

**IMPLEMENTATION OF UN STANDARD RULES ON
THE EQUALIZATION OF OPPORTUNITIES
FOR PERSONS WITH DISABILITIES**

*Brazzaville, Republic of Congo
17–19 November 2004*

Intercountry Meeting Report

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Executive Summary

In 1993, the United Nations General Assembly adopted The Standard Rules on the Equalization of Opportunities for Persons with Disabilities, to give direction on the rights of persons with disabilities. It states in part: “The principle of equal rights implies that the needs of each and every individual are of equal importance, that those needs must be made the basis for the planning of societies, and that all resources must be employed in such a way as to ensure that every individual has equal opportunity for participation.”

An intercountry meeting of the Africa Region was held in Brazzaville (Republic of Congo) from 17 to 19 November 2004, on implementation of UN Standard Rules related to health care with the following objectives:

- (a) Share experiences of countries regarding the promotion of services for people with disabilities
- (b) Discuss the current situation of application of UN Standard Rules 2, 3, 4 and 19 in the participating countries
- (c) Identify major constraints to the implementation of the Standard Rules
- (d) Recommend strategies for overcoming the constraints and for strengthening the application of these four Standard Rules.
- (e) Draft proposals on the implementation of the Standard Rules.

The seven countries that were represented at this meeting were Eritrea, Ethiopia, Kenya, Malawi, Tanzania, Zambia and Zimbabwe.

The meeting included presentations, group and plenary discussions on the four UN Standard rules linked to health – Rule 2 (Medical Care), Rule 3 (Rehabilitation), Rule 4 (Support Services) and Rule 19 (Personnel Training). In addition, a field trip to rehabilitation projects in Brazzaville was organized for the participants during the meeting.

General Recommendations

- (i) **A national policy on disability and rehabilitation should be in place in each country.** Different aspects such as medical care, support devices, training, and cultural issues should be addressed in the national policies. Advocacy is needed for Governmental policies, and budget increases for disability and rehabilitation services.
- (ii) **Poverty and under-development should be tackled as major causes for exclusion of persons with disability from full participation.**
- (iii) **National authorities should be accountable to implement international declarations and regulations concerning the rights of persons with disabilities.**

- (iv) UN Standard Rules linked to health (Rules 2, 3, 4, 19) should be included in training curricula at different levels including diploma, certificate and degree courses. Raising awareness on UN Standard Rules is also needed for Organizations of Disabled Persons (DPOs) and for persons with disabilities.
- (v) **Sharing of information** and experiences among countries in the region should be strengthened. Intercountry information sharing about specific services (for example speech therapy, and hearing-aids), existing programmes and training courses available in different countries of the region is required.
- (vi) Governments should give attention to the **training** of rehabilitation professionals. Persons with disabilities should be promoted for training as rehabilitation professionals. Mainstreaming of disability and rehabilitation should be done in all curriculum development for health professionals.
- (vii) **DPOs** should be strengthened and involved from the onset in planning, implementation, and monitoring of activities related to disability and rehabilitation.
- (viii) **Focal persons** should be identified with clear job descriptions in all line-ministries dealing with disability and rehabilitation issues. Wherever possible, these focal persons should be persons with disabilities.
- (ix) Governments should give due attention for infrastructure and development of **information technology** that are accessible to disabled persons.
- (x) World Health Organization Regional Office for Africa should organize meetings regularly to **monitor the progress** of implementation of health related UN Standard Rules.

In addition, countries also made some country-specific recommendations for strengthening of implementation of UN Standard Rules related to health care.

Abbreviations

AFRO	WHO Regional Office for Africa
AMRO	Regional Office of WHO for Americas
AU	African Union
CBR	Community-based Rehabilitation
CHAM	Christian Health Association of Malawi
DAR	Disability and Rehabilitation
DPO	Disabled Persons Organization
EPI	Extended Programme of Immunization
ILO	International Labour Organization
MACOHA	Malawi Council for the Handicapped
MoH	Ministry of Health
NEPAD	New African Partnership for Development
NGO	Non-Governmental Organization
PandO	Prosthetics and Orthotics
PHC	Primary Health Care
SADAC	Southern Africa Development Community
SEARO	WHO Regional Office for South-East Asia
UN	United Nations
UNESCO	United Nations Educational, Scientific and Cultural Organization
VIP	Violence and Injury Prevention
WHO	World Health Organization

Background

In 1993, the United Nations General Assembly adopted The Standard Rules on the Equalization of Opportunities for Persons with Disabilities,¹ to give directions on the rights of persons with disabilities. It states that: "The principle of equal rights implies that the needs of each and every individual are of equal importance, that those needs must be made the basis for the planning of societies, and that all resources must be employed in such a way as to ensure that every individual has equal opportunity for participation."

In May 2001 in Oslo, Norway, the Disability and Rehabilitation (DAR) team of World Health Organization (WHO) organized an international consultation in collaboration with organizations of persons with disabilities and organizations of health professionals. The theme was "Rethinking Care—from the perspective of disabled persons." In the same period, in consultation with UN Special Rapporteur on disability, WHO/DAR carried out a survey in 68 countries in the different world regions about implementation of UN Standard Rules. These were specifically in relation to four rules related to the health care (rule 2, rule 3, rule 4 and rule 19). As a result of these initiatives, it was recommended that the implementation of UN Standard Rules at country level be strengthened. WHO/DAR in consultation with regional offices of WHO proposed intercountry meetings involving persons from ministries of Health and Social Welfare as well as representatives of national organizations of persons with disabilities to promote the implementation of these UN Standard Rules.

The first intercountry meeting on implementation of UN Standard Rules was organized in the WHO Regional Office for South-East Asia (SEARO) in 2003. The present meeting organized by WHO Regional Office for Africa (AFRO) is the second of these intercountry meetings. A similar meeting is planned for Regional Office of WHO for Americas (AMRO) in 2005.

The intercountry meeting in the Africa Region was held in Brazzaville (Republic of Congo) from 17–19 November 2004. Its objectives were as follows:

- (a) To share experiences of countries regarding the promotion of services for people with disabilities
- (b) To discuss the current situation of application of Rules 2 (medical care); 3 (rehabilitation); 4 (support services); and 19 (personnel training) in the participating countries
- (c) To identify major constraints to the implementation of the Standard Rules
- (d) To recommend strategies for overcoming the constraints and to strengthen the application of these four Standard Rules.
- (e) To draft proposals on the implementation of the Standard Rules.

¹ United Nations 1994. The document can be ordered free of charge from: Disabled Persons Unit, Department for Policy Coordination and Sustainable Development, United Nations, Room DC2-1302, New York, NY 10017, USA, Fax: +1 212 963-3062. It can also be found on: <http://www.un.org/esa/socdev/enable/dissre00.htm>

At the end of the meeting it was expected that there would be a compilation and a clear understanding of the major challenges and constraints in implementing the Standard Rules. Participating countries were also expected to hand in draft proposals.

The seven countries that participated in this meeting and sent their representatives were Eritrea, Ethiopia, Kenya, Malawi, Tanzania, Zambia and Zimbabwe. **Annex 1** provides the list of the participants and their addresses; **Annex 2** provides the programme of the intercountry meeting.

Opening session

Dr Ibrahim Samba, the WHO Regional Director for Africa formally inaugurated the meeting. Dr Samba welcomed the participants to AFRO in Brazzaville. In his address he specified that the regional level meeting on disability was significant in that it was the first held in the World Health Organization Regional Office for Africa. He drew from his personal experiences with disability remarking that the importance of the issue is often ignored. He singled out the World Health Organization Regional Office for Africa building as not being easily accessible to wheelchair users and suggested that the situation be corrected. Attitudes towards certain groups of persons with disabilities is another issue that raises concerns. He indicated the importance of individuals taking action rather than constantly seeking funds from outside. Mr Samba further pointed out that disability has never been discussed in a regional committee of World Health Organization Regional Office for Africa, and suggested that a resolution on disability and rehabilitation be proposed at regional level in AFRO and to the African Union (AU). A news release on this theme would be circulated to all WHO country offices and news media in Africa. World Health Organization Regional Office for Africa were invited to urgently take action on this subject and he guaranteed his personal support.

Dr Olive Kobusingye (regional focal point for DAR, Violence and Injury Prevention (VIP)/AFRO) opened the meeting by welcoming the participants. She explained the aims and objectives of the meeting, specifying that the meeting would focus on the four rules related to health care (rule 2, rule 3, rule 4 and rule 19). In closing, Dr Kobusingye explained the expectations of the meeting in terms of identifying constraints and making country specific proposals for implementation of UN Standard rules.

Following this presentation, other issues were raised. These included links between Standard Rules and the new Convention on Disability, African decade of disabled people, different support from various UN agencies such as WHO, International Labour Organization (ILO) and United Nations Educational, Scientific and Cultural Organization (UNESCO).

Mr Chapal Khasnabis of DAR/HQ gave a presentation on his team. He pointed out that the DAR is a small team charged with the responsibility of seeking rehabilitation services that are not often available. The DAR considers it a priority to examine strategies to improve coverage of services, and to strengthen them. The majority of disabled persons live in rural areas, where services are usually lacking. As part of its strategy DAR actively promotes community-based rehabilitation (CBR). CBR should be seen as a means towards poverty alleviation and equal

opportunities. One of the priorities for DAR is to develop guidelines for implementing CBR. The provision of assistive devices is another significant area that needs to be strengthened.

Implementation of the UN Standard Rules

Introduction

A recommendation from Mr Ishamael Zhou of Zimbabwe was made that all meeting documents be made available in a format accessible to persons with disabilities. He pointed out that this was a prerequisite for their active participation in such meetings.

The session started with an introductory presentation on the history and significance of the UN Standard Rules by Dr Sunil Deepak. He explained the process undertaken by the UN starting from 1946 when the first social commission and temporary social welfare committee were created. He highlighted the activities of the UN decade on disability (1982–1992) and the World Programme of Action, following which the UN General Assembly approved the UN Standard rules in 1993. He briefly touched on different models of disability. And finally discussed the ways in which the countries can use UN Standard Rules.

This was followed by a plenary discussion to clarify the potential role of UN Standard Rules in shaping policies and strategies at national and international level.

Country reports

All the countries participating in the meeting presented a report about the status of the implementation of the four rules (2, 3, 4 and 19), explaining the gains made over the past decade as well as the problems encountered in the implementation.

Eritrea

In a population of 3.5 million, Eritrea has about 150,000 persons with disabilities. The ministries of Health, and Labour and Social Welfare are involved in rehabilitation activities. The Ministry of Labour and Social Welfare is the leading agency for rehabilitation while the Ministry of Health (MoH) mainly focuses on medical care. The National Constitution of Eritrea stipulates equality of all persons, including disabled persons. In 1999, a new national policy on disability was approved.

The MoH promotes a primary health care approach and provision of free medical care to disabled persons. However, lack of trained personnel is a serious constraint. Eritrea has chosen Community-based Rehabilitation (CBR) as its basic rehabilitation strategy but it lacks support at referral level. Support services for supply of aids and appliances are insufficient to meet all the needs.

Ethiopia

There are about 1 million persons with disabilities in Ethiopia. The Federal Ministry of Labour and Social Affairs is the lead ministry for rehabilitation. In 1994 a proclamation on the rights of disabled persons to employment was made. This policy, together with the developmental social welfare policy approved in November 1996, set ambitious goals for rehabilitation, raising awareness, and institution-based and community-based rehabilitation. Another important policy is the national education policy for education and training for persons with disabilities.

The national health policy focuses mainly on prevention of disabilities. There are public health centres for the poor but their coverage is limited especially on both institution-based and community-based rehabilitation activities. Constraints regarding support services include high costs for and shortage of assistive devices along with a lack of awareness on the importance of assistive devices within the community. There is training for special education teachers. Physiotherapy training has recently been established with support from the World Bank. The current constraints for CBR workers are lack of training centres on disability issues and insufficient support from the Government.

Kenya

Kenya has an estimated 3 million persons with disabilities. They face major problems in education and employment. Additionally, disabled persons are not involved in planning and policy making. Poverty, socio-cultural and economic prejudices are other issues affecting persons with disabilities. Disabled women are more disadvantaged as compared to men. A Disability Act was adopted in 2004 and a policy has been drafted for promoting their integration in the national development process. The Ministry of Gender, Sports, Culture and Development is the lead ministry for rehabilitation.

The MoH is mandated for health in a global sense. It promotes activities of early screening, prevention, and diagnosis. CBR is integrated in primary health care (PHC) since it works through the same infrastructure.

Malawi

The MoH looks after rehabilitation services together with the Ministry of Social Development and Disability. There is a severe shortage of qualified personnel in government service therefore most services are provided by NGOs like Malawi Council for the Handicapped (MACOHA). There is a multisectoral CBR programme. The ministry also provides support for disabled students to study. There are no opportunities for physiotherapist training in the country and only a rehabilitation technician training course is available. There is only one orthopaedic workshop (in Blantyre) thus limiting supply of assistive devices. The UN Standard Rules have been translated into local languages and widely disseminated. A national disability policy has been drafted and was scheduled for approval before the end of 2004.

Tanzania

The Tanzanian government adopted a national policy on rehabilitation in March 2004. This policy aims at mainstreaming disability issues, and provides operational guidelines for all stakeholders. According to the population census of October 2002, Tanzania had 676 502 disabled persons. The country has promoted devolution and decentralization of health services at district level. It was recommended that the needs of disabled persons be specifically taken into consideration in making district plans.

A multisectoral rehabilitation national task force has been revived. Training of personnel in rehabilitation medicine has continued with support for training of new specialities added over the last few years. These specialities are occupational therapy, optometry, ophthalmology, speech therapy and CBR.

Zambia

Zambia has a population of 10 million of whom 270 000 (2.7%) are disabled. The government is committed to improving the quality of health of the citizens. There were decentralization reforms in 1991, and rehabilitation services are now available at central, general and district hospital levels. The MoH has yet to develop a national rehabilitation policy. Zambia offers diploma and degree courses in physiotherapy.

There are no national rehabilitation policy guidelines, therefore developing services is a challenge. Most rehabilitation services are provided only in three main hospitals, which are a long distance away from most disabled persons who live in rural areas.

Zimbabwe

There are an estimated 1.2 million disabled persons in the country. The National Disabled Persons Act was passed in 1992 and envisages equal opportunities and full participation. Institutional rehabilitation services are accessible to only 24 000 (2%) disabled persons and those in rural areas are neglected. In 2002, a general population census was conducted, during which information about disability was collected by using broad definitions as given in the WHO manual. A category for albinos was added. The report is expected in December 2004.

Rehabilitation is mainly carried out in communities. In 1981, rehabilitation services were established at district level and were intended to provide outreach services as well as promote CBR. The process is not yet complete. Zimbabwe has a new cadre of rehabilitation workers—the rehabilitation technicians. CBR was initiated in 1988 and covers all districts despite difficulties due to limited resources and personnel.

Review of Rules

Rule 2--Medical care

Dr Deepak made a brief presentation to highlight some of the major issues linked to medical care services for disabled persons. He mentioned the difficulties in organizing different approaches to service delivery including institution-based and community-based services, the difficulties of access to medical care, lack of multi-disciplinary teams, difficulties in early detection, the greater focus on curative aspects and the plight of more severe cases.

Participants were then divided into two groups for discussions on medical care. These discussions raised the issues of medical services, poverty, accessibility, decentralisation, use of funds and DPO involvement.

Medical services: There are different factors that may affect the provision medical services to disabled persons and to children with disabilities. Among these are ignorance and lack of knowledge about disabilities, cultural barriers, inaccessibility of services, long distances, lack of clear national policies on this issue, shortage of resources, lack of political will and security. Medical facilities may be inaccessible to mothers or caregivers. Sometimes there are barriers in communicating and medical personnel sometimes use (technical) terms not easily understood by the clients. Direct community awareness to eliminate cultural barriers is required and policies should be clear with distinct guidelines to health personnel. This requires resources and political will. Good policy, advocacy, awareness campaigns and the mass media can be used so that referral systems of medical care can function better.

Poverty amongst caregivers contributes to disability. Often, there are no resources for advocacy skills. Thus mobilisation of all the actors—governments, NGOs, other institutions—is needed.

Accessibility: Medical services can be made accessible either by exemptions or by subsidizing such that disabled persons pay less for the services.

Decentralization of the medical care services can be helpful, but a streamlined approach is needed in the referral systems. The issue of funding and proper budgeting at every level is important.

Use of funds: Improper allocation or misappropriation of funds for medical care activities for disabled persons will lead to these finances being used for other purposes.

Limitations of Disabled Persons Organizations: DPO involvement in planning and evaluation is limited because of different factors, including:

- (a) lack of capacity among disabled persons to take such roles. They might lack the necessary education and experience;
- (b) poor leadership skills in the disabled persons;
- (c) lack of financial resources to support their participation;
- (d) lack of a formal policy to involve DPOs in medical care issues;
- (e) DPOs may be working in isolation and sometimes there are conflicts between different DPOs.

Strategies to involve DPOs in planning and monitoring of medical care services require clear policies. Capable DPOs participating in planning and monitoring can lead to more effective and efficient service, and a sense of ownership among disabled persons.

This session was chaired by Ms Sheila Chidyausku from Zimbabwe and deputized by Mr Emmanuel Makundi from Tanzania.

Rule 3–Rehabilitation

Mr Chapal Khasnabis gave a presentation to explain the different issues linked to rehabilitation services, different approaches of rehabilitation and the general context of living for the majority of disabled persons in the world, raising different challenges that need to be tackled.

During the discussion session, issues of the role of institution-based rehabilitation were raised. It was clarified that countries need different levels of services including specialised rehabilitation services. It was also pointed out that a CBR programme can not run without support from referral level institutions. These specialised institutions also play a key role in activities such as training and research.

The group discussions raised the issues of a national rehabilitation policy, use of media, awareness and knowledge, rehabilitation services and human resources, focus on women and children and lack of data. Other issues also raised were DPOs, family support, CBR activities, poor co-ordination, low salaries, focal points, budgeting, collaboration and millennium development goals.

National rehabilitation policy: Countries need a clear national rehabilitation policy, which is also useful to in bringing together all the stakeholders.

Media: The media can play a vital role and should be better used to inform the public and decision-makers.

Strategies: The strategies must make sure that services are available to all disabled persons, and to all age groups. CBR is a good strategy to promote access to all disabled groups.

Awareness and knowledge among community health workers and leaders on early diagnosis of impairments is needed. There is also a lack of awareness, and negative attitudes towards disability, even among planners and decision makers. This situation should be changed.

Rehabilitation services and human resources: Costs of rehabilitation services and lack of skilled human resources are responsible for limitation of rehabilitation services. More emphasis should be placed on primary health care services since these are often not considered as a priority. Resources should also be provided and recognition of the fact that rehabilitation is a right and not a charity issue.

Focus on women and children: Women and children may not benefit equally from rehabilitation services as they face more obstacles to access of services. Key hurdles are:

- (a) Lack of knowledge among personnel and families. Some donor-driven funding only focuses on certain disabilities.
- (b) Centralisation of services. Services are concentrated mainly in specific urban locations, thus ignoring rural areas.
- (c) Delivery systems are sometimes inefficient and there is a lack of information. People do not know that services exist and that they are accessible. These services are also too costly especially for children and elderly.

Data: Lack of data about disabled persons and their rehabilitation needs is a problem.

Disabled Persons Organizations: DPOs need to decentralise to lower levels. Most DPOs are based in national capitals without any links to the grassroots. By decentralising they can play a more active role at community level. If DPOs are united they can advocate better for their rights.

Family support: Persons with disabilities and their families play an insufficient role in planning and monitoring of rehabilitation services. Some of the constraints related to this issue include negligence from planners and very limited choices for disabled persons. The “nothing about us without us” principle should be respected. Environments and attitudes need to change to promote participation of disabled persons in planning and implementation of services. This requires that persons with disabilities be empowered in terms of education, training, employment, and health, among others.

CBR activities are mostly at local levels in some areas and need to be extended to cover larger areas until they reach national level. CBR programmes also need to be integrated into PHC to help in extending the coverage. Involving school health, reproductive health, and youth programmes can also help. Positive role models, for example, disabled persons in parliament, can play a key role in influencing decisions. The economic impact of rehabilitation services in the medium- and long-term needs to be understood and used for advocating more resources for rehabilitation services, especially at community levels.

Poor co-ordination between different stakeholders, and between different ministries, can create confusion and reduce efficiency.

Low salaries: Low salaries of the personnel are some times very low so trained persons do not remain in the country and there is high level of brain drain. To reduce this, career and employment opportunities need to be addressed.

Focal person: A focal person on disability matters at national level in MoH (or other lead ministry) is required. There is often quick turn-over of these persons and there is lack of consistency on follow-up. Focal persons at sub-national levels can provide additional support for monitoring and planning of activities. Even when focal persons are appointed, there is need to monitor if the person can and does dedicate sufficient time to disability issues.

Budgets: Ministries need to provide a budget allocation for disability and rehabilitation services. Those making budget decisions should be convinced to consider disability and rehabilitation a priority. Budget allocation is based on different criteria, such as the “burden of disease”, or an essential health package. Without data, there may be estimates and projections. Advocates for

rehabilitation need to understand how the budgets are decided, in order to use that specific information to advocate adequate resources for disability and rehabilitation services.

Collaboration: Strengthening intersectoral and interdisciplinary collaboration between ministries and other stakeholders is needed. , Mainstreaming the disability agenda is needed at all levels. Rehabilitation should not be seen only at the national level but also in the community, and planners may lack this kind of knowledge. When thinking about community level activities, planners tend to consider PHC and immunisation services to the exclusion of disability and rehabilitation.

Millennium Development Goals: MDGs and their links with disability issues in terms of poverty reduction, child mortality reduction and environmental sustainability are very important. Countries must therefore view disability and rehabilitation issues in terms of MDG and make use of funds available in order to strengthen rehabilitation services.

This session was chaired by Mr Solomon Beiene Tseggai of (Eritrea) and deputized by Ms Beatrice Mwape (Zambia).

Rule 4–Support services

The presentation on rule 4 highlighted indicated that support services and rehabilitation should go hand-in-hand as both are important. Assistive devices are part of support services. However, among rehabilitation services, they are often neglected. These include mobility aids, orthotics, prosthetics, hearing aids, walking aids, Braille machines, signalling devices and low vision aids. For example, a mobile phone in vibrating mode for messages can be an important aid for the hearing-impaired. Support services by themselves do not resolve problems and need to be linked with accessibility, affordability and CBR programmes, wherever possible. Communication and information technology can help in significantly reducing the impact of disability. Only 2–5% of disabled persons can access rehabilitation services. Governments should play a key role in supplying assistive devices and ensuring support services as envisioned in UN Standard rules. Nevertheless, there can be lack of co-ordination between different providers.

A brief discussion followed the presentation. Among the issues included were acceptability of devices to users, problems with donated assistive devices, which are not always appropriate, cost, collaboration among countries in the same region, and adaptation of technology imported from other countries. The groups discussed constraints to support services and strategies to overcome them.

The issues emerging during the group discussions on support services included lack of resources for assistive devices, local production, costly devices, country needs, personal assistance, financial support and post-rehabilitation awareness.

Lack of resources for assistive devices: There is often a lack of finances and funds from the World Bank and other agencies such as the International Committee of the Red Cross (ICRC) have been used to provide assistive devices. Aid from donors is also used commonly for supporting orthopaedic workshops. Governments must assume the overall responsibility for providing the

assistive devices, although they can sub-contract the supply of devices if needed. Additionally, governments can facilitate NGOs to provide funds to cover some costs; play a catalyst role with NGOs and private sector by introducing tax exemption for import and other measures that can help in lowering the costs; elaborate clear policies on support services; and establish technical committees (involving relevant NGOs) for defining need for assistance and technical advice on appliances. Assistive devices for paraplegic patients, in particular catheters and orthopaedic beds, are often excluded from discussions and are very difficult to get anywhere in Africa. Innovative ideas are needed in considering how to solve this problem.

Local production: As far as possible, assistive devices should be produced locally, and if needed, expertise can be imported to train local personnel. It was suggested that more complicated assistive devices can be produced regionally and this should be supported through proper national policies. National Policies should foresee links between governments and NGOs for co-ordinating the supply of devices. Poor disabled persons require subsidized or free assistive devices although organizing an effective system for this may not be easy. Local materials for production of appliances should be standardised. This is because the quality of materials used locally can be very different and sometimes inferior. Standardisation would ensure that only devices that are acceptable are put into the market.

Costly devices: Some aids such as hearing aids can be very costly even with tax exemption. Thus, they remain inaccessible to the poor. A supply of such costly devices at more accessible prices in Africa should be identified. Regional collaboration for such devices should be promoted and the supply of such devices should be subsidized.

Country needs: Often the needs of the country are not known and there is no full picture in understanding the shortage of different appliances. Epidemiological studies about the need of assistive devices are needed urgently.

Personal assistance: This can be a problem at home, work, school, or in community activities. Lack of resources limits the possibilities for providing this kind of support. In some countries, sight-impaired teachers may receive support or those working in offices may be provided personal assistance. Sign language interpreters are provided in the judicial system within different countries.

Financial support: Poor families with disabled children need support for counselling, guidance and other resources. Some countries give a small pension or allowance for very poor disabled persons, the elderly and children at risk but this is available only in a few countries. Furthermore, only a small percentage of persons that need such help receive it. These schemes seem to have limited impact, partly because allowances are small. National policies ought to be more structured, and could consider giving loans for income-generation instead of small monetary handouts.

Post-rehabilitation awareness: Information on the steps and services to take after rehabilitation is required. Assistive devices should suit the context and living conditions of the users, otherwise they will not be used. Additionally, devices are sometimes abandoned for cultural and economic reasons. When people are desperately poor, giving them assistive devices without giving them hope of a livelihood will be failed rehabilitation.

This session was chaired by Mr Asfa Ashengo Agago (Ethiopia) and deputized by Ms Charity Wachira.

Rule 19—Personnel training

In his presentation on different issues related to rule 19, Mr Khasnabis pointed out that the disabled population is growing due to various factors—aging, injuries, wars, chronic disease and lack of access to health services. For example, 1–2 million persons become blind every year due to lack of services and 75% of this disability could have been prevented. Families and professionals may have different priorities and perceptions about needs. The training curriculum and contents may not always reflect the working needs of health professionals after training. Disabled persons and DPOs are usually not involved in developing of the training curriculum of rehabilitation personnel.

This presentation stimulated a lot of discussion. It was pointed out that some of the issues raised might be outside the mandate of health professionals. CBR requires a multisectoral approach and health professionals need to be aware of links with other issues such as education, vocational training, income and social status. If professionals are unaware of important issues such as the Standard Rules, they cannot provide proper care. The UN Standard rules should be part of the training curriculum of all professionals, including all health professionals and not just for persons working in disability and rehabilitation-related activities. The conflict between health professionals and DPOs is an acute issue and health professionals need to participate in this process in a constructive manner.

Questions that arose during these discussions included the role of professionals in rehabilitation; professionals' understanding of the real needs of persons with disabilities; extent of information required for health professionals in order for them to be able to properly serve persons with disabilities.

Following the plenary discussions, participants were subdivided in two groups for further discussions. The issues discussed included disability issues, MoH focus, traditional skills, training, capacity-building and the role of disabled women and girls.

Disability issues may not be included in training curricula for nurses and doctors so this has a negative effect on referral services. It should be made a part of the examinable content of the courses.

Ministries of health focus more on curative services rather than on preventive, promotive and rehabilitative services. It is important to show success stories of rehabilitation to convince health professionals. There is often limited prioritisation on the issues of disability and rehabilitation in key ministries.

Traditional skills aimed at disabled persons need to expand to more intellectually challenging skills such as computer skills. A change from the conventional thinking that all these persons can do is weave baskets and act as telephone operators is drastically required.

Training: Basic, secondary and higher level education and training for disabled persons is important. DPOs can play a vital role as advocates for training. Training should be given to disabled persons and families as well. It is important to clarify the objectives of such training and

the UN Standard Rules should be included. The number of institutions that can accept disabled students are very limited. Physical barriers are an obstacle, as is the lack of skills among teachers to work with disabled students.

Capacity-building for DPOs and disabled persons is crucial. Without this they will not be able to take on the responsibilities that they should. In some countries, ministries may reserve a percentage of training seats for disabled persons, for example, teachers' training. Training institutions should be user-friendly and accessible to disabled students. Training materials should also be accessible in appropriate formats, with accompanying aids (e.g. texts in Braille with Braille readers.) DPOs are involved in curriculum development in a few countries and all countries should follow this example.

The role of disabled women and girls: Special care is needed for promoting role of disabled women and girls. They are often left out of programmes. Promotion of schooling at lower levels is also needed otherwise disabled persons will not benefit from employment opportunities as they do not fulfil minimum conditions.

General Recommendations

Mr Khasnabis presented the draft resolution on disability and rehabilitation that has been approved by the Executive Board of WHO and that will be presented to World Health Assembly in May 2005. The participants then formed two groups to make broad recommendations to national ministries, African regional collaboration agencies, DPOs and WHO. Country-specific proposals were also prepared.

National policy on disability and rehabilitation: A national policy on disability and rehabilitation should be in place in each country. The policies should address different aspects such as medical care, support devices, training and cultural issues. Advocacy is needed for governmental policies in order to increase the budget allocation for disability and rehabilitation services.

Poverty and under-development: These are the main causes for exclusion of persons with disability from full participation. National authorities must implement international declarations and regulations.

Information-sharing: Information-sharing and exchange of experiences among countries in the region should be strengthened. Information-sharing at intercountry level about specific services such as speech therapy and hearing-aids available in different countries should be encouraged. Intercountry manpower development and sharing of information about existing programmes and training courses in different countries in the region need to be promoted.

UN Standard Rules: The rules linked to health (Rules 2, 3, 4, 19) should be included in various training curriculum at different levels including diploma courses, certificate courses and degree courses. Awareness raising on UN Standard Rules is also needed for DPOs and for persons with disabilities.

Training of rehabilitation professionals: Governments should focus on the training of rehabilitation professionals. Persons with disabilities should be provided with training as

rehabilitation professionals. Disability and rehabilitation issues should be mainstreamed is needed in all curriculum development for health professionals.

Strengthening DPOs: DPOs should be strengthened and actively involved from the onset in planning implementation and monitoring of activities related to disability and rehabilitation.

Focal persons with clear job descriptions should be identified in all ministries dealing with disability and rehabilitation issues. Some of these focal persons should be persons with disabilities. Governments should give due attention to infrastructure and also develop information technology that is accessible to disabled persons.

Regular stakeholder meetings: World Health Organization Regional Office for Africa should organize such meetings regularly to monitor the progress of implementation of health related UN Standard Rules.

Country recommendations

Zimbabwe

The stakeholders' meeting of health professionals and DPOs should be organized to examine the four UN Standard Rules related to health. They should also begin preparations on a national policy on disability and rehabilitation. The MoH should develop mechanisms to sustain a national disability and rehabilitation policy.

Personnel development and training should be promoted. There is need for speech therapists, for which training is needed. A training course for upgrading rehabilitation technicians is needed, from certificate to diploma level. Technical assistance is needed for this. Retraining of community health workers and primary health care nurses to revive the CBR programme is also needed. Capacity-building for DPOs is considered a priority for working together.

The country requires WHO assistance in identification and provision of equipment. This would include linkages with Botswana for the possible supply of hearing aids, linkages with the International Committee of the Red Cross and for exchange visits. Children with disabilities should be identified early and rehabilitated. Disability and rehabilitation activities must be mainstreamed and sign language should be promoted at all levels.

Advocacy is required for budget allocation in different ministries for activities related to disability and rehabilitation.

Zambia

The country requires support from WHO for definition of a national policy that will help in implementation and monitoring of rehabilitation programmes. Reference materials and guidelines on national policy for disability and rehabilitation are needed.

In order to promote multidisciplinary participation of different professionals such as physiotherapists, speech therapists, personnel training for responsible persons dealing with

disability and rehabilitation, including DPOs, is required. This will help build up a pyramid with a large-scale trained force at the base.

Special awareness meetings that bring together persons from different ministries, professions, DPOs, and NGOs on disability and rehabilitation issues should be promoted. Support from WHO for organizing such meetings would be appreciated.

Tanzania

A focal person is needed in the Ministry of Health for disability and rehabilitation issues. Awareness on the UN Standard Rules on health should also be promoted. The Ministry of Health budget should cater for disability and rehabilitation activities.

Institutions should be sensitised to include disability and rehabilitation issues during the curriculum review for training of different health professionals, and promote inclusion of persons with disabilities in training and service programmes.

Malawi

Human resource development is needed with emphasis on personnel such as physiotherapists, speech therapists, etc. This can be done with help of NGOs. A Disability and Rehabilitation desk should be established at the Ministry of Health.

MACOHA should strengthen and expand the CBR programme to cover the whole country. DPOs should also be strengthened and supported in capacity-building activities.

Eritrea

WHO should continue assisting the capacity-building of rehabilitation workers in Eritrea. The organization should also continue to support and strengthen development of orthopaedic workshops at zonal level. World Health Organization Regional Office for Africa and WHO Eritrea should support disability and rehabilitation related activities.

Ethiopia

The existing laws, rules and regulations must be enforced. External resources and technical support is needed. Accessibility of services (including physical access to many places) is still a big challenge and should be improved. Training programmes for rehabilitation professionals need more attention and support, including development of curricula and establishment of new institutions.

Lobbying, advocacy and awareness for stronger DPOs is needed so that they can play a more significant role and claim their rights. The possibility of linking disability and rehabilitation issues with New Partnership for Africa's Development (NEPAD) for accessing resources should be explored.

A continental plan of action for the African Decade on Disability (1999–2009) has been made. These should be linked to the implementation of the UN Standard Rules related to health.

Kenya

The Disability Act that came into effect in July 2004 should be implemented. The Plan of Action on the African Decade on Disability should also be put into operation. The development of a national disability and rehabilitation policy should be promoted, along with mainstreaming disability and rehabilitation activities in all programmes of Government at all levels. Finally, the data on disabled persons should be improved.

Field visit

As part of the field visit, participants went to the following three centres:

National Association for Empowerment of Disabled Persons in Congo

This is a small NGO based in a small village at the southern periphery of Brazzaville. It comprises war widows with disability who are involved in income-generation activities.

National Centre for Professional Rehabilitation

This is an International Labour Organization- (ILO) supported state organization where professional and vocational training is given to persons with disability.

Bifouti Cooperative of Young Deaf Persons

This NGO provides medical services and education to deaf persons. The beneficiaries are involved in income-generation mainly through a commercial carpentry workshop.

Conclusion

Mr Nega Mekonnen (Ethiopia) gave a vote of thanks as the meeting drew to a close. He thanked the organizers, participants and everyone involved in the meeting for their support for organizing this meeting on UN Standard Rules and expressed his appreciation for the constructive discussions held. In his appreciation, he singled out the methodology, ample time devoted for discussions and the involvement of DPOs in the meeting.

Dr Kobusingye, the AFRO representative, also thanked all the participants on behalf of her organization.

ANNEX 1

Country Reports

Eritrea

Eritrea is divided into six zones. There are about 150 000 persons with disabilities in a population of 3.5 million. The disabilities common in the country include mental illness, physical disabilities, blindness and deafness. The main causes of the disabilities are wars, accidents, diseases and congenital factors. Many different ministries including Ministry of Health and Ministry of Labour and Social Welfare are involved in rehabilitation activities. The National Constitution of Eritrea asks for equality of all persons including disabled persons. In 1999, a new national policy on disability was approved. The Ministry of Labour and Social Welfare is the leading agency for rehabilitation while Ministry of Health looks mainly after medical care aspects.

Medical care activities: The activities carried out include promotion of primary health care approach, training of families for early detection of disabilities and provision of free medical care to disabled persons. Constraints for implementation of medical care activities include insufficient trained personnel especially for mental illness. A national board on disability with members from both governmental and non-governmental organizations has been created.

Rehabilitation activities: CBR programmes are the main strategy for rehabilitation in Eritrea. At the same time, there is shortage of specialised rehabilitation personnel in the country. Referral level services support for the CBR are therefore insufficient.

Support services: Locally produced and imported assistive devices are not enough to satisfy the demands and needs in the country. Disabled persons and their families are not aware about the availability of the devices. Local production of devices is below international standards.

Personnel training: There are some training centre in the country such as Orotta School of Medicine, College of Nursing (it also trains psychiatric nurses and physiotherapists) and College of Health Sciences. Some people receive scholarships for training abroad. It is very important to create linkages and to network between different government ministries and departments, religious institutions, NGOs, village committees and CBR workers that work in rehabilitation.

Ethiopia

Ethiopia has a population of 72 million. There are about 1 million persons with disabilities (data from the general census in 1994, which does not include homeless persons). The Federal Ministry of Labour and Social Affair is the lead ministry for rehabilitation. The Constitution of Ethiopia foresees support for persons with disabilities. A proclamation on the rights of disabled persons to employment was made in 1994. This proclamation includes focus on ending discrimination towards disabled persons in employment and states that any governmental and private sectors should reserve suitable posts for disabled persons. This policy together with the developmental social welfare policy approved in November 1996 set ambitious goals for rehabilitation, awareness raising, institutional- and community-based rehabilitation and for

promoting self-reliance among disabled persons. Another important policy is the national education policy for education and training for persons with disabilities.

The national health policy focuses mainly on the prevention of disabilities. In 1999, a national programme of action concerning rehabilitation was launched and includes prevention of disabilities as well as implementation of rehabilitation activities. It also promotes inclusion of disability issues in all developmental work with the goal of mainstreaming disability. This document was translated into Amharic and awareness-promoting workshops organized.

Medical care: Public health centres for poor exist but coverage is poor. Among the constraints are poor access to health centres, language barriers, and a lack of awareness among health professionals about disability.

Rehabilitation: Coverage of both institution-based and community-based rehabilitation activities is limited. There are few special schools for blind and deaf persons. Rehabilitation services are run mainly by the government and are located only in urban areas. Poverty worsens the situation of disabled persons. Other constraints include lack of capacity, resources and skilled personnel.

Support services: Constraints regarding support services include high costs for and shortage of assistive devices. There is also a lack of awareness of the importance of assistive devices in the community. There are six orthopaedic workshops in country that provide devices on cost-sharing basis.

Personnel training: The country trains fifty special education teachers annually and physiotherapy training has recently been established with World Bank support. For CBR workers, constraints are lack of training centres on disability and insufficient support from Government. There are no training possibilities for occupational and vocational therapists.

Networks: There is a network of different DPOs, the Ethiopian Federation of Persons with Disabilities. There is also an informal forum of 60 organizations active in disability that was recently created. Finally, there is a CBR network of eight organizations involved in CBR.

Kenya

Persons with disabilities represent 3 million persons, which is about 10% of the total population. There are major problems in relation to education and employment, and disabled persons are not involved in planning and policy-making. Poverty, socio-cultural and economic prejudices are other issues affecting persons with disabilities. Disabled women are more disadvantaged compared to men.

A Disability Act was adopted in 2004. It deals with human rights and equal opportunities. The Kenya National Plan of Action for African Decade was launched in January 2004. A disability policy has been drafted for promoting integration in the national development process. The Ministry of Gender, Sports, Culture and Development is the lead ministry for rehabilitation. It would like all institutions to make plans for implementing the ideas of the national policy and would like to develop a strategy for monitoring the implementation of this policy. In its implementation, a district action plan should be made in all 72 districts of the country. Journalists

are a special target group for awareness activities. Kenya is also studying the draft proposed UN convention on disability. The National Disability Act needs to be simplified and translated into Kiswahili. It is also planned that a national steering committee be created. Kenya also has the Children Act, with specific provisions for disabled children. Similarly, there is also a Gender Act.

The MoH has the mandate for health in a global sense. This ministry promotes early screening, diagnosis, prevention, and vaccination. If disability has already occurred, it promotes involvement of multi-specialist teams to reduce disability. Physiotherapy plays an important role in this process. CBR has been added among the activities and there is need to expand its coverage. CBR is integrated in primary health care since it works through the same infrastructure. A division of rehabilitation has been created in the ministry. Interdisciplinary collaboration with other ministries and departments is encouraged. AIDS is a major contributor to disability; therefore voluntary counselling centres for deaf persons have been started. All health centres have been provided with equipment to promote rehabilitation. This ensures that action on disability is at different levels. A comprehensive data bank on disability is an interest of the MoH.

Malawi

Rehabilitation: The Ministry of Health works with the Ministry of Social Development and Disability. MoH is mainly responsible for prevention of disabilities. Most of government services are provided free. Christian Health Association of Malawi (CHAM) is an NGO that requires some payment for the services they provide. Since the MoH cannot cover all areas, some areas are covered by CHAM and the government pays salaries of their personnel. Polio and leprosy control programmes have been successful. The blindness prevention programme is also proceeding well. Village committees that work for early detection of disabilities have been set up by the ministry. There is a severe shortfall of qualified personnel in governmental services so most services are provided by NGOs like MACOHA. Rehabilitation activities are done mainly by MACOHA with support from the Ministry of Social Development and Disability. The Minister himself is a disabled person and is highly aware of disability issues. There is a multisectoral CBR programme. The MoH also supports disabled students for studies.

Training of personnel: There are many possibilities for vocational training but none for physiotherapist training in the country as there is only a rehabilitation technician training course. There is a need to train physiotherapists.

Medical care: There are hospitals such as Malawi College of Medicine and the College of Health Sciences among others that provide services. The Ministry of Health is mainly concerned with curative care and medical rehabilitation services are not seen as a priority.

Support services: There is only one orthopaedic workshop, located in Blantyre, so there is a big gap in supply of assistive devices. Some NGO-supported hospitals also provide appliances. The MoH has no budget for appliances so they have to rely on donations.

UN Standard Rules: The rules have been translated into local languages and distributed widely. A national disability policy has been drafted and should be approved before the end of 2004. The Ministry of Social Development and Disability recently organized a disability awareness workshop targeting government officials, planners and decision-makers. DPOs were also involved

in this meeting. A major constraint is lack of sufficient funds so service provision is not satisfactory. DPOs do not have the capacity to advocate and support government in laws that guarantee equal opportunities for persons with disabilities.

Tanzania

Following participation in the World Health Organization Regional Office for Africa intercountry meeting held in Asmara in November 2001, there were many key recommendations that have had an important impact in Tanzania. A national policy on rehabilitation was adopted by the government in March 2004. This policy aims at mainstreaming disability issues and has operational guidelines for all stakeholders.

It was decided that the national census should include disability data. As a result, in October 2002 this question was added in the population census and it showed 676,502 disabled persons (1.96% of the population). A study has been carried out at community level in all 21 regions of Tanzania to assess the burden of disability. When data about disability discovered in the national census was circulated, there was some concern about the accuracy of the data. This may be because not all categories of disabled persons were included in the census. Experience from this census will serve in making future improvements.

Tanzania has promoted the devolution and decentralisation of health services at district level. It was recommended to specifically assess needs of disabled persons for making district plans. It has also been recommended to recruit social welfare officers by the end of 2005 in all districts. Districts are autonomous and if they do not include plans for disabled persons there will be problems, therefore the ministry has made recommendations about including disability in district plans.

A multisectoral national task force has taken on new vigour following discussions with key stakeholders. This team has been in existence for last ten years but has not functioning effectively. Another meeting for the task force on strengthening of national disability is planned for December 2004.

Training of rehabilitation medicine personnel has continued with support for training of other new specialities added over the last few years. These include occupational therapy, optometry, ophthalmology, speech therapy and CBR. Other training programmes such as physiotherapy training also continue. Additional rehabilitation services have been established in some consultant/regional hospitals. The budget for rehabilitation has increased over the last five years.

Challenges include low awareness; lack of clarity about priorities for resource allocation; poor co-ordination with the social welfare department which is part of the Ministry of Labour, Youth Development and Sports; low skills of personnel in terms of managing and planning of activities; and inadequate services for persons with disabilities. There are few referral hospitals and few regional governmental hospitals, while support comes from a few missionary hospitals.

Zambia

There are 10 million people in the country of which 2.7% are disabled. Out of all disabled persons, 39% are physically disabled while the remaining include blind persons, partially sighted, persons with hearing and speech impairments, the mentally ill and persons with intellectual impairment. The government is committed to improving quality of health of the citizens and there have been reforms for decentralisation in 1991.

There are three central hospitals, eight copper-mine hospitals, one military hospital, 18 general hospitals (regional), 72 district and mission hospitals, 899 rural health centres and 187 urban health centres. Rehabilitation services are available only at central, general and district hospital levels. Physiotherapy services are also available at some private hospitals. The basic strategy is that cost-effective, quality health care is provided as close as possible to the individual's family. The MoH still has to develop a national rehabilitation policy. Some orthopaedic workshops have been developed with German assistance. Zambia has a diploma course and a degree course in physiotherapy. There is need to mobilise funds for procurement and maintenance of rehabilitation equipment.

There are no national rehabilitation policy guidelines, so developing services is a challenge. Constraints include lack of equipment, old equipment, shortage of qualified personnel and the issue of brain drain. Disability-related responsibilities are fragmented between different ministries. The MoH, Ministry of Youth, Sports and Child Development, and the Ministry of Community Development and Social Services all play a role but these activities are not adequately co-ordinated. Most rehabilitation services are provided only in three main hospitals that are too far away for most disabled persons living in rural areas. The level of poverty is very high in rural areas. In 2000, 80% of persons in rural areas and about 25% in urban areas were considered poor. The problem of poverty is even worse for disabled persons as they have no job, no access to education, and they can't access rehabilitation services.

Ideas for the future include developing a national policy, training of personnel, procurement of rehabilitation equipment and improvement of infrastructure. Zambia would like to involve WHO for development of national policy and guidelines. It might then be easier to involve donors.

Zimbabwe

The total population is about 12 million of whom 70% live in rural areas. There are an estimated 1.2 million disabled persons in the country. The National Disabled Persons Act was enacted in 1992 and foresees equal opportunities and full participation.

Health services are organized at different levels. At hospital level, 50% of disabilities that are seen are due to soft-tissue injuries (physical), 17% are neurological, 12% are medical such as respiratory infections and 7% are burns. Other common disabilities include psychiatric illness, visual disabilities and hearing disabilities. Institutional rehabilitation services are accessible only to 2% of disabled persons. Disabled persons in rural areas are neglected where social prejudice and attitudes create more barriers. In 2002, a general population census was conducted, during which

information about disability was collected by using broad definitions as given in the WHO manual and adding to it the category of albinos. The report of this data collection is projected for release in December 2004.

Medical care: This is organized mainly in terms of prevention, such as the extended programme of immunisation (EPI). The aim is to provide improved quality of care in hospitals, promote training of medical personnel and strengthen a two-way referral system between different levels. Community level workers are linked to rural health centres that are staffed by nurses. The nurses can refer cases to doctors at district level. Services such as emergency care, ambulances and intensive care are needed to minimise the number of disabilities following accidents.

Rehabilitation: This is mainly in terms of CBR. In 1981, rehabilitation services were established at district level and they were supposed to provide outreach services as well as promote CBR. The idea was to promote rehabilitation in remote rural communities with decentralisation of rehabilitation services. The process is not yet completed. Zimbabwe has a new set of rehabilitation workers—the rehabilitation technicians—who can study for a further diploma or degree qualification. Training of rehabilitation technicians is also provided for other countries such as Lesotho and Gambia. CBR was initiated in 1988, and covers all districts despite facing difficulties due to limited resources and personnel.

Support services: These are under the mandate of both MoH and Ministry of Social Welfare and Labour. The MoH is also responsible for orthopaedic workshops that manufacture Prosthetics and Orthotics (PandO). These appliances are given to the poor with a 25% subsidy. The Ministry of Labour provides vocational training, assistive devices and support for income-generation activities. Local governments also help with housing. Television broadcasts in sign language are available once a week, while the government has provided some tax incentives for services related to disabled persons (for example, since August 2004, there has been a customs duty waiver for vehicles for disabled persons). According to the national rules, all new buildings must be accessible to people with disabilities. The front seats in buses are reserved for disabled persons, and blind persons can travel free on national railways.

Challenges: These include poor access to community activities, lack of social and cultural activities, difficulties in accessing health services due to fees, physical barriers, issues of gender sensitivity, disability rights, discrimination, poor access to land redistribution, communication barriers (lack of translation into Braille and sign languages), limited availability of appliances, lack of information on HIV and other health problems.

Creating links between rehabilitation services and other programmes such as non-communicable diseases or reproductive health, communicable diseases, issues of children's rights and law enforcement agencies are needed. There should be a focal person concerned with disability in every ministry. Zimbabwe proposes a disability desk at Southern Africa Development Community (SADAC). Zimbabwe has a 3% AIDS tax on salaries and there is a proposal for a disability tax to fund rehabilitation activities.

ANNEX 2

LIST OF PARTICIPANTS

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