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Strengthening Social Protection for Persons with Disabilities in Arab Countries

Economic and Social Commission for Western Asia

Strengthening Social Protection for Persons with Disabilities in Arab Countries



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Contents

	<i>Page</i>
Acknowledgements	iii
Acronyms	vii
Glossary	ix
Executive Summary	xi
Technical Note on Statistical Data	xiii
Introduction	1
1. Disability and the 2030 Agenda for Sustainable Development	7
2. Social Protection for Persons with Disabilities in the Arab Region	23
A. Overview	24
B. Legal and institutional frameworks	29
C. Coverage of persons with disabilities	30
D. Eligibility and targeting	40
E. Other elements of disability inclusive social protection	44
3. Conclusions and the Way Forward	49
Recommendations	53
References	55
Annex. Selection of Social Assistance Programme in the Arab Region	67
Endnotes	71

List of Tables

Table 1. Countries using the WG-SS in census and household surveys	xiv
Table 2. Signatures and formal confirmations/accessions/ratifications of the CRPD and Optional Protocol, ESCWA member States	4
Table 3. SDGs with targets and/or indicators that directly refer to persons with disabilities	10

List of Figures

Figure 1. Interlinkages of CRPD and 2030 Agenda components	14
Figure 2. Total disability prevalence rates by gender, selected countries, different years	14
Figure 3. Total disability prevalence rates and rates for people aged 65+, 2007-2016	15
Figure 4. Total disability prevalence rates and persons aged 65+ as percentage of total population, 2007-2016	16
Figure 5. Persons aged 10+ with and without disabilities with no educational attainment, Iraq, 2013	17

Figure 6.	Disability prevalence rate among children aged 0-4, 2007-2016	17
Figure 7.	Employment rate among persons with and without disabilities aged 15-64	18
Figure 8.	Economic inactivity, unemployment and employment among men and women with and without disabilities aged 15-64, Saudi Arabia, 2016	19
Figure 9.	Primary education attainment in urban areas among females aged 10+ with and without disabilities, 2007-2013	20
Figure 10.	Primary education attainment in rural areas among females aged 10+ with and without disabilities, 2007-2013	21
Figure 11.	Percentage of persons with disabilities who received any kind of support for their disability in the past 12 months, Yemen, 2013	32
Figure 12.	Percentage of persons with disabilities having disability cards, Tunisia, 2014	32
Figure 13.	Utilization of disability card by purpose, 2015	33
Figure 14.	Salaried employment as percentage of total employment among persons with and without disabilities aged 15 and above, 2007-2016	35
Figure 15.	Salaried employment as percentage of total employment among persons with and without disabilities aged 15 and above, Iraq, 2013	35
Figure 16.	Health insurance coverage among persons with disabilities and the overall population, Morocco, 2013-2015	38
Figure 17.	Households including at least one person with a disability as percentage of households covered by PNAFN/AMGI, by AMGII, by neither, and all households, Tunisia, 2014	38
Figure 18.	Aspects of social protection requiring improvement according to persons with disabilities, Algeria, Morocco and Tunisia, 2015	47

Acronyms

AMG	Assistance Médicale Gratuite (Tunisia, Free Medical Assistance)
CRPD	Convention on the Rights of Persons with Disabilities
CNOPS	Caisse Nationale des Organismes de Prévoyance Sociale (Morocco, National Social Insurance Fund)
CNSS	Caisse Nationale de Sécurité Sociale (Morocco, National Social Security Fund)
CT	Cash Transfer
ESCWA	Economic and Social Commission for Western Asia
GDP	Gross Domestic Product
ICF	International Classification of Functioning, Disability and Health
IGED	Inter-sessional Group of Experts on Disability
ILO	International Labour Organization
NAF	National Aid Fund (Jordan)
NSO	National Statistics Office
PMT	Proxy Means Testing
PNAFN	Programme National d'Aide aux Familles Nécessiteuses (Tunisia, Assistance to Needy Families Programme)
PNCTP	Palestinian National Cash Transfer Programme
RAMED	Régime d'Assistance Médical (Morocco, the Medical Assistance Scheme)
RCAR	Régime Collectif d'Allocation de Retraite (Morocco, Collective Retirement Allowance Scheme)
SDG	Sustainable Development Goal
SIP	Social Initiatives Program (Sudan)
SPF	Social Protection Floor
WHO	World Health Organization

Glossary

Contributory scheme	Social protection scheme in which entitlement to benefits is contingent upon prior contributions. Membership is typically tied to (formal) employment, and contributions may be paid by the employer and/or by the state as well as by the employee
Economically active	Persons who partake in the labour force, i.e. who are employed or unemployed
Economically inactive	People within the working age population who are not part of the labour force, such as students
Employment rate	The proportion of employed persons within the working age population (15-64 years)
Informal employment	Employment that does not imply coverage of contributory social protection
Labour force	The sum of the number of persons employed and the number of unemployed (individuals without work who are available for work and looking for work), i.e. of persons who are economically active
Labour-force participation rate	The proportion of persons within the working age population who take part in the labour force, i.e. who are economically active. Calculated by expressing the number of people in the labour force as a percentage of the working age population
Non-contributory scheme	Social protection scheme in which entitlement to benefits is not contingent upon prior contributions, but based on e.g. citizenship, poverty or disability
Social assistance	Non-contributory social protection that may be targeted at specific groups, such as the poor, or provided to the population as a whole

Social health insurance	Health insurance provided on a contributory basis, entitling the insured person, and often his or her dependents, to access health care
Social insurance	A contributory form of social protection aimed at ensuring income security in the event of e.g. old age, disability or unemployment
Social protection floor	A nationally defined set of basic social security guarantees which secure protection aimed at preventing or alleviating poverty, vulnerability and social exclusion
Social protection	Initiatives which aim to ensure income security and access to health care. Such initiatives can be contributory, such as social insurance and social health insurance, or non-contributory, such as social assistance and freely provided health care
Unemployed population	The unemployed comprise all persons within working age, who are (i) not in paid employment or self employment, (ii) available for work and (iii) seeking work
Unemployment rate	Proportion of unemployed persons within the labour force. Calculated by expressing the number of unemployed people as a percentage of the total labour force

Note: Labour market indicators follow the calculation methods and definitions of the International Labour Organization.

Executive Summary

Persons with disabilities in the Arab region, as elsewhere in the world, are one of the most marginalized and excluded population groups. They are often not visible in public life, as the social and physical environments remain inaccessible, and they are disproportionately affected by crises and disasters. Reporting on the ongoing violent conflicts across the region is largely silent on the plight of persons with disabilities, who are unable to run away from destruction, unaware of dangers facing them, or even left behind by their families. It is important to keep in mind that for each person killed, many more are severely injured or permanently disabled.

Arab countries are committed to improving the situation of persons with disabilities, as shown by the fact that most of them have signed, ratified or acceded to the Convention on the Rights of Persons with Disabilities (CRPD). However, implementing legislation and realizing ambitions often proves challenging, and the exclusion of persons with disabilities is in part self-perpetuating. Inclusive social protection is critical in order to overcome these challenges. Importantly, though, social protection needs to be an integrated component of the larger development agenda. Moving from the charity model to a rights-based one will empower persons with disabilities in the Arab region. Better social protection can foster the shift from a “not able to work” approach to “social participation”.

Chapter 1 focuses on disability rights and the 2030 Agenda. Monitoring progress towards implementation of the Sustainable Development Goals requires a comprehensive set of reliable data. However, this is still largely unavailable for the Arab countries, as shown by the gaps in the statistics most recently collected by ESCWA. Those statistics indicate that there are considerable differences in disability prevalence between Arab countries. While hardly any data directly relating to poverty among persons with disabilities is available, the statistics show that they are to a much lesser extent than persons without disabilities educated and employed, which strongly indicates that they are also more likely to be poor. Women with disabilities are particularly disadvantaged.

Chapter 2 concerns social protection. Data on social protection coverage of persons with disabilities is largely lacking, and when it is available it is frequently hard to interpret. Whereas it appears that persons with disabilities across the region are strongly underrepresented among the population covered by social insurance and contributory health insurance, data on their coverage of social assistance and non-contributory health insurance show more variegated results. Targeting for social assistance programmes and for non-contributory health insurance programmes is increasingly done through proxy means testing (PMT), which may be problematic if disability related costs are not (sufficiently) included when the poverty level of households is evaluated.

When eligibility for social protection is contingent upon disability status, access depends on how disability is determined. Frequently in the Arab region, disability is defined as work inability, which may serve to discourage labour force participation among persons with disabilities. Persons with disabilities' access to social protection is also restricted by the lack of information, arduous application procedures, and barriers in the physical and social environment. Even when social protection is accessible, it is often inadequate in the sense that monetary benefits are too low, or health services do not correspond to the needs of persons with disabilities – something that particularly affects women with disabilities and people living in rural areas.

The concluding chapter makes the point that ensuring social protection for persons with disabilities requires the integration of social protection systems into the broader policy framework. Other goals of the 2030 Agenda and CRPD provisions, such as accessibility of the physical and social environment, need to be implemented alongside core social protection objectives in order to achieve the transformative commitments of the 2030 Agenda. The chapter details a range of recommendations to assure that social protection is accessible and adequate, that it furthers the autonomy of persons with disabilities, and that it conforms to the principles of the CRPD in order to achieve this objective.

Technical Note on Statistical Data

Arab countries are changing their approach to disability statistics. By transitioning to the method recommended by the Washington Group on Disability Statistics (WG) in censuses and surveys, they achieve a more uniform definition of disability for statistical purposes.

The WG defines persons with disabilities as those at greater risk than the general population of experiencing restrictions in performing specific tasks or participating in role activities due to limitations in basic activity functioning - such as walking, seeing, hearing, or remembering - even if such limitations are ameliorated by using assistive devices, a supportive environment or plentiful resources.

The WG's first priority was the development of a Short Set of questions (WG-SS) suitable for censuses and surveys. The purpose of this is to disaggregate the population by disability status in order to ascertain if persons with disabilities are participating equally in all aspects of society. The WG-SS addresses six functional domains: seeing, hearing, walking, cognition, self-care, and communication. These were selected based on two criteria. First, they cover the large majority of functional limitations that people might have. Second, they are functional domains that can be adequately captured with a single question.

The second priority was to develop an **Extended Set of questions on functioning** (WG-ES) to be used in surveys to capture more extensive information on disability. The WG-ES was designed to add additional functional domains to identify persons with disabilities who are not captured by the WG-SS. These additional domains include upper body mobility, psychosocial functioning, pain and fatigue. In addition, questions were added to collect more information on existing domains (e.g., walking a short distance and walking a longer distance) to better capture the continuum of functioning.

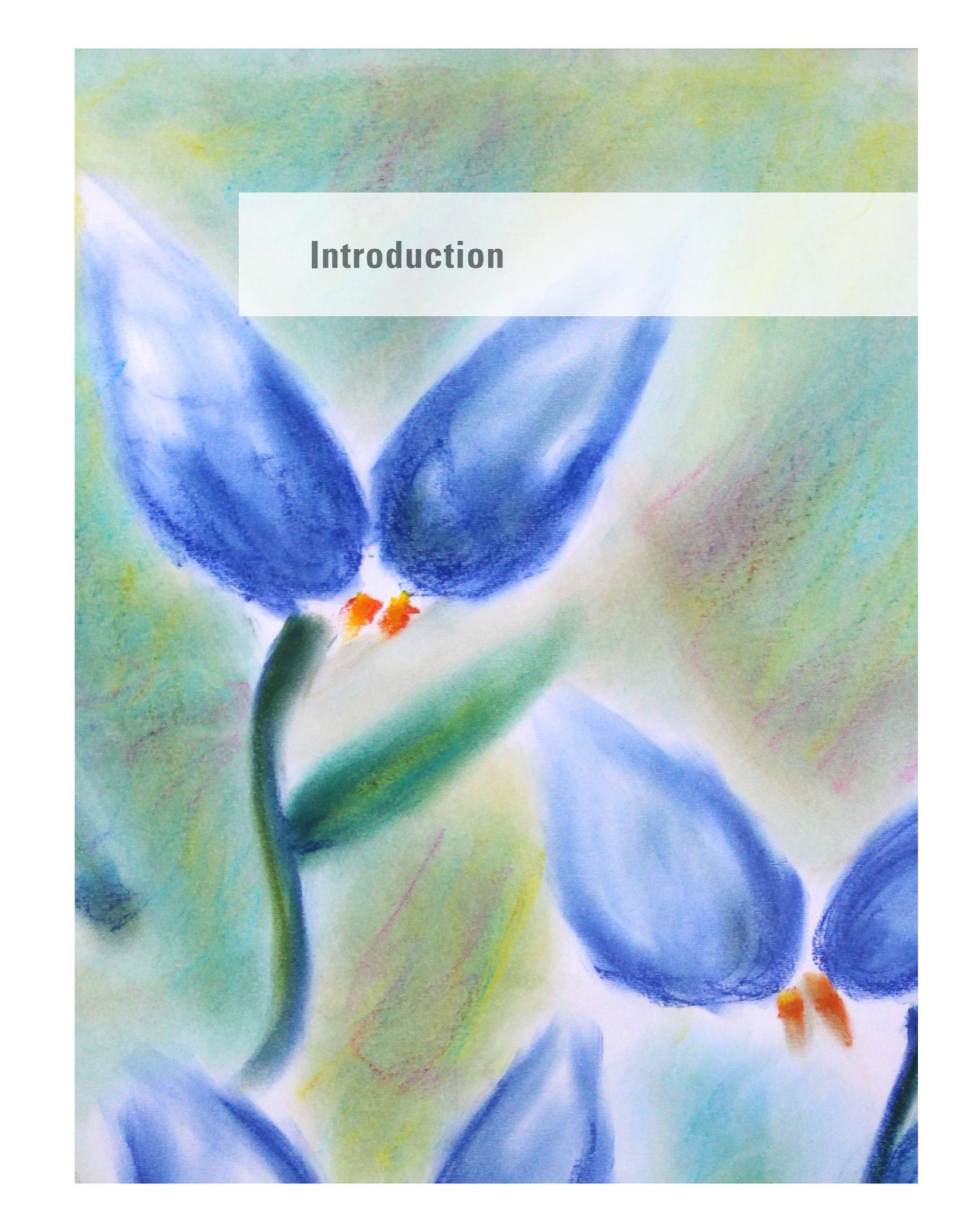
Statistical offices in countries participating in ESCWA data collection that have not adopted the WG-SS (Bahrain and Mauritania) have aligned their national response categories with those of the WG.¹

Significant variations in disability prevalence reported globally are in part due to different definitions, connected with different cut-off points. Some countries may prefer to include persons who report "some difficulty" into their national register of persons with disabilities. Variations across countries also depend on whether countries chose to include all residents in the data collection or only the national population.

Table 1. Use of the WG-SS on functioning in census and household surveys²

Censuses		Household surveys	
Countries using the WG-SS on functioning in census and household surveys			
Jordan	Census 2015	Egypt	LFS 2016
Morocco	Census 2014	Saudi Arabia	DHS 2016
Oman	Census 2010	United Arab Emirates (Abu Dhabi)	LFS 2014
State of Palestine	Census 2007	Yemen	HBS 2014
Qatar	Census 2010	Lebanon	HBS 2011
Tunisia	Census 2014	Iraq	I-PMM 2013
Countries not using the WG-SS on functioning in census and household surveys			
Bahrain	Census 2010	Syrian Arab Republic	Budget Survey 2007
Sudan	Census 2008	Libya	PAPFAM 2014
Mauritania	Census 2013		

Notes: LFS, labour force survey; DHS, Demographic and Health Surveys; HBS, household budget survey; I-PMM, Iraq Poverty Mapping and Maternal Mortality Survey; and PAPFAM, Pan Arab Project for Family Health. Qatar, Tunis and Egypt (WG) in addition to the Sudan and the Syrian Arab Republic (Non-WG), are in process of being completed. Data are published once received and verified by ESCWA. ESCWA is contacting the rest of the countries to complete and share the data. Data for Oman and Saudi Arabia pertain to nationals only.

A watercolor painting of blue flowers with orange stamens and green leaves on a light background. The flowers are rendered in various shades of blue, with some petals showing darker tones. The stamens are a vibrant orange, and the leaves are a soft green. The background is a mix of light green and yellow, with some faint red and blue lines. The overall style is soft and artistic.

Introduction



Introduction

Inclusive development that leaves no one behind is the basis of the 2030 Agenda for Sustainable Development. This aspiration resonates profoundly with persons with disabilities across the world, as they are one of the most marginalized and excluded population groups. In terms of employment, educational attainment, access to adequate services as well as participation and individual autonomy, persons with disabilities are disadvantaged. Progress towards the inclusion of persons with disabilities into mainstream society may thus by itself be seen as a gauge for achieving the 2030 Agenda and the Sustainable Development Goals.

Arab governments are increasingly committed to improving the situation and ensuring the social inclusion of persons with disabilities. This is demonstrated by the fact that most Arab countries refer to the rights of persons with disabilities in their constitutions, which is the highest possible commitment and underlines that the inclusion of persons with disabilities is an aspiration of the country. As shown by table 2, 21 out of 22 Arab countries have signed, ratified or acceded to the Convention of the Rights of Persons with Disabilities (CRPD). Several are also party to the optional protocol, which opens the way for individual or collective complaints against perceived violations of the Convention to the UNCRPD Committee. Furthermore, all have adopted overarching disability laws, and several have developed disability strategies and action plans.³

However, progress on translating ambitions, commitments and legislation into practical change is often slow. This is partly due to the complexity of disability policy, which cuts across policy domains and sectoral responsibilities, thus going beyond the sphere of any single ministry. It is also due to prejudice and stigma, which are still deeply embedded in social attitudes, and which lead to a vicious circle: the less persons with disabilities are visible in everyday social, economic and political life, the less their needs and preferences are understood and met. The continuing exclusion of persons with disabilities is also in large part a consequence of the linkage between disability and poverty: persons who are poor are more likely to have disabilities, and persons with disabilities are more likely to become or remain poor.

Social protection is one of the main vehicles that can serve to break the exclusion of persons with disabilities. However, social protection cannot function in isolation, but needs to be integrated into a wider framework of policies. Such other policies, in turn, require the existence of social protection in order to work. Positioning social protection in the wider framework of the CRPD and the 2030 Agenda underlines its complexity, and confirms the need for a comprehensive approach.

This report focuses on social protection in the Arab region, taking its basis in the understanding of social protection as

an integral part of the CRPD and the 2030 Agenda. The objective is to provide an overview of the social protection systems in several Arab countries, and to set these in relation to the specific situation and needs of persons with disabilities in light of the

provisions of the CRPD and the Agenda 2030 with its 17 Sustainable Development Goals. It aims to enrich and expand the current discussion about ongoing reforms of social protection systems in several Arab countries.

Table 2. Signatures and formal confirmations/accessions/ratifications of the CRPD and Optional Protocol, ESCWA member States⁴

Country	Convention		Optional Protocol	
	Signed	Confirmed/acceded to/ratified	Signed	Confirmed/acceded to/ratified
Algeria	30/3/2007	4/12/2009	30/3/2007	-
Bahrain	25/6/2007	22/9/2011	-	-
Comoros	26/9/2007	16/6/2016	-	-
Djibouti	-	12/06/2012	-	12/06/2012
Egypt	4/4/2007	14/4/2008	-	-
Iraq	-	20/3/2013	-	-
Jordan	30/3/2007	31/3/2008	30/3/2007	-
Kuwait	-	22/8/2013	-	-
Lebanon	14/6/2007	-	14/6/2007	-
Libya	1/5/2008	-	-	-
Mauritania	-	3/4/2012	-	3/4/2012
Morocco	30/3/2007	8/4/2009	-	8/4/2009
Oman	17/3/2008	6/1/2009	-	-
State of Palestine	-	2/4/2014	-	-
Qatar	9/7/2007	13/5/2008	9/7/2007	-
Saudi Arabia	-	24/6/2008	-	24/6/2008
Somalia	-	-	-	-
Sudan	30/3/2007	24/4/2009	-	24/4/2009
Syrian Arab Republic	30/3/2007	10/7/2009	-	10/7/2009
Tunisia	30/3/2007	2/4/2008	30/3/2007	2/4/2008
United Arab Emirates	8/2/2008	19/3/2010	12/2/2008	-
Yemen	30/3/2007	26/3/2009	11/4/2007	26/3/2009

Source: United Nations Treaty Collection.

The report is based on desk research conducted by the ESCWA Social Development Division and on individual discussions and communication with policy focal points from ESCWA member countries in the ESCWA Committee on Social Development Inter-Sessional Group of Experts on Disability (IGED). The report was discussed at an Expert Group Meeting in April 2017 in Beirut as well as in a meeting of the IGED in Amman in July 2017. Drafts versions have been reviewed by IGED focal points as well as by international experts in the fields of disability and social protection. In order to provide as complete a picture as possible, the report is based on a broad spectrum of sources, including information coming directly from national governments, civil society organizations, international organizations, as well as media, academia and foreign development agencies as available.

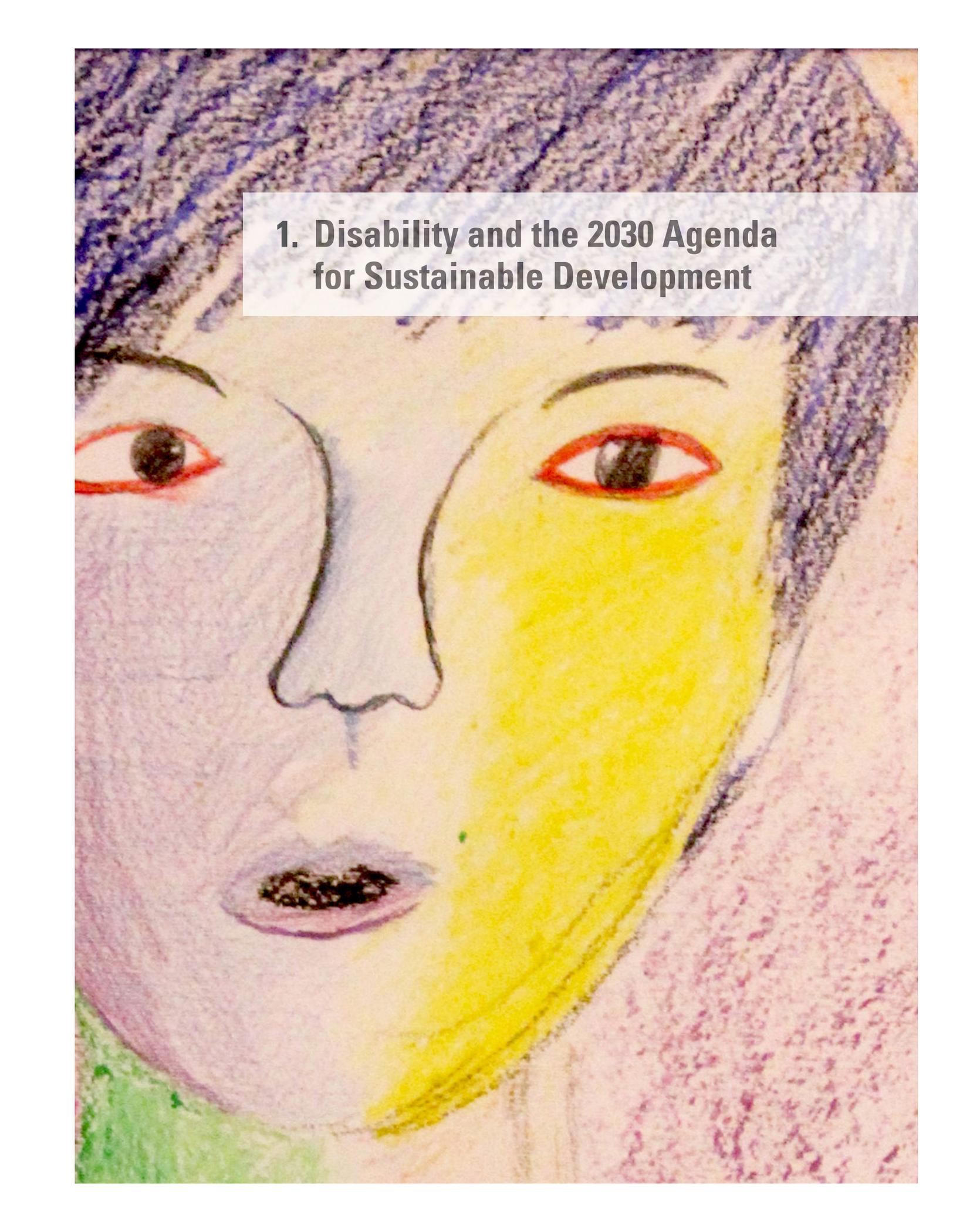
The statistics and data tables in the report partly result from a recent data collection by the ESCWA Statistical Division (sourced ESCWA 2017). The data will be presented and analyzed in more detail in a second edition of the ESCWA publication “Disability in the Arab Region” in 2018.

Some specificities and limitations should be taken into account. With more attention to the situation of persons with disabilities, the concept of disability as well as its reflection in official government statistics is evolving rapidly. This can be observed in changing definitions of disability. In line with the stipulations of the CRPD, policy makers prefer an open definition of disability to emphasize the dependence of functional limitations on a more or less enabling environment and the existence of barriers and obstacles to participation. Statisticians on the

other hand depend on precise definitions for measurement purposes. In order to adopt a uniform approach to statistical measurement, countries increasingly adopt the recommendations of the Washington Group on Disability Statistics (WG), which does not address conditions in the person’s environment.⁵ The WG short set of questions (WG-SS) is meant to explore restrictions in six core functional domains (walking, seeing, hearing, cognition, self-care and communication). Respondents are asked to assess their level of functioning according to four categories, ranging from “no, no difficulty”, “yes, some difficulty”, “yes, a lot of difficulty” to “cannot do at all”. For measurement purposes, the Washington Group recommends defining the last two categories as persons with disabilities.

It has to be noted that this report does not discuss the specific challenges currently facing persons with disabilities who are part of the regrettably large population of refugees and internally displaced persons in several Arab countries. Relevant data was not readily available, and its collection would have involved a larger data mining effort than was feasible for the current report. This topic will thus be treated in detail in an upcoming separate ESCWA publication on disability in conflict and crisis.

Another knowledge gap regards the social protection of children with disabilities, especially early detection and intervention. The report discusses early childhood intervention for children with disabilities to the extent that information is available. However, ongoing wars and conflicts with their profound impact on children, including malnutrition and trauma, require a more specialized discussion, which will be taken up in the framework of the above mentioned upcoming publication.



1. Disability and the 2030 Agenda for Sustainable Development



1. Disability and the 2030 Agenda for Sustainable Development

Reaffirming the universality, indivisibility, interdependence and interrelatedness of all human rights and fundamental freedoms and the need for persons with disabilities to be guaranteed their full enjoyment without discrimination... Emphasizing the importance of mainstreaming disability issues as an integral part of relevant strategies of sustainable development... Recognizing the valued existing and potential contributions made by persons with disabilities to the overall well-being and diversity of their communities.

Preamble to the
Convention on the Rights
of Persons with Disabilities.

The SDGs and targets are integrated and indivisible, global in nature and universally applicable.

The 2030 Agenda for
Sustainable Development.

The 2030 Agenda for Sustainable Development was adopted by the UN General Assembly on 25 September 2015. Consisting of the 17 Sustainable Development Goals (SDGs) and 169 targets, the Agenda covers a broad array of issues including poverty, hunger, education, and health, as well as climate change, clean energy, and responsible consumption and

production. It entails comprehensive aspirations and transformative commitments towards making societies more inclusive and ensuring that everyone will be able to realize their human potential in dignity and equality. Persons with disabilities are mentioned three times in the declaration and are explicitly referred to in seven of the SDG targets. In addition, numerous references to population categories such as “those in vulnerable situations” are understood as encompassing persons with disabilities.

In order to guide decision making and for the purpose of reviewing what progress is being made towards realizing the SDGs and targets, 232 global indicators have been developed. 14 of these make direct reference to persons with disabilities or are attached to targets that do. For example, indicator 8.5.2 says that progress towards meeting target 8.5, relating to decent work for everyone, should be reviewed taking into account “[u]nemployment rate, by sex, age and persons with disabilities”. In addition, Member States are expected to develop regional, national, and sub-national indicators, in large part to be based on the global ones.⁶

These specific references imply considerable progress as compared to the eight Millennium Development Goals, which were adopted in 2000 and preceded the SDGs, since those did

not include any specific references to persons with disabilities. The fact that persons with disabilities are directly mentioned in the 2030 Agenda and in the global indicators makes it

likely that they will be included more explicitly in the implementation plans developed by states and other actors, and that any failure to include them will be detected.

Table 3. SDGs with targets and/or indicators that directly refer to persons with disabilities

Goal	Target	Indicator
1 End poverty in all its forms everywhere	1.3 Implement nationally appropriate social protection systems and measures for all, including floors, and by 2030 achieve substantial coverage of the poor and the vulnerable	1.3.1 Proportion of population covered by social protection floors/systems, by sex, distinguishing children, unemployed persons, older persons, persons with disabilities, pregnant women, newborns, work injury victims and the poor and the vulnerable
4 Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all	4.5 By 2030, eliminate gender disparities in education and ensure equal access to all levels of education and vocational training for the vulnerable, including persons with disabilities, indigenous peoples and children in vulnerable situations	4.5.1 Parity indices (female/male, rural/urban, bottom/top wealth quintile and others such as disability status, indigenous peoples and conflict affected, as data become available) for all education indicators on this list that can be disaggregated
	4.a Build and upgrade education facilities that are child, disability and gender sensitive and provide safe, non-violent, inclusive and effective learning environments for all	4.a.1 Proportion of schools with access to: (a) electricity; (b) the Internet for pedagogical purposes; (c) computers for pedagogical purposes; (d) adapted infrastructure and materials for students with disabilities; (e) basic drinking water; (f) single sex basic sanitation facilities; and (g) basic handwashing facilities (as per the WASH indicator definitions)
8 Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all	8.5 By 2030, achieve full and productive employment and decent work for all women and men, including for young people and persons with disabilities, and equal pay for work of equal value	8.5.1 Average hourly earnings of female and male employees, by occupation, age and persons with disabilities 8.5.2 Unemployment rate, by sex, age and persons with disabilities
10 Reduce inequality within and among countries	10.2 By 2030, empower and promote the social, economic and political inclusion of all, irrespective of age, sex, disability, race, ethnicity, origin, religion or economic or other status	10.2.1 Proportion of people living below 50 per cent of median income, by sex, age and persons with disabilities

Goal	Target	Indicator
11 Make cities and human settlements inclusive, safe, resilient and sustainable	11.2 By 2030, provide access to safe, affordable, accessible and sustainable transport systems for all, improving road safety, notably by expanding public transport, with special attention to the needs of those in vulnerable situations, women, children, persons with disabilities and older persons	11.2.1 Proportion of population that has convenient access to public transport, by sex, age and persons with disabilities
	11.7 By 2030, provide universal access to safe, inclusive and accessible, green and public spaces, in particular for women and children, older persons and persons with disabilities	11.7.1 Average share of the built-up area of cities that is open space for public use for all, by sex, age and persons with disabilities 11.7.2 Proportion of persons victim of physical or sexual harassment, by sex, age, disability status and place of occurrence, in the previous 12 months
16 Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels	16.7 Ensure responsive, inclusive, participatory and representative decision-making at all levels	16.7.1 Proportions of positions (by sex, age, persons with disabilities and population groups) in public institutions (national and local legislatures, public service, and judiciary) compared to national distributions 16.7.2 Proportion of population who believe decision making is inclusive and responsive, by sex, age, disability and population group
17 Strengthen the means of implementation and revitalize the Global Partnership for Sustainable Development	17.18 By 2020, enhance capacity-building support to developing countries, including for least developed countries and small island developing States, to increase significantly the availability of high-quality, timely and reliable data disaggregated by income, gender, age, race, ethnicity, migratory status, disability, geographic location and other characteristics relevant in national contexts	17.18.1 Proportion of sustainable development indicators produced at the national level with full disaggregation when relevant to the target, in accordance with the Fundamental Principles of Official Statistics 17.18.2 Number of countries that have national statistical legislation that complies with the Fundamental Principles of Official Statistics 17.18.3 Number of countries with a national statistical plan that is fully funded and under implementation, by source of funding

At the same time, however, it is critical to remember that *all* SDGs and targets, being “global in nature and universally applicable”, apply to persons with disabilities just as much as to anyone else: the fact that persons with disabilities are directly mentioned in seven targets does *not* mean that the other 162 do not concern them. This understanding is consonant with the overall intent of the 2030 Agenda itself. As noted above, the preamble of the SDGs confirms that the goals are universal, i.e. applying to everyone without exception. It also emanates from target 17.18, which calls for increasing the quantity and accuracy of data that is disaggregated by disability among other parameters.

Furthermore, the interpretation of the 2030 Agenda as applicable in its entirety to persons with disabilities is supported by the CRPD. The Convention not only reaffirms the universal nature of human rights and the inadmissibility of discrimination, but also directly calls for disability rights to be mainstreamed in development strategies.

Though the SDGs and targets are aspirational in character, considerable overlaps in content between them and the CRPD give the 2030 Agenda a certain legally binding character. For instance, SDGs 3 and 4, relating to health and education, correspond to CRPD Articles 24 and 25. This means that parties to the CRPD are in fact required by international law to pursue many of the SDGs and targets in a way which does not exclude persons with disabilities. Thus, implementing Agenda 2030 in a disability inclusive fashion will effectively serve to honour the provisions of the CRPD, and the indicators developed to measure progress with regard to

the SDGs and targets can be used to monitor compliance with the CRPD.

The SDGs and targets are highly interdependent. Similarly, the stipulations of the CRPD are in large part contingent upon each other. That is recognized in the respective preambles of the 2030 Agenda and the CRPD: the former notes that all SDGs and targets are “integrated and indivisible”, and the latter reaffirms the “interdependence and interrelatedness of all human rights and fundamental freedoms”. Thus, no SDG or target, and no CRPD provision, can be realized in isolation. This is true not only on a general plane, but also with regard to the inclusion of persons with disabilities. In other words, ensuring the inclusion of persons with disabilities in the implementation of one SDG or target, or in one CRPD provision, requires the same being done in the implementation of others.

Figure 1 illustrates this by concentrating on four essential components of development incorporated in the 2030 Agenda as well as in the CRPD (and, it should be noted, in other human rights treaties). Decent work, the topic of SDG target 8.5 and of CRPD Article 27, will not be possible to achieve for persons with disabilities unless they are granted access to quality education, the subject of SDG 4 and of CRPD Article 24. Meanwhile, employment and education are conditional upon a high standard of health, the theme of SDG 3 and CRPD Article 25, since poor health status often poses an obstacle to partaking in the workforce or to the pursuit of education. At the same time, these three objectives are all contingent upon the existence of accessible means of transport, an objective specifically included in SDG target

11.2 and CRPD Article 9, since workplaces, schools and health centres will otherwise be hard to reach for persons with disabilities.⁷ Of course, each of the four areas illuminated in the figure can in turn be connected to other ones in the 2030 Agenda and in the CRPD.

The 2030 Agenda, which is based on the notion of “leaving no one behind”, will fall short if persons with disabilities are excluded. Meanwhile, ensuring their inclusion will make it easier to realize the whole agenda for everyone. For instance, the fact that persons with disabilities frequently do not have access to adequate health care⁸ does not merely imply that their basic social and economic human rights are left unfulfilled: it also entails an avoidable loss for their societies, since improved health status would render it possible for more persons with disabilities to study, work and contribute to social cohesion, growth and prosperity. Notably, this acknowledgement of “the valued existing and potential contributions made by persons with disabilities to the overall well-being and diversity of their communities”⁹ is a tenet of the CRPD.

Monitoring progress towards meeting the commitments of Agenda 2030 and the CRPD is an ongoing challenge for statistical offices around the world. The global framework of indicators has only recently been adopted,¹⁰ and the metadata for a number of them have yet to be developed. This includes some 14 indicators

that have been identified as a priority for exploring the situation of persons with disabilities, as mentioned above. Despite remarkable progress, the need to develop more comprehensive disability data in Arab countries is reflected by the gaps in the most recent statistics, collected by the ESCWA Statistical Division.¹¹ The remainder of this chapter provides a brief snapshot of those statistics, as well as some additional data, as currently available.

The statistics collected by ESCWA indicate that persons with disabilities, defined in line with the recommendations of the Washington Group (see above), make up between 0.2 and 5.1 per cent of the total populations in those Arab countries for which data is available.

The sharp differences across countries in terms of overall prevalence, the comparatively low overall prevalence rates in some countries as compared to in the rest of the world,¹² as well as the fact that in most countries the disability rate is somewhat lower among women than among men, warrant explanation. This is not completely available at this point and requires deeper research.¹³ However, in all Arab countries, as shown in figure 3, the disability prevalence rate is considerably higher among the elderly than among the population at large. Thus, the fact that overall disability prevalence differs within the region may in part be due to the fact that some countries have older populations.

Figure 1. Interlinkages of CRPD and 2030 Agenda components

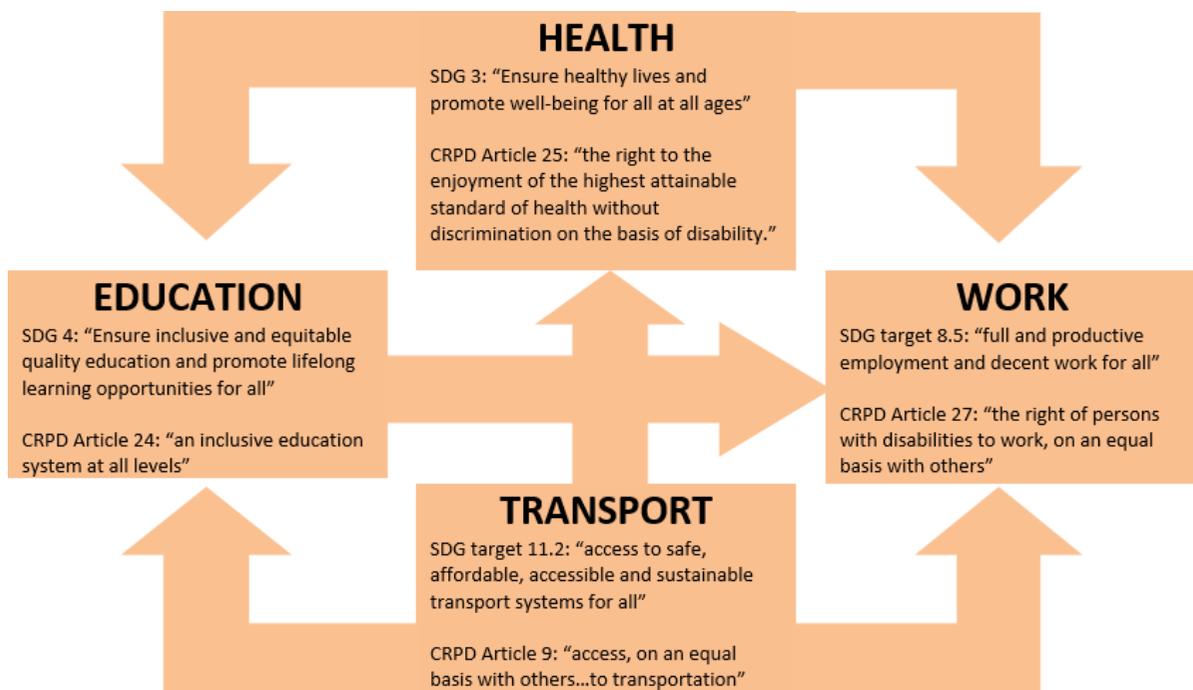
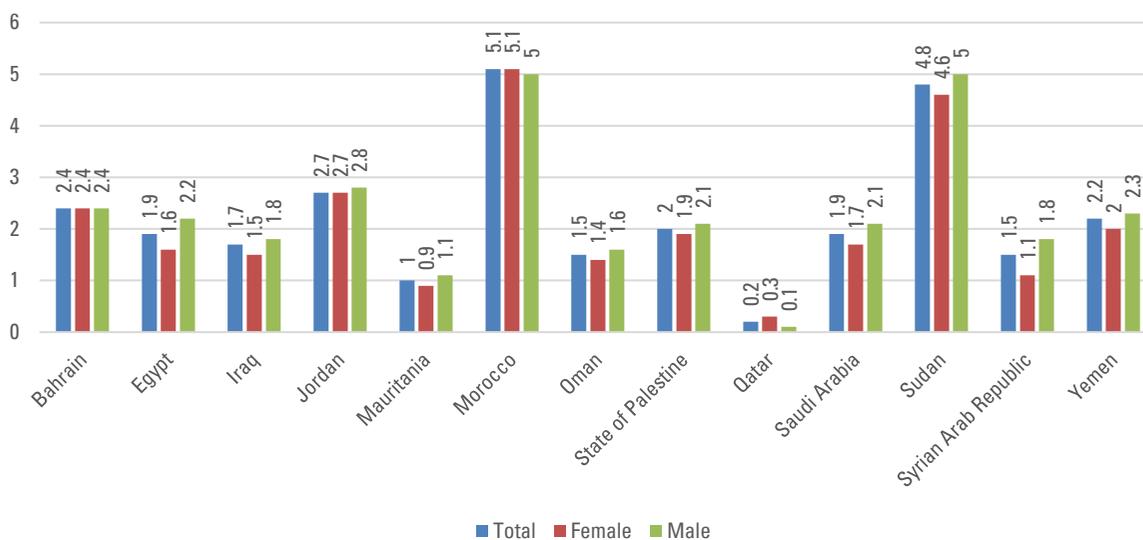
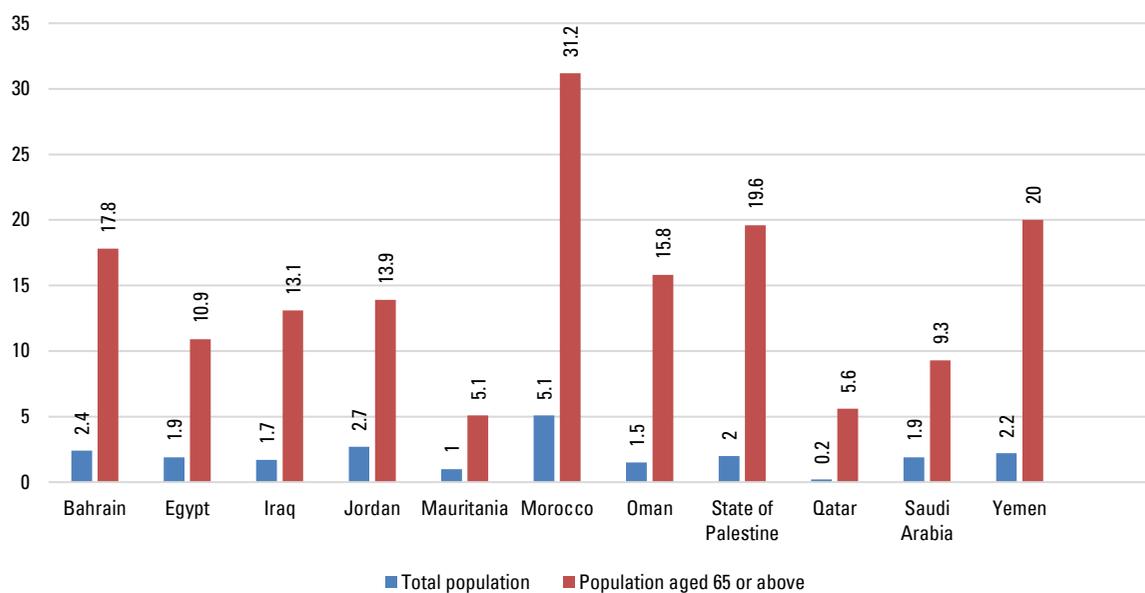


Figure 2. Total disability prevalence rates by gender (percentage), selected countries, different years



Source: calculated from ESCWA, 2017d, based on data provided by NSOs from the: Bahrain, Census 2010; Egypt, Labour Force Survey, 2016; Iraq, I-PMM 2013; Jordan, Census 2015; Mauritania, Census 2013; Morocco, Census 2014; Oman, Census 2010; State of Palestine, Census 2007; Qatar, Census 2010; Saudi Arabia, DHS 2016; Sudan, Census 2008; Syrian Arab Republic, Budget Survey 2007; and Yemen, Household Budget Survey 2014.

Figure 3. Total disability prevalence rates and rates for people aged 65+, 2007-2016 (percentage)



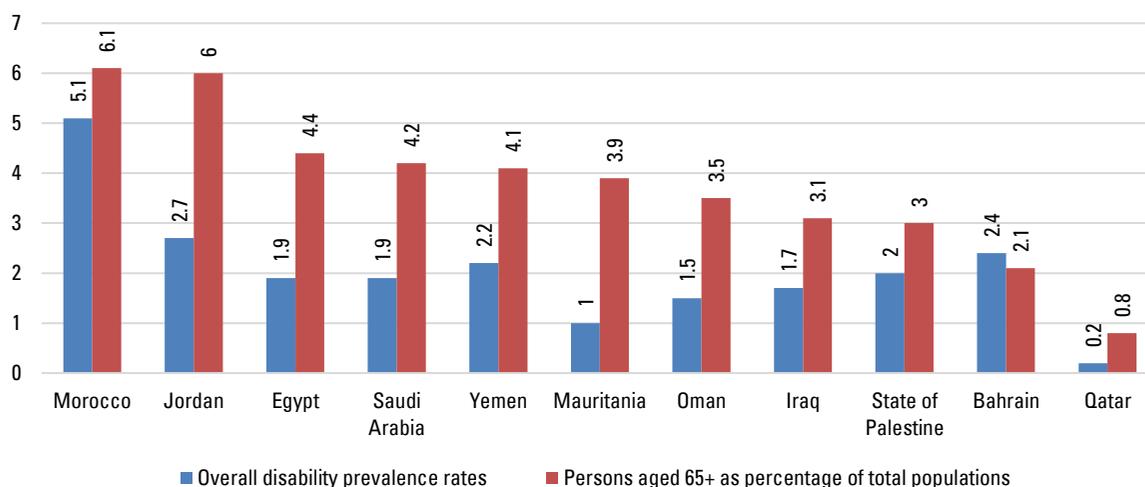
Source: calculated from ESCWA, 2017d, based on data provided by NSOs from the: Bahrain, Census 2010; Egypt, Labour Force Survey, 2016; Iraq, I-PMM 2013; Jordan, Census 2015; Mauritania, Census 2013; Morocco, Census 2014; Oman, Census 2010; State of Palestine, Census 2007; Qatar, Census 2010; Saudi Arabia, DHS 2016; and Yemen, Household Budget Survey 2014.

As shown by figure, persons aged above 65 years generally constitute a larger proportion of the total population in countries with relatively high disability prevalence rates. For example, in Morocco, the country with the highest disability prevalence rate (5.1 per cent), persons aged 65 or older make up 6.1 per cent of the total population, whereas in Qatar, the country with the lowest disability prevalence rate (0.2 per cent), persons aged 65 or older constitute merely 0.8 per cent of the total population.

The low prevalence rates could also be a consequence of the social stigma still attached

to disability, since that may result in underreporting. This might also in part lie behind the comparatively low female rates, since there are indications that the stigma is stronger with regard to women and girls. Data collection methods which imply interviewing only the head of the household, instead of each household individual separately, may result in disability not being reported. In addition, persons with disabilities living in institutions – including disability institutions, care institutions for elderly people, as well as prisoners - are only counted in censuses and surveys if households report them as family members living outside of the house.¹⁴

Figure 4. Total disability prevalence rates and persons aged 65+ as percentage of total population, 2007-2016



Source: calculated from ESCWA, 2017d (see figure 3).

Goal 1: no poverty

A major data gap relates to poverty, one of the key indicators of the new development agenda. Little data directly related to poverty among persons with disabilities as compared to persons without disabilities is yet available. One of few countries for which such data has been produced is Mauritania: according to its 2014 Poverty Profile, the disability prevalence rate among the poorest quintile of the population was almost four times higher than among the richest quintile. Meanwhile, households that included at least one person with a disability were more than twice as likely to be poor than those who did not.¹⁵

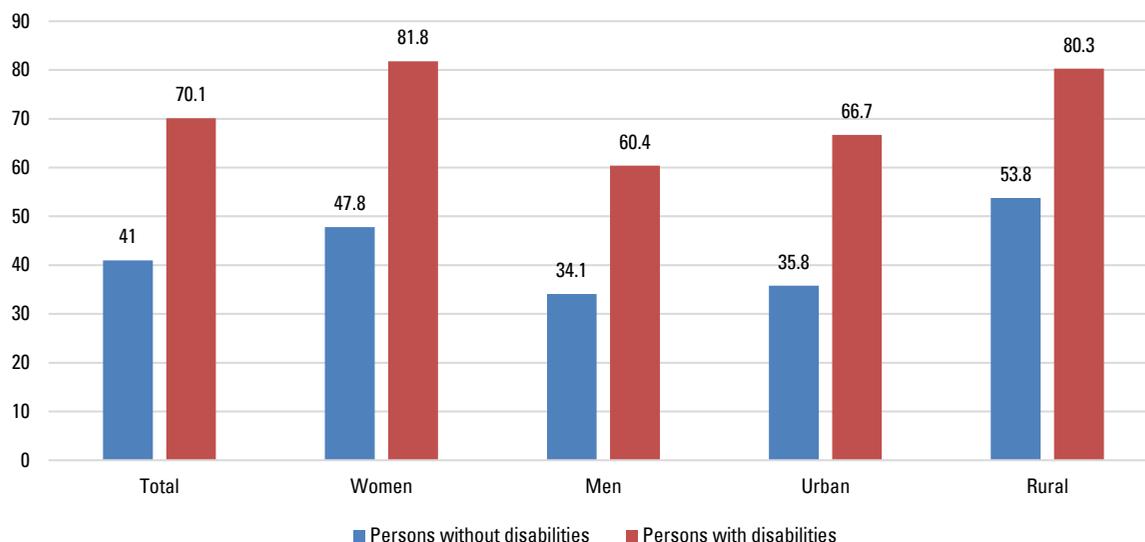
Surveys undertaken by Handicap International in areas of Morocco, Algeria and Tunisia seem to confirm that persons with disabilities' income is very low: in Tunisia, 59.3 per cent reported not having any individual income, and 16.7

per cent stated that their individual income was lower than 150 dinars (approximately \$76) per month.¹⁶

Goal 4: quality education

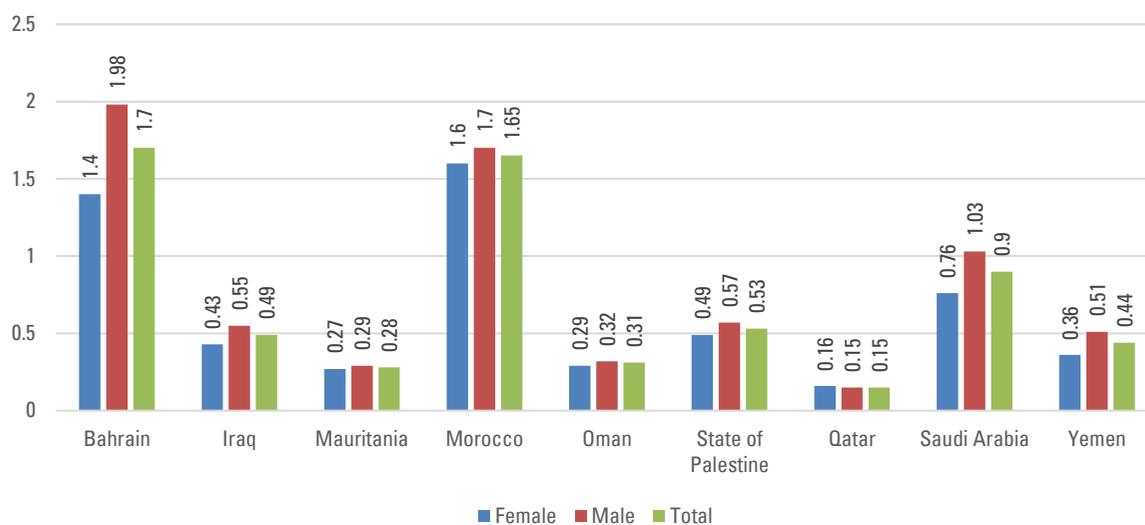
High poverty rates among persons with disabilities are partly due to their limited access to education. In the Arab region, the educational attainment of persons with disabilities is considerably lower than that of persons without disabilities, and it is particularly low among women with disabilities and persons with disabilities in rural areas. Figure 5 shows the proportion of persons with and without disabilities in Iraq with no educational attainment, disaggregated by sex and residence. While 41 per cent of Iraqis without disabilities lack education, 70.1 per cent of those with disabilities do. Furthermore, 81.8 per cent of women with disabilities have no educational attainment.

Figure 5. Persons aged 10+ with and without disabilities with no educational attainment, Iraq, 2013 (percentage)



Source: calculated from ESCWA, 2017d, based on data from the I-PMM 2013.

Figure 6. Disability prevalence rate among children aged 0-4, 2007-2016 (percentage)



Source: calculated from ESCWA, 2017d, based on data provided by NSOs from the: Bahrain, Census 2010; Iraq, I-PMM 2013; Mauritania, Census 2013; Morocco, Census 2014; Oman, Census 2010; State of Palestine, Census 2007; Qatar, Census 2010; Saudi Arabia, DHS 2016; and Yemen, Household Budget Survey 2014.

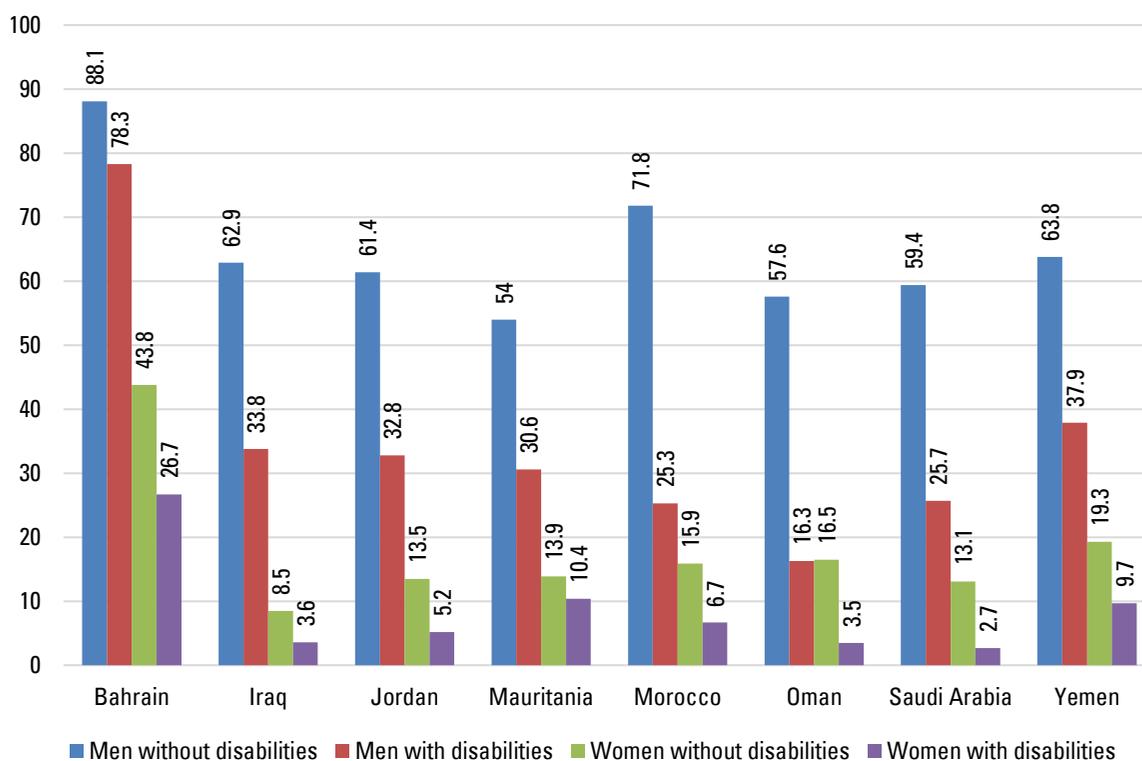
Target 4.2 refers to early childhood development, and specifically indicator 4.2.1 aims to identify the “proportion of children under five years of age who are developmentally on track in health, learning and psychosocial well-being”, disaggregated by sex. This is an important value to be followed in the future, as it relates to early detection and intervention aiming to identify and prevent disability among small children. At present data on this indicator is not available. Figure 6 shows the disability

prevalence among children up and including the age of four years.

Goal 8: decent work

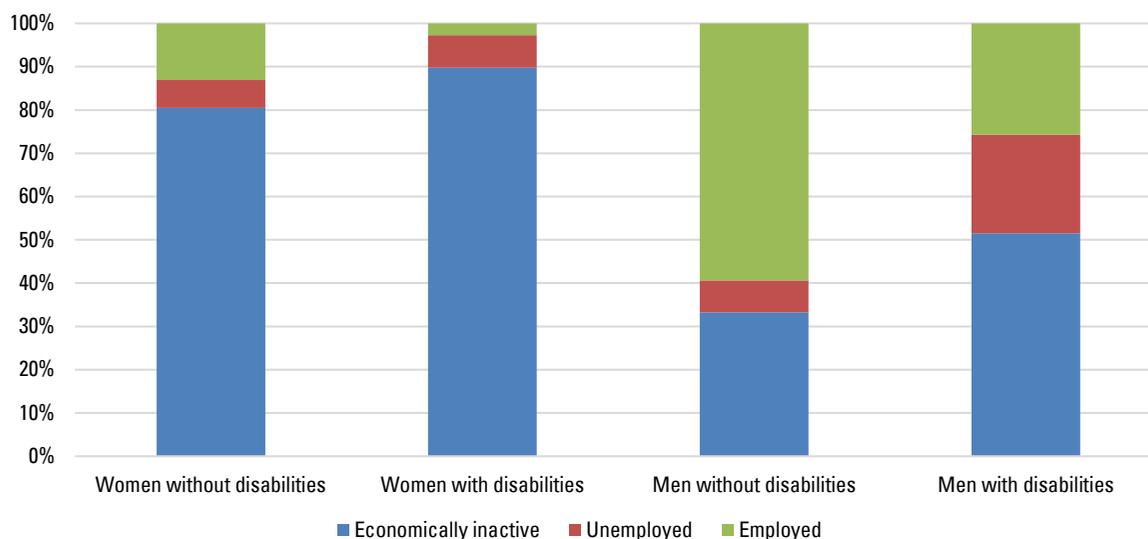
The employment rate is considerably lower among persons with disabilities than among those without (see figure 7). The data confirm comparatively low employment rates in Arab countries, especially among women, and indicate that women with disabilities are a particularly excluded group.

Figure 7. Employment rate among persons with and without disabilities aged 15-64 (percentage)



Source: calculated from ESCWA, 2017d, based on data provided by NSOs from the: Bahrain, Census 2010; Iraq, I-PMM 2013; Jordan, Census 2015; Mauritania, Census 2013; Morocco, Census 2014; Oman, Census 2010; Saudi Arabia, DHS 2016; and Yemen, Household Budget Survey 2014.

Figure 8. Economic inactivity, unemployment and employment (percentage) among men and women with and without disabilities aged 15-64, Saudi Arabia, 2016



Source: calculated from ESCWA, 2017d, based on data from the Saudi Arabia DHS 2016.

The low employment rate among persons with disabilities is due to their disproportionately high rates of economic inactivity as well as of unemployment. This is illustrated in figure 8, which focuses on the example of Saudi Arabia. While economic inactivity there is as high as 80 per cent among women without disabilities, it is almost ten percentage points higher among women with disabilities. Among men with disabilities, economic inactivity is almost 20 percentage points higher than among men without disabilities, reaching 51.5 per cent. Unemployment, notably, is more than three times higher among men with disabilities than among men without disabilities. Relatively generous survivors' benefits in the social insurance schemes may support the high rates of inactivity among persons with disabilities. No data is available on average hourly earnings as requested by SDG indicator 8.5.1.

Goal 11: sustainable cities and communities

Accessing the built environment (homes, buildings and public spaces) presents a common challenge to persons with disabilities. SDG target 11.7 calls for open access to public spaces, though few countries have data available. In the State of Palestine, 85.3 per cent of people with mobility disabilities have reported some or a lot of difficulty getting around outdoors in their local area.¹⁷ With regard to accessible transport, the subject of SDG indicator 11.2.1, 76.4 per cent of Palestinians with disabilities "do not use public transportation due to absence of necessary adaptation in the infrastructure".¹⁸ A survey carried out by the Moroccan Ministry of Family, Solidarity, Equality and Social Development indicated that 37.7 per cent of persons with disabilities in the country were unable to access

public transport, and that 36.6 per cent could access it only with difficulty.¹⁹

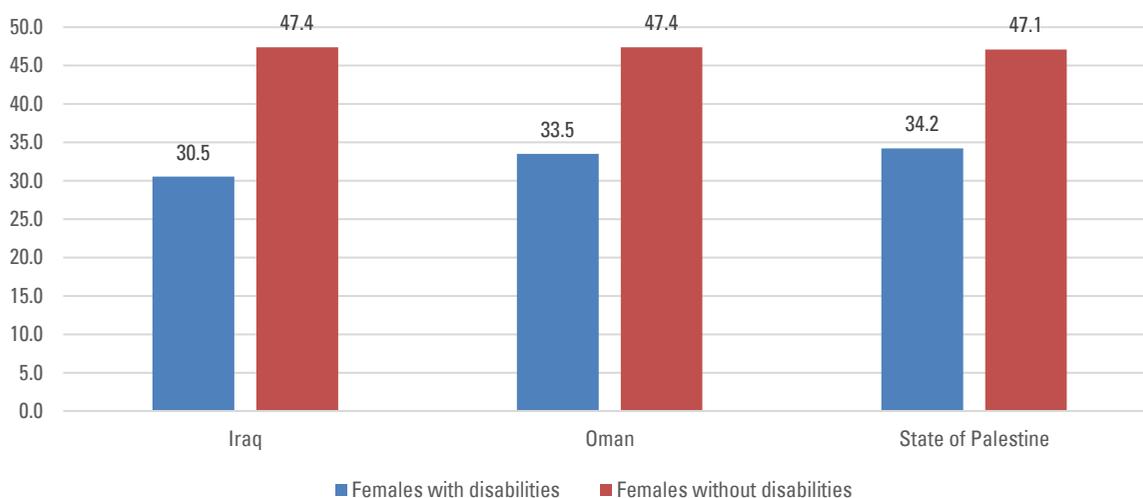
Goal 5: gender equality

Increasing the visibility of women and girls and their position in development in general is one of the objectives of the Agenda 2030 in its entirety. The preceding discussion of selected SDG indicators clearly reflects the weaker position of women in general and of women with disabilities in particular, and thus confirms previous findings.²⁰ Official statistics show lower overall prevalence rates for women and girls, but they are evidently more disadvantaged in education and employment. The double discrimination often faced by females with disabilities not only limits girls' development perspectives, but may also deprive elderly, often widowed or unmarried, women of necessary support.²¹

Goal 17: partnership for the goals

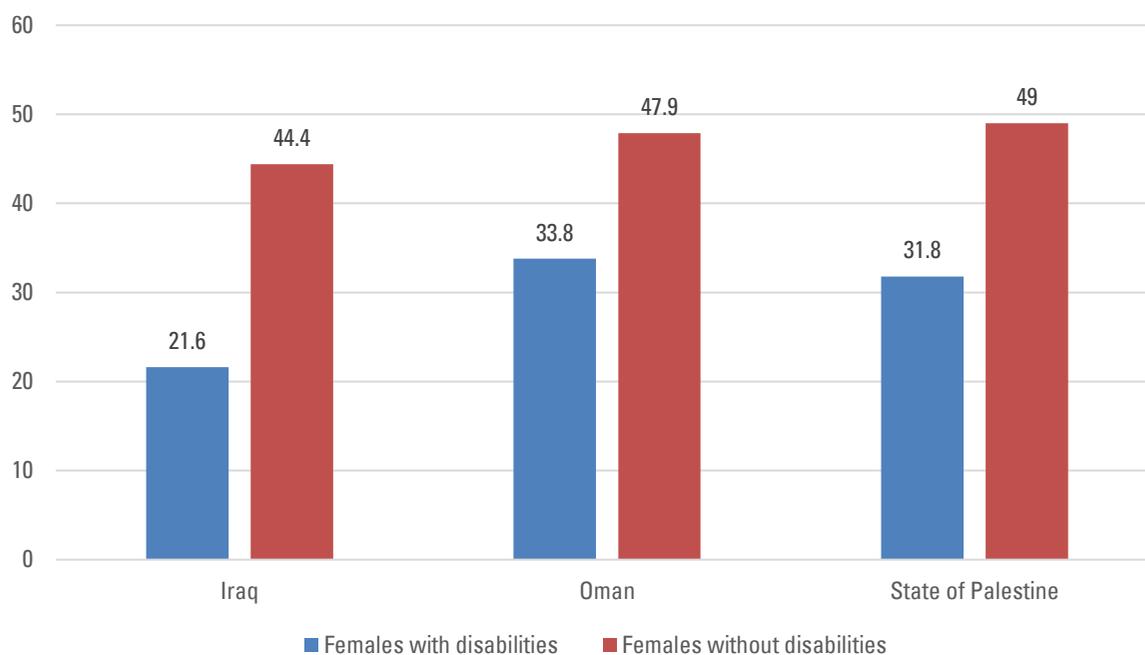
Goal 17 details the support and partnership that is required for achieving the 2030 Agenda and the SDGs in areas such as finance, technology, capacity building and data collection, which are highly relevant to persons with disabilities. In particular, technological development can further their autonomy and social inclusion. Assistive technologies such as screen readers for persons with visual impairments and caption services for those with hearing impairments can accommodate workplaces to the needs of persons with disabilities. Other technologies, such as specific web applications, can assist persons with mobility impairment to search for accessible restaurants, cinemas and transport in their cities. Specific research related to technology solutions for persons with disabilities is still in its infancy, although progress is being made in the region, as exemplified later in this report.

Figure 9. Primary education attainment (percentage) in urban areas among females aged 10+ with and without disabilities, 2007-2013



Source: calculated from ESCWA, 2017d, based on data from the: Iraq, I-PM 2013; Oman, Census 2010; and State of Palestine, Census 2007.

Figure 10. Primary education attainment (percentage) in rural areas among females aged 10+ with and without disabilities, 2007-2013



Source: see figure 9.

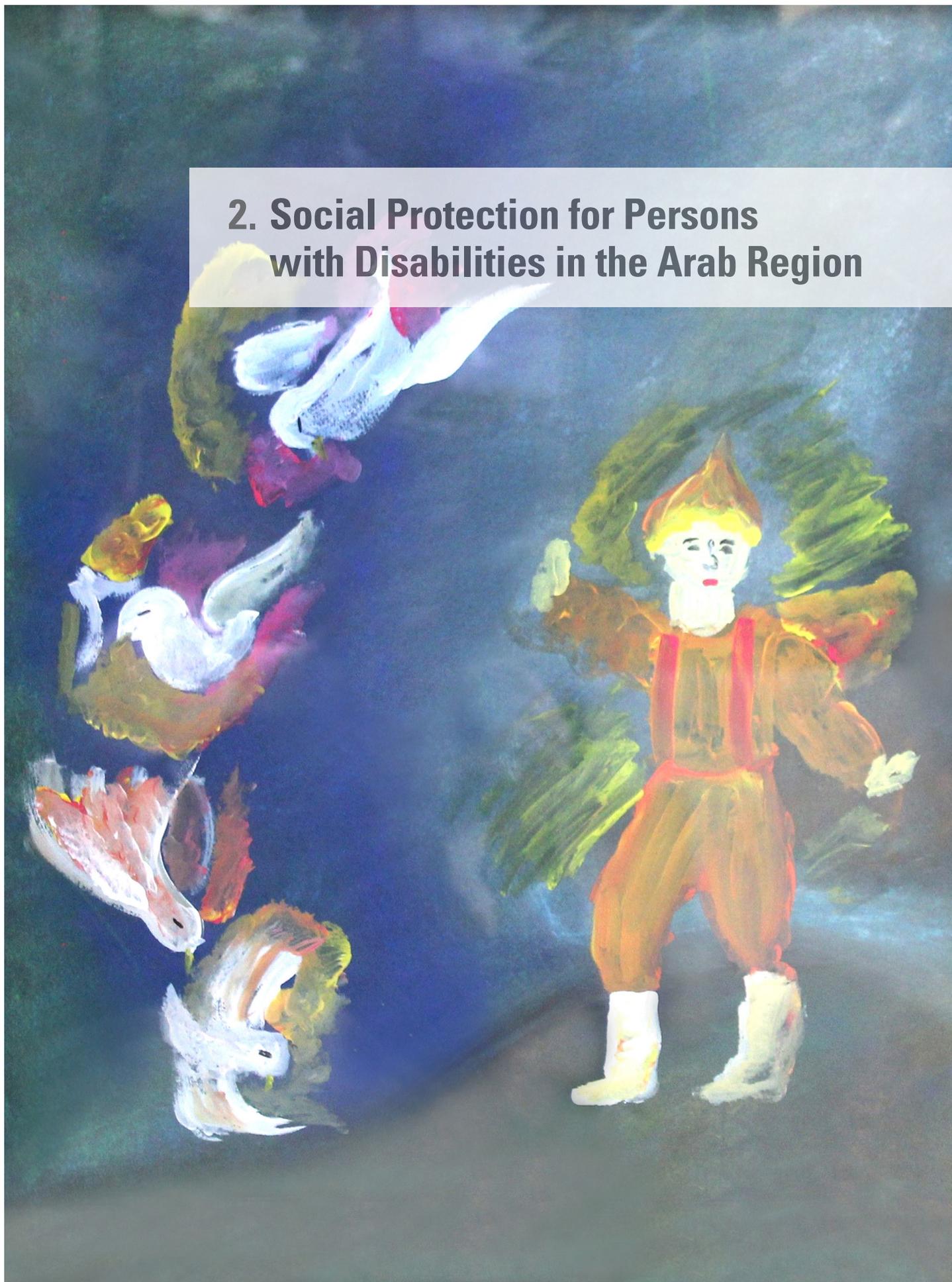
Several indicators of Goal 17 relate directly to the situation of and research on social protection for persons with disabilities in the Arab world. Target 17.18 entails accurate data collection, particularly in developing States, disaggregated by gender, migratory status, disability and other relevant factors. Such disaggregation will allow for a better understanding of, for example, the multiple disadvantages often faced by women and children with disabilities in rural areas. One example of such multiple disadvantage is presented in figure 9 and 10, which shows that rural girls with disabilities are disadvantaged in primary education not only in comparison to girls without disabilities, but also in comparison to their peers in urban areas.

The need for timely and reliable data collection becomes more apparent throughout the report, specifically related to prevalence rates, labour force status, and coverage of social protection schemes in the Arab world. For example, statistical information about target 1.3 and indicator 1.3.1, relating to the “proportion of population covered by social protection floors/systems”, disaggregated for disability status, did not become available through the recent ESCWA data collection. In order to progress towards the social inclusion of persons with disabilities, and to break the vicious circle of exclusion and poverty, social protection has a key role to play. Being part both of the 2030 Agenda and of the CRPD, social protection needs to be an integrated component of the wider development effort.

This report thus approaches the question from the policy side, laying out the social protection systems, and refers information about coverage as available. It also lays out policies to ensure access of persons with disabilities to health care as a component of the social

protection floor, which also relates to SDG goal 3, target 3.8, aiming at universal health coverage. It will show that Arab countries have made substantive progress towards this end, but that much work nevertheless remains to be done.

2. Social Protection for Persons with Disabilities in the Arab Region



2. Social Protection for Persons with Disabilities in the Arab Region

A. Overview

The inclusion challenges that many Arab countries face point to the importance of social protection. SDG targets 1.3 and 10.4 call on governments and other stakeholders to “[i]mplement nationally appropriate social protection systems and measures for all, including floors, and by 2030 achieve substantial coverage of the poor and the vulnerable”, and to “[a]dopt policies, especially fiscal, wage and social protection policies, and progressively achieve greater equality”.

The fact that social protection systems and measures, are to be implemented *for all* means that persons with disabilities are inherently entitled to be included in the undertaking. This is further underlined by the fact that substantial coverage is to be achieved for the poor and the vulnerable, among whom persons with disabilities tend to be overrepresented. Moreover, including persons with disabilities in the establishment and expansion of social protection systems will ensure compliance with the CRPD, whose Article 28.2 reads: “States Parties recognize the right of persons with disabilities to social protection and to the enjoyment of that right without discrimination on the basis of disability”.

ILO's Recommendation 202 of 2012 stipulates that Social Protection Floors (SPFs) should comprise, at minimum, the guarantees of access to essential health care and basic income security. Those components could thus be considered the “core” of social protection. The two main forms of social protection serving to uphold the right to income security are social insurance and social assistance. Whereas social insurance is contribution-based and limited to workers in the public and formal private sectors, social assistance is funded by general government revenue and provided on a targeted or universal basis. Health care, meanwhile, can be paid for at the point of use or provided on the basis of contributory or non-contributory health insurance. It can also be offered for free to selected groups or to everyone.

1. Social insurance²²

Generally, public sector workers are automatically enrolled in social insurance schemes. Enrolment is also in most cases mandatory for salaried employees in the private sector. However, this is often not enforced in practice, meaning that many private sector workers are employed on an informal basis and thus lack social insurance coverage. In some countries, voluntary schemes have during

recent decades, with various rates of success, been set up for groups such as the self-employed and seasonal and agricultural workers. It has been estimated that around two thirds of workers in the Arab region are not covered by social insurance. Generally speaking, the rate of informality is higher in countries with a low GDP per capita.²³

The main pillar of social insurance schemes is old-age insurance, e.g. pension benefits, which are given to insured workers once they have reached the legal retirement age.²⁴ Another crucial part is made up of disability benefits, also called disability pensions. These are given to workers covered by social insurance who incur a disability. As a rule, insured workers must, in order to access the disability pension, be declared to have a specific degree of disability. He or she must also have been enrolled in the social insurance system for a certain period and/or have made a certain number of contributions within a specific time-span. In Egypt, for instance, the worker must “have at least three consecutive months or a total of six months of contributions”. Furthermore, “[t]he disability must begin while in covered employment or within a year after employment ceases; 10 years of contributions are required if the disability began more than a year after employment ceased.”²⁵

Basic disability benefits are usually calculated through a formula incorporating the beneficiary’s length of contribution as well his or her level of earnings. There are often minimum and/or maximum thresholds: in the United Arab Emirates, for instance, the disability benefit is never lower than 10,000 dirhams (approximately \$2,700) per month,²⁶ and in Morocco’s public-sector Régime Collectif d’Allocation de Retraite

(RCAR) scheme it never exceeds 60 per cent of the beneficiary’s average wage.²⁷

In determining eligibility and calculating the benefit, many schemes make allowance for disabilities incurred as a result of service. In Yemen, for example, a work-related total disability entitles an employee enrolled in the private sector scheme to a benefit corresponding to 100 per cent of his/her highest monthly salary during the last year of employment, while a non-work-related disability entitles the employee to a salary worth just 50 per cent of the average monthly pay.²⁸

It is common that the size of the benefit is somehow contingent upon the severity of the disability. In Algeria, full-disability benefits and partial-disability benefits amount, respectively, to 80 and 60 percent of the insured person’s salary. Most social insurance schemes include some type of supplement given to those whose disability means that they need special support. The scheme for private sector workers in Mauritania, for example, offers a constant attendance allowance, corresponding to 50 percent of the pension, “if the insured requires the constant attendance of others to perform daily functions”.²⁹

Other benefits provided within the framework of social insurance schemes can include provisions for persons with disabilities within the insured person’s household. In Jordan, old-age pensioners with a person with a disability in their family may be eligible for a dependent’s supplement amounting to 12 per cent of the pension.³⁰ In Tunisia, family benefits within the social insurance scheme for private sector workers are normally paid for children up to 16-21 years of age, depending on if they are

studying, but no such age limit is in place for children with disabilities.³¹ Similar exceptions often apply to the rules concerning when a beneficiary's survivors (orphans, widows, widowers) are entitled to inherit their benefits. In Saudi Arabia, for instance, the survivor pension is paid to sons of the insured person if they are younger than 21-26 years old (depending on whether they are pursuing studies), but no age limit exists for those deemed "unable to work".³²

2. Social assistance

The limited coverage of social insurance in the Arab region implies an important role for social assistance. As mentioned, social assistance is by definition funded from general government revenue and provided freely to selected groups or to everyone rather than provided on the basis of members' contributions. It may consist of grants in the form of cash – called cash transfers (CTs) – or in-kind support. Other forms of social assistance include public works programmes, subsidies and tax exemptions. It may be provided to persons with disabilities either through *mainstream schemes*, i.e. social assistance schemes catering to persons with and without disabilities alike, or through *disability specific* schemes, i.e. social assistance schemes set up specifically for persons with disabilities.

Mainstream social assistance schemes in the Arab region have historically been made up largely of universal energy and food subsidies. Recently, however, governments have taken decisive measures to replace these with other forms of social assistance deemed more effective and efficient.³³ In particular, CT

programmes have been introduced, enlarged and/or recalibrated. In Egypt, for example, a CT programme called Takaful and Karama has been established. The State of Palestine has introduced its Palestinian National Cash Transfer Programme (PNCTP), and in Tunisia the Programme National d'Aide aux Familles Nécessiteuses (PNAFN) has been rapidly expanded since 2011. Sudan, similarly, has launched a CT scheme within the framework of its Social Initiatives Program (SIP),³⁴ and Mauritania has begun implementing a programme called Tekavoul.³⁵

Some of the CT schemes are *conditional*, meaning that beneficiaries in order to receive the transfers must fulfil certain conditions. These usually include ensuring that the household's children attend school.³⁶ For example, this is the case with regard to the Tayssir scheme in Morocco. The Takaful component of the Takaful and Karama scheme in Egypt is conditional, whereas the Karama component is not. In a number of countries where CT schemes have been implemented, including Mauritania and Sudan, policymakers intend to add conditions at a later stage.³⁷

Disability specific CT schemes, i.e. schemes exclusively targeting persons with disabilities, exist in a number of countries. For example, Algeria's La Pension Handicapée à 100% grants persons with a full disability a monthly CT of 4,000 dinars (approximately \$36).³⁸ There are also some social assistance schemes catering to those who care for persons with disabilities. In Jordan, for instance, under the Handicapped Care Cash Assistance scheme, "[a] regular payment may be made to families that consistently care for a disabled family member suffering from a chronic

mental illness”.³⁹ A similar scheme exists in Iraq.⁴⁰ Mauritania has a CT programme for families of children with multiple disabilities.⁴¹

A few social assistance initiatives channelling in-kind support specifically to persons with disabilities can also be found. In Morocco, for example, food aid is provided to persons with disabilities,⁴² and in Mauritania there exists a scheme through which persons with disabilities are given land lots for housing.⁴³

Another type of social assistance takes the form of so-called public works programmes, sometimes referred to as “cash for work” or “workfare”. The idea of these is that paid work opportunities, usually on a short-term basis, are created for the poor. In Yemen, such a scheme was implemented in 2008,⁴⁴ and Sudan plans to initiate one within the framework of its SIP.⁴⁵ Mauritania, meanwhile, runs a form of public works scheme specifically targeting persons with disabilities, for whom “income generating activities”, consisting primarily of selling telephone cards or foodstuffs, are created.⁴⁶

Most countries also have in place a number of subsidies and tax exemptions for persons with disabilities. In Algeria and Egypt, for example, persons with disabilities are entitled to use various types of public transport at a cheaper rate or for free.⁴⁷ Tax reductions or exemptions applying to the manufacturing, importation and/or purchase of equipment specially fitted for persons with disabilities, notably vehicles, are also very common in the region.⁴⁸

3. Provision of health care

Health care is provided by a range of actors, including governments, civil society, and the

for-profit private sector.⁴⁹ In some countries, certain forms of care are provided free of charge to citizens as a matter of right or charity. Otherwise, access is contingent upon ability to pay directly (so-called out of pocket spending) or upon having health insurance, which exists in different forms. So-called social health insurance (SHI) is provided on the same basis as social insurance, meaning that it is largely limited to formal sector workers and their dependants.⁵⁰ Sometimes social insurance and SHI are even provided through a single scheme, such as Algeria’s Caisse Nationale d’Assurances Sociales. There is also private health insurance which, unlike SHI, typically is not linked to employment or earnings.⁵¹

In the Arab region, persons with disabilities are often formally entitled to free health care coverage. The precise means through which this right is supposed to be realized vary. In some countries, such as Lebanon, persons with disabilities are theoretically eligible for free health care at hospitals run or contracted by the government simply by presenting their disability card.⁵² In other countries, persons with disabilities are legally entitled to be enrolled for free in SHI schemes. Notably, such provisions exist in Algeria,⁵³ Sudan⁵⁴ and Jordan,⁵⁵ and in Egypt for children with disabilities.⁵⁶ Although gaining access to free health care and to free health insurance might seem, effectively, to be the same thing, it appears that the choice of administrative mechanisms sometimes impacts upon whether the right to access health care is fulfilled in practice, as will be discussed later. SHI coverage is also sometimes extended for free to all beneficiaries of certain social assistance programmes, as is the case in the State of Palestine and again in Sudan⁵⁷ and Jordan.⁵⁸

Non-contributory health insurance may also be granted through separate schemes set up specifically for this purpose. Conceptually, such schemes are similar to social assistance schemes, since they are funded by general revenue, and since access is based on need rather than on past contributions. Morocco's Régime d'Assistance Médical (RAMED) and Tunisia's Assistance Médicale Gratuite (AMG) are two examples. Each of these two schemes is graded, such that insurance is provided entirely for free to those deemed most in need, and on the basis of a small contribution for those considered to be vulnerable but not among the poorest.⁵⁹ In Tunisia, the totally non-contributory part is called AMGI, and the one requiring a small contribution AMGII. However, persons with disabilities covered by AMGII are by law entitled to free health care on the same basis as AMGI beneficiaries.⁶⁰ As will be elaborated further below, the eligibility criteria and targeting mechanism for AMGI are the same as for the CT scheme PNAFN, meaning that coverage of one programme implies coverage of the other.

B. Legal and institutional frameworks

A majority of countries in the region have, in various ways and more or less explicitly, incorporated the rights of persons with disabilities to social protection in their constitutions.⁶¹ For instance, the preamble of the 2011 Moroccan constitution commits the State to “[t]o ban and combat all discrimination whenever it encounters it, for reason of sex, or colour, of beliefs, of culture, of social or regional origin, of language, of handicap or whatever personal circumstance that may be”. The

constitution of Iraq, adopted in 2005, stipulates that “[t]he State shall care for the handicapped and those with special needs, and shall ensure their rehabilitation in order to reintegrate them into society, and this shall be regulated by law.”⁶² The Basic Law of the State of Palestine, as amended in 2003, states that “[m]aintaining the welfare of...the disabled is a duty that shall be regulated by law. The National Authority shall guarantee these persons’ education, health and social insurance”.⁶³

Almost all countries, furthermore, have adopted laws specifically relating to the rights of persons with disabilities. Like the constitutions, these laws differ in how and to which extent they refer to social protection. The United Arab Emirates’ Federal Law No. 29 of 2006 states that it “aims to guarantee the rights of the person with special needs and to provide all the services within the bounds of his abilities and capacities. The special needs may not be a reason to hinder the person with special needs from obtaining such rights and services especially in the field of welfare and social, economic, health, educational, professional, cultural and promotional services.”⁶⁴ Algeria’s law 02-09, of May 2002, stipulates that “persons with disabilities without income receive social assistance, which takes the form of support or a financial allocation”.⁶⁵ It also contains a number of more specific provisions concerning social protection. The State of Palestine has included attention to the needs of persons with disabilities into its ICT strategy.⁶⁶

In most countries, the ministry of social affairs plays a central role and is charged with coordinating the provision of social protection, including for persons with disabilities, within the government. Sometimes this mandate

derives directly from the legal framework relating to the rights of persons with disabilities. For instance, the State of Palestine's Law no. 4 Concerning the Right of the Disabled, adopted in 1999, specifies that the Ministry of Social Affairs is "in charge of coordination with all relevant and competent bodies to secure the welfare and rehabilitation of the disabled".⁶⁷

A growing number of countries in the region have also, in conformity with Article 33.1 of the CRPD, established specific bodies - often called councils, committees or commissions - tasked with coordinating matters related to the rights of persons with disabilities. Typically, these institutions are formally autonomous but connected to the ministry of social affairs. Sometimes the disability councils themselves function as providers of social protection. In Iraq, for example, the caretakers' salaries are distributed by the country's Commission on the Care of Persons with Disabilities and Special Needs, whose creation was mandated by Law no. 38 of 2013.⁶⁸ In Jordan, the passing of Law no. 20 of 2017 will imply that the provision of support hitherto provided by the High Council for Disability, including CTs, be taken over by the Ministry of Social Affairs, which will allow the council to focus on its core roles of policy-making, monitoring and coordination.⁶⁹

These developments in terms of legislation and institutions testify to the commitment among countries in the region to provide disability-inclusive social protection. However, the remainder of this chapter will show that much remains to be done in order to ensure that legislation is enforced, that disability is consistently defined in conformity with the CRPD, and that targeting is carried out in a way that does not overlook the needs of persons

with disabilities. It will also be shown that since social protection is interlinked with policy areas across governments, it is necessary to further enhance coordination among ministries and other actors.

C. Coverage of persons with disabilities

Arriving at precise or comparable rates of social protection coverage for persons with disabilities in different contexts is highly challenging. For one thing, definitions of social protection measures as well as of disability differ between, and frequently within, countries, as will be discussed below. Furthermore, persons with disabilities may benefit from a social protection scheme by reason of, for example, being poor or old rather than because of their disability. This could mean that the statistics in fact underestimate the number of persons with disabilities who are covered. Another factor which risks undermining the validity and reliability, and thus the comparability, of the data on social protection coverage is that it is sometimes unclear whether it refers only to direct coverage, or whether it also includes indirect coverage, such as that enjoyed by the spouse or children of a formal worker.

To the extent that data on social protection coverage for persons with disabilities is available, it usually pertains only to specific schemes. Although such statistics can give an indication about the ability of particular programmes to include persons with disabilities, it is difficult to draw conclusions about the overall social protection coverage of persons with disabilities due to the fact that in most countries there exist more than one

programme. Data on coverage of persons with disabilities is usually not available for all programmes, and some persons with disabilities may be covered by more than one.

One of few examples from the Arab region of overall (rather than scheme-specific) coverage among persons with disabilities is included in Yemen's 2013 National Health and Demographic Survey. The results, presented in figure 11, indicate that, at the time of the survey, 26.1 per cent of persons with disabilities had during the past year received medical care, 5.9 per cent "welfare", 2.6 per cent financial support, and 1.1 nutritional support. 66.5 per cent, meanwhile, had received no care or support. Furthermore, men with disabilities were apparently covered to a higher degree than women with disabilities, even if the difference was not large. Similarly, persons with disabilities in urban areas were slightly more likely to be covered by some sort of social protection than those living in rural areas, though the latter group were more often covered by social protection in the form of "welfare" and nutritional support.

Interpreting these results, however, is not easy. For one thing, it is not entirely clear if the data pertains merely to disability specific types of social protection, or whether it also includes mainstream schemes,⁷⁰ nor whether it encompasses support given to other members of the household or only that given persons with disabilities themselves. Furthermore, it is difficult to know whether the data extends to social

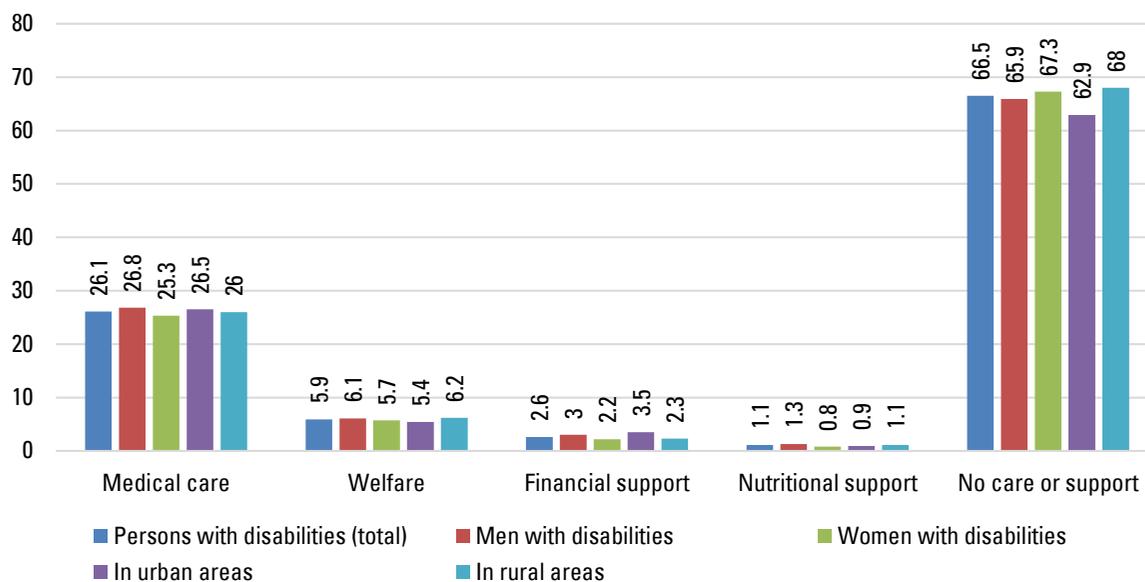
protection provided by actors other than the State, and what "welfare" for this purpose signifies. The survey does not present comparable data for persons without disabilities.

In many countries, various provisions of social protection for persons with disabilities are granted only to those who have a disability card (also referred to as disability ID). The proportion of persons with disabilities who have such cards could thus provide some indication of social protection coverage, though the specific provisions to which the cards grant access differ from country to country. Generally, having a card is necessary to access disability specific provisions.

In Lebanon, the disability card is the key to virtually all disability specific services provided by the State.⁷¹ As of 2016, 97,735 persons in the country had disability cards. Of them, over 60 per cent were men.⁷² The lack of other data on disability in Lebanon makes it difficult to extrapolate how big a proportion of persons with disabilities had cards, and whether (or to which extent) the gender discrepancy reflected the actual distribution of disability.⁷³ However, it may be noted that the number of card holders had increased by almost 25 per cent since 2013.⁷⁴

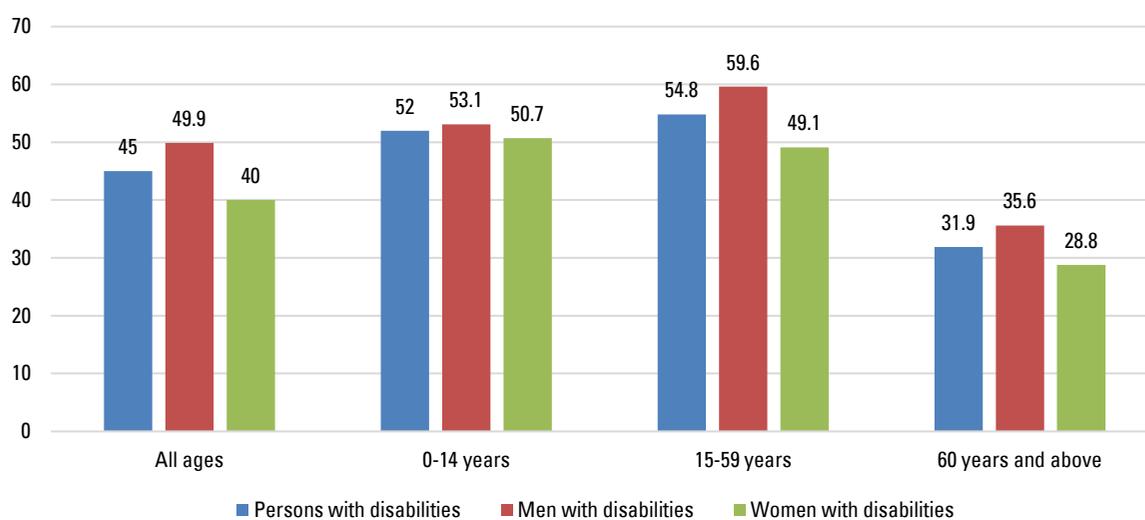
In Tunisia, the 2014 census found that only 45 per cent of persons with disabilities had a disability ID, and that there were considerable differences between men and women, and – in particular – between age groups (see figure 12).⁷⁵

Figure 11. Percentage of persons with disabilities who received any kind of support for their disability in the past 12 months, Yemen, 2013



Source: Yemen, Ministry of Public Health and Population and Central Statistical Organization, 2015.

Figure 12. Percentage of persons with disabilities having disability cards, Tunisia, 2014



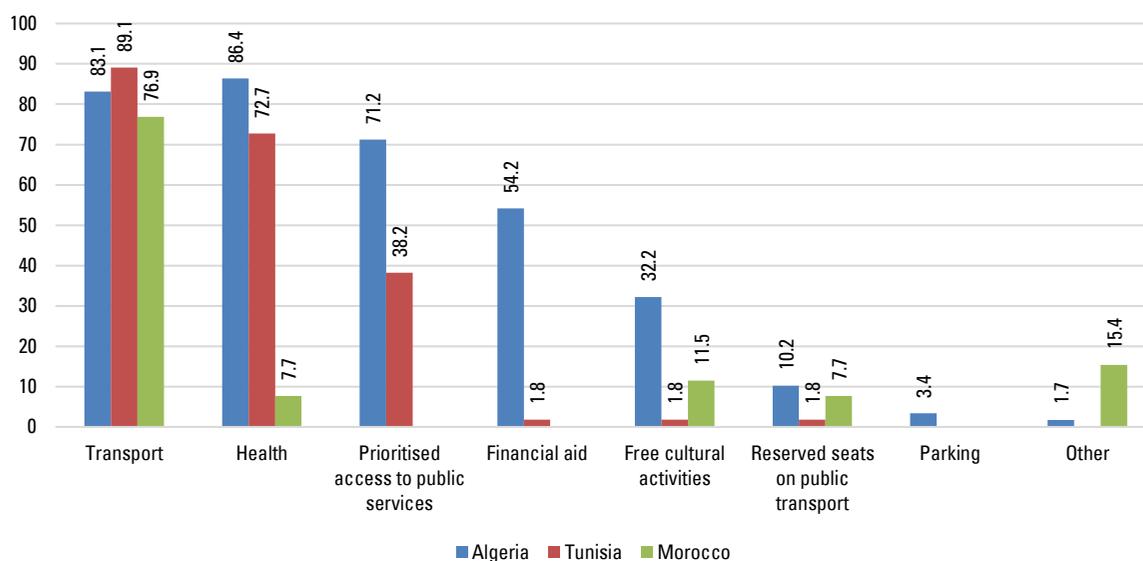
Source: Adapted from Tunisia, National Institute of Statistics, 2016b.

A study carried out by Handicap International, on the other hand, found that as many as 95 per cent of persons with disabilities in two selected areas of Tunisia used a disability card.⁷⁶ The large discrepancy between this finding and the one of the census might in part be due to the fact that respondents were for the purpose of the Handicap International study identified by the help of local disability organizations, which may have biased the selection towards disability card holders.⁷⁷ Furthermore, the two areas in which the study was carried out may not be representative of the country as a whole. Similar studies by Handicap International undertaken in areas of Algeria and Morocco found that the proportions of respondents who used a disability card were 100 and 50 per cent respectively.⁷⁸ It may be noted that in Morocco, this was the case even though the Moroccan disability card was not actually valid at the

time of the survey, since the regulatory framework pertaining to it was being revised.⁷⁹

The Handicap International studies also asked respondents having disability cards for which purpose they used these. This is interesting since it gives an indication concerning the extent to which disability cards in practice grant access to social protection. As shown by figure 13, a large majority of disability card holders were in all three countries able to use the cards to access transport. In Algeria and Tunisia, furthermore, most respondents also reported that the cards allowed them to access health care. Only in Algeria, however, did it transpire that the disability card enabled a significant number of persons with disabilities to access financial aid. This is not surprising, considering that Algeria, as mentioned above, has a disability specific CT programme called La Pension Handicapée à 100%.

Figure 13. Utilization of disability card by purpose, 2015



Sources: Pinto, Pinto and Cunha, 2016a, p. 30; 2016b, p. 30; and 2016c, p. 31.

Since data on overall coverage of social protection is rare and imperfect, the remainder of this section will discuss coverage from the perspectives of specific social protection forms and schemes, focusing in turn on social insurance, social assistance and health care.

1. Coverage of social insurance

Although there are virtually no statistics available directly pertaining to social insurance coverage among persons with disabilities in the Arab region, data on factors which correlate with social insurance coverage give an indication of the overall picture. As shown in the previous chapter, persons with disabilities, and especially women with disabilities, are on average considerably less likely than persons without disabilities to work. This alone suggests that their social insurance coverage is low, since such coverage is coupled to employment status. Moreover, when they do work, persons with disabilities are disproportionately unlikely to do so on a permanent, salaried basis. This further indicates that persons with disabilities who work are less likely than persons without disabilities to do so formally, since salaried workers are the ones who are most often covered by social insurance.⁸⁰

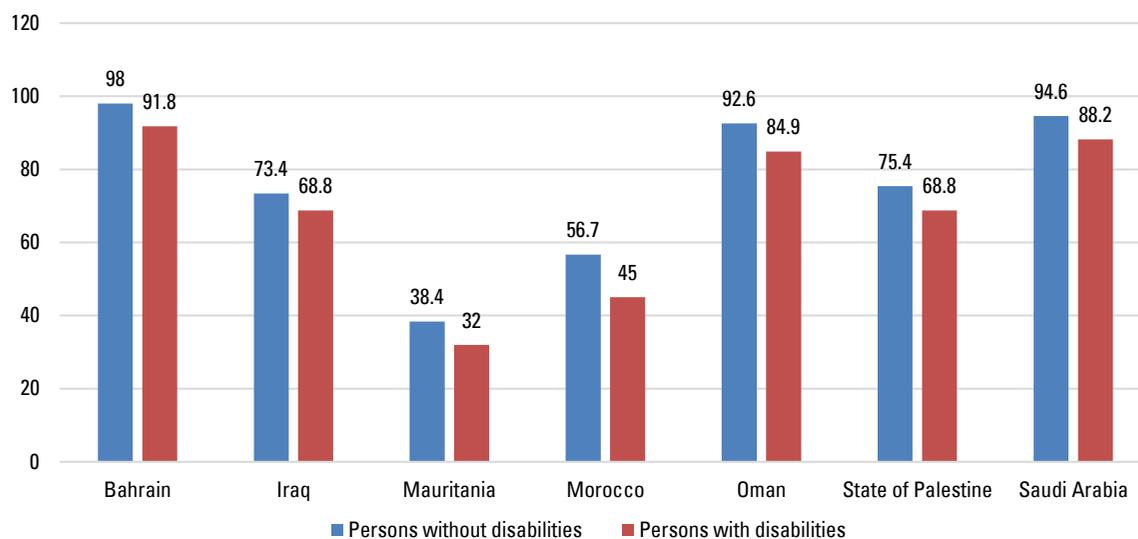
For example, in Morocco, the overall proportion of workers not covered by social insurance (i.e. the informality rate), has been estimated to 81.9 per cent. However, among salaried employees, the informality rate was 67.1

per cent.⁸¹ Meanwhile, data from the 2014 census indicate that whereas 56.7 per cent of persons without disabilities in employment were salaried employees, the equivalent rate among persons with disabilities in employment was only 45 per cent. As shown by figure 14, the same pattern can be seen in all countries in the region for which data is available.

Details of the situation in Iraq are provided in figure 15. It indicates that persons with disabilities in employment are underrepresented among salaried employees whether they are women or men, and whether they live in urban or rural areas. However, disability appears to have the biggest impact among women, since working women without disabilities are considerably more likely than working women with disabilities to be salaried employees.

In the Arab region, as elsewhere in the world, there is a pronounced correlation between low educational attainment and informal work. For example, it has been estimated that in the Syrian Arab Republic, the informality rate among workers with tertiary education as of 2004 was 24.3 per cent, whereas for workers with only primary education or below, the rate was 86.2 per cent.⁸² As shown previously, persons with disabilities' educational attainments are much lower than those of persons without disabilities, and women with disabilities are especially disfavoured. This further suggests that social insurance coverage among workers with disabilities is likely to be lower than among workers without disabilities, and that it is particularly low among women with disabilities.

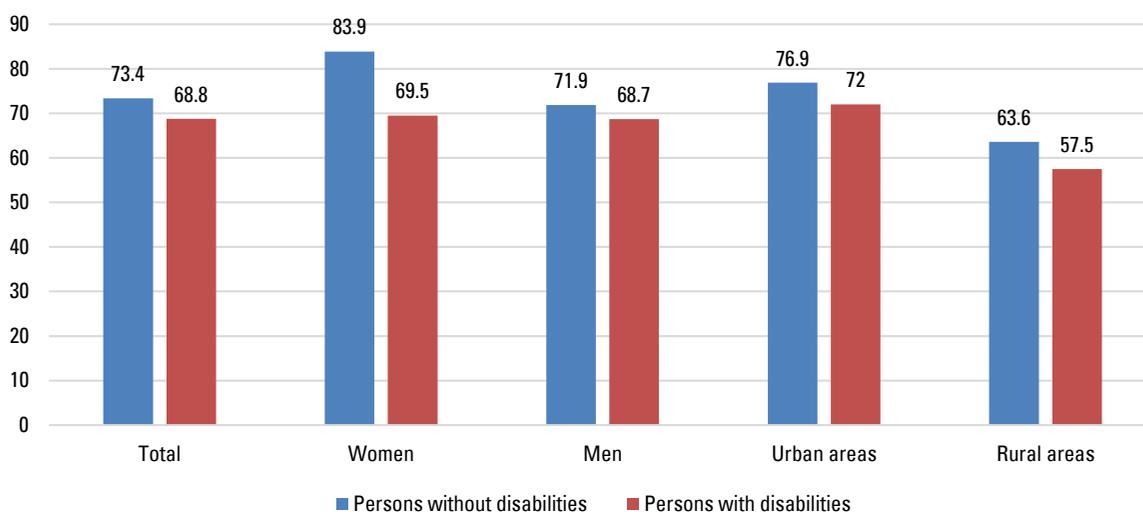
Figure 14. Salaried employment as percentage of total employment among persons with and without disabilities aged 15 and above, 2007-2016



Source: Calculated from ESCWA, 2017d, based on data from the: Bahrain, Census 2010; Iraq, I-PMM 2013; Mauritania, Census 2013; Morocco, Census 2014; Oman, Census 2010; State of Palestine, Census 2007; and Saudi Arabia, DHS 2016.

Note: In sources, employment status types other than salaried employee are employer, own-account worker and contributing family worker. For Morocco, Saudi Arabia and State of Palestine there is also unclassified worker.

Figure 15. Salaried employment as percentage of total employment among persons with and without disabilities aged 15 and above, Iraq, 2013



Source: Calculated from ESCWA, 2017d, based on data from the I-PMM 2013.

Almost all Arab countries have employment quotas according to which persons with disabilities must make up a certain percentage of employees in the public and sometimes private sector.⁸³ Generally, however, the targets set by these quotas are not met,⁸⁴ confirming the lack of access among persons with disabilities to formal employment and, thus, to social insurance. Adding to this, the poverty-disability nexus implies that persons with disabilities are also less likely than others to benefit indirectly from social insurance coverage, i.e. from having an insured person in their household.

2. Coverage of social assistance

Concerning social assistance, statistics are sometimes available on the number of persons with disabilities benefiting from particular schemes. However, as mentioned above, it is difficult to draw conclusions from such statistics about the total number of persons with disabilities covered by social assistance, since in most countries there exist more than one programme. Furthermore, the available statistics are calculated and presented in different ways, meaning, for instance, that whereas some report the number of persons with disabilities benefiting from a programme, others report the number of beneficiary households that include one or more persons with disabilities. This complicates the comparison of coverage between programmes and countries.

The non-conditional Karama component of the Takaful and Karama programme in Egypt as of 2016 had 61,949 beneficiaries, of whom 50,206 –

i.e. 81 per cent – were persons with disabilities.⁸⁵ As of 2014, 39.1 per cent of the 225,525 households benefiting from Tunisia's PNAFN included at least one person with a disability. This would imply a relatively high coverage of persons with disabilities, considering that only 8.04 per cent of all households in Tunisia included one or more persons with a disability (see also figure 17 further below).⁸⁶ According to Jordan's National Aid Fund (NAF), as of 2015 12,000 persons with disabilities benefited from its assistance (including mainstream as well as disability specific CTs).⁸⁷ This corresponds to approximately 12 per cent of all NAF beneficiaries.⁸⁸

Households benefiting from the State of Palestine's PNCTP reportedly comprise 761,532 persons, of whom 65,980 – or 8.7 per cent – have disabilities.⁸⁹ In Morocco, 8,295 children with disabilities lived in households benefiting from the country's CT programme targeting widows in 2017. They thus made up some 6.9 per cent of all children in beneficiary households.⁹⁰ In Algeria, as of 2016, a total of 238,968 persons with disabilities benefitted from La Pension Handicapée à 100%.⁹¹

In Mauritania, in 2017, the families of 110 children with multiple disabilities received CTs targeted to this group⁹² and 200 persons with disabilities have been given land lots for housing.⁹³ Meanwhile, 244 persons with disabilities in the country as of 2016 benefitted from income-generating activities.⁹⁴ However, the proportion of persons with disabilities in the region benefiting from mainstream public works schemes (i.e. those not specifically targeting

persons with disabilities), such as the one in Yemen, is likely to be low, since the nature of such work is often physically demanding, making it difficult for persons with mobility and other physical disabilities to partake.

3. Coverage of health care

Measuring coverage of health care systems is hardly easier than measuring coverage of social insurance or social assistance. This section focuses mainly on persons with disabilities' coverage of health insurance. However, it should be recognized already at this stage that coverage of health insurance (whether contributory or not) is an imperfect proxy for access to health care. In some countries, as mentioned above, health care is provided freely to everyone, which reduces the relevance of having health insurance. Furthermore, even when persons with disabilities are covered by health insurance or live in contexts where health care is in theory free for all citizens, there may in practice be considerable problems regarding access and adequacy.

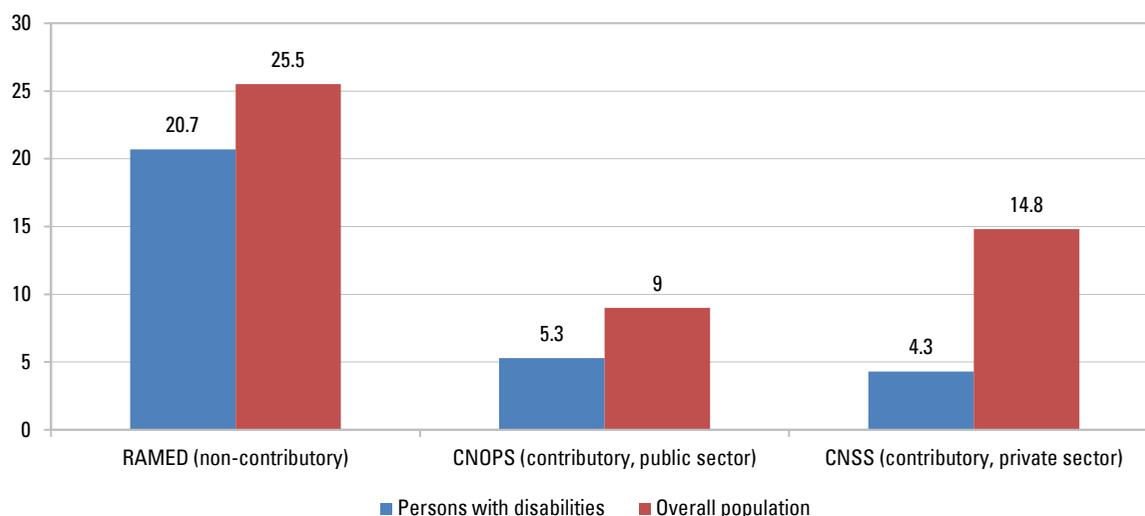
Out-of-pocket expenditure on health care is comparatively high in the region,⁹⁵ indicating that access often requires paying upfront. The fact that persons with disabilities, on the one hand, are disproportionately poor and, on the other hand, tend to face even higher costs of health care than persons without disabilities seems to imply that their ability to pay upfront for the care they need (or to purchase private insurance) is restricted.

The number of persons with disabilities benefiting from SHI should in most countries

more or less mirror their social insurance coverage number, and therefore be low. In countries such as Jordan, where SHI has been freely extended to persons with disabilities, their coverage should theoretically be 100 per cent. However, the 2015 census indicated that around a third of Jordanians with disabilities were not covered.⁹⁶ The 2013 census in Sudan found that only 60 per cent of persons with disabilities had SHI.⁹⁷ In Egypt, the provision of free SHI for children with disabilities in practice applies only to children who are registered in school, implying that coverage is far from complete.⁹⁸

In Morocco, as shown by figure 16, only 5.3 per cent of persons with disabilities surveyed about their health insurance status indicated that they were – directly or indirectly – covered by the Caisse Nationale des Organismes de Prévoyance Sociale (CNOPS), the scheme for public sector workers, and 4.3 per cent that they were covered by the Caisse Nationale de Sécurité Sociale (CNSS), the scheme for private sector workers. Among the population as a whole, the corresponding rates were 9 and 14.8 per cent, respectively. These figures suggest that persons with disabilities are underrepresented among beneficiaries of both schemes, and that coverage through private sector employment is particularly inaccessible to them. The same survey also showed that 20.7 per cent of persons with disabilities benefitted from the non-contributory health insurance scheme RAMED. This would imply that they are underrepresented among RAMED beneficiaries as well, since the total number of such beneficiaries as of 2015 amounted to some 8.5 million – around a quarter of all Moroccans.⁹⁹

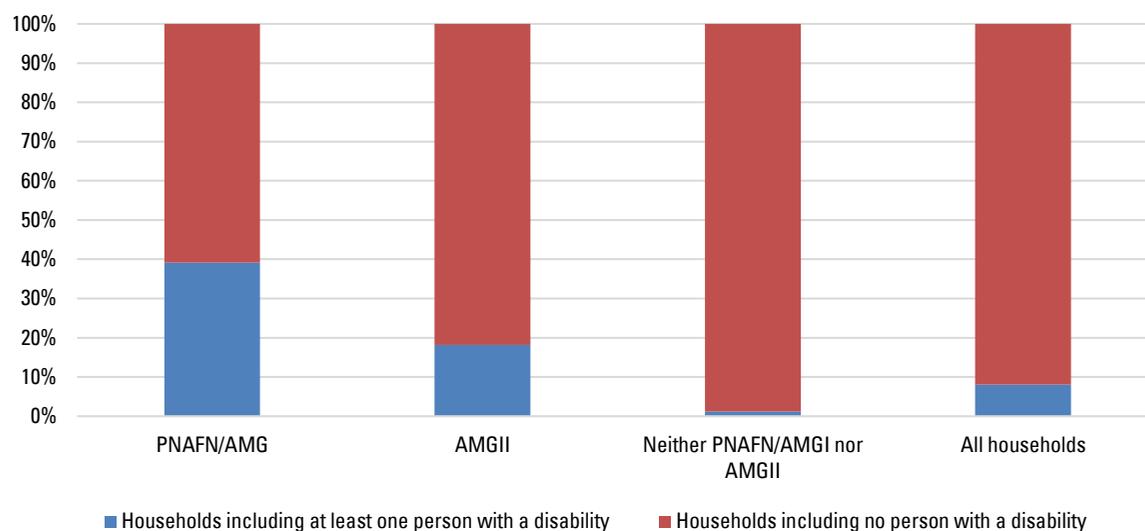
Figure 16. Health insurance coverage (percentage) among persons with disabilities and the overall population, Morocco, 2013-2015



Source: Morocco, Ministry of Family, Solidarity, Equality and Social Development, 2014, p. 59; CNOPS, n.d.; CNSS, 2014, p. 40; and World Bank, 2015a, p. 25.

Note: Data on coverage among persons with disabilities is based on self-reporting, total coverage calculated on data from CNOPS, CNSS and World Bank. Comparisons presented should therefore be viewed as indicative.

Figure 17. Households including at least one person with a disability as percentage of households covered by PNAFN/AMGI, by AMGII, by neither, and all households, Tunisia, 2014



Source: Center for Research and Social Studies (CRES) and African Development Bank, 2017, pp. 167, 179.

As mentioned above, 39.1 per cent of households benefiting from Tunisia's PNFAN as of 2014 included at least one person with a disability. This can also be used as indicator of the extent to which persons with disabilities in that country were covered by the non-contributory health insurance programme AMGII, since it and the PNFAN share the same targeting mechanism (see further below) and beneficiary pool. Among the 588,199 Tunisian households benefiting from AMGII, which provides heavily subsidized health insurance, 18.2 per cent included at least one person with a disability.¹⁰⁰ As observed above, households with one or more persons with a disability constituted only 8.04 per cent of all households in Tunisia, meaning that such households were highly overrepresented among AMGII beneficiaries, though not to the same extent as among PNFAN/AMGI beneficiaries. It may further be observed that only 1.21 per cent of households which did not benefit from PNFAN/AMGI or from AMGII included one or more persons having a disability (see figure 17).¹⁰¹

Although it is difficult to compare the coverage rates for Morocco and Tunisia, primarily since they are based on different units of analysis (individuals/households) and since the definitions of disability used may diverge, it would appear that persons with disabilities in Tunisia are to a higher extent covered by health insurance than in Morocco. In addition, as shown by figure 18 further below, the surveys conducted by Handicap International and national disability organizations in Morocco and Tunisia have indicated that persons with disabilities in the former country to a much higher extent than in the latter consider access criteria to be a major concern. The discrepancy

in terms of coverage of persons with disabilities may in large part be a result of the fact that disability, as will be elaborated upon below, is included in the targeting formula for PNFAN/AMGI.

In Lebanon, as noted above, the disability card should in theory grant persons with disabilities free health care. Reportedly, however, that is not the case in practice, as government hospitals frequently are reluctant to provide care to disability card holders. This has been attributed to the lack of funding allocated by the government to reimburse hospitals, and to the fact that "the [disability] card is not like insurance cards that are produced by insurance companies or the social security. Without being linked to any central information unit, the disability card does not provide either medical history or extents of coverage".¹⁰² Attempts to improve the collaboration between the Ministry of Social Affairs, which issues the disability cards, and the Ministry of Public Health have apparently not been fruitful,¹⁰³ though it was recently announced that the two will renew their efforts to ensure that persons with disabilities are guaranteed health care.¹⁰⁴

These findings from Lebanon can be contrasted to those presented by Handicap International regarding Algeria and Tunisia. As shown above, a large proportion of disability card holders in those countries reported being able to use the cards to access health care. In Algeria, notably, this is the case even though the disability card in itself does not suffice to access care: persons with disabilities must first obtain the disability card, and secondly a so-called chifa-card, on which is registered data concerning the card holder's identity and medical history.¹⁰⁵

Importantly, data on the social protection coverage of persons with disabilities predisposes a definition of disability. The fact that definitions, as will be discussed in the next chapter, often vary between and within countries mean that data on coverage cannot easily be interpreted or compared. This indicates the importance not only of producing more data on the social protection coverage of persons with disabilities, but also of ensuring the quality of such data.

D. Eligibility and targeting

1. Disability definition and determination

In large part as a consequence of the global disability movement's achievements during recent decades, it is increasingly recognized that disability should be understood as an effect of the interaction between individuals and their environment. To enable the adoption of such an interactive model, the World Health Assembly in 2001 approved the International Classification of Functioning, Disability and Health (ICF). The ICF "provides a standard language and a conceptual basis for the definition and measurement of health and disability" incorporating components relating to body function; body structure; activities and participation; and environmental factors. It thus facilitates the transition from the medical model, which focuses solely on impairment at the individual level, towards an interactive understanding of disability, which should inform the implementation of both the CRPD and the 2030 Agenda.

The legislative frameworks of Arab countries increasingly incorporate definitions of disability

which are not based solely on the medical model, but which are more aligned with the interactive approach of the CRPD and the ICF. For instance, according to Kuwait's law no. 8 of 2010, a person with a disability is "[o]ne who suffers from permanent, total, or partial **disorders...that may prevent him/her** from securing the requirements of life to work or participate fully and effectively in society on an equal basis with others."¹⁰⁶

Tunisia's law 2005-83, like the ICF, mentions ability to perform daily activities: "A person with a disability is any person who has a permanent **impairment...that limits his ability to perform one or more basic daily, personal or social activities** and that reduces the chances of his/her integration into society."¹⁰⁷ Morocco's law 97-13, following Article 1 of the CRPD, quite explicitly points to the causal link between the environment and the impairment, defining a person with a disability as "[a]ny person presenting, in a permanent way, a limitation or **restriction...whose interaction with various barriers** may impede his/her full and effective participation in society on an equal basis with others".¹⁰⁸

In the regulations of social insurance schemes, disability is typically coupled with work inability. According to the disability pension eligibility criteria in Egypt, for instance, a worker "[m]ust be assessed with a total or partial disability *and permanent incapacity for any gainful employment*".¹⁰⁹ The work inability requirement is also common in social assistance and health insurance programmes. Algeria's La Pension Handicapée à 100%, for example, is restricted to those who have a disability "entailing a total incapacity to work".¹¹⁰ In Morocco, SHI coverage extends to family members, including adult

children with disabilities “who are totally, permanently and definitively unable to engage in gainful employment”.¹¹¹ RAMEE includes an almost identical provision.¹¹²

The identification of disability with inability to work may be problematic if environmental factors are not sufficiently taken into account. Persons with disabilities may be perfectly able to work in productive employment if the workplace is accommodated to their needs. For example, screen readers and similar equipment may enable blind people to perform office functions, and barrier-free buildings can facilitate the participation of wheelchair users. New technological inventions and innovations continuously enhance the possibility to make the working environment more accessible, but they may not be harnessed towards this end if persons with disabilities are from the outset presumed to be inherently incapable of working. It is therefore important that disability assessments are conducted taking into account environmental as well as medical factors.

Typically, a person applying for a social protection benefit on the basis of having a disability needs to submit a medical certificate (and, in most cases, a number of other documents) to a designated body. In Jordan, for instance, the Central Medical Committee determines disability status for the purpose of the country’s main social insurance scheme.¹¹³ In Egypt, the Medical Commission evaluates the disability status of Karama applicants.¹¹⁴ To the extent that information is available regarding the nature of these medical certificates and how the bodies in question evaluate them, there seems to be some variation concerning the degree to which

social and environmental factors, in addition to strictly medical ones, are taken into account.

In Tunisia, the medical form to be handed in by disability card applicants to the Regional Commission for Persons with Disabilities, which evaluates such applications, incorporates the ICF factors related to activities and participation. For instance, under the category of “domestic life”, the doctor submits with how much difficulty (if at all) the applicant can perform the daily tasks of shopping, cooking, and undertaking housework.¹¹⁵ In the State of Palestine, for comparison, applications for disability pensions and the disability status of PNCTP applicants are evaluated by committees which seem to adhere more closely to the traditional medical model.¹¹⁶

Overall, countries seem to be slow in adapting their assessment mechanisms to the ICF. This is understandable considering the complexity of the issue, the problems related to obtaining sufficient information about the individual’s environment, and the fact that no standard guidelines for managing the transition are currently available. ESCWA has worked with the National Council for Persons with Disabilities of Sudan to review the current assessment mechanism in the light of the ICF, and some Arab countries such as Morocco and Jordan are currently working with the WHO on finding solutions.

It appears, as mentioned above, that definitions of disability frequently differ not only between countries, but within them as well. In Iraq, for instance, different ministries reportedly use different definitions.¹¹⁷ In Egypt, “[t]here is no

consistency between the eligibility criteria used in the various social protection programs due to the multiplicity of definitions of disability. For example, there is a definition according to the Rehabilitation Act and there is a definition according to the Social Security Act in addition to the multiple medical assessments and classifications used.”¹¹⁸ In those cases where social protection programmes are targeted on the basis of disability, these shortcomings in terms of how disability is defined and determined can make the difference between inclusion and exclusion.

2. Targeting mechanisms and eligibility criteria

As mentioned above, the overall trend as concerns social assistance in the Arab region is that general subsidies are being reduced or abolished and that more targeted measures, particularly CT programmes, are given a more important role in the effort to reduce poverty. Simultaneously, there is a shift in how targeting for such programmes is carried out: whereas categorical targeting has historically been predominant, governments are increasingly turning towards proxy means testing (PMT), whereby a household’s level of poverty is estimated based on a number of factors such as educational attainment and whether it has access to electricity. Similar targeting methods are also used to select beneficiaries for non-contributory health insurance programmes.

One of the first social assistance schemes in the Arab region to utilize PMT on a large scale was the State of Palestine’s PNCTP, which was introduced in 2009. It replaced two previous programmes of which the biggest one had relied

on categorically targeting groups deemed vulnerable, including persons with disabilities.¹¹⁹ The overhaul of the main CT programme in Iraq is another telling example of the regional trend.¹²⁰

Sudan has recently begun reforming its SIP. This undertaking includes elaborating a new PMT formula, which will serve to identify beneficiaries for the CT programme as well as for the public works scheme that will also form part of the SIP. There will also be an element of community-based targeting, meaning that members of the local community will play a role in evaluating who should receive the benefits.¹²¹ In Mauritania, similarly, eligibility for the new Tekavoul programme will be determined through a combination of PMT and community targeting.¹²²

In Egypt, meanwhile, the Takaful and Karama programme is based on a combination of categorical targeting and PMT. Eligibility thus requires belonging to a certain demographic category *and* passing the poverty test. Persons with disabilities, as the statistics cited above suggest, constitute one of the main targeted groups (the other one being the elderly) of the Karama component, whereas the Takaful component targets families with children.¹²³ Morocco’s Tayssir programme, on the other hand, relies exclusively on categorical and geographic targeting, the beneficiary group consisting of families with children in the poorest parts of the country. However, within the coming years, the Moroccan authorities intend to extend the programme to the entire country, and start selecting beneficiaries through PMT.¹²⁴

Among CT programmes in the region, the Palestinian one is noteworthy since disability has been directly incorporated in the PMT formula as

part of a “vulnerability” variable. This was done in 2011 after stakeholders raised concerns about persons with disabilities and other vulnerable groups being excluded.¹²⁵ There are indications that other programmes in the region are moving in a similar direction. For instance, the Moroccan Ministry of Health will review the eligibility criteria of RAMED to make the programme more disability inclusive.¹²⁶ In Sudan, the SIP targeting formula will be adjusted to take into account disability related costs.¹²⁷

In Tunisia, a targeting process which incorporates disability is used to select beneficiaries for the PNAFN and for the AMGI.¹²⁸ A household’s adjusted annual income, which according to the programmes’ joint criteria must not exceed 585 dinars, is calculated according to a formula taking into account its declared revenue, its size, the number of persons with disabilities within it, and whether accommodation is rented.¹²⁹ For instance, if a family’s annual revenue is 5,000 dinars, if it consists of six persons of whom two are persons with disabilities, and if it rents its accommodation, its adjusted income will be calculated as $((5,000 - (600 \times 2)) - 500) / 6 = 550$. The family, thus, will have passed the revenue test and be eligible for CTs as well as non-contributory health insurance, whereas it would not have done so if it had not included any persons with disabilities. However, it is unclear exactly how much weight the adjusted revenue is given in the eligibility process as relative to other factors which are also considered, including absence of the household’s head and work incapacity of its members.¹³⁰

Beneficiaries of Morocco’s RAMED programme are selected by means of a combination of PMT,

through which a score measuring a household’s life conditions is distilled,¹³¹ and an adjusted measure of its income (in urban areas) or a score based on its assets (in rural ones).¹³² These measures are used to determine whether a household is eligible for RAMED, and if it is, whether it is eligible for the variety that is fully free or merely for the one requiring a small annual contribution.¹³³ It does not appear that disability is specifically taken into account at any stage of the targeting process. However, the income/PMT targeting is complemented with an element of community-based targeting carried out by permanent local committees, which may consider “other information provided by applicants such as their health status and health care-related expenses.”¹³⁴

While the old schemes based on categorical targeting have frequently been labelled ineffective and regressive for their alleged propensity to benefit the rich rather than the poor,¹³⁵ it is possible that this critique has been somewhat overstated, at least with regard to categorical targeting of persons with disabilities. If the poverty level among persons with disabilities was calculated in a way that took into account the added expenses they face, instead of looking only at income or assets, the findings would likely show that their standard of living is considerably lower than has been thought.

The risk, then, is that the shift from categorical targeting methods to poverty-based ones, if the latter do not sufficiently take into account disability related costs, will imply that persons with disabilities who were previously deemed eligible for support lose this entitlement, with the result that they are pushed below, or further below, the poverty line. In contexts where no

specific measures targeted to persons with disabilities existed in the first place, the risk is that the exclusion of this group in large part continues even as CT programmes or the like are rolled out. Complementing the PMT process with community targeting could theoretically serve to rectify this, if the community members who carry out the targeting are aware of who the persons with disabilities are and what costs they face. However, it is far from certain that they do, and it is at any rate worth asking whether the degree of arbitrariness that community based targeting entails is compatible with the rights-based approach.

In many countries, including Egypt, Morocco and Mauritania, new social protections schemes are being implemented in parallel with the establishment of social or single registries. A social registry is essentially a registry of poor and vulnerable individuals or households, which can be used by a variety of social assistance programmes, as well as by non-contributory health insurance schemes, in order to identify beneficiaries. A single registry is more comprehensive and more complex, as it collects information from contributory as well as non-contributory programmes, i.e. from the social protection system as a whole.¹³⁶ While registries like these may potentially serve to enhance the efficiency, transparency, complementarity and consistency of social protection programmes, the risk is that if disability related costs are not (sufficiently) taken into account by them, this oversight will be generalized across all social assistance programmes or throughout the social protection system (depending on the nature of the registry). For example, if a social registry does not contain information

on disability, no social assistance programme using the registry to target beneficiaries will be able to take disability into account either.¹³⁷

Notably, when disability is regarded as synonymous with work inability, and when targeting formulas do not take into account disability related costs, persons with disabilities who are able to work and are successfully included in the labour market risk being deemed ineligible for support both because they are able to work and because they may earn too much to be considered poor – even though their disability related costs may be very high and even exceed their incomes.

E. Other elements of disability inclusive social protection

The issues highlighted above – of how disability is defined, and of eligibility and targeting – critically impact upon whether social protection is disability inclusive or not. However, even if disability determination is based on the interactive rather than the medical model of disability, and if the added costs of disability are taken into account by targeting formulas, shortcomings relating to access and adequacy may prevent that the right to income security and health care, the two main components of the SPF, is ensured. As explained in the previous chapter, social protection is part both of the 2030 Agenda and of the CRPD, and it is interlinked with other components of each. Thus, it must be embedded into a larger framework consisting of factors which may be beyond the SPF itself, but which are nevertheless necessary for its implementation.

1. Accessibility of workplaces, information and the broader environment

As regards social insurance and social health insurance, a huge obstacle limiting the coverage of persons with disabilities is simply the lack of job opportunities in the formal economy. Measures to promote such work include the employment quotas mentioned above. Some countries, such as Algeria and Tunisia, have also introduced social security contribution reductions or income tax exemptions for persons with disabilities, as well as various other financial incentives to employ them.¹³⁸ Reasonable accommodation of workplaces, accessibility of buildings, and means of transport - all are factors that are not part of the core definition of the SPF, but which are nevertheless needed to facilitate the inclusiveness of social protection measures.

Even when social protection is available, there are in practice a number of obstacles which frequently render it inaccessible, particularly for persons with disabilities. The locations necessary to visit in order to access support are often geographically distant, especially in rural areas, or otherwise physically inaccessible. This obstacle may be aggravated by bureaucratic, time-consuming and expensive application procedures, which frequently call for numerous visits and re-visits to a number of government offices. Among persons with disabilities in Morocco who do not benefit from RAMED, fully 49 percent have cited “administrative difficulties” as their reason for this.¹³⁹ In Iraq, similarly, obstacles of this sort have posed a momentous hindrance for persons with disabilities trying to access CTs.¹⁴⁰ This has especially affected women with disabilities, who have faced

obstacles in the form of sexual harassment and culturally imposed mobility restrictions, making it particularly difficult for them to go through the lengthy application process.¹⁴¹

Another major obstacle is lack of information about the available social protection measures. In Morocco, for instance, 13 percent of persons with disabilities not enrolled in RAMED stated that they had no knowledge of the scheme.¹⁴² Only 9.2 percent of persons with disabilities declared being aware of the services furnished by the Ministry of Family, Solidarity, Equality and Social Development.¹⁴³ Furthermore, as noted above, there are indications of confusion concerning the disability card. In Egypt¹⁴⁴ and Tunisia,¹⁴⁵ similarly, there is reportedly some confusion among persons with disabilities regarding where and how to access social protection services.

Governments have resorted to various measures to alleviate these problems. For example, Saudi Arabia’s Compatibility Programme, launched in 2012 by the Ministry of Labour, comprises a broad set of initiatives to increase employment among persons with disabilities. As part of this, the ministry “is endeavouring to turn its internal working environment into a model environment adapted to the needs of employees and visitors with disabilities of various kinds”. Notably, this programme also implies cooperation between the Ministry of Labour and the Ministry of Social Affairs aiming to ensure that persons with disabilities in employment be covered by social insurance.¹⁴⁶

As noted, persons with disabilities are in many countries in the region entitled to free or

subsidized public transport, which could partly remedy the problem of prohibitive geographic distances and thus make the broader environment more accessible. In the United Arab Emirates, applications for disability cards, as well as for other forms of social protection such as CTs, are submitted online, which may reduce the need for persons with disabilities to visit potentially inaccessible government offices. In Tunisia, relatedly, efforts have been made to make administrative websites disability accessible,¹⁴⁷ which could open up a venue for persons with disabilities to gain information about social protection programmes. Countries are also making efforts to enhance persons with disabilities' access to internet.¹⁴⁸ A telling example of the increased awareness within the region of accessibility for persons with disabilities is the AccessAbilities Expo in Dubai. This event, scheduled to take place in November 2017, will bring together a large number of stakeholders, including from governments and from companies providing new technological products enabling persons with disabilities to live independently.¹⁴⁹

2. Adequacy of benefits and services

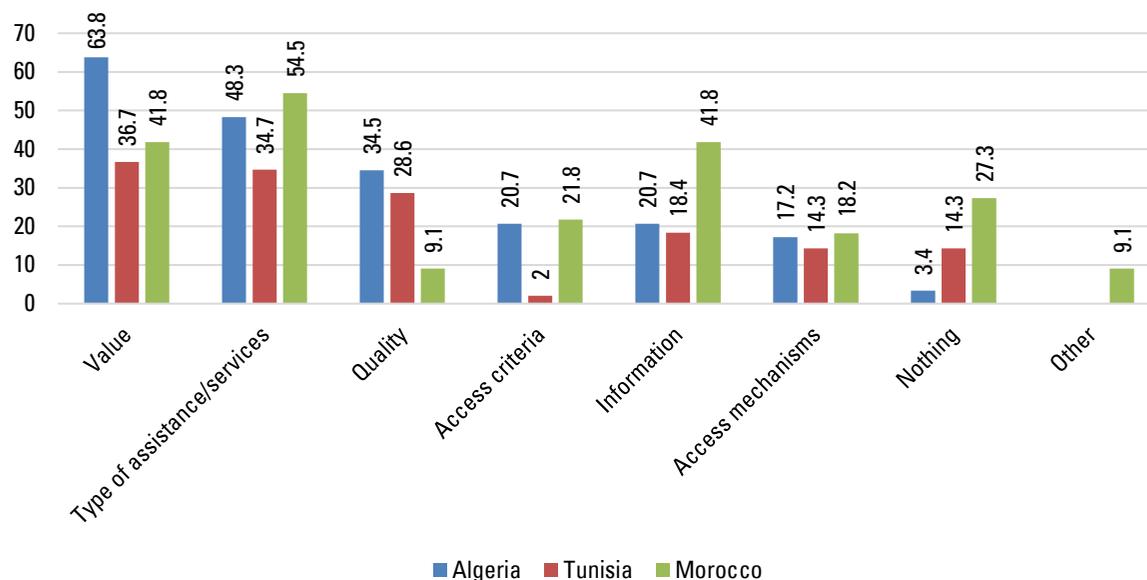
Even when monetary benefits are available and accessible, their small size frequently means that they do not suffice even to cover the added costs of disability. Since insurance-based disability pensions are typically calculated at least in part based on length of service and on the average or end-of-career salary, they are frequently lower for persons with disabilities than for old-age beneficiaries. In the State of Palestine, for example, the average disability benefit within the public sector social insurance

scheme is 1,800 Israeli shekels, compared to 2,288 Israeli shekels for all social insurance benefits.¹⁵⁰ Within the framework of the studies carried out by Handicap International and national disability organizations in Morocco, Tunisia and Algeria, persons with disabilities have stressed the low value of CTs as one of the biggest problems regarding social protection in their countries, as illustrated in figure 18.

Social assistance grants distributed within the framework of mainstream programmes are often fixed in size, meaning that persons with disabilities, despite the higher costs of living they typically face, receive the same sum as other beneficiaries. The PNCTP in the State of Palestine is an exception: there, the size of the CT is set based on a household's poverty gap, calculated by means of the PMT formula (which, as noted, takes into account disability-related costs). Available data indicates that PNCTP beneficiary households which include persons with disabilities do indeed on average receive more generous grants.¹⁵¹

The inclusiveness of social protection is dependent, both directly and indirectly, upon whether social services are available, accessible and adequate. Extending health insurance to persons with disabilities is of limited utility if there are no hospitals or health clinics for them to use. The shortage of such facilities particularly affects persons with disabilities in rural areas and can undermine their access to other forms of social protection. For instance, this could be the case when the health clinics tasked with issuing the medical certificates used to determine disability status are not available or accessible.

Figure 18. Aspects of social protection requiring improvement according to persons with disabilities, Algeria, Morocco and Tunisia, 2015



Sources: Pinto, Pinto and Cunha, 2016a, p. 35; 2016b, p. 35; and 2016c, p. 37.

Health care, even when available and accessible, is often of inadequate quality or otherwise not meeting the needs of persons with disabilities. For instance, persons with disabilities in a number of countries in the region have raised the issue of prostheses and other forms of equipment being very expensive, of poor quality, or not available at all through the health care system.¹⁵² The studies by Handicap International and disability organizations in Algeria, Morocco and Tunisia indicate that persons with disabilities regard the type and the quality of services as among the most acute shortcomings relating to social protection, as shown by figure 18. Civil society organizations in the region have emphasized that women with disabilities are particularly affected by inadequate health-care systems,

which often overlook their reproductive needs.¹⁵³

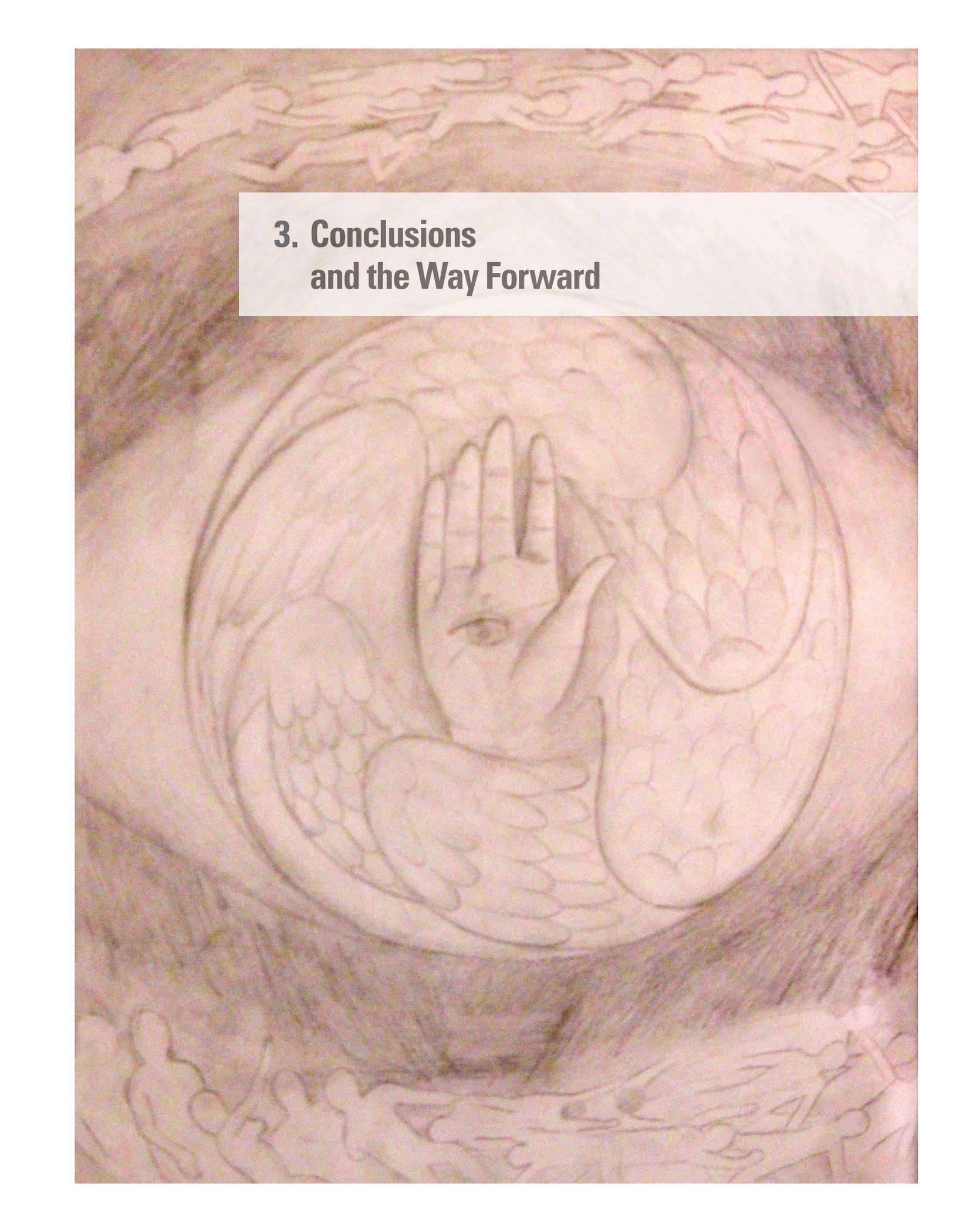
Consequently, persons with disabilities, despite provisions in place to ensure their access to health care, often end up paying large sums of money for care and equipment, or not accessing it at all. Although CT beneficiaries in the State of Palestine benefit from free health insurance, a study in that country found that “the cost of expensive equipment or necessary medical supplies” often exceeds the value of the PNCTP grant.¹⁵⁴

In Tunisia, as noted above, it appears that persons with disabilities are relatively well covered by the CT programme PNAFN and by the programmes providing free or heavily

subsidized health insurance, AMGI and AMGII. However, a recent survey has indicated that 64 per cent of PNAFN/AMGI beneficiary households including at least one person with a disability face disability related expenses that are not covered by the program. For AMGII households including at least one person with a disability, the rate is 58 per cent.¹⁵⁵ The average non-reimbursed disability related costs for households benefiting from the PNAFN/AMGI or from AMGII and that include at least one person with a disability amount, respectively, to 54 dinars (\$32) and 71 dinars (\$42) per month and per person with a disability.¹⁵⁶ It should be noted that about five per cent of beneficiary households with at least one person with a disability benefiting either from PNAFN/AMGI or AMGII face non-reimbursed costs amounting to 200 dinars (\$118) or more per person with a disability.¹⁵⁷

The absence of education opportunities can critically impede persons with disabilities'

access to social protection – in the long term, since persons with low or no education are unlikely to find formal employment, but also in the more immediate term. This is exemplified by how children with disabilities in Egypt are excluded from social health insurance if they are not enrolled in school. Furthermore, as noted above, a number of countries in the region have made CTs conditional upon children's' school attendance, and other countries plan to do so. However, households can only fulfil such conditions if schools are available and accessible. This raises questions about whether households with children with disabilities risk not being able to access the CTs.¹⁵⁸ Certain schemes, such as the one in Morocco targeting widows,¹⁵⁹ have explicitly exempted children with disabilities from education-related conditions. Though this may in the short term be the most advisable approach, it risks reinforcing the perception that children with disabilities are not meant to go to school and thus perpetuate their exclusion.



3. Conclusions and the Way Forward



3. Conclusions and the Way Forward

Social protection for persons with disabilities as presented in this report follows the structure and requirements of the Social Protection Floor (SPF) as laid out in Recommendation 202 of the ILO. At the same time, it has showed that social protection systems need to be well integrated into the broader policy framework beyond social protection policies. The 2030 Agenda and the CRPD both refer to complex inter-linkages of political objectives, which are particularly challenging in the case of disability policy.

For instance, the fact that persons with disabilities are often excluded from contributory social protection provided through formal labour testifies to the importance of including them in the implementation of SDG 8 and in CRPD Article 27, relating to decent work. Problems deriving from the lack of information and the inaccessibility of buildings and transport systems illustrates the need to implement SDG target 11.2, cited above, and Article 9 of the CRPD, which stipulates that “States Parties shall take appropriate measures to ensure to persons with disabilities access, on an equal basis with others, to the physical environment, to transportation, to information and communications”. The fact that social protection requires the existence of social services further emphasizes that it must be thought of as part of the wider development agenda. As mentioned earlier, health care and education are the subjects of SDGs 3 and 4, and of the CRPD Articles 24 and 25. It is possible to think of many additional components of the

2030 Agenda and of the CRPD that are necessary to enable social protection.

The need to integrate social protection in the broader framework of social policies and implementation of the SDGs becomes especially clear with regard to children. Their social protection coverage must go beyond indirect coverage through their parents, to encompass early childhood care and education (goal 4.2) and closer monitoring for early childhood development (indicator 4.2.1 as mentioned above). Children with disabilities may be particularly exposed to the risk of not being registered at birth and of not being granted a legal identity, as provisioned by SDG target 16.9 and CRPD Article 18. Legal identity is a fundamental human right, and the basis for the fulfilment of a range of other civil, political, social and economic rights.¹⁶⁰

Importantly, ensuring the inclusion of persons with disabilities in the realization of the 2030 Agenda will require that disability is defined in a way that takes into account social and environmental factors in addition to medical ones. Such an interactive definition is enshrined in the CRPD, and its application is facilitated by the ICF. The fact that disability is often defined on the basis of the medical model and/or coupled with work inability excludes many of those whose disabilities are in part related to social or environmental factors, or who are able to work but who nevertheless face such high disability related costs that they live in poverty.

The limited inclusion of persons with disabilities in social protection systems measures often results from deficits in the implementation of other provisions of the 2030 Agenda and the CRPD, as shown by the examples in the previous section. However, ensuring that persons with disabilities in the Arab region have access to social protection will equally be necessary to fulfil other commitments, such as bringing poverty and hunger to an end as well ensuring healthy lives - the subjects of SDGs 1, 2, and 3 and CRPD Articles 25 and 28. Social protection could also give families the means or incentives needed to send children with disabilities to school, which would help fulfil SDG 4 and CRPD Article 24. However, social protection will only fill these functions if it is adequate – that is, if CTs are sufficiently generous to compensate for disability related costs, and if health services are adapted to the needs of persons with disabilities.

Social protection can play a role in fulfilling another provision of the 2030 Agenda and the CRPD: decent work for all. There is compelling evidence showing that cash transfers often enable the poorest to take up employment, for instance by allowing them to pay for transport costs associated with commuting.¹⁶¹ However, questions may be raised about whether social protection measures in the region presently serve to encourage labour force participation of persons with disabilities. The fact that disability status for the purpose of eligibility determination is frequently based on work inability may reinforce the conception that having a disability is not reconcilable with partaking in the labour market. When confronted with the choice between, on the one hand, receiving cash grants, and, on the other hand, joining the work force, persons with

disabilities may wish to take up employment as it facilitates their social integration. However, they may also be compelled to choose the benefit if the job on offer does not pay as well as the benefit or is of uncertain duration. This risks creating an incongruity between, contributory social and health insurance, which is contingent upon work, and social assistance provided free of charge, which is contingent upon inability to work. Social protection systems need to foster the shift from the “not able to work” approach towards “social participation”.¹⁶²

There are examples of social protection programmes in the Arab region being shaped to stimulate rather than discourage labour force participation among persons with disabilities, e.g. the public works programme in Mauritania. CTs provided in the United Arab Emirates are commensurately reduced – rather than immediately suspended – when the beneficiary has another source of income.¹⁶³ The positive potential effect of this is that no financial disincentive to take up work paying less than the value of the grant is created. The country also provides job training for social assistance beneficiaries with disabilities.¹⁶⁴ In Saudi Arabia, similarly, job training is provided to persons with disabilities, and those who undergo such training receive a monthly financial support.¹⁶⁵

Social protection thus has the potential to further the individual autonomy and independence of persons with disabilities – one of the main principles of the CRPD. It can do so both directly, by giving persons with disabilities the means to live independently, or indirectly, for instance by stimulating labour force participation allowing and encouraging persons

with disabilities to earn an income from work, also by facilitating work place adaptations and accessibility of buildings. However, it is arguably problematic that benefits are often targeted at the household level rather than at the individual one, or to those deemed to be the “providers” or “caretakers” of persons with disabilities rather than to persons with disabilities themselves. Thus, it appears that the focus is not so much on enabling the individual independence and autonomy of persons with disabilities, but rather on easing the burden they supposedly impose on their families.

Recommendations

The Arab region is made up of countries which differ widely from each other in numerous respects, including in terms of economic development, political context, and geographic characteristics. There are also considerable differences within countries, for instance between urban and rural areas. Furthermore, persons with disabilities are diverse, consisting of individuals with different needs, capacities and preferences. Therefore, the same set of social protection measures will not suit all countries, or even all areas within individual countries, and certain policies may be viewed favourably by some persons with disabilities but unfavourably by others. Nevertheless, some overall policy recommendations can be distilled from the findings above.

Ensure that social protection is accessible

- In order to increase coverage of social insurance and social health insurance among persons with disabilities, enhance their

access to formal work in the public and private sectors, e.g. by ensuring that employment quotas are fulfilled and by enacting and enforcing non-discrimination laws.

- Ensure that the targeting formulas of social assistance and non-contributory health insurance programmes take into account disability-related costs in their evaluation of applicants’ poverty status.
- When social assistance is conditional upon utilization of certain social services, such as school attendance, persons with disabilities should be exempted from the conditions if these services are not accessible to them, though this should only be a short-term solution until the services have been made accessible.
- Ensure that persons with disabilities are entitled to use health care services for free or at an affordable price, and that such services are accessible in practice.
- Conduct outreach to inform persons with disabilities about social protection programmes that they are entitled to, and ensure that application procedures are clear and accessible.

Ensure that social protection is adequate

- Ensure that cash benefits are set at a level which takes into account the added costs of disability. This can be done by increasing the benefits given to persons with disabilities within mainstream schemes and/or by creating or maintaining disability specific schemes as a complement to the mainstream schemes.
- Ensure that health care is adequate to the needs of persons with disabilities, paying

particular attention to the needs of women and children with disabilities.

Ensure that social protection furthers autonomy and participation

- When access to social protection schemes, or the level of benefits provided within them, is contingent upon disability status, ensure that the definition of disability used in the determination process is not based solely on the medical model, but that it also takes into account social and environmental factors as mandated by the CRPD.
- Ensure that social protection furthers the autonomy of persons with disabilities, for instance by giving cash grants to persons with disabilities themselves rather than to their families.
- Ensure that social protection measures encourage labour force participation and that they do not reinforce the perception that persons with disabilities are inherently incapable of working. In particular, disability should not be conceptualized as work inability, and if cash transfers are withdrawn when beneficiaries find another source of income, this should be done in a way that

ensures that taking up work never leaves persons with disabilities worse off.

Ensure that social protection systems are inclusively governed

- Work to ensure that the needs and preferences of persons with disabilities are truly taken into account in policy-making process, for instance by strengthening the standing of disability councils, and by ensuring that persons with disabilities are able to wield real influence over those bodies.
- Bearing in mind the interlinkages between social protection and other policy spheres, seek to further enhance coordination between government ministries and other stakeholders, and ensure that persons with disabilities can participate in decision making at all levels across the policy spectrum.
- Raise awareness among government officials and other stakeholders about the rights and needs of persons with disabilities.
- In order to give policymakers a clear image of the present state of social protection for persons with disabilities, ensure the collection of reliable data.

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Annex. Selection of social assistance programmes in the Arab region

Country	Programme name or description	Implementing agency	Nature of benefit	Mainstream or disability specific	Conditional or unconditional	Beneficiaries	Targeting method	Number of beneficiaries	Number of beneficiaries with disabilities
Algeria	La Pension Handicapée à 100%	La direction de l'action sociale et de la solidarité de wilaya	Cash transfers	Disability specific	Unconditional	Persons with disabilities of a 100% degree who lack resources ^a	Categorical targeting, means testing	238 968 persons with disabilities (2016) ^b	
Egypt	Takaful and Karama	Ministry of Social Affairs	Cash transfers	Mainstream	Conditional (Takaful) and unconditional (Karama)	Poor households (Takaful), poor elderly persons and poor persons with disabilities (Karama)	Proxy means testing, categorical targeting, geographical targeting	1.5 million households, up to 6.7 million people (2017) ^c	50 038 Karama beneficiaries with disabilities (2016). ^d No data on prevalence in Takaful beneficiaries
Iraq	Caretakers' salaries	Commission on the Care of Persons with Disabilities and Special Needs	Cash transfers	Disability specific	Unconditional	Persons caring for persons with disabilities	Categorical targeting	1 700 persons caring for persons with disabilities (2016) ^e	
Jordan	Handicapped care cash assistance	National Aid Fund	Cash transfers	Disability specific	Unconditional	Households earning less than 450 dinars per month who consistently care for a person with a disability ^f	Categorical targeting, means testing	7 100 families (2010) ^g	
Mauritania	Activités Génératrices de Revenus	Ministry of Social Affairs, Childhood and Family	Creation of employment opportunities	Disability specific	Unconditional	Persons with disabilities	Categorical targeting	244 persons (2016) ^h	
Mauritania	Tekavoul	Tadamoun agency	Cash transfers	Mainstream	Conditional ⁱ	Poor households	Proxy means testing, geographical targeting	5 100 households, 33 600 persons (2017) ^j	N/A
Mauritania	Cash transfers for children with multiple disabilities	Ministry of Social Affairs, Childhood and Family	Cash transfers	Disability specific	Unconditional	Households of children with multiple disabilities	Categorical targeting	110 children with multiple disabilities and their households (2016) ^k	
Mauritania	Distribution of land lots for persons with disabilities	N/A	Distribution of land lots for habitation	Disability specific	Unconditional	Persons with disabilities	Categorical targeting	200 beneficiaries (2016)	

Country	Programme name or description	Implementing agency	Nature of benefit	Mainstream or disability specific	Conditional or unconditional	Beneficiaries	Targeting method	Number of beneficiaries	Number of beneficiaries with disabilities
Morocco	Aide en Nature	Entraide Nationale	Food aid	Disability specific	Unconditional	Persons with physical and visual impairments ^l	Categorical targeting	5 584 beneficiaries (2014) ^m	
Morocco	Tayssir	Ministry of Education	Cash transfers	Mainstream	Conditional	Poor households	Categorical targeting, geographical targeting	526 400 households, 860 100 schoolchildren (2017) ⁿ	N/A
State of Palestine	Palestinian National Cash Transfer Programme (PNCTP)	Ministry of Social Development	Cash transfers. Beneficiaries also get access to health insurance and other programmes ^o	Mainstream	Unconditional	Poor households	Proxy means testing	761 532 persons ^p	65 980 persons with disabilities ^q
Sudan	Social Initiatives Program (SIP)	Ministry of Welfare and Social Security	Cash transfers, public works ^r	Mainstream	Unconditional ^s	Poor households	Proxy means testing ^t	500 000 households (2016) ^u	N/A
Tunisia	Programme National d'Aide aux Familles Nécessiteuses (PNAFN)	Ministry of Social Affairs	Cash transfers. Beneficiaries also get access to health insurance.	Mainstream	Unconditional ^v	Households who are poor, members are incapable of working, head is absent, lack any support or whose housing conditions are degraded ^w	Means testing, proxy means testing, categorical targeting	230 000 households (2015) ^x	Survey suggests 39.1% of beneficiary households, against 8.04% of all households, include at least one person with a disability ^y
Yemen	Labour Intensive Public Works Project	Ministry of Planning and International Cooperation	Public works	Mainstream	Unconditional	Poor households	Geographical targeting, self-targeting, proxy means testing, community based targeting ^z	112 712 months of employment created (2016) ^{aa}	N/A

a Algeria, Law No. 02-09 of 8 May 2002 on the protection and promotion of disabled persons. Available from http://www.africanchildinfo.net/cldr/Legislation%20Per%20Country/algeria/algeria_disability_2002_fr.pdf.

b Algeria, Ministry of National Solidarity, Family and the Status of Women, "Programmes du secteur: protection et promotion des personnes handicapées" (Sector programmes: protection and promotion of persons with disabilities), (n.d.). Available from <http://www.msncf.gov.dz/fr/> (accessed 31 March 2017).

c Afrah Alawi Al-Ahmadi, "Egypt, Arab Republic of - Strengthening social safety net project: P145699 - Implementation status results report: sequence 04" (Washington, D.C., World Bank Group, 2017), p. 2. Available from <http://documents.worldbank.org/curated/en/288871493085672050/pdf/ISR-Disclosable-P145699-04-24-2017-1493085656041.pdf>.

d Egypt, Ministry of Social Solidarity, "Strengthening social protection systems: Takaful and Karama", report presented by Social Solidarity Minister Ghada Waly, Mexico, September 2016. Available from https://www.gob.mx/cms/uploads/attachment/file/153881/Strengthening_Social_Protection_Systems__Takaful_and_Karama_-_H.E._Minister_Ghada_Waly.pdf.

- e United Nations Assistance Mission for Iraq and Office of the United Nations High Commissioner for Human Rights, Report on the Rights of Persons with Disabilities in Iraq (Baghdad, 2016). Available from http://www.uniraq.org/index.php?option=com_k2&view=item&task=download&id=2118_ba29368d4a62b7b36938b845a174394d&lang=en.
- f Sources differ on eligibility criteria. Only households including a person suffering a chronic mental illness are eligible, according to United Nations Development Programme, "Jordan poverty reduction strategy: final report" (2013), p. 54. Available from <http://www.jo.undp.org/content/dam/Jordan/docs/Poverty/Jordanpovertyreductionstrategy.pdf>. The programme targets families caring for a child with a disability, according to Hanna Röth, Zina Nimeh and Jessica Hagen-Zanker, A Mapping of Social Protection and Humanitarian Assistance Programmes in Jordan: What Support are Refugees Eligible for? Working Paper no. 501 (London: Overseas Development Institute and Maastricht University, 2017). Available from <https://www.odi.org/sites/odi.org.uk/files/resource-documents/11253.pdf>.
- g UNDP, "Jordan poverty reduction strategy" (see endnote vi).
- h Abdallahi Diakite, Ministry of Social Affairs, Childhood and Family, Mauritania, email to authors, 5 May 2017.
- i Conditions are limited to participation in so-called promotion activities, but according to the World Bank, "over time, where the provision of basic services is sufficient, the program will explore the option of making payments conditional on the actual use of such services". See World Bank, "Mauritania – Social safety net system project, Project Appraisal Document, no. PAD1185" (Washington, D.C., 2015), pp 40-44. Available from <http://documents.worldbank.org/curated/en/395981468179329737/pdf/PAD1185-PAD-P150430-IDA-R2015-0092-1-Box391434B-OUO-9.pdf>.
- j "Tadamoun Director General chairs regional workshop on Tekavoul programme implementation", L'Authentique (Mauritania), 17 April 2017; Aline Coudouel, "Mauritania social safety net system: P150430 - Implementation status results report: sequence 05", p.5. (Washington, D.C., World Bank Group, 2017). Available from <http://documents.worldbank.org/curated/en/405311498757687697/pdf/ISR-Disclosable-P150430-06-29-2017-1498757676565.pdf>.
- k Diakite, email to authors (see endnote viii).
- l Morocco, "L'Entraide Nationale en Chiffres" (National assistance figures), (2013), p. 113. Available from http://www.social.gov.ma/sites/default/files/تحميل_18.pdf.
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- n Ahlam Nazih, "Abandon scolaire: Tayssir, neuf ans après" (School dropout: Tayssir, nine years later), L'Economiste (Morocco), no. 5062 (11 July 2017). Available from <http://www.leconomiste.com/article/1014817-abandon-scolaire-tayssir-neuf-ans-apres> (accessed 30 August 2017).
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- p Iqbal Kaur and others, West Bank and Gaza - Disability in the Palestinian territories: Assessing Situation and Services for People with Disabilities (Washington, D.C., World Bank Group, 2016), p. 59. The source does not specify a date for the data. Available from <https://openknowledge.worldbank.org/bitstream/handle/10986/25182/Disability0Study.pdf?sequence=1&isAllowed=y>.
- q Ibid.
- r The public works component of the SIP had not been launched in June 2017, though beneficiaries had been identified. See Randa G. El-Rashidi, "Sudan social safety net project: P148349 - Implementation status results report: sequence 02" (Washington, D.C.: World Bank Group, 2017), p. 5. Available from <http://documents.worldbank.org/curated/en/951321498662183860/pdf/ISR-Disclosable-P148349-06-28-2017-1498662159270.pdf>.
- s The public works pilot scheme will reportedly inform a gradual transformation of the current programme into a broader social safety net system, combining unconditional and conditional CTs, and livelihood support activities. See World Bank, "Africa – Sudan social safety net project. Project Information Document, report no. 102657" (Washington, D.C. World Bank, 2015), p. 5. Available from <http://documents.worldbank.org/curated/en/968341467999972249/pdf/102657-PID-P148349-Appraisal-stage-Box394837B-PUBLIC-Disclosed-1-11-2016.pdf>.
- t A new PMT formula is being introduced. See World Bank, "Africa – Sudan social safety net project" (see endnote xix).
- u World Bank, "World Bank launches new project to strengthen Sudan's social protection systems", press release, Khartoum, 11 February 2016. Available from <http://www.worldbank.org/en/news/press-release/2016/02/11/world-bank-launches-new-project-to-strengthen-sudans-social-protection-systems>.
- v While the basic PNAFN grant is unconditional, the programme includes a top-up grant for each child enrolled in school. It is not known whether exceptions are made for children with disabilities who cannot access education.
- w Dorothea Chen and others, Assistance Technique de la Banque Mondiale sur le Financement de la Sante en Tunisie: Etude sur l'Assistance Medicale Gratuite (World Bank technical assistance on health financing in Tunisia: study on free medical assistance), (Washington, D.C., World Bank Group, 2016). Available from <http://documents.worldbank.org/curated/en/687831472236995453/Assistance-technique-de-la-Banque-Mondiale-sur-le-financement-de-la-sante-en-Tunisie-etude-sur-l-medical-free-help>.

- x Centre de Recherches et d'Etudes Sociales and African Development Bank, *Évaluation de la performance des programmes d'assistance sociale en Tunisie* (Evaluation of the performance of social assistance programmes in Tunisia), (May 2017), p. 34. Available from http://www.cres.tn/uploads/tx_wdbiblio/Rapport_CRES_mai_2017.pdf.
- y *Ibid.*, p. 179.
- z ESCWA and the International Labour Organization, "Study on the labour intensive work programme in Yemen", Working Paper (ESCWA, 2014), pp. 29-31. Available from https://www.unescwa.org/sites/www.unescwa.org/files/page_attachments/study_on_the_labour_intensive_work_programme_in_yemen_0.pdf.
- aa Sabine W. Beddies, "Yemen, Republic of – Labor intensive public works project: (P122594) – Implementation status results report: sequence 10" (Washington, D.C., World Bank Group, 2016), p. 6. Available from <http://documents.worldbank.org/curated/en/976071479771197406/pdf/ISR-Disclosable-P122594-11-21-2016-1479771178971.pdf>.

Endnotes

1. ESCWA, 2017d, p. 5.
2. ESCWA, 2017d.
3. ESCWA and League of Arab States, 2014, p. 14.
4. For a glossary on treaty actions, see United Nations Treaty Collection.
5. For more information see United Nations Statistical Commission, Washington Group on Disability Statistics, 2017.
6. United Nations Statistical Commission, 2016, p. 7.
7. Bearing in mind that the 2030 Agenda as a whole applies to persons with disabilities, accessible transport can also be coupled to SDG 9, which inter alia concerns resilient infrastructure.
8. World Health Organization and World Bank, 2011, chap. 3.
9. CRPD preamble.
10. United Nations Statistical Commission, 2017.
11. ESCWA, 2017d.
12. The 2011 World Disability Report, issued by the World Bank and the WHO, estimated the global disability rate to 15.6 percent. However, it must be noted that this number is based on a broader definition of disability than that recommended by the WG, making it hard to compare outright with the numbers for the Arab region.
13. As the current publication is mainly devoted to social protection of persons with disabilities as one of the priority aspects of the SDGs (target 1.3), this section only reflects some of the SDGs. A more complete data analysis will be available in the upcoming publication "Disability in the Arab Region 2018".
14. Information about the share of persons with disabilities living in disability institutions is currently not publicly available and is the subject of an ongoing ESCWA research project.
15. Mauritania, Ministry of Economic Affairs and Development and National Statistics Office, 2015, pp. 63-64.
16. Pinto, Pinto and Cunha, 2016a, p. 28. To set this in context, it may be noted that the official minimum wage for a person working 40 hours a week was in 2015 raised to 290 dinars – see Tunisia, 2015. The national poverty line and extreme poverty line were in the same year set to 1706 dinars and 1032 dinars per person and year, respectively corresponding to 142 dinars and 86 dinars per month - see Tunisia, National Institute of Statistics, 2016a. For the studies in Algeria and Morocco, see Pinto, Pinto and Cunha, 2016b, and 2016c.
17. Palestinian Central Bureau of Statistics and Ministry of Social Affairs, 2011, p. 74.
18. *Ibid.*, p. 22.
19. Morocco, Ministry of Family, Solidarity, Equality and Social Development, 2014, p. 59.
20. Nagata, 2003, pp. 11-12.
21. UN Women, n.d.
22. For a recent comprehensive overview of social insurance systems in the Arab region, see Price and others, 2017.
23. Angel-Urdinola and Tanabe, 2012, pp. 2, 8.
24. Many schemes also include provisions for early retirement, which typically implies a lower benefit.
25. International Social Security Association, n.d.,d.
26. United Arab Emirates, General Pension and Social Security Authority, 2015. The Dubai Economic Council reportedly set the national poverty line to 80 dirhams per day, corresponding to 2,400 dirhams per month, which would seem to suggest that the minimum disability benefit is quite high. See Al Kamali and Al Bastaki, 2011.
27. Morocco, RCAR, 2015, p. 12.

28. International Social Security Association, n.d.,e. It should be noted that the ongoing crisis in Yemen calls into question whether disability pensions and other social insurance benefits are in fact being paid out.
29. International Social Security Association, n.d.,a.
30. International Social Security Association, n.d.,b.
31. Pinto, Pinto and Cunha, 2016a, p. 23.
32. International Social Security Association, n.d.,c. Orphan daughters are eligible as long as they are not married.
33. ESCWA, 2017a.
34. World Bank, 2015b.
35. World Bank, 2015c.
36. ESCWA, 2017b.
37. World Bank 2015c, pp. 40-41; World Bank 2015b, p. 5.
38. It is noted the value of this benefit is 4.5 times lower than the Algerian minimum wage, which is set at 18,000 dinars; see Algeria, 2011, and 2015.
39. UNDP, 2013, p. 54; Röth, Nimeh and Hagen-Zanker, 2017.
40. United Nations Assistance Mission for Iraq and UN OHCHR, 2016, p. 17; Iraq, 2015.
41. Mauritania, 2016.
42. Morocco, 2014, p. 113; Angel-Urdinola, El Yamani and Pallares-Miralles, 2015, p. 25.
43. Mauritania, 2016.
44. ESCWA and ILO, 2014b.
45. World Bank, 2015b.
46. Mauritania, Ministry of Social Affairs, Childhood and Family, 2016.
47. Algeria, Ministry of National Solidarity, Family and the Status of Women, n.d.; Egypt, 2015; Stars of Hope Society, 2013, p. 29.
48. Such measures exist in, for instance, Algeria, Egypt, Jordan, Mauritania, Morocco and United Arab Emirates. See United Nations Committee on the Rights of Persons with Disabilities, 2015a, p. 40; Egypt, 2015; United Arab Emirates, 2006, Article 27; Morocco, Ministry of Family, Solidarity, Equality and Social Development, 2016a; Algeria, Ministry of National Solidarity, Family and the Status of Women, n.d.; Mauritania, 2006, Articles 30 and 31.
49. ESCWA, 2014.
50. Social health insurance may be conceptualized as a form of social insurance, though for the purpose of this paper each is treated separately, so that social insurance pertains exclusively to schemes providing income security.
51. See International Labour Organization, 2015.
52. UNESCO, 2013, pp. 13-14.
53. Algeria, 1983, Articles 5 and 73.
54. ESCWA, 2017c, p. 16.
55. UNDP, 2013, p. 171.
56. Egypt, 2015.
57. Turkawi, 2015, pp. 16, 51.
58. Nazih, 2017, pp. 68-71.
59. L'Agence Nationale de l'Assurance Maladie (ANAM), 2015a; Centre de Recherches et d'Etudes Sociales (CRES) and African Development Bank, 2016, p. 32.
60. Tunisia, 2005b, Article 15.
61. ESCWA and League of Arab States, 2014, p. 14.
62. Iraq, 2005, Article 32.
63. State of Palestine, 2003, Article 22.
64. United Arab Emirates, 2006, Article 2.

65. Algeria, 2002, Article 5.
66. State of Palestine, Ministry of Communications and Information Technology, 2014.
67. State of Palestine, 1999, Article 10.
68. United Nations Assistance Mission for Iraq and UN OHCHR, 2016, p. 17; Iraq, n.d.
69. Azzeh, 2017.
70. The data is presented as “[p]ercentage of disabled people who received any kind of care and support for their disability” (emphasis added), which would seem to indicate that only disability-specific forms of social protection are intended. However, from the questionnaire itself it appears that the questions put to respondents was only whether they during the past year had “receive[d] any care or support”, which would seem to include mainstream as well as disability-specific form of social protection. See Yemen, 2015, pp. 206, 278.
71. UNICEF, n.p., p. 12; Lebanon, Ministry of Social Affairs, 2016.
72. UNICEF, n.p., p. 10.
73. UNESCO, 2013, p. 11, suggests that the disability prevalence may be higher among men since “Lebanese males are more prone to acquire disabilities due to the wars and car and work related accidents as the number of workers and drivers is larger for males”.
74. UNESCO, 2013, p. 9.
75. “Tunis – 45% of disabled people hold disability card”, 2016.
76. Pinto, Pinto and Cunha, 2016a, p. 30.
77. Pinto, Pinto and Cunha, 2016a, p. 47.
78. Pinto, Pinto and Cunha, 2016b, p. 29; 2016c, p. 31.
79. Pinto, Pinto and Cunha, 2016c, pp. 26-27, 31, 36.
80. Angel-Urdinola and Tanabe, 2012, pp. 13-14.
81. *Ibid.*, pp. 2, 8.
82. *Ibid.*, p. 12.
83. ESCWA and the League of Arab States, 2014, pp. 16-17.
84. See, for example, Egypt, 2015; United Nations Assistance Mission for Iraq and UN OHCHR, 2016, p. 14; Conseil Economique et Social du Maroc, 2012, p. 10; Pinto, Pinto and Cunha, 2016b, p. 39; Stars of Hope Society, 2013, p. 29.
85. Egypt, Ministry of Social Solidarity, 2016.
86. Centre de Recherches et d'Etudes Sociales (CRES) and African Development Bank, 2017, pp. 167, 179.
87. Jordan, 2015.
88. Zureiqat and Shama, 2015, p. 29; UNDP, 2013, p. 54.
89. Kaur and others, 2016, p. 59. The source does not specify a date for the data.
90. Ahmed Cheikhi, Ministry of Family, Solidarity, Equality and Social Development, Morocco, email to authors, 15 May 2017.
91. Algeria, Ministry of National Solidarity, Family and the Status of Women, n.d.
92. Abdallahi Diakite, Ministry of Social Affairs, Childhood and Family, Mauritania, email to authors, 5 May 2017.
93. Mauritania, 2016.
94. Diakite, email to authors.
95. World Bank, 2017.
96. Jordan, Department of Statistics, 2015.
97. ESCWA, 2017c, p. 23; Stars of Hope Society, 2013, p. 49.
98. Egypt, 2015; United Nations Committee on the Rights of the Child, 2010, p. 15.
99. 3.8 percent of persons with disabilities, furthermore, reported being covered by other forms of insurance, including the private variety (0.7 percent) and “professional” insurance (3.1 percent). It is not entirely sure what the latter signifies. Since no comparative rates are available for the population as a whole, coverage of this sort has not been included in the figure.

100. Centre de Recherches et d'Etudes Sociales (CRES) and African Development Bank, 2017, pp. 167, 179.
101. Ibid.
102. UNESCO, 2013, pp. 13-14
103. Ibid., p. 13.
104. United Nations Economic and Social Council, 2016, p. 5.
105. Pinto, Pinto and Cunha, 2016b, p. 24; Algeria, La Caisse Nationale de Sécurité Sociale des Non-Salariés (CASNOS), 2014.
106. Kuwait, 2010, Article 1.
107. Tunisia, 2005b, Article 2.
108. Morocco, 2016, Article 2.
109. International Social Security Association, n.d.,d.
110. Algeria, 2003.
111. L'Agence Nationale de l'Assurance Maladie (ANAM), 2015b.
112. L'Agence Nationale de l'Assurance Maladie (ANAM), 2015c.
113. International Social Security Association, n.d.,b.
114. Angel-Urdinola, El Yamani and Pallares-Miralles, 2015, p. 48.
115. Tunisia, 2005a, Annex 2.
116. Kaur and others, 2016, p. 5; Alghaib, u.p., p. 12.
117. United Nations Assistance Mission for Iraq and UN OHCHR, 2016, pp. 4-5.
118. Egypt, 2015.
119. Jones and Shaheen, 2012, pp. 19-20.
120. Alkhoja, Neman and Hariz, 2016, p. 1; USAID, 2014, pp. 15-16.
121. World Bank, 2015b, p. 4. For a general description of community based targeting, see Hanlon, Barrientos and Hulme, 2010, pp. 113-115.
122. World Bank, 2015c, p. 34.
123. Angel-Urdinola, El Yamani and Pallares-Miralles, 2015, pp. 32-33.
124. Gattioui, 2016.
125. Pereznieto and others, 2014, pp. 27, 33.
126. Ahmed Cheikhi, Ministry of Family, Solidarity, Equality and Social Development, Morocco, email to authors, 15 May 2017. See also Morocco, 2015.
127. Bdraldeen Ahmed Hassan Mohamed, National Council for Persons with Disabilities, Sudan, email to authors, 16 July 2017.
128. Chen and others, 2016, pp. 14-15. Eligibility for the "upper" part of AMG, which requires some contributions and co-payments, is provided based on annual income, which must not exceed 1-3 times the annual minimum wage, depending on the household's size.
129. African Development Bank Group (AfDB), 2013, p. 76; Chen and others, 2016, pp. 14-15.
130. African Development Bank Group (AfDB), 2013, p. 17; Chen and others, 2016, pp. 14-15; Arfa and Elgazzar, 2013, p. 7.
131. L'Agence Nationale de l'Assurance Maladie (ANAM), 2015d.
132. Morocco, 2008.
133. Morocco, 2011.
134. Angel-Urdinola, El Yamani and Pallares-Miralles, 2015, p. 30.
135. See, for example, Levin, Morgandi and Silva, 2012, p. 22; Alkhoja, Neman and Hariz, 2016, p. 1.
136. Thus, a social registry may be included as a component of a single registry. The latter may also be connected to additional databases, e.g. the civil registry. See Chirchir and Farooq, 2016.
137. For critical comment on social registries, see Kidd, 2017.

138. In Algeria, workers with disabilities earning less than 20,000 dinars per month are exempted from general income tax. See Algeria, Ministry of National Solidarity, Family and the Status of Women, n.d. Tunisian law stipulates that employers should benefit from reduced social security contribution fees when employing persons with disabilities, depending on the degree of disability as stated on the employee's disability card. See Tunisia, 2005b, Article 34.
139. Morocco, Ministry of Family, Solidarity, Equality and Social Development, 2014, p. 60.
140. The application procedure for the older, categorically targeted CT programme is detailed in USAID, 2014. It should be noted that this applies to the CT scheme prior to its adoption of PMT.
141. United Nations Assistance Mission for Iraq and UN OHCHR, 2016, pp. 16-17; USAID, 2014, p. 17-19.
142. Morocco, Ministry of Family, Solidarity, Equality and Social Development, 2014, p. 60.
143. *Ibid.*, p. 74.
144. Hakky, 2015, p. 61.
145. Pinto, Pinto and Cunha, 2016a, pp. 32-33.
146. United Nations Committee on the Rights of Persons with Disabilities, 2015b, pp. 47-50.
147. United Nations Committee on Economic and Social Council, 2015, p. 45.
148. See, for example, United Nations Economic and Social Council, 2015, p. 45; United Nations Committee on the Rights of Persons with Disabilities, 2015b, p. 19; United Nations Committee on the Rights of Persons with Disabilities, 2016, p. 31.
149. AccessAbilities Expo, 2017.
150. World Bank, 2016a, p. 59. The source does not specify a date for data. As of 2016, one Israeli shekel corresponded to \$3.9.
151. Kaur and others, 2016, p. 59.
152. See for Iraq, USAID, 2014, p. 25; for Morocco, Pinto, Pinto and Cunha, 2016c, pp. 33-34; for Algeria, Pinto, Pinto and Cunha, 2016b, pp. 33-34.
153. See, for example, Stars of Hope Society, 2013, pp. 48, 51; Information and Research Center and others, 2017, pp. 6, 11; Advocates for Human Rights & Mobilising for Rights Associates, 2017, pp. 15-16.
154. Perezniето and others, 2014, p. 29.
155. Centre de Recherches et d'Etudes Sociales (CRES) and African Development Bank, 2017, p. 180.
156. As noted earlier, the Tunisian national poverty line and extreme poverty line were in 2015 set to 1706 dinars and 1032 dinars per person and year, corresponding respectively to 142 dinars and 86 dinars per month.
157. CRES and African Development Bank, 2017, pp. 180-181.
158. For a general reference on disability and conditional cash transfers, see Mont, 2006.
159. Morocco, Ministry of Family, Solidarity, Equality and Social Development, 2016b.
160. Dahan and Gelb, 2015.
161. Hanlon and others, 2010, pp. 73-76.
162. International Labour Office and International Disability Alliance, 2015, p. 8.
163. United Arab Emirates, 2017.
164. United Nations Committee on the Right of Persons with Disabilities, 2014, p. 48.
165. United Nations Committee on the Right of Persons with Disabilities, 2015b, p. 51.

This report presents an overview of social protection for persons with disabilities in Arab countries through the prism of the 2030 Agenda and its Sustainable Development Goals. It focuses on social insurance, social assistance and health care, and explores whether social protection is accessible to persons with disabilities and adequately responds to their needs and preferences. Based on recent data on key SDG indicators, and other material, including legislation, policies and civil society inputs, it finds that persons with disabilities have limited access to labour markets and thus to contributory social protection measures.

Some countries have already adjusted the eligibility criteria and targeting mechanisms of non-contributory forms of social protection to acknowledge the particular expenses faced by persons with disabilities and their families. However, disability is still frequently defined in a way that does not conform to the standards of the Convention on the Rights of Persons with Disabilities, which may discourage their social participation and inclusion in the labour market. The report reaffirms that social protection systems cannot be implemented in isolation but must be integrated into a more comprehensive development effort, and concludes by suggesting ways to move forward.

