measures aimed at persons with disabilities and their relatives as well as to mainstream elements intended to systematically foster the inclusion of persons with disabilities systematically.

Within the health service delivery component, which aims to improve service quality, a mapping was conducted to identify available services and current activities. After a first phase focused on promoting networking and facilitating discussions on collaboration options, a Knowledge, Attitude and Practice (KAP) analysis was conducted. The analysis aimed to gain a better understanding of the knowledge, attitudes and practice of local health facility staff, school administrators, commune council members and villagers with and without disabilities. Workshops and training events were organised in order to raise awareness among both local government and non-government partners of the challenges faced by persons with disabilities in accessing health care and other services. Group work and open discussion allowed participants to share their experiences and clarify common misconceptions related to types of impairment, causes and risk factors, effective preventive measures, and international and national mandates and laws on the protection of the rights of persons with disabilities. One important issue during the workshops and discussions was also to elaborate on the communicative and physical barriers faced by persons with different disabilities. Thus, an exchange and greater awareness amongst

Measures at Community Health Centre Level

The Cambodian Ministry of Health, GIZ and Handicap International began to cooperate closely both at national level and field level in the provinces Kampot and Kampong Thom, starting in March 2013. To address accessibility and the quality of specialised services, the activities were designed to focus on screening and detection at the community health centre level.

The specific goal of the measures is to decrease the number of Disability Adjusted Life Years (DALYs) - which is a measure of overall disease burden expressed as the number of years lost due to ill-health, disability or early death. To maximise the effectiveness of interventions, proactive screenings for children are implemented in three age brackets: after birth, 9-12 months, and 5-6 years. Children who are found to have impairments, are delayed in development or showing warning signs such as malnutrition, chronic infection etc. are referred to appropriate government or NGO services. Where services are judged to be inaccessible or impractical, providers are trained in giving basic home-based care. This training focuses on aspects such as nutrition, play stimulation, self-care and ensuring a safe environment. After being referred, the health centre staff works in the community to ensure follow-up, with two health volunteers allocated per village. Follow-up has been identified as a critical and logistically difficult component in ensuring the continuum of care, as most parents initially have shown a tendency not to use the available services. Costs, transportation problems and the prioritising of income generating activities are some of the major obstacles identified.

To address these issues, village health volunteers are assigned the task of encouraging and motivating people to seek out services, as well as following up those who have sought services and assisting them with additional or unfulfilled needs. In addition, training and tools on screening protocols have been developed by a steering committee of administrative and technical experts from the Ministry of Health, government hospitals, universities and the Ministry of Education's School Health Department, as well as individuals from a number of NGOs. These training events are coupled with the provision of information on the referral process, home-based care and follow-up measures.

It is intended that data and lessons learned from implementing these screenings and referral systems will be shared with the Ministry of Health and other government and non-government partners so as to enhance the information and knowledge base at national level.

health practitioners was created through an input by DPO representatives who underlined the challenges in accessing health services. The recommendations drawn from the consultations highlighted the need for prevention, additional services in the fields of chronic disease and rehabilitation. They also noted the lack of screening and referral systems and service provision for children and adults with impairments or those at high risk. Finally, it was found that community level health centre staff is often unfamiliar with specialised services and facilities.



Key Elements: Cooperation, Capacity Building and Inclusion

Efforts to include persons with disabilities in the Social Health Protection Project and to make health services more inclusive of vulnerable groups, including persons with disabilities and older persons, revolve around three key elements: cooperation, capacity building and inclusion. Intense cooperation between different partners from governmental to grass-roots level is an essential success factor. In addition, activities must serve both to strengthen civil society organisations and to involve persons with disabilities during different project phases.

Cooperation of Different Stakeholders

In many countries, development programmes are not implemented by a single ministry or organisation but in cooperation with different stakeholders. Donor cooperation and harmonisation is one aspect of a general shift towards a more integrated and coordinated approach to implementing development programmes. Another aspect is the involvement of self-advocacy groups, non-governmental organisations from grass-roots to international level, international organisations, development agencies and governments. Cooperation can also include service providers and medical companies or foundations. In Cambodia, development agencies and non-governmental organisations play an important role in providing health care services to vulnerable groups such as persons with disabilities. Partnerships and cooperation with different stakeholders are therefore a crucial factor in achieving the systematic inclusion of persons with disabilities and improving access to high quality services.

In the frame of the GIZ supported Social Health Protection Project various actors cooperate throughout the implementation at different levels such as the Cambodian Ministry of Health, Handicap International, the Cambodian NGO MoPoTsyo Patient Information centre, the NGO Epic Arts as well as several Disabled People's Organisations (DPOs).

The Cambodian Government ratified the CRPD in December 2012, committing itself to promoting equality for persons with disabilities in all spheres of society. Access to health care is an important right enshrined in the Convention. In line with the Strategic Plan of the Cambodian Ministry of Health, the GIZ social health protection team provides assistance in designing national health and social protection strategies and various measures to improve access to and quality of health services, financing systems, patients' rights and institutional capaci-

ties. GIZ uses a multi-level approach involving both policy advice to the Ministry and technical support to ensure the inclusion of persons with disabilities at implementation level.

During a planning workshop in January 2013, the Cambodian Government and GIZ agreed to build on existing health and social protection initiatives by GIZ and Handicap International that support the Cambodian Ministry of Health. It was decided that the inclusion of persons with disabilities in the health sector would be focused on at provincial level.

The partnership between GIZ and Handicap International is of central importance in the context of inclusion in Cambodia's health sector. While GIZ works closely with the Cambodian ministry on health and social protection at policy level, it also cooperates with organisations specialised in the inclusion of persons with disabilities. This includes local Disabled People's Organisations (DPOs) as well as non-governmental organisations working at international level. The experience and expertise of specialised organisations is crucial in reaching persons with disabilities on the ground and working successfully towards increasing their inclusion in the implementation of activities.

The partnership between Handicap International and GIZ in Cambodia benefits both organisations by enabling them to share expertise and resources, liaise with different stakeholders and implement measures jointly. Furthermore, the inclusion of Disabled People's Organisations (DPOs) and grass-roots organisations in the project measures increases the focus on meeting the needs of persons with disabilities, ensuring a greater impact.

The success and effectiveness of the measures is closely linked to the cooperation between relevant stakeholders from different sectors such as education, social affairs and health on the inclusion of persons with disabilities in the context of a joint project. This multi-sectoral approach combines resources, knowledge and experience and creates synergies, which help to promote exchange and cooperation at national as well as local level. The experience gained in the project can later feed into the political dialogue and inform decision makers on how to design and implement laws, regulations and programmes which directly benefit persons with disabilities in their daily life.



Strengthening Civil Society Organisations and Including Persons with Disabilities

In Cambodia, civil society groups such as Disabled People's Organisations (DPOs) and local NGOs conduct a range of activities, aiming at multiple target groups and various geographical locations, and often specialise in certain areas and focus on specific needs of social groups. The landscape of actors working to improve the situation of persons with disabilities in Cambodia is very fragmented, especially at local level. Various NGOs and DPOs have emerged in small communities in order to support specific groups of persons with disabilities. Their work is crucial for persons with disabilities, as they themselves fulfil a representative function and can directly advocate for equality and the right to accessible, affordable and high quality health services.

Local DPOs, however, are also confronted with challenges, relating to aspects such as co-ordination and joint activities, which go beyond the specific interest of their members. In addition, local DPO membership can be exclusive of some persons with disabilities due to social stigma or geographic distance. Weak organisational management and a lack of support from national level DPOs are additional difficulties faced. These problems affect cooperation and joint activities with NGOs, development agencies and governmental organisations.

The approach of GIZ and Handicap International has therefore focused both on involving and strengthening persons with disabilities and Disabled People's Organisations (DPOs), a concept enshrined in the CRPD. The relevance of targeted measures and systematic improvements of programmes has been underlined in the process of various consultations which have shown that persons with disabilities, older persons and persons living with non-communicable diseases are particularly marginalised in the health system, with health care providers showing limited awareness of their rights and health care needs. Throughout the process, the partners emphasised the inclusion of persons with disabilities and Disabled People's Organisations (DPOs) as well as other vulnerable groups at different levels and in different programme components. Activities included the following:

- *Taking into account the perspectives of persons with disabilities:* In 2010, the study *Healthcare for Vulnerable Groups in Cambodia* (GIZ 2010) was commissioned to clarify the situation of vulnerable groups in relation to health care systems. One key element of the study was its specific focus on the perspectives and needs expressed by persons

with disabilities themselves, gathered through interviews and focal groups.

- *Inclusion in decision making:* The partners promoted dialogue on the needs and rights of persons with disabilities in order to strengthen participatory sub-national decision-making processes in the health sector. Representatives of DPOs and local NGOs were invited to participate in workshops and training events and encouraged to share their personal experiences and views relating to health services and social protection.
- *Raising awareness among council members:* The capacity of local councils to represent the interests of vulnerable groups was enhanced by raising awareness on the rights of persons with disabilities, their health needs and barriers preventing access to health care among council members.
- *Involving clients with disabilities and chronic health conditions and enhancing health service quality through participatory feedback mechanisms:* One component of the Social Health Protection Project aims to inform clients about their rights and involve them in the planning and monitoring of health care services at sub-national level. In cooperation with councils and civil society organisations, awareness raising measures on patients' rights have already been conducted in Kampong Thom and Kambot. The population is encouraged to use participatory feedback mechanisms on the quality of health services with the objective of ensuring providers are better informed, addressing health service provision gaps and achieving equal access to high quality services. Since March 2013, this component has also explicitly taken the inclusion of persons with disabilities into account.
- *Promoting a positive image of persons with disabilities and other groups:* GIZ and Handicap International have also cooperated with the NGO Epic Arts to raise awareness and promote a positive image of persons with disability in the community. Epic Arts' theatre and dance shows performed by persons with disabilities have been a successful component of several GIZ/Handicap International workshops and will be applied further in community settings as part of outreach activities. The combination of a basic introduction to sign language with music and dance has been very effective in capturing the interest of participants and engaging them in new ways of thinking.



Conclusion and Outlook

Confronted with the barriers hindering persons with disabilities to access health care services of high quality described in the first part of this article, the Royal Government of Cambodia and GIZ on behalf of the BMZ, in cooperation with Handicap International and other organisations, developed measures aimed at improving the inclusion of persons with disabilities within the Cambodian health sector. The design of the measures follows the main ideas of the BMZ Action Plan for the Inclusion of Persons with Disabilities by applying a rights-based approach towards persons with disabilities and other population groups.

First Lessons Learned from Measures under the Social Health Protection Project

Since the inclusion of persons with disabilities is still a quite recent development of the Cambodian-German Social Health Protection Project, it is difficult to evaluate results and their impact on persons with disabilities themselves. Considering that the project explicitly refers to the inclusion of persons with disabilities as being mainstreamed in all project components, this can be considered a success.

Concerning the activities conducted jointly by the Royal Government of Cambodia, GIZ and Handicap International, first monitoring reports indicate that they are well received by persons with disabilities, their communities and organisations. By including civil society organisations in activities such as planning workshops or capacity trainings, by linking groups and organisations with each other and providing resources, awareness was raised and exchange fostered. However, the above mentioned studies and focus groups discussions also indicated the need for further work to be done in developing a stable knowledge and information base on the situation of persons with disabilities in Cambodia.

Key Factors in the Process of Mainstreaming the Inclusion of Persons with Disabilities in the Cambodian-German Development Cooperation on Social Protection and Health

- *Political commitment:* relevance of legal frameworks and relating strategies such as the CRPD ratification in Germany and in Cambodia, BMZ's Action Plan Inclusion of Persons with Disabilities
- *Commitment from decision makers and different stakeholders:* local and national authorities in Cambodia; like-minded partners from civil society (local and international) and from the donor side
- *Resource allocation:* GIZ staff resources at head-office and country level, financial support for including measures to include vulnerable groups into mainstream programs
- *Cooperation with and support of organisations of persons with disabilities, (I)NGOs, health sector organisations, partner country's national and Provincial administration*
- *Availability of information and data:* studies on the specific situation of vulnerable groups including persons with disabilities were conducted and shared with ministerial and other partners
- *Project mainstreaming:* no separate project but extension of designed project proposal to specific vulnerable groups in addition to persons living in poverty or are at risk to become poor.
- *Bringing different groups into focus:* persons with disabilities, persons living with non-communicable diseases and older persons were identified to face particular obstacles in accessing for example health services and financing
- *Combining capacity development and inclusion:* Capacity development at provincial and local level is combined with participation in planning processes which is crucial for strengthening civil society organisations among which are also Disabled People Organisations (DPOs).

The cooperation between different actors and especially between the three partners, the Royal Government of Cambodia, GIZ and Handicap International turned out to be very fruitful. Through regular exchange, first steps have been taken to improve the situation for persons with disabilities in terms of better access to health care and the enforcement of their rights as stated in the CRPD. Disabled People Organisations (DPOs) have an important role to play since they represent and reach persons with disabilities. Therefore further strengthening of DPO's capacity is important. GIZ and HI have several activities planned on how to further improve the situation of persons with disabilities at local level and they are currently exploring possibilities to support basic primary ear and eye trainings at health centres to raise awareness around both prevention of disability and the situation of persons living with disabilities.

Other potential activities include the piloting of screening and referral systems in primary schools and measures addressed to improve



sexual and reproductive health care for women with disabilities.

Mainstreaming in the Health Sector and Beyond

The first experiences stemming from the Cambodian-German Social Health Project can serve as reference for identifying conducive factors, which foster the systemic inclusion of persons with disabilities in the Cambodian health sector.

Beyond the Cambodian-German Development Cooperation on social protection and health several other initiatives have emerged with the aim to systematically include persons with disabilities in development programs and policies in Cambodia.

Currently, BMZ supports the piloting of the Model Disability Survey, developed by WHO and the World Bank, to be implemented in Cambodia. The piloting will be carried out by Statistics Norway in partnership with the Cambodian National Institute of Statistics (NIS) and in consultation with UNDP and GIZ. The objective is to develop a standardised survey that can collect comprehensive and internationally comparable information on the situation of persons with disabilities. From the side of the Royal Government of Cambodia, initiatives include its commitment to the regional framework of the Asian and Pacific Decade of Persons with Disabilities and its 2013-2022 strategy Make the Right Real, implying progressive adaptation of national policies.

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Zusammenfassung: Während der Regierungsverhandlungen zwischen der Königlichen Regierung Kambodschas und der Deutschen Regierung im Jahr 2011 wurde eine Kooperation bezüglich der Inklusion von Menschen mit Behinderungen in der Entwicklungszusammenarbeit beschlossen. In der Folge wurden erste Maßnahmen zur Verbesserung der Inklusion von Menschen mit Behinderungen in der Entwicklungszusammenarbeit im Gesundheitssektor eingeführt. Bezüglich der Deutsch-Kambodschanischen Technischen Zusammenarbeit wurde diese politische Verpflichtung von verschiedenen staatlichen und nichtstaatlichen Akteuren umgesetzt, wie zum Beispiel vom kambodschanischen Gesundheitsministerium, der Deutschen Gesellschaft für Internationale Zusammenarbeit im Auftrag des Bundesministeriums für wirtschaftliche Zusammenarbeit und Entwicklung, Handicap International sowie von verschiedenen lokalen zivilgesellschaftlichen Organisationen einschließlich Organisationen von Menschen mit Behinderung. Die Partner banden zunehmend Aspekte der Inklusion von Menschen mit Behinderungen in die Konzeption und die Umsetzung des Deutsch-Kambodschanischen Projekts zum sozialen Gesundheitsschutz ein. Die Bandbreite der Aktivitäten reichte von Workshops zur Bewusstseinsbildung bis zu Trainings zur besseren Zugänglichkeit für Klienten mit Behinderung zu Services kommunaler Gesundheitszentren. Organisationen von Menschen mit Behinderung wurden sowohl in die Planung als auch in die Umsetzung einbezogen und hatten somit eine Schlüsselrolle im Prozess. Mit diesem Artikel möchten die AutorInnen einen Überblick über die ersten Schritte auf dem Weg zum Mainstreaming von Inklusionsprozessen von Menschen mit Behinderungen in den kambodschanischen



Gesundheitssektor geben. Neben Informationen zur speziellen Lage von Menschen mit Behinderungen in Kambodscha bezogen auf das Gesundheitswesen unterstreicht der Artikel die Schlüsselemente und Erfolgsfaktoren des Mainstreaming Prozesses.

Résumé: Pendant des consultations entre gouvernements en 2011, le gouvernement royal du Cambodge et le gouvernement allemand ont décidé de coopérer en matière d'inclusion des personnes handicapées dans une coopération commune au développement. En conséquence, des premières mesures ont été implémentées améliorant l'inclusion des personnes handicapées dans le secteur de la santé.

En ce qui concerne la coopération technique germano-cambodgienne, cet engagement politique a été traduit en pratique par des différents acteurs étatiques et non-gouvernementaux comme le Ministère cambodgien de la santé, la Deutsche Gesellschaft für Internationale Zusammenarbeit travaillent au nom du Ministère fédéral allemand pour la coopération économique et le développement, Handicap international et des divers organisations de la société civile, y compris des organisations de personnes handicapées. Les partenaires ont progressivement intégrés des aspects d'inclusion des personnes handicapées dans la conception et les activités du 'Projet germano-cambodgien de la protection de la santé'. Les activités allaient d'ateliers de sensibilisation aux formations et à l'amélioration de l'accès des clients handicapés aux centres communautaires de soins médicaux. Les organisations des personnes handicapées ont été incluses à la fois dans la planification et dans l'implémentation, jouant ainsi un rôle clé dans ce processus.

Avec cet article, les auteurs visent à donner une vue d'ensemble sur les premiers pas sur le chemin de la généralisation de l'inclusion des personnes handicapées dans le secteur de santé cambodgien. A côté des informations spécifiques sur la situation des personnes handicapées au Cambodge en lien avec les services de santé, cet article souligne les éléments clé et les facteurs de succès du processus de généralisation.

Resumen: Durante consultas intergubernamentales en 2011, el Gobierno Real de Camboya y el Gobierno alemán decidieron cooperar en la inclusión de personas con discapacidad. Como consecuencia, las primeras medidas se han

implementado para mejorar la inclusión de las personas con discapacidad en el sector de la salud.

En cuanto a la cooperación técnica entre Camboya y Alemania, este compromiso político se ha traducido en la práctica por los distintos actores estatales y no gubernamentales, como el Ministerio de Salud de Camboya, la "Deutsche Gesellschaft für Internationale Zusammenarbeit", que opera en nombre del Ministerio Federal Alemán de Cooperación Económica y Desarrollo, Handicap International y varias organizaciones locales de la sociedad civil, incluidas las organizaciones de personas con discapacidad. Los socios integrarán progresivamente aspectos de la inclusión de las personas con discapacidad en el diseño y en las actividades del "Proyecto Camboyano-Alemán de Protección Social en Salud". Las actividades iban desde talleres de sensibilización hasta las capacitaciones a los servicios del centro de salud de la comunidad para que sean más accesibles a los clientes con discapacidad. Las organizaciones han participado tanto en la planificación como en la ejecución, desempeñando así un papel clave en el proceso.

Con este artículo los autores pretenden dar una visión general sobre los primeros pasos en el camino hacia la integración de la inclusión de las personas con discapacidad en el sector de salud de Camboya. A parte de la información sobre la situación específica de los discapacitados relacionados con los servicios de salud, el artículo destaca los elementos claves y los factores de éxito del proceso de implementación.

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Poverty, Maternal Education and Child Disability: Evidence from Bhutan

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Mother's education is significantly correlated with lower rates of moderate or severe disabilities among children in Bhutan, but not mild disabilities. This suggests either that the causes of disability are different for children of differently educated mothers, or that there is a significant impact of mother's education on preventing mild disabilities from progressing to more serious conditions. The paper also explores other factors associated with disability among children aged 2-9 in Bhutan, including poverty, which is positively correlated with disability.

Introduction

Disability is both a cause and consequence of poverty (WHO/World Bank 2011; Groce/Kett et al. 2011). Poor nutrition, inadequate health care, and unsafe living conditions contribute to the onset of disability, and people with disabilities face barriers to education, employment, and other aspects of the social and economic life of their communities. The potential impact of disability can be greater for children than for adults, because the disabling circumstances affect how children with impairments can acquire the social and human capital that serves as the foundation for a full life. Studies show that the early onset of disability has a bigger impact on employment and poverty than onset in adulthood (Mont/Cuong 2011). Unfortunately, information on children with disabilities in developing countries is limited because of the lack of good quality data. (UNICEF 2008; UNICEF 2013; Mont 2013).

This was also true in Bhutan until the Government of Bhutan and UNICEF incorporated special disability modules into the Multiple Indicator Cluster Survey to estimate the prevalence of childhood disabilities in Bhutan among 2-9 year olds (Government of Bhutan/UNICEF 2012). This study is drawn from that report and uses that data (collected between April and June of 2010) to explore the relationship between personal, family, and community factors with childhood disability. The goal is to provide information relevant for developing and implementing public policy aimed at ensuring that children with disabilities have access to basic services, such as education, health care and social protection.

Definition of Disability

This study follows the approach of the WHO's International Classification of Functioning, Dis-

ability and Health (ICF) by identifying children who have difficulty in performing an age appropriate activity in various functional domains (WHO 2001). Disability is not seen as a medical diagnosis, but rather the result of an interaction of functional limitations caused by various impairments with barriers in the environment.

The study uses eight functional domains: gross motor, fine motor, vision, hearing, speech, cognition, behaviour and seizures. It is acknowledged that seizures are not really a functional domain, but they are often a symptom of a neurological dysfunction, and thus relevant when diagnosing disability.

Functional limitations are not binary. They encompass a wide range from relatively minor difficulties in functioning to being completely unable to do an activity (Loeb/Mont 2010). This study therefore differentiates between two categories – the first is for children who only have a mild impairment in one or more of the eight functional domains examined. These children will be referred to as having a low threshold disability. The other group are children who have moderate or severe difficulties in at least one domain. They will be referred to as children with high threshold disabilities. Mild disability means that a child has some difficulty in carrying out an activity in one of the examined functional domains. Moderate and severe difficulties mean the child has a lot of difficulty or is unable to carry out that activity (e.g. walking). Data analysis showed no significant differences in the patterns or associations between children with a moderate impairment and children with a severe impairment. Considering also the low absolute number of severe disability cases, limiting meaningful data analysis, it was decided to combine data regarding children with moderate and severe disabilities into one category of children with a high threshold disability.



Methods

Data on disability among children was collected based on a two-stage procedure: The first stage involved the use of a screening tool, the Ten Question Screening Instrument (TQSI) (Durkin/Davidson et al. 1994). This instrument is the most commonly used measure of disability in children in developing countries (UNICEF/University of Wisconsin 2008). The first stage consists of set of questions designed as a screen to identify children at high risk of having a disability. The second stage consists of a detailed assessment of those children (and a small sample of children screened negative) to arrive at a final determination of disability that can generate an overall prevalence rate. The small sample of children screened negative was included in the second stage in order to test and account for the rate of false negatives from that stage.

In Bhutan, the first stage TQSI was included in the 2010 Bhutan Multiple Indicator Survey (BMIS) administered to mothers – or if the mother was not in the household or was dead to the primary caregiver of children aged 2-9 using a multi-stage, stratified cluster sampling methodology. The sample was stratified by *dzongkhags* (districts) across rural and urban areas. Within each stratum, a specified number of village clusters in rural areas and blocks in urban areas were selected using a probability proportional to size sampling method. After listing households within each selected enumeration area, a systematic random sample of 20 households was drawn from among each of them. A total of 15,400 households were selected into the sample.

In the second stage, health or other professionals conducted an assessment determining whether the children screened positive in the first stage were actually living with a disability. These assessments used the Rapid Neurodevelopmental Assessment (RNDA) (Khan/Muslima et al. 2010). The RNDA is a detailed rubric for assessing the functional status in primitive reflexes, gross motor, fine motor, vision, hearing, speech, cognition, behaviour, and seizures.

The total sample for the second stage included 3,500 children who screened positive to the Ten Questions Screening Instrument (TQSI) and 10% of those negatively screened (787 children) making the total sample 4,287 children. During this second stage screening, children were classified by the level of their functional difficulties in each domain – mild, moderate, or severe.

During the second stage assessment, the assessors made up to three attempts to assess

each child, but because of non-response, harsh weather, and children moving away or aging out of the 2 to 9 age range in between the two stages, only 3,491 children were assessed, for an 81% coverage rate.

A more detailed description of the two-stage methodology can be found in Two Stage Disability Survey Bhutan 2010-2011, a report by the National Statistics Bureau and Ministry of Education of Bhutan and UNICEF Bhutan (2012).

Results

Prevalence

Table 1 shows the prevalence of childhood disability using different thresholds. Low and high threshold children together add up to the total number of children with disabilities. The low threshold measure refers to children who are classified as having a disability even if they only have some difficulty doing activities, whereas the high threshold measure refers to children who have a lot of difficulty or are unable to do the activity.

Table 1: Percentage of Children with a Disability by Degree of Disability, Age, and Gender

	Any Disability	Low Threshold	High Threshold
All children	21.3 (1.1)	18.6 (1.0)	2.8 (0.4)
By gender			
Male	20.7 (1.6)	18.0 (1.4)	2.7 (0.6)
Female	22.0 (1.6)	19.0 (1.4)	2.8 (0.6)
By age			
2-5 Years	26.8 (1.7)	22.7 (1.4)	4.1 (0.7)
6-9 Years	15.3 (1.5)	13.9 (1.4)	1.3 (0.3)

Standard errors in parentheses

Prevalence is 21.3%, but that mostly consists of children with only some difficulties in performing various activities in at least one functional domain. Only 2.8% of children have a disability according to the high threshold definition. No significant differences emerge by gender, but older children are significantly less likely to be disabled. It is unclear to what extent this is because of a rising rate of disability, the fact that some children receive services that lessen their functional difficulties, or some children with significant disabilities will not survive to older ages.



Table 2: Prevalence of Type of Childhood Disability

Domains	Number of children	Any Disability		
		Prevalence-rate	95% Confidence Interval	
			Lower	Upper
1 Gross Motor	86	2.0%	1.3%	2.7%
2 Fine Motor	199	5.5%	4.2%	6.7%
3 Vision	16	0.2%	0.1%	0.3%
4 Hearing	35	0.5%	0.2%	0.7%
5 Speech	102	2.3%	1.5%	3.0%
6 Cognition	528	15.1%	13.1%	17.1%
7 Behaviour	198	5.6%	4.3%	6.8%
8 Seizures	52	1.0%	0.5%	1.4%

Domains	Number of children	Low Threshold		
		Prevalence-rate	95% Confidence Interval	
			Lower	Upper
1 Gross Motor	63	1.8%	1.0%	2.5%
2 Fine Motor	171	5.0%	3.8%	6.2%
3 Vision	9	0.1%	0.0%	0.3%
4 Hearing	20	0.2%	0.1%	0.3%
5 Speech	55	1.4%	0.8%	2.0%
6 Cognition	461	13.8%	11.9%	15.7%
7 Behaviour	155	4.9%	3.7%	6.1%
8 Seizures	37	0.8%	0.4%	1.2%

Domains	Number of children	High Threshold		
		Prevalence-rate	95% Confidence Interval	
			Lower	Upper
1 Gross Motor	23	0.2%	0.1%	0.4%
2 Fine Motor	28	0.5%	0.2%	0.8%
3 Vision	7	0.1%	0.0%	0.1%
4 Hearing	15	0.3%	0.0%	0.5%
5 Speech	47	0.9%	0.5%	1.3%
6 Cognition	67	1.3%	0.8%	1.9%
7 Behaviour	43	0.7%	0.3%	1.0%
8 Seizures	15	0.2%	0.1%	0.2%

Table 2 shows the prevalence of various types of disabilities. They sum to greater than the overall prevalence rate because some children have difficulties in more than one functional domain. The striking finding is the large number of children who have cognitive disabilities, in particular those who have only "some difficulty" with cognitive difficulties (as opposed to "a lot of difficulty" or are "unable to do"). Overall, 15.1% of children have cognitive difficulties, whereas the next two highest domains – behaviour and fine motor skills – only have a prevalence of about 5.5%. In Bangladesh, using the same TQSI, about 18% of children were found to be disabled, and only about 5% of

these had cognitive difficulties (Khan/Ferdous et al. 2011). In Jamaica, over 8% of children had a cognitive disability using the TQSI (Paul/Desai et al, 1992).

Poverty and Disability

Many socio-economic and demographic characteristics are correlated with disability (WHO/World Bank 2011; UNICEF 2008; Mont 2013). Being poor can mean living in unsanitary conditions or without adequate health care, which is a main contributor to childhood disability (Loeb/Eide 2004; Trani/Loeb 2010; Eide/Nhiwathiwa et al. 2009). Sometimes this operates through the absence of micro-nutrients (Hack/Klein et al. 1995; Wang/Harris et al. 1997). Even controlling for poverty, having mothers with lower levels of education is also correlated with disability (Khan/Muslima et al. 2010). Table 3 displays the prevalence rates across a number of the characteristics, combining children with both low and high threshold disabilities. As anticipated, the disability prevalence rate is higher among poor children with 26% for the lowest quintile and 14% for the highest.

Table 4 shows the relationship between background characteristics and disability prevalence. The odds ratio gives the predicted impact of each factor on the relative odds of having a disability, controlling for other factors (which the earlier tables with descriptive statistics do not do). A value of one means there is no effect, greater than one means it increases the probability of a disability.

The most significant factor is age. Younger children are nearly twice as likely to have a disability, even after controlling for the other factors. This estimate is highly statistically significant. The cause is unclear. This might result from low survival rates of children with disabilities, but could also be indicative of a growing incidence of disability over time.

The other highly significant factor is wealth quintile. A child in the poorest quintiles is more than twice as likely to be disabled as a child from the richest household.

As disability varies a lot by type, cause and degree, it could be that the factors correlated with lower threshold – the more common, mild – disabilities, might be different than those for higher threshold disabilities, moderate and severe disabilities. To that end, a multinomial logit was estimated to compare the association of



Table 3: Weighted Prevalence of Disability by Characteristics

	Prevalence rate	Standard Error	95% Confidence Interval		Number of children (unweighted)
			Lower	Upper	
Bhutan	21.3%	1.1	19.1%	23.6%	764
Gender					
Male	20.7%	1.6	17.6%	23.9%	387
Female	22.0%	1.5	19.1%	24.8%	377
Region					
Western	20.8%	1.9	17.0%	24.6%	247
Central	23.3%	1.8	19.7%	26.9%	281
Eastern	20.0%	1.8	16.6%	23.5%	236
Residence					
Rural	23.1%	1.3	20.6%	25.7%	657
Urban	14.1%	2.0	10.1%	18.1%	107
Mothers Education					
None	22.8%	1.3	20.2%	25.3%	625
Primary	18.6%	3.1	12.5%	24.6%	76
Secondary+	13.5%	2.8	8.0%	19.0%	63
Age					
2-5 years	26.8%	1.7	23.5%	30.1%	502
6-9 years	15.5%	1.4	12.8%	18.2%	262
Wealth Quintile					
Poorest	26.0%	2.6	21.0%	31.1%	236
Second	25.6%	2.2	21.3%	29.9%	188
Middle	21.2%	2.2	17.0%	25.5%	159
Fourth	14.4%	2.0	10.5%	18.3%	120
Richest	14.0%	2.7	8.8%	19.3%	61

various factors with higher and lower threshold disabilities.

Whereas the logit in Table 4 models the probability that a child had a disability, the multinomial logit in Table 5 jointly estimates the probability of having a low threshold or a high threshold disability, and thus allows for factors to have a different influence on the two degrees of disability.

For technical reasons, odds ratio cannot be computed with a multinomial model, but Relative Risk Ratios (RRR) are the conceptual equivalent. They show the relative risk of being in one par-

ticular category (having a mild disability, or having a moderate or severe disability) compared to the base condition of not living with a disability.

The relationship between wealth and disability differs by the degree of difficulty. For children identified with the lower threshold definition (that is both mild and more extensive disabilities) being in the lowest quintile gives a child the highest risk, while for more significant disabilities it is the second lowest quintile. This might be the case because children with more significant disabilities in the lowest quintile are more likely to die, and thus be missing from the sample. This could be because those children have less access to good nutrition, health care, or other services.

The multinomial logit model also allows us to test if any explanatory power is gained by allowing for the possibility that factors have a differently sized impact on different levels of disability. If all the factors had the same impact on

Table 4: Logit Model: Dependent Variable – Presence of Any Disability

Any Disability	Odds Ratio	Standard Error	P> z	95% Confidence Interval	
Boy	0.95	0.08	0.56	0.81	1.12
Age 2-5	1.94	0.17	0.00	1.64	2.30
Mother's Education-Primary	0.89	0.13	0.43	0.68	1.18
Mother's Education-Secondary	0.88	0.15	0.43	0.63	1.22
Central Region	0.91	0.10	0.36	0.74	1.12
Eastern Region	0.72	0.08	0.00	0.58	0.89
Rural	1.08	0.16	0.59	0.81	1.44
Wealth-Quintile 2	0.82	0.10	0.09	0.66	1.03
Wealth-Middle	0.63	0.08	0.00	0.50	0.81
Wealth-Quintile 4	0.51	0.08	0.00	0.38	0.69
Wealth-Richest	0.43	0.09	0.00	0.28	0.65
Constant	0.31	0.06	0.00	0.21	0.45
Log likelihood =	-1775.01	LR chi2(11) =	116.68		
		Prob>chi2 =	0.00		
		Pseudo R2 =	0.032		

Number of observations = 3487



Table 5: Multinomial Logit: Dependent Variables Level of Disability

Disability Severity Level	RRR	Standard Error	P> z	95% Confidence Interval	
None	(Base category)				
Low Threshold					
Boy	0.91	0.08	0.30	0.76	1.09
Age 2-5	1.99	0.19	0.00	1.66	2.39
Mother's Education-Primary	0.96	0.14	0.76	0.71	1.28
Mother's Education-Secondary	0.95	0.17	0.75	0.67	1.34
Central Region	0.86	0.10	0.18	0.69	1.07
Eastern Region	0.65	0.08	0.00	0.51	0.82
Rural	1.18	0.18	0.30	0.87	1.59
Wealth Quintile 2	0.74	0.09	0.02	0.58	0.95
Wealth-Middle	0.64	0.08	0.00	0.49	0.82
Wealth-Quintile 4	0.52	0.08	0.00	0.38	0.71
Wealth-Richest	0.43	0.10	0.00	0.28	0.67
Constant	0.26	0.05	0.00	0.17	0.39
High Threshold					
Boy	1.18	0.22	0.36	0.83	1.70
Age 2-5	1.73	0.33	0.00	1.20	2.51
Mother's Education-Primary	0.58	0.22	0.15	0.28	1.21
Mother's Education-Secondary	0.52	0.25	0.17	0.20	1.31
Central Region	1.28	0.32	0.33	0.78	2.11
Eastern Region	1.22	0.31	0.43	0.74	2.00
Rural	0.64	0.22	0.19	0.32	1.26
Wealth Quintile 2	1.28	0.30	0.28	0.82	2.02
Wealth-Middle	0.60	0.17	0.07	0.34	1.05
Wealth-Quintile 4	0.41	0.16	0.02	0.19	0.87
Wealth-Richest	0.39	0.20	0.07	0.14	1.08

both degrees of disability, then nothing is gained by using a multinomial logit. However, if factors have a different impact on mild as opposed to more severe disabilities, then a multinomial logit is the appropriate model to use because it allows those differences to be identified. A *Wald* test is a standard test for determining if a multinomial logit is the proper model – in this case, that is to see whether there is statistical evidence that factors are not related to both mild and more significant disabilities in the same way.

Table 6 reveals that the different levels of disabilities are better explained with the multinomial model rather than the logit in Table 4. This means the hypothesis that high and low threshold disabilities represent the same state, meaning the various factors have the same in-

fluence on them, can be rejected at the 98% confidence level (1 - 0.02). The process leading to low threshold disabilities in children appears to be different in certain respects than the process leading to high threshold disabilities. The various characteristics assessed impact on mild disabilities differently to moderate or severe disabilities.

Mother's Education

A key finding of this study is the relationship between maternal education and childhood disability. Among children whose mothers have no education the disability prevalence rate is 22.8%, while it is only 13.5% for the children with mothers who attended secondary education.

More striking is the finding that a mother's education has no impact on the presence of low threshold disabilities (odds ratio not statistically different from 1). However, for higher threshold disabilities it reduces the risk by nearly half. The RRR for primary and secondary education are not statistically significant different from each other, so the fact that a mother has at least some education implies their children are disabled at only a 50-60% rate of the children of mothers

without education.

This does not necessarily mean that a mother's education only reduces the risk of severe disability. It is possible that maternal education reduces the risk of minor disabilities and also shifts some children who would otherwise have severe disabilities into the minor disability

Table 6: Wald Test based on Multinomial Logit

Categories tested	chi2	df	P>chi2
None - mild	101.45	11	0.00
None - moderate/severe	35.50	11	0.00
Mild - moderate/severe	23.11	11	0.02



category. The net effect could thus be a similar rate of mild disabilities for children with educated and non-educated mothers and a lower rate of severely disabled children of educated mothers. More in-depth data collection would be required to determine this.

Some caution is advised because none of the education coefficient estimates are statistically significant at the 95% confidence level, but they are significant at the 85% level for the high threshold disabilities compared with only 25% for more moderate disabilities. The difference warrants further study into the relationship between a mother's education and the level of disability. It could be that educated mothers take actions that prevent mild disabilities from becoming more severe.

Conclusions

This paper explores two aspects of disability among children age 2-9 years old in Bhutan, the prevalence of disability and the potentially associated factors. When disability is defined as the presence of any difficulty in eight functional domains – gross motor skills, fine motor skills, vision, hearing, speech, cognition, behaviour (and/or seizures, which is correlated with functional difficulties in several domains) the prevalence of disability in this age group in Bhutan is 21.3%.

Cognitive disabilities are by far the most common type of disability with a prevalence rate of 15.1%. While cognition is the functional domain with the most difficulties for children with both high and low threshold disabilities, it is relatively more common among children with fewer difficulties. Speech difficulties are relatively more likely among children with higher threshold disabilities.

Using multivariate analysis, the prevalence of disability was found to be strongly associated with poverty. Notably, when mothers have more education their children have only a little more than half as much of a chance of having moderate or severe disabilities. This finding suggests either different causes of more mild disabilities or the impact of a mother's education on preventing mild disabilities from progressing to more serious conditions. The mother's education also had a strong association with the presence of cognitive disabilities.

These findings suggest that implementing risk mitigation projects such as increasing community awareness on family and community based early child stimulation, establishing early child care development programs, improving accessibility to education and health care serv-

ices for mothers and improving the socio-economic, nutrition and environmental conditions could help reduce disability or mitigate its effects. These efforts should definitely take maternal education into account and make significant efforts to reach mothers with less education.

This paper concludes with a set of recommendations based on the findings presented.

1. *It is important to establish a clear definition of disability that takes into account the level of functional difficulties.* The definition should be based on the difficulties children experience in functional domains. Cut-offs should be established for delineating lower and higher threshold disabilities.
2. *Investigations of the potential causes of disability are needed.* The potential causes are probably common to other countries – including poor maternal and child health care, consanguinity, sanitation, living conditions, and poverty – but the relative importance of these may differ.
3. *In Bhutan, emphasis should be given to cognitive disabilities.* Given that cognitive disabilities are by far the most common disability in Bhutan, special emphasis should be placed on determining the causes of cognitive disabilities and the interventions that could prevent cognitive disabilities as well as provide parents and children with the advice, services and opportunities to improve their lives and promote the children's participation in society.
4. *Research should explore the differences between low and high threshold disabilities.* This study shows that the factors associated with low threshold disabilities differ in both nature and degree from higher threshold disabilities. All studies should therefore take note of this in their design.

The recommendations regarding building systems and services for children living with a disability are the following:

5. *Promote early detection programs.* Awareness raising and early detection programs need to be institutionalised to promote early detection and timely intervention. For example, a community schoolteacher or a local health centre staff can be trained how to use standard assessment instruments. They can provide early interventions such as home based stimulation, positive parenting exercises or simple advice. Such a system will also facilitate early referral for serious disability cases to specialised centres. The survey has also identified many children who will benefit from orthotics and assistive de-



vices such as hearing aids and wheelchairs.

6. *Promote parental education and outreach for early child development.* Children whose mothers are literate and children exposed to early childhood care and development programmes performed better in the assessments. Services related to early childhood care and development programmes, and a child friendly environment at home could enhance children's developmental capacity. Programs educating parents on health, nutrition, early detection, parental interventions, and types of government support could reduce both the prevalence and the severity of disability.

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Zusammenfassung: Die Bildung von Müttern korreliert signifikant mit geringeren Raten an mäßigen oder schweren Behinderungen von Kindern in Bhutan, aber nicht mit leichter Behinderung. Dies deutet darauf hin, dass entweder die Ursachen für Behinderungen für Kinder von unterschiedlich gebildeten Müttern unterschiedlich sind oder dass die Bildung der Mütter einen signifikanten Einfluss darauf hat, ob sich eine leichte Behinderung zu einer schwereren Behinderung entwickelt. Der Artikel untersucht auch andere Faktoren, die mit Behinderung bei Kindern von 2-9 Jahren in Bhutan in Zusammenhang stehen, einschließlich Armut, die positiv mit Behinderung korreliert.

Résumé: L'éducation des mères est en corrélation significative avec des taux plus faibles d'handicaps modérés ou sévères auprès des enfants de Bhutan, mais pas avec les handicaps légers. Cela laisse supposer que les causes des handicaps sont différentes pour les mères avec des taux d'éducation différents, ou que l'éducation des mères a un impact différent sur la prévention d'une progression d'handicaps légers vers des conditions plus graves. Le document de recherche analyse également d'autres facteurs associés aux handicaps des enfants entre deux et neuf ans à Bhutan, en incluant la pauvreté, qui est en corrélation positive avec les handicaps.



Resumen: *La educación de la madre en Bután se correlaciona significativamente con una menor tasa de discapacidad moderada o grave en niños, pero no se correlaciona con discapacidades leves. Esto sugiere que las causas de la discapacidad son diferentes para los hijos de madres de diferentes niveles de educación o que existe un impacto significativo de la educación de la madre en la prevención de discapacidades leves de progresar a condiciones más serias. El documento también analiza otros factores asociados con la discapacidad entre los niños de 2-9 años de edad en Bután, incluyendo la pobreza, que se correlaciona positivamente con la discapacidad.*

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Inclusion of Deaf Patients into Medical Health Care in Cameroon – An Exploratory Study in the Centre Region

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The UN Convention on the Rights of Persons with Disability (CRPD) claims health as a human right. Given the high prevalence of hearing loss in the global south, this article explores deaf patients' access to health care in Cameroon. Problems, strategies and recommendations of deaf patients, their family members and health care personnel have been investigated in the Francophone Centre region. Compared to the state of the art published in Anglophone countries of the global north, similar and specific problems as well as specific resources have been discovered. The results may be linked to the biopsychosocial model of disability (WHO 2002).

Introduction

Health and Disability in Cameroon

Article 25 of the Convention of the Rights of Persons with Disabilities claims access to health without discrimination on the basis of disability as a human right (UN 2006). Over 5 % of the world's population can be referred to as deaf or hard-of-hearing, the majority live in the global south. Half of the incidence of hearing loss is preventable through measures of primary prevention, such as immunisation, avoiding ototoxic drugs or early assessment of hearing (WHO 2013a). In Cameroon a predominance of putative environmental causes of childhood deafness – the most common being post-meningitis – as well as a late medical diagnosis have been documented (Wonkam et al 2013:23). The country profile shows a high prevalence of communicable diseases combined with a low health workforce to population ratio (WHO 2013b). In a survey on the living conditions and needs of people with disabilities in Cameroon, only 31 % of the participants indicated that they had ever received health care (Mosoh 2010:23).

Deaf and Hard-of-Hearing Persons Receiving Health Care in the Global North

The health care system, as one sector of society, should be looked upon as one relevant sector of inclusion. So far however, scientific research has shown only little interest in its accessibility for deaf persons. The only literature available has been published in Anglophone countries of the global north.

Deaf and hard-of-hearing persons as a heterogeneous group (Meador/Zazove 2005:218) share a common poorer perceived health status (Zazove et al. 1993:748). Several difficulties in health care provision "can be directly or indirectly traced to difficulties with communication" (Zazove/Doukas 1994:387).

Preventive health care requires various cognitive and social skills, so called health literacy, which is dependent on general levels of literacy as well as critical to empowerment (WHO 1998:10). Among deaf or hard-of-hearing citizens, a lack of knowledge concerning HIV/AIDS due to communication and educational barriers has been documented. Most of the communication channels that are used to transfer knowledge about HIV/AIDS to the general population, such as hearing-related mass media, do not meet their communication needs. Written information without visual aids can be difficult to understand for learners of written English as a second language. Educational barriers concern basic knowledge about the human body and sexual education, which was proven to be underemphasised in the curricula of schools for deaf students (Bat-Chava/Martin/Kosciw 2005:624). These specific findings apply to health literacy in general. For instance, a lack of knowledge was documented among deaf adults in Australia about "basic first aid, preventive health care, understanding of simple prescriptions and recognition of common medical terms" (Mohay/Kleinig 1991:498).

Fewer physician visits have been documented for deaf adults as for other linguistic minority groups (Thew/Smith et al. 2012:1498). Elderly people reported practical barriers in accessing health care such as scheduling appointments by telephone or being informed orally by the receptionist that it was their turn to see the physician (Witte/Kuzel 2000:18-19). These barriers may lead patients to access an emergency department directly rather than a general practice (Steinberg et al. 2006:262).

During consultation, deaf and hard-of-hearing patients face several communication barriers with health care providers. This aspect can be qualified as most significant "because the whole medical process of diagnosis and ther-



apy is dependent upon precise communication" (Zazove et al. 1994:387). Communication or cultural barriers are known causes of misdiagnoses and following inappropriate treatment (Thew et al. 2012:1497). Obtaining medical history of the patient can be impeded if no adequate communication is established between doctor and patient or if the patient is "poorly informed about previous medical conditions and their treatment" (Mohay et al. 1991:498) due to former communication problems.

Under the given circumstances, it is unlikely that the patient receives full disclosure and discussion of all treatment alternatives, thus all information necessary to take decisions that can be qualified as an informed consent (Zazove et al. 1994:388). It is also unlikely that the patient practices so called compliance in following prescription instructions, if those instructions are not understood (Bat-Chava et al. 2005:625).

The reliance on family members as interpreters must be assessed as inadequate and unacceptable not only because of their unproven skills in challenging medical contexts, but also because "these lay interpreters are not unbiased, so the objectivity and accuracy of their information must be questioned, as must their awareness of the need for confidentiality" (Mohay et al. 1991:499). Sharing medical information with a proxy may compromise the doctor-patient interaction due to a loss of confidentiality (Zazove et al. 1994:388). Concerning HIV/AIDS, the frequent use of family members or friends as interpreters in medical settings might impede a patient to access health care at all (Bat-Chava et al. 2005:625).

Some deaf and hard-of-hearing patients expressed a fear of prejudices of the medical staff (Witte et al. 2000:19) and held concerns about being treated differently than other patients (Bat-Chava et al. 2005:632). Common misconceptions about deafness have been documented amongst physicians (Zazove et al. 1994:388). Prejudices may lead physicians to "underestimate the intelligence of deaf patients and give reassurances or oversimplified explanations" (Ralston/Zazove/Gorenflo 1996:168). Physicians reported a lower level of comfort in dealing with deaf patients compared to their general patients. Reasons for a perceived difficult patient-provider relationship remain unclear as does the question "whether the difficulties are unique to the deaf patient population, to all non-English speaking populations, or to patients with all types of disabilities" (Ralston et al. 1996:172).

Recommendations for Action in the Global North

Further improvement demands to distinguish between the needs of deaf or hard-of-hearing patients using different modes of communication. Education material on health-related issues should be available in the respective appropriate form, e.g. through community workers trained on the subject (Bat-Chava et al. 2005:625;632). Handouts and consent forms should also meet the linguistic needs of deaf patients (Meador et al. 2005:220).

Medical staff should be educated about those different communication needs and the limitations of communication strategies such as lip-reading and writing. They should furthermore be educated about the needs of their deaf patients using input from the deaf community (Zazove et al. 1994:389–390), for instance about psychosocial impacts and cultural aspects of deafness (Witte et al. 2000:20–21). Some authors present material to train medical students with the support of volunteers from the deaf community who act as patients (Lock 2003:1232) or as health care providers in a role-reversal exercise, hence in a form of cross-cultural education (Thew et al. 2012:1497).

Medically experienced professional interpreters with proper etiquette should be provided whenever possible (Meador et al. 2005:218; Mohay et al. 1991:499; Thew et al. 2012:1498; Zazove et al. 1994:389). In the United States of America, health care providers are obliged to ensure accessibility of their services under the Americans with Disabilities Act, Title III, section 36.303 (c), for instance by providing interpreters (Department of Justice of the United States of America 2010). Health care providers should be familiar with a proper etiquette if using interpreters, such as talking directly to the patient (Meador et al. 2005:221). Depending on the number of deaf patients in the practice and available resources, even more simple communication strategies with some form of non-verbal communication might improve health care for deaf patients (Witte et al. 2000:21). Reaching beyond the medical context, the provision of self-advocacy educational programs is postulated (Steinberg et al. 2006:265).¹

Methods

The study-at-hand was carried out during an internship with the *Association Bouche des Sourdes d'Afrique* (ABSA) within the scope of the ASA-Program. ABSA is an actor of civil society that promotes the integration of deaf citi-



zens into the Cameroonian society. ASA, a program based in Germany, promotes exchange and learning about our One World through personal experience. The aim of this study was an exploratory analysis and the combination of perspectives of deaf patients, their family members and medical staff on health care for deaf patients in Cameroon.

Sample

Between July and September 2011, semi-standardised interviews were carried out with 25 members of staff of various medical institutions, 12 family members as well as 12 deaf persons in the Centre region of Cameroon. We used a non-probability sampling strategy due to limited resources, and since no sampling frames about the total population of two groups of interest, deaf persons and their families in the Centre region of Cameroon, were available. We decided on a quota based on assumptions about the population of interest, and chose 12 out of 28 districts of the Centre region of Cameroon in several rural as well as urban areas with diverse cultural backgrounds to cover the cultural diversity of the Cameroonian society. In each district, we initially interviewed the chief of medicine to profit from his or her overview, and to follow the obligation of the delegate of health of the Centre region, who approved the study design and permitted ABSA to talk to health-care personnel. The chief of medicine in each district directed us towards medical institutions or health care personnel to talk to. In the respective institutions, we asked if deaf patients were known in the region. Thus, this sampling strategy can be characterised as a snowball sampling. If no contacts of deaf patients were available, we had to rely on personal contacts of ABSA in the region to find interview partners. Since the sampling is not random, it is also not representative. Therefore, no information about frequencies is stated below. Families were interviewed in their homes, medical staff at work and deaf participants at school with the support of an interpreter.

Questionnaire Design

We developed a semi-standardised interview guideline for medical staff and one for proxies, as well as a questionnaire for deaf participants. We posed the following questions in the fields of prevention, medical consultation and rehabilitation: Which problems do our interview partners encounter in health care for deaf patients? Which strategies do they apply to solve these problems? Which actions do they propose to ameliorate the current situation? Deaf par-

ticipants were furthermore interviewed about their knowledge on several health-related topics.

Analysis

We used qualitative content analysis (Mayring 2010) to analyse the given material. The three main questions – problems, strategies, recommendations – were used as deductive categories to structure the material. Additionally formed inductive categories are elaborated below.

Results

In the following section, our results are presented structured by the deductive categories mentioned above. After each inductively formed category, it is stated if this category is mentioned by deaf patients (p), their family members (f) and/or medical staff (st).

Problems Reported

Our interview partners are confronted with the following problems concerning health care for deaf patients: A problem of communication was stated that manifests itself with the consequences of an impeded exchange of information (p, f, st), a compromised confidentiality (f, st) or an altered relationship between health care provider and patient (st). A problem of individual resources, thus of time or patience of the medical staff (p, st) or of availability of the proxy (f) was mentioned as well as a problem of financial means (f, st). A problem of attitude can be noticed when health personnel only addresses the proxy instead of the patient (f), but also if they neglect responsibility for deaf patients and refer them to an otorhinolaryngology specialist regardless of their medical issue (this attitude was extracted from given answers of the staff). Several of our interview partners affirmed that there is no particular problem between the medical staff and their deaf patients. They justify this statement with human rights (f, st), an established relationship between staff and patient (f, st) or the specialisation of staff members on the reception of deaf patients (st).

Strategies Reported

Our interview partners describe various strategies to solve the above mentioned problems. Generally, they rely on the support of proxies as lay interpreters (p, f, st) or as care-takers for the monitoring of treatment prescriptions (f, st). Staff members also withdraw to professional activities that are free from communication with the patient, such as physical examinations, monitoring of medication on-site or insistence



on follow-up appointments (st). They use different strategies to communicate with their deaf patients, for instance through gestures, drawings, lip reading or writing (p, f, st). Or they treat their deaf patients similar to children or patients who do not speak French (f, st).

Actions Proposed

Our interview partners propose various actions for the improvement of the present situation: The education of staff in sign language (p, f, st) as well as in the reception of deaf patients in general (p, f). Less often, a specialised consultation for deaf patients or the creation of rehabilitation centres are recommended (st), as is the implementation of a support system that compensates expenses for health care and auxiliaries for deaf and hard-of-hearing persons (p, f, st). The empowerment of deaf persons through education as well as through their representation in civil society is postulated (st). Other claims cover the prevention and early diagnosis of deafness (st).

Conclusions

Deaf persons receiving health care, their families and health care personnel agree on central problems and actions proposed to ameliorate the current situation. The existing barrier in doctor-patient interaction as well as the problematic reliance on family members as intermediaries can be resolved by providing interpreters or staff training in sign language. These central findings of the study-at-hand are consistent with the state of the art on the subject. Similar problems and claims have been reported in literature from the Anglophone global north.

Staff members in the Centre region of Cameroon expressed a high degree of willingness to be trained. This attitude might be due to the insight that a communication barrier exists as a problem of daily life. None of the members of staff we encountered stated that he or she had never treated a deaf patient. However, it could also be an effect of social desirability.

The perspectives fall apart when it comes to staff members' negative attitudes or prejudices against deaf persons and the proposition to train staff in the reception of deaf patients. No deaf interview partner stated that there was no problem, whereas some family members and members of staff did. It might be assumed that deaf persons receiving health care cannot neglect existing problems, as the other actors can, because they are personally affected.

Specific problems in the Cameroonian context concern the local living conditions of deaf

persons. They can be defined as side-effects of exclusion in other sectors, namely education and economy, since they are not originally health-related. The findings of the study-at-hand underline the importance of intersectoral action in health policy. Deaf and hard-of-hearing persons might not be reached and thus excluded of efforts of health promotion if no measures are taken in other sectors. Especially school education and the acquisition of a sign language to enable a certain level of literacy remain irreplaceable. If deaf persons are not able to communicate in one of the common sign languages, the provision of interpreters is useless. In both contexts, the Centre region of Cameroon as well as Anglophone countries of the global north, a risk of exclusion concerning knowledge on health-related issues has been reported.

Further investigation should also look upon the link between economic exclusion and health, on deaf persons who do not have any access to health care as outlined in the study of Mosoh (2010). This group could not be reached by the design of the study-at-hand. However, some of the proposed actions are linked to the economic situation of deaf persons and their families: avoiding preventable incidences, early detection and the compensation for auxiliaries.

Concerning the strategies to resolve the mentioned problems all three groups agree on the importance of the support of family members in the present situation and describe strategies to handle existing communication barriers. The cultural and linguistic diversity of Cameroon can be classified as a specific resource. Health care personnel seem to be equipped with cross-cultural communication strategies. Since linguistic diversity is portrayed as problematic in countries of the global north, it will be fruitful to further investigate the strategies applied by medical staff in Cameroon when treating patients who do not speak the official language(s) of the country.

The actions proposed by our interview partners may be referred to the biopsychosocial model of disability (WHO 2002) as they concern interventions on different levels. Propositions to educate staff in sign language or the reception of deaf patients as well as the creation of a social security system tackle contextual factors of the social environment. Prevention, early detection and provision of auxiliaries intervene on the level of body function and structures. School education enables activities in the domain of communication, whereas claims to empower deaf persons as members of civil society regard the level of participation.



This diversity points out the necessity of a combination of actions from different sides to ameliorate health care for deaf patients in Cameroon.

Notes

- 1 Even though this *state of the art* has been published against the background of health care systems, country health profiles and living situations of deaf persons that are fundamentally different from the situation in Cameroon as outlined above, we still decided to refer to these publications. A comparison of our findings with recommendations published in more diverse contexts would have been desirable. Since this broader picture is not available, we chose to use the existing information to at least allow a comparison with other authors who have done research on this subject. This problem is not specific to the study-at-hand, an egocentric view of science from the global north has been documented before. Hierarchies persist in the production of knowledge in the number of publications as well as the reception of data and theories (vgl. Keim 2013:23-25).

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Zusammenfassung: Die UN Konvention über die Rechte von Menschen mit Behinderungen (BRK) fordert Gesundheit als Menschenrecht ein. Angesichts der hohen Prävalenz von Hörverlust im globalen Süden untersucht dieser Artikel den Zugang gehörloser Patienten zur Gesundheitsversorgung in Kamerun. Probleme, Strategien und Empfehlungen von gehörlosen Patienten, ihren Familienmitgliedern und dem Gesundheitspersonal wurden in der frankophonen zentralen Region untersucht. Verglichen mit dem publizierten Stand in anglophonen Ländern des globalen Nordens wurden ähnliche und spezifische Probleme als auch spezifische Ressourcen gefunden. Die Ergebnisse können mit dem biopsychosozialen Modell von Behinderung (WHO 2002) verknüpft werden.

Résumé: La Convention des Nations Unies relatives aux droits des personnes handicapées demande de faire de la santé un droit de l'homme. Étant donné la prédominance importante de la perte de l'ouïe dans le 'Sud global', cet article analyse l'accès des personnes sourdes aux soins médicaux au Cameroun. Une recherche a été menée sur les problèmes, stratégies et recommandations des patients sourds, des membres de leur famille et du personnel médical dans la région centrale francophone. Comparé à l'état de l'art publié dans les pays anglophones dans le 'Nord global', des problèmes similaires et concrets et des ressources spécifiques ont été découverts. Les résultats pourraient être liés au modèle biopsychologique d'handicap (OMS 2002).

Resumen: La Convención de la ONU sobre los Derechos de las Personas con Discapacidad (CDPD) reivindica la salud como un derecho humano. Tomando en cuenta la alta prevalencia de la hipoacusia en el sur global, este artículo explora el acceso de los pacientes sordos a la salud en Camerún. Los problemas, las estrategias y las recomendaciones de los pacientes sordos, sus familiares y el personal de atención de la salud han sido investigados en la región central francófona. En comparación con el estado de la técnica publicada en los países anglófonos del norte global, problemas similares y específicas, así como los recursos específicos se han descubierto. Los resultados pueden ser relacionados con el modelo biopsicosocial de la discapacidad (OMS, 2002).

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Kurzmeldungen/Announcements

The 66th World Health Assembly Adopted a Resolution Calling for Better Health Care for Persons with Disabilities

The resolution calls on the World Health Organisation (WHO) to prepare a WHO action plan in consultation with United Nations organisations and Member States based on the recommendations of the World Report on Disability and in line with the UN Convention on Rights of Persons with Disabilities (CRPD).

Information: http://www.who.int/disabilities/actionplan_form/en/index.html

General Assembly High-Level Meeting Adopts Outcome Document Seeking to Promote Disability-Inclusive Development

The General Assembly adopted a landmark outcome document aimed at promoting disability-inclusive development. During its first-ever high-level meeting on this topic, its President underlined the text's significance as the instrument to guide efforts towards the creation of a fully inclusive society through 2015 and beyond.

The international community has now realised that it would be impossible to meet development targets, including the Millennium Development Goals, without incorporating the rights, well-being and perspective of persons with disabilities. By the text adopted on September 23, 2013, Heads of State and Government reaffirmed their resolve to work together for disability-inclusive development and for the international community's commitment to advancing the rights of all persons with disabilities, which is deeply rooted in the goals of the United Nations and the Universal Declaration of Human Rights. World leaders also underlined the need for urgent action by all relevant stakeholders towards the adoption and implementation of more ambitious disability-inclusive national development strategies, while expressing their resolve to undertake various commitments to address barriers, including those relating to education, health care, employment, legislation, societal attitudes, as well as the physical environment and information and communications technology.

The text urged the United Nations system as well as Member States to stay engaged in efforts to realise the Millennium Development Goals and other internationally agreed development targets for persons with disabilities towards 2015 and beyond. It encouraged the international community to seize every opportunity to include disability as a cross-cutting issue on the global development agenda, including the emerging post-2015 United Na-

tions development framework. Assembly President Ashe (Antigua and Barbuda) emphasised that persons with physical, sensory, mental and intellectual disabilities were the world's largest minority, numbering more than 1 billion. Turning to the Convention on the Rights of Persons with Disabilities, adopted by the General Assembly in 2006, he noted that 134 countries had ratified or acceded to the treaty, which had been envisaged from inception as both a human rights and a development instrument. Secretary-General Ban Ki-moon said 80% of persons with disabilities were of working age, and the same percentage lived in developing countries. Too many of them lived in poverty, suffered from social exclusion, and lacked access to education, employment, health care as well as social and legal support systems. Women and girls with disabilities often experienced double discrimination, and it was therefore necessary to emphasise the gender dimension of a disability-inclusive development agenda. Quoting International Labour Organisation (ILO) statistics, he warned that excluding persons with disabilities could cost economies as much as seven per cent of gross domestic product (GDP).

Information: <http://www.un.org/News/Press/docs/2013/ga11420.doc.htm>

UN Survey Shows Needs of Persons with Disabilities Largely Ignored During Disasters

A high proportion of persons with disabilities die or suffer injuries during disasters because they are rarely consulted about their needs and governments lack adequate measures to address them, according to a United Nations survey released on October 10th ahead of the International Day for Disaster Reduction.

The online survey, produced by the UN Office for Disaster Risk Reduction (UNISDR) and partners, consulted nearly 6,000 persons with disabilities in 126 countries on how they cope and prepare for disasters. The results show that persons living with disabilities across the world are rarely consulted about their needs in times of disasters. In cases where they need to evacuate, such as during floods or earthquakes, only 20% of respondents said they could evacuate immediately without difficulty, six per cent said they would not be able to evacuate at all, and the remainder said they would be able to evacuate with a degree of difficulty. Released ahead of the International Day for Disaster Reduction, which is commemorated annually on 13 October and this year recognises the critical role of persons with disabilities in fostering disaster resilience, the



survey shows that the inclusion of the topic of disability must be a central concern in all emergency communications. It notes that the challenges of evacuation ranged from having a degree of difficulty of hearing, seeing, walking or climbing steps and having difficulty communicating. If given sufficient time, the percentage of those who could evacuate with no difficulty almost doubles, rising from 20% to 38%, which underlines the importance of early warning systems and ensuring that warnings reach all members of the community. In addition, many respondents said that if they receive an early warning, they would take measures that would better prepare them for disasters. For example, one respondent said that if he had prior knowledge of bad weather overnight, he would sleep in his wheelchair to be able to take cover quickly. Another respondent said an early warning on bad weather would allow him to stock up on medicines, and another one expressed concern of being unable to receive alerts because he cannot hear sirens.

The 22-question survey also shows that 71% of respondents have no personal preparedness plan for disasters and only 31% always have someone to help them evacuate while 13% never have anyone to help them. Persons with disabilities also face difficulties after disasters have struck, as emergency and care systems are poorly designed for persons needing help or having impairments/disabilities. The top five hazards or disaster risks faced by survey respondents were floods, extreme weather, tornados, drought, and earthquakes. UNISDR will continue the survey until the end of the year to expand the sample.

Information: <http://www.un.org/disabilities/news.asp?navid=29&pid=1421>

Key to Post-2015: Hold Donors to Account

On 23 September, the United Nations General Assembly convened a High-level Meeting on Disability and Development at the level of Heads of State and Government, with the overarching theme *The Way Forward: a Disability Inclusive Development Agenda Towards 2015 and Beyond*. For the meeting, it was critical to ensure that the next development agenda elevates the participation of persons with disabilities – not only as recipients but, more importantly, as decision-makers. Inclusion of persons with disabilities into human rights and development funding is still marginal. Persons with disabilities make up one billion people around the world – one in seven – and yet receive only 3-4% of human rights and development funding. They are largely absent from the donor decision-making table. With the participation of persons with disabilities as decision makers, the Disability Rights Fund (DRF) and Disability Rights Advocacy Fund (DRAF) have been able to fund extraordinary rights advances. By ensuring that persons with disabilities drive funding strategies and decisions, and by supporting Disabled People's Organisations

to implement the UN Convention on the Rights of Persons with Disabilities (CRPD), DRF and DRAF are helping to ensure that rights – not charity – set the frame for an approach to disability. The post-2015 process must do the same: ensure that no person with disability is left behind by mandating inclusion and equity in all stages of development.

Information: <http://www.disabilityrightsfund.org/news/press-releases/2013/09/23/key-post-2015-hold-donors-account.html>

Human Rights at Heart of New Development Agenda

Many people have been denied the benefits of economic progress or access to economic opportunities, resources, and services as a result of discrimination linked to gender, age, ethnicity, disability, religion, caste, or other social status. For example, Human Rights Watch has documented major and systemic barriers to education for children with disabilities in Nepal and China. The Millennium Development Goals do not include goals or targets for marginalised populations – such as persons with disabilities – and are not grounded in a human rights framework. As a result, there has been no incentive or accountability for national governments, bilateral donors, or international financial institutions to address inequality or discrimination in the current development agenda. Human Rights Watch research over a number of years has demonstrated the risk of abuse or exclusion when development is not rooted in human rights. Such programs often leave the poorest and most marginalised communities behind, including women, children, ethnic and religious minorities, indigenous persons, and persons with disabilities. A post-2015 agenda firmly grounded in human rights would draw attention to issues of discrimination and inequality and prompt action to address them. A rights-based approach to development would also strengthen accountability, with decision-makers answerable for the impact of their policies on a country's poorest groups. Human rights have emerged as a major theme from the UN-led process and debate to set a post-2015 development agenda. At the General Assembly special event and over the next year, it will be important to reinforce commitments to human rights where they exist and to further strengthen commitments to rights across the whole of the sustainable development agenda.

Information: http://www.hrw.org/sites/default/files/related_material/MDG_brochure0913_LOWRES_SPREADS.pdf,
<http://www.hrw.org/news/2013/09/22/un-put-human-rights-heart-new-development-agenda>



The Rights of Persons with Disabilities are Referred to in Outcome Document of the EU-Africa Civil Society Forum

From 23 to 25 October 2013, approximately 100 representatives from African and European civil society gathered in Brussels to hold the second Inter-Continental Civil Society Forum. This meeting came at a crucial time: Six months ahead of the Africa-EU summit of Heads of States and Governments; it also took place in a context of reforming the Africa-EU partnership in a view to focus on fewer priorities.

The main goal of the Forum was to develop the position of civil society, in order to influence the content of the upcoming summit. Before looking towards the future, participants assessed the last six years of the Africa-EU partnership. While progress was made in some areas such as human rights, most participants were disappointed with the level of concrete implementation of agreed actions. There was a general feeling that too much time was spent

on designing the institutional architecture of the Partnership, rather than focusing on achieving tangible progress for people. The event addressed a number of key thematic issues relevant for the future of both continents. These included: food security, environment, human rights and governance, inequalities, peace and security, trade, and migration. In all thematic areas, there was large consensus that the Africa-EU Partnership should be about addressing those issues at political level. This also means to raise issues of disagreement (e.g. in the area of trade) in an open manner. At the end of the three days, the forum adopted a declaration outlining main concerns as well as key recommendations for the way forward. One of the recommendations calls for the Africa-EU Partnership to strengthen the voice of the poorest and most marginalised groups; it specifically refers to persons with disabilities.

Information: http://www.cbm.org/article/downloads/108079/CSO_Brussels_Declaration_on_the_JAES.pdf,
<http://www.cbm.org/The-Voice-of-Civil-Society-428895.php>



Literatur

UN Broadband Commission for Digital Development/G3ICT/IDA/ITU/Microsoft/Telecentre.org Foundation/UNESCO

The ICT Opportunity for a Disability-Inclusive Development Framework

The International Telecommunication Union (ITU) launched a report on the potential of information and communication technology (ICT) on 23 September to promote the social and economic inclusion of people with disabilities, including indicators to measure disability inclusion through ICTs. Based on input from 150 experts on ICT, disability and development issues in 55 countries, the report analyses barriers and proposes priority actions and indicators for measuring progress on disability inclusion through ICTs.

Bezug: http://www.itu.int/en/action/accessibility/Documents/The%20ICT%20Opportunity%20for%20a%20Disability_Inclusive%20Development%20Framework.pdf, <http://post2015.iisd.org/news/itu-partners-propose-indicators-on-ict-accessibility/>

Disability Rights International The Rights of Persons with Mental Disabilities in the New Mexican Criminal Justice System

The report explores the treatment of persons with disabilities within the criminal justice sector in Mexico that is in the midst of its implementation. The rights of persons with mental disabilities and their protection under the system so far have been ignored and not taken into account in the implementation process. The report explores the access to justice for persons with disabilities who are currently before the criminal system. It identifies problems and gives recommendations to ameliorate the situation of persons with disabilities in the justice system.

Bezug: http://www.disabilityrightsintl.org/wordpress/wp-content/uploads/Report__Access-to-justice-and-Persons-with-mental-disabilities_-Final.pdf

Human Rights Watch Rights Should Be Central to Post-2015 Development Agenda

The Human Rights Watch report shows that a lack of focus on human rights leads to exclusion, discrimination, and inequality. As a consequence, the report asks world leaders to commit to fully integrating human rights into the post-2015 global development agenda and targets.

Bezug: http://www.hrw.org/sites/default/files/related_material/2013post2015dev-goals.pdf

Human Rights Watch

Barriers Everywhere – Lack of Accessibility for Persons with Disabilities in Russia

The 118-page report is based on 123 interviews with persons with disabilities and their families in six cities across Russia. It documents the everyday hurdles persons with disabilities meet when going to government offices, shops, healthcare centres and places of employment, and trying to access public transportation. Human Rights Watch interviewed persons with different types of disabilities or multiple disabilities in the cities of Moscow, St. Petersburg, Ulan-Ude, and Sochi and in smaller towns in the Moscow and Leningrad regions. In the interviews, men, women, and children described a range of barriers they experience.

Bezug: http://www.hrw.org/sites/default/files/reports/russia0913_ForUpload.pdf

WHO/CBM/IFRC/IOM/UNISDR/UNICEF Guidance Note on Disability and Emergency Risk Management for Health

The guidance note is intended primarily for health actors working in emergency and disaster risk management at the local, national or international level, and in governmental or nongovernmental agencies. Persons with disabilities, those working in the disability sector and those working in other sectors that contribute to improved health outcomes related to emergency risk management, may also find this guidance note useful. It is a short, practical guide that covers actions across emergency risk management such as risk assessment, prevention (including hazard and vulnerability reduction), preparedness, response, recovery and reconstruction. It outlines the minimum steps health actors should take to ensure that specific support is available for persons with disabilities when needed and to ensure that disability is included in the development and implementation of general health actions in all emergency contexts (natural and technological hazards, epidemic diseases and other biological hazards, and conflicts and other societal hazards). This dual strategy – of both mainstream and specific support – will help ensure that the long-term needs of the community are met.

Bezug: http://apps.who.int/iris/bitstream/10665/90369/1/9789241506243_eng.pdf



UN Partnership to Promote the Rights of Persons with Disabilities **Towards an Inclusive and Accessible Future for All**

The present publication documents the voices of persons with disabilities on what a disability inclusive post-2015 framework should look like, and contains practical suggestions on how to achieve this objective. The key messages presented in this report are gathered from data taken from the online consultation, A Disability Inclusive Development Agenda Towards 2015 and Beyond, that took place between March and April 2013, and also a series of follow-up interviews with disability advocates in July 2013 which explored issues raised in the online consultation in more depth.

Bezug: g3ict.org/download/p/fileId_990/productId_300;
<http://www.undp.org/content/undp/en/home/librarypage/poverty-reduction/towards-an-inclusive-and-accessible-future-for-all/>



Aus der Höhe der Treppe ergibt sich die Länge der Rampe.

Inklusion ist machbar. Einfach rechtzeitig daran denken. Wenn Barrieren verschwinden, können sich Menschen beteiligen.

Entwicklung ist, wenn alle mitmachen

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VERANSTALTUNGEN/EVENTS

- 27.03.2014 Singapore Rehabilitation Conference 2014, Singapore.
Information: <http://www.singaporerehab.com.sg>; Kontakt: Singapore Rehabilitation Conference 2014 Secretariat, c/o SGH Postgraduate Medical Institute, 20 College Road, Academia, Level 2, Singapore 169856; Tel.: 0065 6576 7658; Fax: 0065 6223 9789; E-Mail: src_secretariat@sgh.com.sg.
- 06.05.2014 1st Global Conference: Sexuality and Disability, Lisbon, Portugal.
Information: <http://www.inter-disciplinary.net/critical-issues/gender-and-sexuality/sexuality-and-disability/call-for-presentations/>; Kontakt: Inter-Disciplinary.net, Priory House, 149B Wroslyn Road, Freeland, Oxfordshire OX29 8HR, United Kingdom; Tel.: 0044 1993 8820 87; Fax: 0044 870 4601 132; E-Mail: Colette Balmain: cb@inter-disciplinary.net Rob Fisher: sd1@inter-disciplinary.net.
- 17.05.2014 Pacific Rim International Forum on the Rights of Persons with Disabilities, Honolulu, Hawaii.
Information: <http://pacrim.hawaii.edu/>; Tel.: 808 956 7539; E-Mail: prinfo@hawaii.edu.
- 19.05. - 20.05.2014 30th Pacific Rim International Conference on Disability and Diversity, Honolulu, Hawaii.
Information: <http://pacrim.hawaii.edu/>; Tel.: 808 956 7539; E-Mail: prinfo@hawaii.edu.



Schwerpunktthemen kommender Ausgaben der Zeitschrift Focal Topics of Upcoming Issues

- 1/2014: Diskriminierung überwinden/Overcoming Discrimination (verantwortlich/responsible: Jana Offergeld)
- 2/2014: Barrierefreiheit in den Bereichen Information und Kommunikation/Information and Communication without Barriers (verantwortlich/responsible: Christine Bruker/Isabella Bertmann)
- 3/2014: Physische Barrierefreiheit/Physical Access without Barriers (verantwortlich/responsible: Christine Bruker/Isabella Bertmann)

Interessierte Autorinnen und Autoren mögen sich für nähere Informationen und unseren *Leitfaden für AutorInnen* bitte an die oben genannten Verantwortlichen wenden. Darüber hinaus sind Vorschläge für weitere Schwerpunktthemen willkommen unter info@inie-inid.org.

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	1/2014	2/2014	3/2014
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