Baseline Study on the Status of Persons with Disabilities and the Influence of the African Decade Pronouncement in Ethiopia

(Policies & Program Implementation)

Submitted to the Federal Democratic Republic of Ethiopia Ministry of Labour and Social Affairs (MOLSA)
Commissioned by the Secretariat of the African Decade of Persons with Disabilities

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‘Final REPORT’
Abbreviations

ALERT: African Leprosy Research and training Institute
ADDP: African Decade of Disabled Persons
ARI: African Rehabilitation Institute
ART: Article
WFD: World Federation of the Deaf
CFE: Cheshire Foundation Ethiopia
CSA: Central Statistics Agency
CSE: Cheshire Services Ethiopia
CwD: Children with Disabilities
DPO: Disabled peoples organization
ENAB: Ethiopian National Association of the Blind
ENAD: Ethiopian National Association of the Deaf
ENAPAL: Ethiopian National Association of Persons Affected by Leprosy
ENAPH: Ethiopian National Association of the Physically Handicapped
ENAIM: Ethiopian National Association for the Intellectually Disabled
EWDNA: Ethiopian Women with Disabilities National Association
NDSC: National Decade Stirring Committee
ENDAN: Ethiopian National Disability Action Network
CBR: Community Based Rehabilitation
CBM: Christopher Blinden Mission
HI: Handicap international
HPDO: Help Persons with Disabilities Organizations
ENABD: Ethiopian National Association for the Blind & Deaf
ESDEP: Education Sector Development program
FDRE: Federal Democratic Republic of Ethiopia
FENPD: Federation of Ethiopian National Association of Persons with Disabilities
GDP: Gross Domestic Product
GLRA: German Leprosy Relief Association
HIV/AIDS:
HSDD: Health Sector Development Strategy
ICF: International Classification of functionning
ILO: International Labour Organization
MDG: Millennium Development Goal
MoE: Ministry of Education
MoH: Ministry of Health
MoLSA: Ministry of Labour & Social Affairs
MoUD: Ministry of Urban Development
MoYC: Ministry of Youth & Culture
NCPB: National Committee for the Prevention of Blindness
NDSC: National Decade Stirring Committee
NGO: Nongovernmental Organizations
OSE: Ophthalmological Society of Ethiopia
PASDEP: Plan for Accelerated Sustainable Development to End Poverty
POC: Prosthetic Orthotic Centre
PPP: Purchasing Power Parity
SADDP: Secretariat of the African Decade of Disabled Persons
CSE: Cheshire Services Ethiopia
CFE: Cheshire Foundation Ethiopia
SNE: Special needs Education
SNNP: Southern Nations & Nationalities Peoples
TB: Tuberculosis
TDA: Tigray Development Agency
TGE: Transitional Government of Ethiopia
TPE: Training & Education Policy
UN: United Nations
UNGA: United Nations General Assembly
USA: United States of America
WHO: World Health Organization
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I. Introduction
Following the decision of the African Union (AU) to dedicate the first 10 years of the new millennium (1999–2009) as the African Decade for Persons with Disabilities (ADPD), three organizations (Viz. The African Union’s Labour and Social Affairs Commission, the African Rehabilitation Institute (ARI) and the International Labour Organisation (ILO)) have joined together in Addis Ababa in 2001 and drafted a Continental Plan of Action that will guide all prescribing African member states to implement the African Decade pronouncement.

As part of this plan, the Secretariat for the African Decade of Disabled Persons (SADPD) was established and incorporated as a Non-Governmental Organization in South Africa in 2004. The secretariat was mainly entrusted with a responsibility of coordinating efforts and resources in disability program in Africa. Among, other things the secretariat is placed at the centre of providing capacity building for member states in their effort towards meeting the decade objective. Nevertheless the primary responsibility of adopting the decade declaration and implementation of the action plan is given to African states.

According to its own record, the secretariat has been instrumental in working with 25 governments1 in mainstreaming disability in national plans and sectoral strategies. As the Decade draws to a close, the Secretariat for the African Decade of Disabled Persons (SADPD) sought to carry out a baseline study on the status of disability mainstreaming in five out of the 25 African countries (Ethiopia, Rwanda, Senegal, Kenya, and Mozambique). The study was also meant to draw lesson from the first decade experience and adopt a better approach for the upcoming decade for which an extension is officially granted.

This study aims to provide information both on the current situation of people with disabilities in Ethiopia and a review of the extent to which disability mainstreaming has taken place in selected sectoral policies and strategies. In doing so, the assessment will also look into the influence of the decade pronouncement on the policy environment and the service delivery situation to PwD in Ethiopia. The study is commissioned by the Secretariat of the African Decade of Persons with Disabilities via the Ethiopian Ministry of Labour and Social Affairs

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1 The list of 25 countries include: Namibia, Lesotho, Malawi, Zambia, South Africa, Burundi, Cameroon, Tanzania, Uganda, Egypt, Mauritania, Tunisia, Gambia, Mali, Cape Verde, Ghana, Liberia, Togo, Guinea, and Burkina, Ethiopia, Rwanda, Senegal, Kenya, and Mozambique.
1.1 Objectives of the study

The main objective of the study is to document the existing situation of people with disabilities with regards to the legal, policy, and socio-economic environment in the country. In line with this broad objective it attempts to achieve the following sub-objectives:

Assess the existing laws, policies and strategies of selected sectors and see the extent to which the issue of disability is reflected and determine the scope of participation in the process by which the laws and policies have come about.

Assess the accessibility and quality of services and programmes relevant to disability and to what extent such services and programmes are inclusive of people with disabilities.

Determine the extent to which the pronouncement of the Decade and the Continental Plan of Action had influenced the situation for people with disabilities in Ethiopia.

Draw lesson that can be used to improve the approach in the extended decade.

1.2 The scope of Work

The scope the study for assessing the laws and policies will be national level but for detail scrutiny it will focus on the performance of the following key ministries: -

- Ministry of Labour and Social Affairs (MOLSA)
- Ministry of Education (MoE)
- Ministry of Health (MoH)
- Ministry of Youth, Culture and Sport (MoYCS)

1.3 Data Source, Methodology and Limitation

The study adopted a mix of qualitative and quantitative research designs involving desk and Internet reviews of relevant documents, interviews and focus group discussions with respondents in government ministries, disabled people’s organizations, non-governmental organizations (NGOs) and human rights organizations. This approach was deemed appropriate because it facilitated the gathering of comprehensive data for the study.
The qualitative data collection process involved 37 organizations. These include 9 government offices and 28 non-governmental offices, mainly DPOs, NGOs and donors (see annex 1 for complete list of contacted organizations). With these organizations, the study has relied on eleven key informants (mainly government office disability focal persons) from line ministries, interview with thirteen DPOs leaders and similar number of directors and program officers from NGOs. The major part of the data came from previous studies in the country, literature review of the policies and international standards, national plan and strategies that includes annual reports, policy documents, program updates (including those released in websites and those available in hard copies).

The study has been limited mainly by the absence of adequate and up-to-date data on the prevalence and current situation of PwDs. Notable the delay in the release of the recent population and housing census has forced the study to rely on census result that was conducted in 1994. On the other hand the study, by design, has been limited to key sectors and could not gather sub-national information from the respective regions.
II. Background

2.1 The Ethiopian Situation

With an area of slightly over 1.1 million square kilometres, Ethiopia is a vast country (about two and three times the sizes of France and Germany respectively). Current Ethiopian population, based on the 2007 population and housing survey, is slightly under 74 million. Using the same census of the Central Statistical Authority (CSA) nearly 62 million out of the total 74 million at that time (or 83.9 % of the total) live in rural areas and are either employees or their dependents of the agricultural sector.

The World Bank’s first country report on Ethiopia in 1950 cited the possibilities for the country’s further economic growth as ‘significant’. This view has been held by many observers and among the emerging African independent nations who have not only held Ethiopia in their highest regard for its success as the only uncolonized African state but went further to adopting the Ethiopian flag as a symbol to their freedom and independence (Easterly & Levine 1997). Despite the hopes, Ethiopia has not lived up to that high expectation in almost all fronts. Until recently, it underwent a staggering slow pace of democratic transformation in which no significant progress has been registered. It is yet long way to recuperate from the negative image cast by successive droughts and civil war. It has had one of the lowest economic growth rates over the past half century and as a result remained one of the least developed nations in the world.

Ethiopia has seen various forms of regimes, from monarchy to left-wing military junta and to the current reformist regime, which took power in 1991. With significant variability from one another, economic and social transformation had not seen any significant leap (for the most part) under all these regimes. As the current reformist regime took power, right after the pick of worst economic performance by the previous one, it has induced a sense of hope and optimism similar to the one that existed in many parts of the world in the 1950’s. However for the first 10-12 years, the relative satiability gained during this time has not produced a proportional progress in the socio economic and political life of the public. During the same period, the country has suffered spells of drought particularly in 2002 and also it has been

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2 The Ethiopian population based on the 2007 census was 73,918,505
dragged into border conflict with neighbouring Eritrea that costed human and economic resources that could otherwise have been made available for developmental activities. Despite the difficulties, encouraging progress is being made in the recent 7 years. The Ethiopian economy has experienced a multiple year successive double-digit economic growth (by government’s account).³

The current government has drafted a constitution in which it introduced a federal system that is based on ethnic and linguistic grounds. At the initial stage, most political forces have generally welcomed the move; it was thought to be the only way to help the over 80 linguistic groups gain autonomy for self administration and to get them on board with equal (proportional) representation in the political and economic arena of the larger Ethiopia; it has also allowed what most people have viewed as the first multi-party democracy in the country. Nevertheless in reality those bold steps have not yet settled well with all political forces in the country neither has it done enough to contain their interest.

The agriculture sector contributes 40 per cent of the value added to GDP and about 84 per cent to the value of exports. Despite its huge significance to the economy, the sector has not shown sufficient improvement of performance (if at all, there is any that surpasses population growth) over the last several decades. The poor performance of the agriculture sector is not an outcome of one or few factors and neither can its entire feature be fully described by merely looking at its economic contribution such as to GDP, export earnings, and to employment. But, the sector has a long spell of structural, socio political and demographic problems that have accumulated over a longer period of time.

Low levels of labour productivity and fast population growth exacerbate the low per capita income in poor countries. Fast growth in population becomes part of the problem rather than the solution when it increases the number of dependents per worker and when the increase in labour force is not accompanied by increase in means of production, including arable land and physical capital. The Population Reference Bureau (2004) projects that Ethiopia’s estimated population of 72 million in 2004 will increase to 117.6 in 2025 and to 176 million in 2050: an increase of 139 percent between 2004 and 2050, which would make the country the tenth most populous nation in the world (Population Reference Bureau 2004).

³ The World Bank and other international organizations also admit the fast growth but put the figure at slightly low, 6-9 percent in the last 5 years. The Economist, international business magazine 2009, described the Ethiopian economy as the fourth fastest growing economy in the world.
The Population Reference Bureau cites a high fertility rate, combined with a large proportion of young population, (what some call ‘the hidden population momentum’\(^4\)), as an explanation for the tremendous projected increase in population of some countries, including Ethiopia. With a fertility rate close to 6 children per woman, Ethiopia’s crude birth and death rates are far greater than the comparable rates in Sub-Saharan African countries and low-income countries as a group. In addition to the high fertility rate in Ethiopia, the population is young, with 45 percent of the population below 15 years of age and 97 percent below 64. The crude death rate per a thousands population is about twenty resulting in an average population growth rate of 2.6 percent for the years 1994 to 2007 (CSA 2007).

The success in the economic front of recent years can be attributed to policy measures the current regime has taken. Most notably the Plan for Accelerated Sustainable Development to End Poverty (PASDEP) and the subsequent triple five-year sectoral development plans have provided sufficient guidance towards ambitiously set targets. Even with the recent encouraging growth of the economy the performance of agriculture sector, as the primary employer of the available human resource, may not be one that can be taken for granted. Investment in education and health care must ensure the release of significant labour force into the non-agriculture sector. Ethiopia’s recent year’s effort to expand primary education in rural areas can be dubbed as success story from the standpoint of building the human capital; however there is much more that has to be done in terms of improving the quality to produce a workforce available for transforming the country.

### 2.2 The situation of Persons with Disabilities

According to the World Health Organization (WHO), there are 300 million people with disabilities in the world out of which 210 million (70 percent) live in developing countries. Apart from demographic reasons, the high prevalence of disability in poor countries shows the existence of causal relationship between poverty and disability. Disability is caused and aggravated by poor living condition, such as poor nutrition, lack of health and sanitation facilities and exposure to various forms of accident (WB XX). On the other hand, in poor countries, disability makes it difficult for people to get out of poverty. The absence of

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\(^4\) The hidden population momentum is a concept that is used to describe the fast growth in population that is expected to happen as a large proportion of currently young people enter to a child bearing age.
rehabilitation centres, lack of (equal) access to education, employment and other services makes it particularly an uphill battle for PwDs to overcome livelihood challenges.

Not surprisingly the most affected groups among the disabled are those that are in developing countries in general and women and children in particular. Statistics by international research organizations\(^5\) show that 80 percent of disabled persons in the developing countries (out of which more than 70 percent are women) do not have working opportunities. The same statistics shows that nearly 98 percent of children with disabilities are not in school while the same percentages of people with disabilities in developing countries do not have access to rehabilitative and other basic health services.

In the case of Ethiopia it estimated person with disabilities are more than 7.3 million\(^6\). Even though there is no current data on the situation of PwD, it is believed that the situation is far worse than the average for developing countries. Based on the 1994 survey and information obtained from Ministry of education the percentage of children in special need education program was nearly negligible. Despite some encouraging effort in recent years, there is little noticeable adjustment in the school system that would help to accommodate the need of disabled people. Lack of access to employment is the major challenge for disabled people. According to official information from the 1994 census, 85 percent of PwD live in rural areas, where there could be no enabling environmental factors for them to contribute to the labour force. Majority of those few who migrate to urban area make their living as beggars or on the merit of some charity organizations.

Despite progress in recent year, there is still some doubt on the functionality of the legal and policy environment in setting the stage for giving full recognition to PwD. There is a sense that the issues of disability are sidelined from major international development goals such as the MDG\(^7\). Given the proportion of disabled people and the situation in which they live, it is difficult to imagine meeting the MDG goals without improving the lives of PwD. The local policy environment in Ethiopia also reflects similar shortcoming when it comes to delivering the final products (details on policies and strategies are in chapter three). The aspect of service delivery is also by far lagging behind from what it ought to be. MoH has in many ways has

\(^5\) [www.Inclusion-international.org](http://www.Inclusion-international.org)

\(^6\) Calculated based on WHO estimate that on average each country has 10 percent its populated affected by disability. The current Ethiopian population (based on 2007 census) is nearly 74 million.

\(^7\) International day of PWD is celebrated in AA in December 3 every year with a motto “making the MGDs inclusive: empowerment of persons with disabilities and their communities around the
world"(2009)
not taken measures in formulating strategies that are tailored to disabled people. The few services that are currently being rendered are mostly sponsored by NGOs and visibly limited to urban areas and places where there is better accessibility.

### 2.3 Defining Disability

The definition of disability has evolved from what is known as an individual focused (medical model) definition to the environment focused (social model) definition. In the case of the former, the focus of the definition is on the physical and mental limitation of the person in contrast with what is deemed as normal physical and mental status. But in the case of the later it looks into a whole range of physical and social environment that can be adjusted in a way that would help the person with functional limitations to release his/her potential in full. In the social model, disability arises from the interaction of the person’s functional status (as opposed to physical/medical status) with the physical, cultural and policy environment (Shakespeare and Watson 1997). The explanation goes up to saying that “…if the environment is designed for full range of human functioning and incorporates appropriate accommodation and support, then people with functional limitation would not be ‘disabled’” (Mont 2007).

Operational definitions have been given by various international organizations in a way that reflects the shift in the understanding of the concept. The conceptual shift has also resulted in guiding the approach of policies and strategies towards ensuring the wellbeing of persons with disabilities. The emphasis, based on the ‘medical model’ was towards providing individual services such as rehabilitation and medical facilities (social welfare program). The shift towards the ‘social model’ has stepped up the approach into creating conducive physical, social and policy environment (right based approach). Two key definitions proposed by the WHO and ILO reflects the shift in the concept of disability as captured in the explanation of the two models.

Disability is any restriction or lack (resulting from impairment) of ability to perform an activity in the manner or with in the range considered as normal for human beings (WHO, 1976).
Disability is a state in which functional limitations and/or impairments are causative factors of existing difficulties in performing one or more activities which, (in accordance with the subjects age, sex and normative social role) generally accepted as essential basic components of daily living such as self care, social relationship and economic activity (ILO 2006)

Lately the WHO wing of the International Classification of functioning, Disability and Health (ICF) has come up with robust conceptual framework for defining and measuring disability. The framework has fully incorporated the effect of personal and environmental factors in creating the limitation.\(^8\)

The recent and most significant UN convention on the rights of people with disabilities also defined PWD as “those who have long term physical mental and intellectual or sensory impairments which in interaction with various barriers may hinder the full and effective participation in society in an equal basis with others (UNGA 2006). In view of the two models, the definition captures the aspects both the individual factor ‘long term physical…’ and the environmental factor ‘various barriers’.

Apart from defining the term, the approach also determines the techniques used for measuring disability. As we shall see latter Ethiopia is progressive in adopting international standards and conventions but it lags in providing reliable statistics on persons with disabilities. The 1994 census has accounted for PwD based on purely the individual/medical model of disability. The operational definition used for head counting was: a person is disabled if “ due to physical conditions or injuries s/he can not perform activities that other healthy person can perform, including work”. The question addressed to respondents in the census was “ is there a member of this HH who is physically or mentally disabled?” this question identifies body functions rather than level of (limitations or hindrance from) participation or activity.

### 2.4 Measuring disability and Disability Prevalence in Ethiopia

Measuring the prevalence of disability dramatically varies across countries of the world. The reasons for variation according to Daniel Mont (2007) are absence of universal definition, differences in methodology of data collection, difference in quality of study design. However differences in the social stigma attached to specific types of disabilities could also be one

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\(^{8}\) See the ICF homepage at [www.who.int/icf/icf%20home](http://www.who.int/icf/icftemplet.cfm)
strong reason for under reporting prevalence. The problem of under reporting disability (disability in hiding) is particularly common in developing countries where awareness levels are generally low. Good illustration for this is the contrast in the prevalence rate of disability in countries such as Kenya, Ethiopia, India and Bangladesh (reported as below 3 percent) where as countries like New Zealand, USA and Canada report above 15 percent.

On the other hand for poor countries like Ethiopia the only source of data for measuring prevalence is the national census whereas in developed countries they conduct surveys specifically designed for gauging disability prevalence rates. Census based information is usually spatially rich but temporally poor (less frequent and mostly outdated) (WB 2007). This is particularly true in poor countries due to the high cost associated to conducting nation wide data collection. In the case of Ethiopia national census is normally conducted once in decade\(^9\). The recent census was conducted in 2007 but the official report is yet to be released from the office of Central Statistical Authority (CSA)\(^{10}\). A draft report on the prevalence of disability is obtained from the 2007 census. The draft contained only the new head count of PwD that is divided by types of disability and segregated into different age group.

**Box 1-A: Ethiopia’s key disability figures from the Census and other studies**

\(^9\) 10 years is the normal interval for national census in Ethiopia but due to several reasons it can be delayed by 3-5 years. For example the recent census (2007) is conducted after 13 years, for which the document is not yet officially released.

\(^{10}\) CSA has released summary of the 2007 Population report of Ethiopia but unfortunately the data on disability is not adequately covered in the summary tables. At the time of writing this report it was not possible to access full statistics on disability such as regional distribution
People with disability are slightly over 800 thousand in number constituting 1.1 percent of the population in Ethiopia in 2007 (showing reduction from 1.9 percent in 1994)

Nearly a third of PwD are over 50 years old in Ethiopia implying causal relationship between old age and disability

Other studies conducted at regional level estimate that PWD constitute 12.7, 14.0 and 16.8 percents of Oromia, Amhara and SNNP regions respectively (the there most populous regions in Ethiopia by order of their population size), 1995.

In 2006, the national prevalence of blindness and low vision were 1.6 and 3.7 percents respectively. Significant variability in the prevalence of blindness is observed across regions, ranging from the highest 5.4 percent in Somali region to the lowest 0.7 percent in SNNP region.

Less than one percent children with disability have access to rehabilitation service

Less than 2 Percent of disabled children in school age have access to education that has special need facility

The causes for disability are numerous but major cause of disability in Ethiopia are man-made disaster (conflict, road accident, work related accidents, etc), prenatal causes, during natal and postnatal periods, alcohol and drug addiction, communicable diseases, harmful traditional practices and they are aggravated by poverty related factors such as malnutrition, lack of environmental hygiene,

The economic loss to Ethiopia as a result of excluding disabled people from the labour market estimated at USD 667 million or five percent of the countries GDP

WHO estimates that the average percentage of disabled people in a given country is around 10 percent (WHO 2001). Given the argument that disability has causal relationship with poverty, the prevalence is expected to be higher in poor nations. The disability statistics based on the 2007 census puts the number of disable people in Ethiopia at slightly higher than 800

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11 Sebastian Buckup, 2009 on ILO discussion paper “the price of Exclusion”
12 There is a counter argument which says disability could be high in rich countries for reasons related to high life expectance and high number of elderly people who are usually disproportionately affected by disability (Mont 2007). The crucial question is which cause is stronger? Poverty or old age
thousand showing that the countrywide prevalence is 1.09 percent. As indicated in table 2-A this new figure is much less than the 1994 census both in absolute number and percentage. In other words the new census implies the PwD have depopulated by over 100 thousand in the 13 years interval. These percentages, in light of WHO’s 10 percent threshold and the fact that Ethiopia is a typical developing country, makes the census result curiously dubious. The number reported by both censuses is far less than other estimates. Understandably, part of the reason for the underestimation is the presence of strong cultural barriers to declare oneself or one’s own child as disabled.

Table 2-A comparing prevalence of disability in the 1994 and 2007 censuses

<table>
<thead>
<tr>
<th>Census</th>
<th>1994</th>
<th>2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population</td>
<td>53379035</td>
<td>73897095</td>
</tr>
<tr>
<td>PwD</td>
<td>991916</td>
<td>805535</td>
</tr>
<tr>
<td>%</td>
<td>1.86</td>
<td>1.09</td>
</tr>
<tr>
<td>0-14</td>
<td>30.90</td>
<td>22.84</td>
</tr>
<tr>
<td>15-29</td>
<td>20.40</td>
<td>23.89</td>
</tr>
<tr>
<td>30-49</td>
<td>23.60</td>
<td>22.30</td>
</tr>
<tr>
<td>50+</td>
<td>24.90</td>
<td>30.97</td>
</tr>
</tbody>
</table>

The 2007 draft census report does not have information on regional distribution of PWD. According to the 1994 census (see table 2-B), Tigray region leads with high prevalence (2.8 percent) followed by Harari (2.23 percent) and Addis Ababa (2.18 percent). Disability focused surveys conducted one year after the census revealed more than 10 percent prevalence in the three most populous regions of the country (Tirusew et al 1995). According to this baseline, the prevalence in Oromia, Amhara and SNNP is estimated at 12.7, 14.0 and 16.8 percentages compared to the corresponding census figure of 2.80, 2.03 and 1.80 for the same regions respectively.
Table 2-B: Prevalence of disability by regional states of Ethiopia (1994 census)

<table>
<thead>
<tr>
<th>No</th>
<th>Region</th>
<th>All persons</th>
<th>PWD’s</th>
<th>Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Tigray</td>
<td>3,134,470</td>
<td>90,742</td>
<td>2.80%</td>
</tr>
<tr>
<td>2</td>
<td>Amhara</td>
<td>13,828,909</td>
<td>281,291</td>
<td>2.03%</td>
</tr>
<tr>
<td>3</td>
<td>Oromiya</td>
<td>18,465,449</td>
<td>333,653</td>
<td>1.80%</td>
</tr>
<tr>
<td>4</td>
<td>SNNP</td>
<td>10,368,449</td>
<td>174,941</td>
<td>1.69%</td>
</tr>
<tr>
<td>5</td>
<td>Addis Ababa</td>
<td>2,100,031</td>
<td>45,936</td>
<td>2.18%</td>
</tr>
<tr>
<td>6</td>
<td>Dirdawa</td>
<td>248,549</td>
<td>4,226</td>
<td>1.70%</td>
</tr>
<tr>
<td>7</td>
<td>Gambella</td>
<td>162,271</td>
<td>2,581</td>
<td>1.59%</td>
</tr>
<tr>
<td>8</td>
<td>Benshangul &amp; Gumuz</td>
<td>460,325</td>
<td>7,341</td>
<td>1.59%</td>
</tr>
<tr>
<td>9</td>
<td>Afar</td>
<td>1,097,067</td>
<td>14,140</td>
<td>1.29%</td>
</tr>
<tr>
<td>10</td>
<td>Harari</td>
<td>130,691</td>
<td>2,909</td>
<td>2.23%</td>
</tr>
<tr>
<td>11</td>
<td>Somali</td>
<td>3,382,702</td>
<td>34,156</td>
<td>1.00%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>53,379,035</strong></td>
<td><strong>991,916</strong></td>
<td></td>
<td><strong>1.85%</strong></td>
</tr>
</tbody>
</table>

The 2007 census has used more cluster (than what has been used in 1994) to identify disability types. The 1994 census used only five types of disability and put the rest of the types in the “others” category.

Table 2-C the 2007 census headcount of PwD by disability types across age groups

<table>
<thead>
<tr>
<th>Age group</th>
<th>PwD</th>
<th>Blind</th>
<th>Seeing diff</th>
<th>Deaf Hearing diff</th>
<th>Unable to speak</th>
<th>Speaking diff</th>
<th>Deaf &amp; unable to speak</th>
<th>non-functional upper limbs</th>
<th>non-functional lower limbs</th>
<th>body movement difficulty</th>
<th>learning difficulty</th>
<th>others</th>
<th>mental health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>805535</td>
<td>94140</td>
<td>154819</td>
<td>27334</td>
<td>73814</td>
<td>11212</td>
<td>12600</td>
<td>46018</td>
<td>60403</td>
<td>160460</td>
<td>48470</td>
<td>41504</td>
<td>74761</td>
</tr>
<tr>
<td>0-14</td>
<td>184019</td>
<td>8845</td>
<td>27291</td>
<td>7075</td>
<td>23499</td>
<td>5483</td>
<td>5502</td>
<td>1497</td>
<td>13454</td>
<td>31895</td>
<td>11521</td>
<td>9747</td>
<td>24855</td>
</tr>
<tr>
<td>15-29</td>
<td>192406</td>
<td>11783</td>
<td>27556</td>
<td>7131</td>
<td>17485</td>
<td>3020</td>
<td>3585</td>
<td>16924</td>
<td>13802</td>
<td>44899</td>
<td>10719</td>
<td>16281</td>
<td>19222</td>
</tr>
<tr>
<td>30-49</td>
<td>179628</td>
<td>16440</td>
<td>30994</td>
<td>5999</td>
<td>14191</td>
<td>1623</td>
<td>2173</td>
<td>9788</td>
<td>16807</td>
<td>41907</td>
<td>11340</td>
<td>10955</td>
<td>17402</td>
</tr>
<tr>
<td>50+</td>
<td>135345</td>
<td>57072</td>
<td>68978</td>
<td>7129</td>
<td>18639</td>
<td>1086</td>
<td>1340</td>
<td>4409</td>
<td>16340</td>
<td>41795</td>
<td>14899</td>
<td>4521</td>
<td>13282</td>
</tr>
</tbody>
</table>

The 2007 census used 12 peculiar types of disabilities and “others” category to account for the prevalence. By so doing it attempted to make fine distinction such as between the various types of mobility problem, speaking and hearing problem, blindness and visual problem and learning difficulty and mental problem etc. As indicated in table 2-C above the census has divide the PwD into 13 different disability groups. Based on this categorization the most common type of disability is walking problem (non-functional lower limb) followed by low-
vision (seeing difficulty). The least common type of disability is speaking difficulty followed by deafness. In general disability has higher prevalence among aged people (over 50 years). However the draft report of 2007 census has not provided information on regional distribution of PwD hence it was not possible to compare results with the previous census result presented in table 2-D.

Depending on the 1994 census classification, out of the total 991,916 disabled persons 320,046 are visually impaired, 319,181 physically disabled, 190,220 hearing impaired, 64,284 mentally impaired, 34,390 leprosy patients, 31,866 multiple disabled and 31,935 are persons with other types of disabilities. The regional distribution of PWD with disability types also shows fairly proportional distribution except in the case of visual problem (blindness) that is relatively higher in Amhara region than Oromia. Tigray region also host higher proportion of visually impaired people. A separate survey conducted on blindness and low vision puts Somali region as the highest prevalent in both blindness and low vision 5.4 and 9.7 percent respectively. However the reason for higher prevalence in Somali region could not be explained by the study (MoH 2006).

Table 2-D distribution of disabled persons in regions by type of disability (1994 census)

<table>
<thead>
<tr>
<th>#</th>
<th>Region</th>
<th>Visually</th>
<th>Physically</th>
<th>Hearing</th>
<th>Mental</th>
<th>Leprosy</th>
<th>Multiple</th>
<th>Others</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Tigray</td>
<td>37,365</td>
<td>22,915</td>
<td>16,761</td>
<td>6,126</td>
<td>1,325</td>
<td>3,279</td>
<td>2,971</td>
</tr>
<tr>
<td>2</td>
<td>Amhara</td>
<td>110,059</td>
<td>77,857</td>
<td>52,418</td>
<td>14,216</td>
<td>9,982</td>
<td>8,817</td>
<td>7,942</td>
</tr>
<tr>
<td>3</td>
<td>Oromiya</td>
<td>93,425</td>
<td>112,695</td>
<td>71,391</td>
<td>21,914</td>
<td>12,536</td>
<td>10,638</td>
<td>11,054</td>
</tr>
<tr>
<td>4</td>
<td>SNNP</td>
<td>47,886</td>
<td>63,002</td>
<td>32,875</td>
<td>11,721</td>
<td>6,852</td>
<td>5,269</td>
<td>7,336</td>
</tr>
<tr>
<td>5</td>
<td>Addis Ababa</td>
<td>12,888</td>
<td>15,320</td>
<td>6,402</td>
<td>5,912</td>
<td>2,673</td>
<td>1,887</td>
<td>854</td>
</tr>
<tr>
<td>6</td>
<td>Dirdawa</td>
<td>942</td>
<td>1,396</td>
<td>608</td>
<td>857</td>
<td>77</td>
<td>233</td>
<td>116</td>
</tr>
<tr>
<td>7</td>
<td>Gambella</td>
<td>917</td>
<td>846</td>
<td>318</td>
<td>176</td>
<td>115</td>
<td>128</td>
<td>81</td>
</tr>
<tr>
<td>8</td>
<td>Benshangul G.</td>
<td>2,141</td>
<td>2,686</td>
<td>1,618</td>
<td>328</td>
<td>173</td>
<td>262</td>
<td>136</td>
</tr>
<tr>
<td>9</td>
<td>Afar</td>
<td>4,516</td>
<td>5,722</td>
<td>2,428</td>
<td>533</td>
<td>46</td>
<td>612</td>
<td>283</td>
</tr>
<tr>
<td>10</td>
<td>Harari</td>
<td>704</td>
<td>790</td>
<td>575</td>
<td>348</td>
<td>334</td>
<td>99</td>
<td>59</td>
</tr>
<tr>
<td>11</td>
<td>Somali</td>
<td>9,203</td>
<td>15,952</td>
<td>4,826</td>
<td>2,153</td>
<td>277</td>
<td>642</td>
<td>1,103</td>
</tr>
<tr>
<td></td>
<td><strong>Total</strong></td>
<td><strong>320,046</strong></td>
<td><strong>319,181</strong></td>
<td><strong>190,220</strong></td>
<td><strong>64,284</strong></td>
<td><strong>34,390</strong></td>
<td><strong>31,866</strong></td>
<td><strong>31,953</strong></td>
</tr>
</tbody>
</table>
III. Legal, Institutional and Policy environment on disability in Ethiopia

Understanding the legal, policy and institutional arrangement allow the identification of both restrictions/barriers and opportunities available and how it affects the lives of people with disabilities. It is increasingly recognized that the process of social development is strongly influenced by laws, policies and institutions, which are the "humanly devised constraints that structure human interaction". These comprise formal constraints (e.g., rules, laws, constitutions) and informal constraints (e.g., unwritten forms of behaviour, conventions, self-imposed codes of conduct and their enforcement mechanisms (North, 1994).

Rules governing relationships, both between and within households, interaction between individual and government (such as on rights and obligations), transactions between individuals and organizations are examples. Organizations are the subset of institutions associated with group or communal activities. In the case of disability, they take the form of DPOs, NGOs, local governments, advocacy groups and other clubs and associations.

3.1 International standards

Since national laws and regulation on rights are mostly derivatives of international conventions, it is necessary to examine laws and policies in light of universal declaration and policies of major donors. To maintain logical order, examining the institutional arrangement and sectoral strategies for implementing/mainstreaming disability issues in the wider development agenda will be done in selected ministries. At the same time, the process of policies and strategy formulation have to be examined in light of the involvement it allowed for the direct and genuine participation of stakeholders such as DPOs and various associations of PWD.

3.2 International declarations, donor policies and their effect on local laws and policies

Prior to the 1960s, issues related to PWDs (such as deprivation of access to economic opportunity and discrimination) have rarely been considered as human right issues. In the
international arena, declarations related to the rights of disabled people were generally
disguised in the broader umbrella of human rights. Major human rights declarations of the UN
such as the Universal declaration on Human Rights in 1946, the UN convention on economic,
social and cultural rights in 1966 and the UN convention on civil and political rights in 1966
did not distinctly mention the case of PWD. Policies and institutions formed in the name or
for the cause of PWDs were merely focused on providing compassionate services in what can
be described as purely a social welfare approach. The shift towards treating disability as a
separate issue and in a “right based” approach began with a series of conventions notably
from the International Labour Organization (ILO) and with the declarations of various UN
agencies and consolidated in the period after the 1970’s.

Taking examples of some key international declaration over several decades, Ethiopia had no
problem of ratifying/adopting the conventions. The Ethiopian government has been
moderately prompt in adopting international standards and reflecting those in the domestic
policies and strategies. The problem as we shall see latter has been mainly on the capacity of
institutions and organization to execute policies and plans on the ground.

<table>
<thead>
<tr>
<th>Key international declarations</th>
<th>Date</th>
<th>Organization</th>
<th>Status in Ethiopia</th>
</tr>
</thead>
<tbody>
<tr>
<td>convention (No 111)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(disabled persons) No 159</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(UNGA)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>International day of PwD declared to be observed on the 3rd of</td>
<td>Yearly</td>
<td>UN members</td>
<td>Observed as per the declaration</td>
</tr>
<tr>
<td>December every year</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>originally for 10 years from 1999 but now extended up 2019</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Apart from those in table 3-A, a number of international proclamations have been passed by the various agencies of the UN umbrella. These declarations and conventions passed in various occasions include (but are not limited to) the following:

- International covenant on Economic, social and cultural rights (ICESCR) in 1966
- The Declaration of Mentally Disabled Rights issued on December 1971 provides rights for significant improvement of social life of those sections of society victimized by the problem.
- The resolution passed on May 6, 1975 to prevent disabilities and expand rehabilitation services urged states not only to give due attention, for the issue but also paved way to undertake profound Study and research on the Subject.
- The Declaration of the Rights of Persons with Disabilities was issued on Dec. 9,1975. It calls for international and national actions to ensure the rights of PWD to all services, enable them to develop their capability and skills to the maximum possible and hasten the process of their social integration.
- In accordance with the resolution passed by the United Nations on December 16, 1976, 1981 was designated to be commemorated as the International Year of Persons with Disabilities.
- In July 1980 the Women’s Decade Conference of the United Nations was held in Copenhagen and adopted a resolution, which enables to improve conditions of women with disabilities in all age groups.
- On December 3,1982 the World Program of Action concerning disabled persons was adopted by the United Nations and the period from 1983-1992 was decided to be United Nations Decade of Disabled Persons.
- In June 1983 the International Labor Organization adopted Convention No. 159 and recommendation No. 168 regarding vocational rehabilitation and employment of people with disabilities.
- The world declaration on Education for All (EFA), 1990: emphasize the inherent right of a child to a full cycle of primary education, equal access to education for all, including those with special needs, in the same setting.
- The United Nations General Assembly held on 20 December 1993 at its 48th session adopted the Standard Rules on the Equalization of Opportunities for Persons with Disabilities
The most recent and comprehensive of such conventions is the UNGA (2006) convention on the rights of persons with disabilities. This convention, as outlined in the objective of the convention itself, “aims at promoting, protecting and ensuring the full and equal enjoyment of all human rights and freedoms by all persons with disabilities and to promote respect for their dignity”. The core principles of the convention include: respect for dignity for individual autonomy and independence, non-discrimination, participation and inclusion in society, equality of opportunities and access and acceptance of diversity of PWD. The convention pays particular attention to the most vulnerable group among the disabled such as women and children and urge prescribing states to ensure protection of the rights of these groups by putting in place appropriate policies and the necessary enforcing and safeguarding mechanisms.

Apart from enacting laws and passing deliberations there is an increasing interest from the UN and major donors to commit resources towards meeting the objectives set out in those declarations. Major donors have made significant stride to mainstream disability into their funding strategy. The shift came with the growing understanding of the link between poverty and disability. Poverty and disability are self-reinforcing factors. Poverty can be a good cause of disability as can be revealed in the situation of poor nutrition, unsafe living situation, poor health and sanitation facilities etc and at the same time disability can also be hindrance to strive for better life because of the barriers disabled people face to take full advantage of economic and social opportunities.

Taking this fundamental link between poverty and disability, the United States Agency for International Development (USAID) adopted a pioneering policy in 1997. The policy, among other things, indicated that USAID will not discriminate against PWD and that it will ensure the inclusion of disability focused activities in all its program funding. USAID has further institutionalized this policy in 2003/04 by issuing another supportive policy that state all USAID funded physical infrastructures have to ensure suitable access to PWD. Similarly the WB embarked on mainstreaming disability in to the Banks operation and analysis in 2002\(^\text{13}\).

\(^{13}\) Daniel Mont 2007, Measuring Disability Prevalence: SP discussion paper # 0706, The World Bank
3.3 Review of Laws and Proclamation on disability in Ethiopia

In what follows, brief description of broader national Laws and proclamations as well as enforcement and implementation mechanisms are presented in view to scan the extent to which the international standards for guiding the protection and wellbeing of PwD are reflected. The subsequent section considers a brief review of pertinent policy frameworks and long-term sectoral development strategies of Ethiopia that are, in one way or another related to PWD.

The government of Ethiopia has almost always prescribed into the United Nations conventions on human rights in general and the rights of persons with disabilities in particular. This trend dates back to the time of the monarchy where the imperial regime ordered (order No 70/1971) to define disability in international standard and set up a vital administrative body for the disabled people. However most of the laws and policies action in relation to the person with disability that exist today are taken following the arrival of the current regime.

The Ethiopian constitution established universal right to education by all groups of society. Art 41 and 91 of the constitution particularly emphasize on the need to allocate resources for assisting people with special needs. The most significant declaration and major policy action taken during this time can be listed as follows:

Table 3-B below summarizes only those selected proclamations related to employment and safety of PwDs and the relevant articles on the Ethiopian constitution. Apart from these, there are several other legal articles (subsidary laws related to PwD). The Ethiopian civil code provides several articles (Article 340, 1728, 48-49, 162) to determine the proceeding of criminal and civil legal cases that involve persons with disability. The articles provide various protection measures for PwDs so that they are not disadvantaged while bringing their case before the court of law. People who have critically reviewed the codes have concluded that in general all the provisions are focused towards giving aid to the PwD and not as such towards respecting the right and dignity of PwD (Frew 2001). The provisions imply that all PwD have no full control of their action and hence cannot control their own affair. While this could be true in many occasions but the gross categorization may not necessarily hold true.
### Table 3-B

<table>
<thead>
<tr>
<th>Names of Pronouncement</th>
<th>Pronouncement type &amp; Issuing Regime</th>
<th>Particulars</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proclamation No. 42/1993, On the employee- employer relation that emanates from employment contract</td>
<td>TGE Labour proclamation</td>
<td>Ensures non discrimination based on religion, ethnic origin, sex and physical outlook</td>
</tr>
<tr>
<td>Proclamation No. 101/1994 (The Right of Disabled Persons to Employment Proclamation)</td>
<td>TGE Labour proclamation</td>
<td>Ensures the right of PWD to occupy jobs that are up to their capacity and competence</td>
</tr>
<tr>
<td>Article 41, sub article 5: Rehabilitation and support to PWD</td>
<td>FDRE 1995 Constitution</td>
<td>The constitutions ascertains it will allocate resource to provide service facilities (rehabilitation) for the physical and mentally disabled persons</td>
</tr>
<tr>
<td>Proclamation No. 262/2002 Art 13: equal opportunity employment to PWD</td>
<td>FEDRE 2002, The federal civil servants Proclamation</td>
<td>Ensures that PWD shall be given equal opportunity in employment and encourages preferential treatment to PwDs in specific occasions.</td>
</tr>
<tr>
<td>Proclamation No. 377/2003 (amended by proclamation 496/2006)</td>
<td>FDRE 2003 (amended in 2006), The federal civil servants Proclamation</td>
<td>Ensure equal job opportunity for PWD and demand similar treatment of PWD as other under represented groups (e.g. women) in the job market</td>
</tr>
<tr>
<td>Proclamation No 515/2007 part five Art 47-56: Occupational safety and health</td>
<td>FDRE 2007, The federal civil servants Proclamation</td>
<td>Defines disablement emanating from employment injury and determines the rights (protection) of persons injured (disabled) in employment</td>
</tr>
<tr>
<td>Proclamation No. 624/2009, Part four Art 36: Facilities for physically impaired persons</td>
<td>FDRE 2009, The Ethiopian Building Proclamation</td>
<td>Ensures that all public buildings should have facilities that allow access suitable for the use of PWD</td>
</tr>
</tbody>
</table>

### 3.4 National Policies and Strategies

Following the provision on the 1995 Ethiopian constitution, various sectoral policies are crafted. Particularly Social welfare, Education, Health and Sport policies were developed in mid 1990’s have clearly outlined policy directions in favour of PWD. Sectoral policies were made to be part of the triple five-year plans of what has become famously known as Plan for Accelerated Sustainable Development to End Poverty (PASDEP). PASDEP is an overarching and comprehensive document that embraces the overall socioeconomic and political
development of the country. But here the interest is focussing on what it defines as specific measures that should be taken and planned achievements targeted towards improving life quality for PWD. The document guides a “three stages” strategic plan for various sectors of the country and defines the milestones at each stage of planning. PASDEP emphasizes on operationalizing laws and polices into more concrete actions in a broader developmental approach of different sectors. Since the description and implementation of policies is incorporated in the PASDEP, we will examine strategies as we go along selected sectors or ministerial policies related to PWD. Policies and strategies that have been in place so far are the following: -

3.4.1 Developmental Social Welfare Policy of the Federal Democratic Republic of Ethiopia by the Ministry of Labor and Social Affairs (MoLSA, November 1996):

The social welfare policy distinguishes the issue of persons with disability at parallel level with other society segments such as youth, women and the elderly whose social welfare is usually a priority of concern. The policy highlights five major problems as follows:

- Since most PWD live in rural areas (85 percent based on the 1994 census) they have limited to no access to social and medical facilities. They are relatively highly exposed to harmful traditions and social stigma.
- Disability in Ethiopia (as it is elsewhere in poor countries) is caused by poverty, ignorance, war and drought and are aggravated by inadequate nutrition absence/limited medical facilities, harmful traditional practices etc.
- Children and the elderly are the most vulnerable segments of PWD. Based on the 1994 census, prevalence of disability disproportionately high in these two groups.
- PWD in Ethiopia have very limited access to rehab centres because of absence of such centres in the country. Those few centres that exist and operate at the time are either costly or geographically inaccessible as they are mostly limited to few urban centres.
- PWD have limited opportunity for education and employment. Their potential to attend normal life activities is constrained by absence of friendly physical environment. Coupled with the stigma and fatalistic view of the society their likely destiny is life-long dependence on other people such as begging.

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Ababa
The policy draft has also stipulated policy actions that have to be implemented in addressing these concern areas. Accordingly it provides a 9 points policy actions directly related to PwD. The pointes are stated as follows:

1. Conditions that will enable persons with disabilities to use their abilities as individuals or in association with others to contribute to the development of society as well as to be self supporting by participating in the political economic and social activities of the country shall be facilitated
2. Efforts aimed at instilling in person with disabilities a sense of confidence and self-reliance through education, skill training, gainful employment opportunities and other services shall be increased and appropriate legislative measure shall be taken to ensure their welfare
3. Mechanisms shall be created by which persons with physical and mental impairment will receive appropriate medical/health services and supportive appliances:
4. Mechanisms by which PWD can receive appropriate support service in the context of their family and community environment shall be created.
5. All effort shall be made to establish special centres where PWDs without any family will be cared for.
6. Appropriate and sustainable educational program shall be launched to significantly raise the level of public awareness concerning the determinants of and consequence of the problems of PWD as well as to change the prevailing harmful traditional attitudes, norms and practices in respect to PWDs
7. Strategies and programs designed to increase our understanding of the causes and prevalence of physical and mental disability and thereby prevent and mitigate their spread shall be formulated.
8. All effort shall be made to gradually remove all physical impediments and make residential areas, work and other public places more physically accessible to PWDs
9. Support and assistance shall be provided to community action-groups, NGOs, voluntary association involved in providing service to PWDs.

Based on this policy a national development plan in which many line ministries participate is formulated. The action points outlined by MOLSA are the following: -
- Propagate necessary education through mass media gathering on causes of disabilities and the care required
- Conduct proper research and Studies
- Conduct national vaccination campaign
- Expand Health Institutions
- Teach proper health at the scene of traffic accidents
- Alleviate socio-economic problems of society
- Encourage PwD and their associates to participate in preventive campaigns
- Include disability education in curriculum
- Make available trained manpower for occupational safety and health control

To accomplish the plan, responsibilities have been given to the ministry of Health, Ministry of labour and social affairs, Ministry of Justice, Ministry of Agriculture, Ministry culture and information, Ministry of Transport and communication, Regional governments, NGO, labour unions and the Federal of Ethiopian National Association of Persons with Disabilities. MOLSA being placed at the centre shoulders the responsibility to coordinate the implementation by involving the line ministries.

3.4.2 Education and Training Policy (TGE 1994)

The education and training policy (TPE) has acknowledged the need for boosting school enrolment as a whole and enrolment to primary education in particular. The policy mainly advocates for decentralization of the education system, as it should be expected from any federal system, and allow high coverage and equal chance of learning opportunity for nations and nationalities. Among other things, it advocates for learning opportunity in ones own language, a shift towards innovative (job creating) learning and self-administration and management of the education system by regions and localities.

The policy had a sub-objective aimed at achieving educational equity to all groups including persons with disabilities. The objective is stated as “to enable both the handicapped and the gifted learn in accordance with their potential and needs” (TGE _MoEd 1994:7). Also in reference of the proposed reform of educational structure it states: “Special education and training will be provided for people with special needs”
Turning these policies into real action has begun with the emergence of a triple five-year plan, which is part of the PASDEP and the different sectoral versions of PASDEP. The Education Sector Development Program (ESDEP) adopted the policy objectives of TGE and put them into a broader and concrete strategy. In the initial round of the five-year plan, the entire focus was on expanding school facilities and raising enrolment rates. The success reached in these period fairly tally with the millstones of MDG and the PASDEP. However by mid of the second round five-year plan, the need for improved quality of education has surfaced more vividly.

As part of the sector strategy and in response to the growing concern for quality, a document on the general package for education quality assurance in Ethiopia was issued (MoE, June 2006). The document underlines the need to look beyond boosting the enrolment rate and put due emphasis on improving quality. In doing so it acknowledged that special need education is far less provided for and the people who ought to benefit from such education have been disadvantaged. Latter on at the beginning of the third five-year plan (2005/2006-2009/2010) MoE launched “strategy for special needs Education program” (MoE 2006). The core elements of the strategy were on promoting inclusive education system and inclusive schools with an aim to meet the goals of UPEC and EFA\(^\text{15}\). It outline a range of actions for improving access to education and underlines on the need to give affirmative actions to those deemed as disadvantaged society groups such as females, pastoral and semi-pastoral resident individuals and those with special needs. The strategy founded itself on the ideals the 1994 TEP and the objectives were to\(^\text{16}\): -

- Implement the TEP and the international principles endorsed by government to honour the rights of citizens to education
- Develop and implement guidelines for curriculum modification and support system development in schools for learners with special needs
- Facilitates the principles of learners with special needs in technical and vocational education and other higher education institutions
- Strengthen special need education programs in teacher education institutions
- Improved supply of trained manpower and appropriate material and appropriate materials to schools and other learning institutions.

\(^{15}\) EFA is the world declaration of education for all declared by UNESCO in 1990

\(^{16}\) MoE 2006, Special Needs education strategy, Addis
Ababa
The SNPES has also identified action points and time frame to implement the strategy with regional education bureaus. In so doing it envisaged to prepare regional strategic plans, capacity building of regional and woreda level education stakeholders, developing guideline and curriculum, training SNE teacher’s education, establishment of support system in regions and sharing of good practices in a wider scale. However, as we shall see in the next chapter, implementation of the action points lagged behind proposed time due to several reasons.

### 3.4.3 Health Policy

The Ethiopian health sector policy that is currently in use has been developed in 1993. Similar to the other sectors, the health policy was made to be the guiding document for the design of the health sector development strategy /HSDS/ (which is part of the PASDEP) and is meant to span over a period of 15 years from 1997 to 2011. The policy has defined the priority groups for whom the health service facilities have to be improved. Among these are women, children and people in remote (rural areas). The policy has also deliberated that the approach of health service has to mainly follow preventive approach such as the use of Information, Education and Communication (IEC), environmental health, Occupational health and safety. With regard to curative service priority is given to provision of new health facilities in areas where the service has not reached, rehabilitation of existing health facilities, curative and rehabilitative heath facilities such as for mental health problems, control of communicable disease, etc.

The HSDP that is currently in the third and final five-year of implementation is mainly derived from the overall development strategy called the PASDEP. The focuses of the strategy is towards decentralizing the sector in line with federal arrangement and allow regional states to run the health sector by setting their own priority areas. Along the same line, the strategy gives special directions to the emergence and development key components such as health education, manpower development of health professionals, inter-sectoral collaboration, availability of drugs, supplies and equipments, health specific research and development, health information management system, referral procedures, liberalizing and systematizing health services organizations. The last phase of HSDP has paid particular attention to expanding health service via mass mobilization of health extension workers and active participation of community groups.

The necessary institutional and organizational arrangements are created within the federal and regional health offices to cater for smooth implementation of the policy and strategies. The
overall success of the health sector in meeting self declared objectives and international milestones such as the MDG and WHO are encouraging. However with regard to specific policy and strategic provision for PwD, the health sector (ministry of health) is relatively inefffectual. The policy has not mentioned the case of PwD in a direct way or as distinct priority groups. The sectoral strategy has not exclusively treated or even mentioned PwD, as group that need particular consideration.

3.4.5 HIV/AIDS Policy

HIV/AIDS is recognized as social problem whose prevention and control actions have to be envisaged not only in the health sector but also in all sectors of the country. With this in mind a comprehensive HIV/AIDS policy has been developed in 1998 and followed by subsequent strategy for mainstreaming the policy into development strategies of all sectors/ministries. The process has gone several steps such as the launching of a five years (2001-2005) strategic response by government and the development of implementation manual in 2007. At organizational level, a national governing body led by the president of the country is created and all participating stakeholders are made to converge at the HIV/AIDS directorate, a body that is created for coordinating HIV prevention efforts and for providing technical and operational support.

HIV/AIDS policy and the subsequent strategies developed and adopted in a wide range of social and economic sectors provide exemplary effort for mainstreaming an agenda in a broader institutional and organizational set up. The policy has been effective in helping various society groups to benefit from projects however the policy, just like the national health policy, has failed to acknowledge the PwD as a distinct group that needs separate strategy and actions. As a result of this omission, PwD (particularly women), remained vulnerable to the pandemic and missed the opportunity to benefit from the policy/strategic attention they deserved.

3.4.6 Sport Policy of the FDRE (Ministry of Youth and sport April 1998)

Similar to the other multi-year sector development plans, the ministry of youth and sport has developed policies that in many ways touch the lives of PwD. The sport segment of the ministry has outlined major policy objectives and methods for implementing them in the broader sectoral strategy. In line with its policy in educational institutions, health & fitness
institutions, it gives considerable attention to PwDs. The policy document issued by the ministry in 1998 has stated the following two objectives as part of the broader sectoral objective in the multi-year development strategy.\textsuperscript{17}

- To give special attention to disabled students and facilitate their participation in sports suitable for their physical conditions.
- Ensure the participation of PWD in sports activities at their locality, educational institutions and working places and to also ascertain their equal sharing of the benefits.

As part of this policy reform the ministry has revived the Para-Olympics federation and revamped its organizational capacity by introducing new structure and by forming various functional committees. The new federation is entrusted with a responsibility to mobilize and lead national level talented sports men and women among the PwD. Among other things, the federation formed regional level offices\textsuperscript{18}, emergency and executive committees and the general assembly.

The national Para-Olympics committee has developed a general vision of enhancing the participation of persons with disabilities in various popular competitive sporting events and put them to becoming active in uplifting the country’s grandeur in this particular sporting front. Along with this general vision the committee has drafted a five-point mission statement stated as follows:

- Establish Para-Olympics federations in all the 9 regional states and ensure the effective outreach of the structures into woreda and kebele level
- Ensure that the persons with disabilities take advantage of sport facilities in places where they live, work and educate.
- Train as many men and women in Para-Olympics sport and help them become capable of winning medals in international competitions.
- Build sporting facilities that are suitable and accessible for persons with disabilities and ensure that those can be used for hosting competitive Para Olympics events in a sustainable way.

\textsuperscript{17} Sport policy of the Federal Democratic Republic of Ethiopia issued on the 24th of April 1998.

\textsuperscript{18} Four regions (Amhara, Oromia, SNNP and Tigray) have formed their own regional federation the other regions except Beneshangul and Gumuz, have formed joint committees that are responsible for functioning as regional equivalent of the Para-Olympics federation. Beneshangul and Gumz reion has not made any distinct organ to for similar function.
• Enrich the Ethiopian para Olympics committee with the necessary financial and material resource so that it can be independent of the government’s budgetary subsidy and become capable of managing its own affair.

As a result of these actions the federation has been able to achieve several successes both in accomplishing its administrative action points and successes in the sporting arena. It has successfully launched local and national level Para-Olympics sporting events in which nearly 300 PwD from all regions have participated. The federation also has taken active part in various continental and international sporting events prepared specifically for PwD. In the continental events held in 1999, 2003 and 2007 in South Africa, Nigeria and Algeria (respectively), Ethiopia has staged 20 competitors in different competitions. Apart from successful participation in these events Ethiopian athletes were able to win on silver and one bronze medal and several top 10 diplomas. In the international Para –Olympics arena, Ethiopia has sent one athlete in the 2004 Athens Olympics.

While these are remarkable achievements, the federation has not been able to deliver on some of the most important objectives such as the provision of suitable sporting facilities for PwDs, the creation of federations in all regions and the financial independence. The policies and action points are not sufficiently backed by financial commitment that is adequate to take the necessary measures. Even though there is relatively better enthusiasm and initiation to take the matter few steps ahead there is far a long way to deliver on the good intentions outlined as policies and missions of the sport sector.

The youth wing of the ministry also has launched youth specific national policy in 2004. The policy among other things, emphasized on ensuring full participation of the youth in a range of economic, social, cultural and political activities of the country and at the same time ensuring that they become beneficiaries from their participation in this process. The policy has acknowledged that PwD are important segment of the youth and they need differential policy provision to ensure their participation in equal terms with the other youth. The policy as good as it may sound, lack specificity. Apart from the gross statement by way of acknowledging the PwD as segment of the youth, it has not given any specific strategy/action that would be taken to make this segment active participation in the youth category.
The policy implementation at the Ministry of Youth & Sport is described as one of the best. The DPOs are generally satisfied with the way the sport policy has come into full force. Following the declaration of the policy in 1990, a separate institutional arrangement called Para Olympics federation has been formed through an election process that involved all the regions. During the election the DPOs were invited and have been asked to ensure the process was free and fair. In addition to these, the ministry has assigned an executive body that oversees the routine activities of the federation on daily basis. As a result of these actions Ethiopia has been able to participate and earn medals in international competitions such as the all-African games and the Olympics.

### 3.4.7 Policy for Prevention of Traffic Accidents (The Federal police commission of Ethiopia)

Roadside traffic accident has been one of the major causes of disability in Ethiopia. Only in four years (2005-2009), 1473 people lost their lives while 2788 and 3429 people endured heavy and light injuries respectively. Adding to this, the enormous damage in personal property and the overall economy, Ethiopia stands one of the worst affected countries in the world by roadside traffic. In response to these the Addis Ababa city government and regional states have passed regulations that will help to ensure better safety both for pedestrians and drivers/passengers. The most notable effort in this regard is the recent road traffic safety regulation issued in December 2009 by the Addis Ababa city government. The regulation introduces new mandatory safety measure and several new offences and the corresponding penalties. Taking into account the growing traffic size and complexity of the city, the new regulation should have come earlier in time.

In addition to passing regulations, the traffic police have been proactive in creating public awareness. These efforts have been particularly enormous in the past five years in which several signboards depicting accident scenes and portraying educational messages have been hanged in various cities and major highways of the country. Educational programs on traffic rules, safety measures and regular reporting of city traffic situation have been incorporated in radio and FM programs. FM stations also cover some live events in Addis Ababa city traffic. Even though the study has not collected detailed information from regions, it has learned that some regions (Viz. Oromia, Amhara and Tigray) have recently developed their own roadside traffic regulations.
VI. Policy Synthesis based on information from key informants

4.1 General impressions

Following the terms of reference, the study has collected impressions on the existing laws, policies and strategies related to PwD from the various expert interviews and FGDs conducted with focal persons of the selected ministries and DPOs. Information gathering is carried out with the aim to gauge the level of satisfaction of PwD (through their representative organization) with the existing laws and policies and also to assess the extent of their involvement in the process of developing those laws and policies. On the government side the aim was to get the other side of the story on the involvement of PwD via DPOs and other advocacy groups in policy formulation, to determine the effectiveness of policy actions by looking at follow up efforts to implement laws and policies.

The following key points are extracted from interviews conducted with focal person of DPOs:-

- Most key informants appreciate the effort of the government for adopting international standards and passing important disability laws (the constitution and various proclamations) and the effort to formulate policies that cater for restoring the rights and dignity of PWD.

- Particular appreciation for enacting new laws (proclamations) on building standard and road traffic. Because the former is meant to improve the life quality of PwD via improved access to public facilities and the latter is aimed at controlling one major cause of disability in the country.

- There is particular concern with reluctance of the government to ratify the recent (the 2006) and most comprehensive UN convention on the right of PwD.

- The most serious concern of all DPOs is the lack/absence of commitment to implement laws and policies. The political will (expressed in the laws and policies) is not sufficiently supported by institutional and financial commitment. There are poor (or no) enforcement mechanisms put in place to check the implementation of regulations in both public and private sector activities.

- Lack of accurate and up-to-date information on the situation of disabled people makes it difficult for developing any policy/program that genuinely addresses the problems.
• Service delivery to PwD, particularly in human resource development (health, education, vocational training etc), are far less provided and as a result PwD are not able take part in the competitive labour market

• Lack of adequate sporting facilities which makes the Ethiopian team to involve in only four types of international competitions out of twenty.

• DPOs welcomed the limited financial grant from MOLSA as a sign of good cooperation, but expressed their concern about the lack of commitment to implement the social welfare policy and the national plan of action.

4.2 Impression on participation level of PwD: In reference to MoE, MoH, MOLSA, MUD and MoYS

The participation of DPOs in policy development and program implementation was assessed in terms of the duties and responsibilities required to carry out both subject matters. Primarily, every policy development involves political leadership (governance), planning, developing the final product and implementation. A blend of expertise on information flow analysis related to legal and other subject matters are vitally important.

On the other hand program implementation refers to an agreed project mission that compels the contracting parties towards legal engagement, joint planning, resource sharing, service delivery and mentoring.

Based on this, three criteria were used to appraise the level of DPOs participation in the wider continuum of policy development and program implementation. These are “Inform”\(^{19}\), “consult”\(^{20}\) and “partnership”\(^{21}\) these classifications are used to label or identify the place DPOs hold in the process of policy development and program implementation. The following matrix depicts the role of DPOs by major stakeholder and issue of concern.

\(^{19}\) Inform refers to stage where the major actor simply invites the DPO as an input at the information analysis stage.

\(^{20}\) Consult refers to a situation where the DPO has been considered as an input to provide of data and at same time have a representation in the technical team.

\(^{21}\) Partnership applies in cases where DPO initiated, planned, shared resource and led the implementation process.
DPOs Participation in Policy Development & Program Implementation

<table>
<thead>
<tr>
<th>No</th>
<th>Major Actor</th>
<th>Role of DPOs</th>
<th>Issues of Participation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Inform</td>
<td>Consult</td>
</tr>
<tr>
<td>1</td>
<td>Parliament</td>
<td>***</td>
<td>-</td>
</tr>
<tr>
<td>2</td>
<td>MOLSA</td>
<td>***</td>
<td>***</td>
</tr>
<tr>
<td>3</td>
<td>MOE</td>
<td>***</td>
<td>***</td>
</tr>
<tr>
<td>4</td>
<td>MUD</td>
<td>***</td>
<td>-</td>
</tr>
<tr>
<td>5</td>
<td>MOH</td>
<td>***</td>
<td>-</td>
</tr>
<tr>
<td>6</td>
<td>MOYS</td>
<td>***</td>
<td>***</td>
</tr>
<tr>
<td>7</td>
<td>NGOs</td>
<td>***</td>
<td>***</td>
</tr>
</tbody>
</table>

The depiction in table 4-A is based on the results of interviews and document review, accordingly contacted DPOs spoke of their access (in various occasions) to attend parliamentary sessions that provided opportunity for them to air their concern and create awareness not only among the people’s representatives but the general public to whom parliament sessions are normally televised. They also attribute the emergence of policies and legal initiatives to their successive effort by creating awareness through various advocacy workshops and public demonstrations which brought positive repercussions.

Despite DPOs contribution at the initial lobbying stage, they have limited participation in the actual policy development process which can be labelled as informative. However in some instances where DPOs were involved in technical working group (MoLSA preparation Proclamation No. 377/2003) it gives their participation level a consultative picture. The same is true for MoE where FENAPD is chairing the national council on disability.

\(^{22}\) Refers to laws or proclamation issued by the parliament

\(^{23}\) Refers to health, education, social….etc policies inclusive of disability issues

37
Refers to policy implementation modality in the form of having joint working group, a counsel…etc
In general, DPOs involvement in policy development is policy vetting\(^\text{25}\), which encourages them to voice their comments before finalization because it helps to identify potential challenges and policy advocates. Some key informants said, the limited capacity of DPOs in terms of leadership, expertise and resource are barriers to make them an independent agent capable of making equal contribution in the legislation and policy development. Mostly government prefers to listen to the voices of PwDs than fully recognize their expertise in any policy development process.

Regarding the question as to who takes the prime role in initiating the government towards disability inclusive policy formulation, respondents gave different answers, the major ones were:

- The influence of the global disability movement mainly the UN declaration which served as an instrument of pressure forcing the government to fulfil its commitment.

- The voice of DPOs in various workshops...... demonstrations, anniversaries (December 3). Few individuals said: “PwD are also represented by their elite leaders such as those highly educated disabled persons and researchers who informally lobby decision makers”.

- The role of NGOs has also been cited as an important factor in raising the awareness level in various discussion platforms, workshops and seminars by providing technical and financial assistance.

In stark contrast with policy formulation, in program implementation DPOs experience an equal (if not more) engagement with their partners. This is mainly because they proactively initiate a project idea, negotiate with donor organization, prepare a proposal, facilitate the necessary legality and directly enter into implementation. This is to assume a partnership role to a long-term commitment by mobilizing resource, technical assistance and service delivery that brings out the DPOs on the frontline. Such instances are witnessed by a number of projects in the areas of public awareness raising, education, economic and organizational

\(^{25}\) Refers to checking a policy for comment with stakeholders and agency constituents before it is finalized
capacity building programs. ([www.ethiodisabilities.org](http://www.ethiodisabilities.org), annual report ENAD, ENAPAL, ENAB).

**V. Program Implementation and PwD’s Access**

The success in program implementation varies from one ministry to the other and also depends on the extent of PwDs participation in the process of laws and policy formulation.

5.1 **Education**

In terms of policy implementation most DPOs acknowledge the effort made by the education sector. Despite delayed action in many fronts, the MoE has made considerable progress towards meeting its own policy objectives. To broaden implementation of special need education program at primary and secondary schools level, they have taken pre-emptive actions to increase the supply of teachers such as by stepping up tertiary level education at universities and colleges. These include the introduction of new programs such as BA program on sign language, Masters and PhD program on special needs education. The Addis Ababa University (the largest and leading university in the country) has facilitated the enrolment of ten blind students into a range of programs annually. Dilla and Haromaya Universities have also started special needs education at BA level while Adwa, Debreberhan, Kotebe and Sebta Collages of teachers education have began special need education at diploma level. The current attendance in these programs shows that there are 10 PhD, 43 MA, 400BA and 1040 diploma students in different collages and institutions (Annual report 2008/09 MoE).

DPOs also gave recognition for the effort of MoE to forming a national disability counsel at the ministry, which so far allowed full involvement of the federation. Even though the function of the council is yet on papers, the intentions are worth appreciation.

The favourable policy environment and strategy of implementation by MoE has induced improved accessibility of educational services in the last few years. The specific areas that can be considered as outcomes of implementing the new policies are: increased enrolment of students with disabilities at primary, secondary and tertiary levels, human resource development and the number of special need education programs in the country.
Table 5-A Primary Enrolment of CWDs by Regions, Type of Disability and Coverage

<table>
<thead>
<tr>
<th>Region</th>
<th>Blind</th>
<th>Handicap</th>
<th>Deaf &amp; Mute</th>
<th>MR</th>
<th>Others</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tigray</td>
<td>694</td>
<td>1423</td>
<td>1157</td>
<td>1055</td>
<td>315</td>
<td>4644</td>
</tr>
<tr>
<td>Afar</td>
<td>13</td>
<td>61</td>
<td>36</td>
<td>57</td>
<td>27</td>
<td>194</td>
</tr>
<tr>
<td>Amhara</td>
<td>1407</td>
<td>4442</td>
<td>1876</td>
<td>3577</td>
<td>489</td>
<td>11791</td>
</tr>
<tr>
<td>Oromia</td>
<td>718</td>
<td>1994</td>
<td>1873</td>
<td>803</td>
<td>460</td>
<td>5848</td>
</tr>
<tr>
<td>Benshengule</td>
<td>80</td>
<td>323</td>
<td>167</td>
<td>217</td>
<td>43</td>
<td>825</td>
</tr>
<tr>
<td>SNNP</td>
<td>2877</td>
<td>5567</td>
<td>2838</td>
<td>2836</td>
<td>760</td>
<td>14878</td>
</tr>
<tr>
<td>Gambela</td>
<td>588</td>
<td>349</td>
<td>238</td>
<td>195</td>
<td>24</td>
<td>1394</td>
</tr>
<tr>
<td>Addis Ababa</td>
<td>293</td>
<td>353</td>
<td>416</td>
<td>380</td>
<td>66</td>
<td>1508</td>
</tr>
<tr>
<td>Dire Dawa</td>
<td>18</td>
<td>38</td>
<td>109</td>
<td>55</td>
<td>17</td>
<td>237</td>
</tr>
<tr>
<td>Total</td>
<td>6698</td>
<td>14550</td>
<td>8710</td>
<td>9175</td>
<td>2201</td>
<td>41319</td>
</tr>
</tbody>
</table>

According to 2008/09 MoE report, students with disabilities constitute barely 1.2 percent\(^26\) of the total enrolment nation wide. The largest proportions of the disabled students enrolled at primary schools are found in SNNP (36%) followed by Amhara (28.5%) and Oromia (14.15%). Afar, Dire Dawa city administration and Beneshangul & Gumuz regions host the least number of students with disabilities. Somali and Harari regions are not covered in the report. Given its population size and anticipated higher prevalence of disability\(^27\), Somali region is a major omission in the report.

In terms of disability type the physically disabled make 35.2% of the total followed by MR (22%), deaf & mute (21.02%) and blind (16.2%). Enrolment rate increases depending on the availability of resource to provide appropriate accommodation for each type of disability. Educational program for the blind, deaf and MR require resources in terms of teaching materials, facilities and expertise. The physically disabled do not demand any special teaching arrangement except the removal of the physical and attitudinal barriers.

Table 5-B Secondary Enrolment of CWDs by Region, Type of Disability and Coverage

<table>
<thead>
<tr>
<th>No</th>
<th>Region</th>
<th>Blind</th>
<th>Handicap</th>
<th>Deaf &amp; Mute</th>
<th>MR</th>
<th>Others</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Tigray</td>
<td>62</td>
<td>310</td>
<td>64</td>
<td>19</td>
<td>23</td>
<td>478</td>
</tr>
<tr>
<td>3</td>
<td>Amhara</td>
<td>165</td>
<td>1047</td>
<td>102</td>
<td>104</td>
<td>94</td>
<td>1512</td>
</tr>
<tr>
<td>4</td>
<td>Oromia</td>
<td>137</td>
<td>449</td>
<td>70</td>
<td>61</td>
<td>72</td>
<td>789</td>
</tr>
<tr>
<td>5</td>
<td>Benshengule</td>
<td>3</td>
<td>36</td>
<td>5</td>
<td>3</td>
<td>2</td>
<td>49</td>
</tr>
<tr>
<td></td>
<td>SNNP</td>
<td>93</td>
<td>477</td>
<td>45</td>
<td>35</td>
<td>20</td>
<td>670</td>
</tr>
<tr>
<td></td>
<td>Gambela</td>
<td>1</td>
<td>20</td>
<td>10</td>
<td>2</td>
<td>-</td>
<td>95</td>
</tr>
<tr>
<td>6</td>
<td>Addis Ababa</td>
<td>95</td>
<td>98</td>
<td>125</td>
<td>6</td>
<td>35</td>
<td>359</td>
</tr>
<tr>
<td>7</td>
<td>Dire Dawa</td>
<td>2</td>
<td>5</td>
<td>12</td>
<td>-</td>
<td>1</td>
<td>20</td>
</tr>
<tr>
<td>Total</td>
<td>558</td>
<td>2412</td>
<td>433</td>
<td>230</td>
<td>247</td>
<td>3910</td>
<td></td>
</tr>
</tbody>
</table>

\(^{26}\) The number could be higher if Somali and Harari regions were covered in the report.

\(^{27}\) Study conducted by the ministry of health (2006), revealed that with 5.4 and 9.7 percent prevalence of blindness and low vision respectively Somali region hosts the highest number of people with vision problem in the country.
Similarly the enrolment of PwDs to secondary schools has the same pattern across the regions except that the highest number in this case is Amhara region followed by Oromiya and SNNPR. In general the report underlines that the enrolment of PwD has improved over the last few years. For example, the enrolment of PwDs to primary schools in 2008/09 has increased by 19.4% over the corresponding figure in 2006/07 (without out data from Harari and Somali regions). It also admits that inclusion of more PwDs into the education system suffered a number of challenges that made the achievements far less than what has been anticipated. The major drawbacks in the special schools and special classes were lack of trained manpower, lack of material and inaccessibility of the physical environment in the facilities.

On the other hand the presence of significant percentage of MR students (6.3% of the total) raises some question on the quality of education in general and on the lack of professionalism in screening special needs students. MR cases, even in developed countries where there is relatively convenient setup for learning, are not expected to go beyond primary school. They are normally transferred to vocational schools before or upon completion of primary education. Therefore significant number of MR cases in secondary school is more of sign for questionable educational system rather than a sign for successful implementation of an inclusive policy.

**Table 5-D Special Needs Education for Students with Disabilities: Coverage by type of Disability and Regional Distribution**

<table>
<thead>
<tr>
<th>Region</th>
<th>Blind</th>
<th>Deaf</th>
<th>MR</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Special classes</td>
<td>Special classes</td>
<td>Special classes</td>
</tr>
<tr>
<td>Tigray</td>
<td>1</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Amhara</td>
<td>22</td>
<td>22</td>
<td>1</td>
</tr>
<tr>
<td>Oromia</td>
<td>4</td>
<td>40</td>
<td>2</td>
</tr>
<tr>
<td>Benshengule</td>
<td>4</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td>SNNP</td>
<td>-</td>
<td>19</td>
<td>5</td>
</tr>
<tr>
<td>Gambela</td>
<td>-</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Addis Ababa</td>
<td>3</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Harari</td>
<td>-</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Dire Dawa</td>
<td>-</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>34</td>
<td>99</td>
<td>15</td>
</tr>
</tbody>
</table>

Note: the five special classes in Addis Ababa are training centres for the mentally challenged
As can be noted from the tables above there are very few special need schools in the country. Making it even worse, most of them are either in Addis Ababa or in one of the regional capitals. 85 percent of PwDs who live in the rural part of the country have limited/no access to such schools. Apart from the effort of the ministry, DPOs and nongovernmental organizations have considerable contribution in the establishment and strengthening of the special needs programs in the country. Good example for this are ENAB and ENAD who both are currently running special schools in Bako, Welayta and Addis Ababa.

The community based rehabilitation projects operating in seventeen different areas of the country are promoting positive attitude of parents and the school community towards the inclusion of children with disabilities.

A study conducted on an impact assessment of three community based rehabilitation projects (HPDO, 2006, CSE, 2008 and CFE, 2006) indicated that, CBR projects consider school enrollment of CWDs as a yardstick to measure the success of the rehabilitation program. Even though there is no accurate data on the level of their intervention, the awareness raising strategy, which mainly target on families, schools and the general community in their respective operating areas, has shown contribution towards the enrollment of children with disabilities.

According to the assessment, after the functional restoration of child they step up to build the attitude of parents and facilitate child friendly environment in the schools through disability clubs. The same study gave reasons for the high dropout of students with disabilities, the changing physical or mental development of the child that comes with varying needs, financial constraints to cover transport cost to and from the school and absence of an individual to escort the child to school are some of the reasons for the frequent dropout rate.

Key stakeholders and informants contacted during this study have generally expressed their positive impression about the conducive policy environment and the strategy in special needs education by MoE. Most notably they showed their concurrence with the inclusive education policy of the government and the steps taken toward creating the capacity for boosting increased enrolment of PwD in recent years. However they raised concern on the gradual pace of the over all process. Some of their major concerns in this regard are summarised as follows:

- As it is elsewhere in most developing countries the prevalence of PwD is underreported in Ethiopia. In other words it is a problems “in hiding”. The cultural
barrier (lack of awareness) will continue to make it difficult for most of the disabled children in rural areas to be reached by special schools and special classes.

- The inclusive approach, as good as it sounds on paper, may not be easy to put into practice. The implantation of it pre-requires availability of special education materials (preferable in-country preparation of them), trained personnel and accessible physical environment.
- The distribution of special schools and special classes is currently confined only to urban areas. There is a need to making these programs available to where most of the CwDs live.

5.2 Health
In stark contrast with the education sector most stakeholders regarded the health sector as laggard in taking the steps towards devising clear policies and strategies and also implementing the few that it has in document. The MoH has not made any significant leap in making health service accessible to disabled persons both in terms of primary and special care. The focus of the health sector as indicated in the HSDP is promotion of preventive approach. In this regard, efforts worth mentioning are program on prevention of blindness, treatment & detection on leprosy, immunization, pre and postnatal care and disease control.

Apart from preventive health, the HSDP, outlines priorities to expand new curative health facilities in remote and rural areas and specifically rehabilitation of existing facilities for mental health and other disease control. The national social welfare policy drafted by MOLSA in 1996 also indicates the specific areas of medical care for PwDs. These include activities such as: strengthening and rehabilitation of medical services, making available strong referral hospitals for PwD, making available adequately trained workers, expansion of medical service devises for PwD, expansion of the supply of assistive device and physiotherapy treatment in line with medical service, expansion of medical service for intellectually disabled persons, provision of sustainable and mobile medical service to PwD, and encouragement of cultural medicine with assistance of scientific evidence.

However, there is little success (if any) in providing these services that is acknowledged by disabled person’s organizations. The MoH has not drafted any action plan that could

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28 Following FEDRE’s Developmental social Welfare policy (MOLSA 1996), a national plan is developed that necessitated joint action by various ministries.
specifically deal with making the health service accessible to PwDs neither has it created a department/unit within itself to attend to matters related with PwDs. The health policy is focused towards prevention but there is no formal coordination among the different preventive packages that relate to disability. The lack of coordination in this regard has made the data collection for this study particularly difficult.

In the health service delivery and quality care unit of the MoH, there are six sub components. Disability prevention/treatment is not a stand-alone component rather it is placed under the “prevention and control of diseases” component (Health Sector Strategic Plan 2005/6-2009/10). Prevention & control of blindness and prevention & control of leprosy are considered as intervention areas through which the ministry aims to tackle the causes of blindness and leprosy. Taking this into account it would be appropriate to look at the two activities separately and the general accessibility of the health service to PwDs.

5.2.1 Prevention of Blindness
The National Strategic Plan for Eye Care has commenced in January 2003 based on a baseline survey conducted in the previous year. It is designed to undertake two phases of implementation from 2003 – 2009. The program is implemented in collaboration with Regional Health Bureaus and some local and international non-governmental organizations (NGOs).

The National Committee for the Prevention of Blindness (NCPB) under the Disease Prevention and Control Department (Blindness sub unit) of MoH is responsible for the implementation, it comprises of thirty members drawn from the MoH, all regional health bureaus, Ophthalmological Society of Ethiopia (OSE), Ethiopian National Association for the Blind, five prominent universities in the country, ALERT Post basic Ophthalmic Nurses Training School, eleven NGOs, two COs and two UN agencies. The purpose NCPB is to coordinate and provide technical advice in the implementation of the strategic plans.

The major focus areas of the five-year national strategic plan are prevention and/or treatment of cataract, trachoma, glaucoma and childhood blindness. The program approach is focused on attaining three core objectives; disease control, human resource development, upgrading
the infrastructure and technology facilities and incorporating the principles of primary health care (Dejene M 2009)\textsuperscript{29}.

Accordingly to the midterm evaluation report the program targeted eight regions and two administrative towns. At mid point of the program implementation the performance of program (achieved versus plannened) was as follows: Addis Ababa (84%), Amhara (30.6%), Dire Dawa (63.3), Oromia (22.3), SNNP(42.3%), Tigray(136.1%), Somali(74.3%). Except Tigray none of the other regions were able to meet their plan. The report also indicated that only 52.8% (67,659 cataract operations out of the planned 128,143) were accomplished nationwide. Personal hygiene education such as the promotion of clean face that is aimed at avoiding childhood blindness has brought limited result except in areas where the implementation was by NGOs such as in SNNP, AMHARA and Oromia Regions (Dejene M 2009)

In terms of human resource there were 4 cataract surgeons, 80 ophthalmic nurses and ophthalmic medical assistants. There were two training programs for ophthalmologists at Addis Ababa and Jimma universities. Jimma, Gondor and Hawassa universities train cataract surgeons. There are 2 ophthalmic nurses training centers in Addis Ababa (ALERT) and Tigray(Quiha). The distribution of eye care workers in the country is uneven and 70% of the ophthalmologists work Addis Ababa. Disregarding Addis Ababa, the ratio of ophthalmologists to the remaining population stands at 1 to 3 million (\textit{National Five year Strategic Plan for Eye care in Ethiopia} 2006 – 2010.)

\textbf{5.2.2 Prevention & Control of Leprosy}

In the prevention and control of leprosy MoH has established an organized leprosy program since 1956 with subsequent policy issued in 1969. Since then the leprosy control was strongly supported by the African Leprosy Research and training Institute (ALERT) and the German Leprosy Relief Association (GLRA). In 1994 leprosy and TB were combined under the national Tuberculosis and Leprosy Program.

Believing that integration of leprosy into the general health services contributes to the reduction of social stigma and sustainability of services health posts, health centres and hospitals incorporated the diagnosis and treatment of leprosy patients. The same document states that the rate of grade 2 disability among newly registered cases has decreased from 70%

\textsuperscript{29} Micheal Dejene (2009): Mid-Term Review of the National Five-Year Strategic Plan for Eye Care in Ethiopia
in 1987/89 to 11% in 2006, there were a total of 4,646 dictated cases for the period 8 July 2006 – 7 July 2007, the case notification per 10,000 is 0.55 and the percentage of patients with disability grade 2 among newly detected cases is 10.7%. (Tuberculosis, TB/HIV and Leprosy prevention and control Strategic Plan August 2007)

5.2.3 General Health Services to PwD

In studying the accessibility of health institutions to PwDs, almost all respondents spoke of the barriers faced by persons with disabilities, some informants said, going any extra mile for PwD is almost unthinkable in the current health system. One respondent wonders, “how can you expect any distinctive handling for PwDs from a health service that is not able to give even the most basic service to the entire population”.

A recent study on the accessibility of health services in three-selected health centres in Addis Ababa indicated that persons with disabilities and their families face considerable physical, technical and psychosocial barriers that exist in the general health system (CFE, December 2009). The finding remarked, the health centres lack the preparedness and accommodation needed to serve persons with disabilities in terms of physical, technical, attitudinal and communication problems. In a focus group discussion where health staffs of the respective health centres were involved discussants expressed the limitations of the service in the following manner.

“I remember once I had to examine a deaf woman who was also illiterate. I found it particularly difficult to communicate to her the instruction as to how she needs to take her medication. The only option I had was to ask her to go back home and bring someone who could help me pass my message to her by any means”

Another health professional responded to the experience of the earlier speaker by saying, there are times when the patient (PwD) wants to avoid his/her own relative whom they bring for interpreting or guidance. In cases of rape, sexually transmitted diseases or other private matters, they prefer to directly communicate with the physician. The second speaker also gave his own personal encounter as follows:

“Once a blind women came to my examination room with her son. She wanted us to get her son out of the room before we start the examination but she struggled to get the
right word to pass her message across to my assistant and me. I myself was confused for while as I saw her murmuring something to herself. After a while she said

"nowadays doctors do not understand our feeling like those in the old good times”

Other studies indicated that Parents of children with disabilities become angry & resentful when they are first told about their child’s disability. The first negative contact sours parents’ attitude with professionals and contributes to the parent’s shock and undesirable reaction until they develop adaptability to the child disability.

In a three years strategic plan on national violence and injury, it is stated that ” The health sector is facing a double burden of disease, since infectious disease are accounting for the major part of the burden, while non communicable diseases and injuries are on the rise”(MoH, Three years Strategic Plan, National Violence and injury)

5.3 Provision of Orthopaedic Appliances

The provision of orthopaedic and orthotic appliances is one major area of support for the physically disabled. The extent of service provision was studied by looking into the number of organizations involved in the production & distribution process, number of appliances distributed and the location of the centres. The following table shows description of the appliance workshops in the country.
In total there are twelve prosthetic/orthotic centres without counting the workshops dedicated for persons affected by leprosy across the country. ICRC is a major donor in providing technical and financial assistance to most workshops by reimbursing social cost of PwDs (transportation, food, and accommodation) and cost of orthopaedic appliances. In addition, the Emergency Demobilization and Reintegration Project implemented from 2001 - 2007 has strengthened six prosthetic orthotic centres (Mekele, Desse, Asella, Arbaminch, Harar & Jijiga). The support included upgrading physical infrastructure, equipments and manpower development.

Although it was difficult to find an accurate data on the overall coverage or distribution of appliances, in 2002 alone the total production and distribution of appliances was 1,902 prostheses, 1,695 orthotics and 4,378 crutches of which 835 prostheses and 43 orthotics were for landmine survivors (*the ICRC, annual report of 2002 indicated*). To further show the extent of production & distribution the Addis Ababa Prosthetic Orthotic Center and Cheshire services Ethiopia (2004 – 2009) exemplifies the situation.
Table 5-G Description of Prosthetic Orthotic Services by Addis Ababa POC & CSE for 2004-2009

<table>
<thead>
<tr>
<th>Organizations</th>
<th>Estimated Coverage by Type of Appliance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Prosthetics</td>
</tr>
<tr>
<td>Addis Ababa Prosthetics-Orthotics Centre</td>
<td>2928</td>
</tr>
<tr>
<td>Cheshire Services Ethiopia</td>
<td>1200</td>
</tr>
<tr>
<td>Total</td>
<td>4128</td>
</tr>
</tbody>
</table>

The Prosthetic Orthotic Centre of Addis Ababa established in 1964, has served as a national centre for the production and distribution of orthopaedic appliances. The centre has provided technical support in the establishment of Harar Orthopaedic Workshop (1982-83), Arbaminch Rehabilitation Centre (1992), National Rehabilitation Centre at Black Lion University Hospital; it also played an advisory role in strengthening five regional Prosthetic & Orthotic Centres during the emergency demobilization and reintegration project (MoLSA, Completion report April 2008).

Cheshire Services Ethiopia is another key player in the provision of appliances (1962) with three orthopedic orthotic centers and an outreach program that extends in almost all regions except Afar, Gambela and Somalia Regions.

An interview with key informants regarding the status of service delivery indicated that, currently there is an improved coverage and quality service in the provision of prosthetic and orthotic appliances in the country, but however the service still lags behind to full fill the needs PWDs in the rural area, they also raised concern about the sustainability of the centres because they are financially dependent on external sources.

5.3.3 Employment Creation

Employment related proclamations described in table 1-B are robust in content but non of those were followed by detailed implementation modalities such as incorporating “equal opportunity criteria” in human resource policies of organizations, no follow up systems/actions are put in place to monitor hiring practices of public and private companies,
no effort is made to get feedback from PwD to gauge their level of satisfaction with the policy. In general the policies have not done much to change the employment situation of PwD.

Furthermore promoting employment opportunity for persons with disabilities must be synchronized with other sectoral development programs in health, education, physical environment, etc. because access to employment entails improved access to education and vocational training that helps to fit into the competitive job market. Currently, employment of PwDs is in its unspeakable circumstance in both the formal and informal economy. The formal economy comprises public and private sector jobs that provide employment security, minimum wage laws, occupational safety and other privileges depending on the employer. In most cases it is the aspiration of everyone to be included in the formal employment which in a way diminishes the chance for disabled persons, according to ILO CBR guideline, in African countries the formal economy does not employ more than 10% of the total labor force. *(Inclusion of People with Disabilities in Ethiopia, ILO).*

According to key informant interview, DPOs insist PwDs are still suffering from inaccessibility of job opportunities due to employer’s negative attitude that considers PwDs as inefficient with an excuse that the disability type is an obstacle to meet the requirements of the job. Lack of access to education and health facilities also makes it difficult for PwD to be competent in the labour market. The modest access that exists in higher education system is limited to only few areas of study in social science. PwDs have hardly any access to vocational training. Almost all training centres are not designed in way that makes it possible for PwD to take part. The equal opportunity proclamation will only be meaningful when the working places have the minimum facility for PwDs.

In the case of Ethiopia studies have confirmed that the employment of PwDs in the formal sector is insignificant. A head of DPO and key informant to this study puts it as follows “ it is still common to see disabled persons with bachelor degree or diploma systematically denied job opportunities in government offices while they are equally competent (at times even more so) than their able bodied counterparts. The situation in the private sector is yet far worse. Equalization of opportunities is far less in the making (particularly) to job market than to any other dimension of life”
Responding to this study, the head of Civil Service Reform admitted his office has not collected information specific to the employment situation of PwD. Regarding Proclamation No. 377/2003, he replied, at the moment the only steps taken are the launching of awareness raising workshops in three regions (ILO assisted) and the preparation of an implementation guideline, which is still underway.

The situation is no different in the informal sector. The only difference in this case could be the form or extent of prejudice. The informal sector, despite varying definitions, is characterized as involving small-scale operation, minimal initial capital, labour intensive, undocumented in government books etc. People engaged in such business not only need to adapt to the physical hardship that the work entails but to the good will of the final recipients of their services/goods. With regard to the informal sector the only advantage for PwDs (over the formal employment sector) is there is quite less entry barrier into such activities. Particularly in some skill demanding home-based enterprises PwD have excelled in quality production and specialization.

A survey on disability in Ethiopia (ILO 1995) indicated that 60 per cent of persons with disabilities of working age were unemployed, of whom some two-thirds were self-employed in rural areas in occupations such as agriculture, animal husbandry or forest activities. Begging and permanent reliance on religious institutions and charities is often a prevalent means of survival for PwD in urban centres.

In view of the barrier at the formal job market, PwDs often organize themselves in self help groups to create self-employment opportunity for themselves. Several local and international NGOs assist this effort by providing skill training and startup capital serving (loan) serving as financial intermediary for starting income generating activities. With this kind of arrangement many PwDs and parents of children with disabilities have taken advantage of these economic opportunities. The following three selected cases/organizations illustrate the significance of economic opportunity programs for PwD at community level.
Case –one

GLRA is an international TB/Leprosy focused organization that implements socio economic rehabilitation in five regions and two administrative counsels. The CBR program which is mainly defined in economic rehabilitation covers 4069 PALs (about 20,345 families members) from 2002 to 2007. The economic program focused only on providing the start up capital through a revolving loan scheme. Participants were made to choose their scheme based on their interest and a business plan that best appeal to their conscience.

Out of the total program participants 23.4% were engaged farming, 20.8% in sheep fattening and 52.9% were engaged in various types petty trades including liquor sell, kiosk and cereal sell. The repayment practices of the selected sample households indicated 40.7% completed full payment, 55% were left with less than 25% outstanding while 4.3% were defaulters. The assessment report remarked the GLRA CBR project has used the credit scheme to economically empower PAL and promote social inclusion of the target group who reside in leprosy colonies with the surrounding community. (Impact assessment 2007)

Case –two

A group of CBR programs working with different types of disabilities in five regions of the country have launched credit scheme to improve the lives of parents of children with disabilities. The credit program was provided in 19 CBR projected located in Addis Ababa, Bahir Dar, Dessie, Lalibela, Jimma and Awassa.

In Addis Ababa only a total of 344 mothers participated in the credit program engaged various petty businesses like guilt, kiosk and liquor sell. Out of the total 40% completed repayment, 23% settled partially and 5% were defaulters. The report concluded as a result of program, mothers were able to cover their daily cost, fulfill school expenses and buy additional household utensils. In general the credit service has raised the expectation of parents for a self-governed saving & credit association that will look after the wellbeing of their children. It also inspired the parents to have work spirit than stay at home in a hopeless situation (impact assessment of the Addis Ababa CBR project (CSE 2008)
The same effect was observed in Dessie, Baherdar and Jimma CBR programs by CFE where a 638 PwDs and parents were provided with the credit support. In addition, as part of employment creation 598 disabled youth received various types of vocational training (of which 46% were females).

Emergency Demobilisation and Reintegration Project(MoLSA, 2008) Which targeted 17,000 severely disabled war veterans, among other services provided vocational and business skills for 642 persons as part of the reintegration program.

**VI. Institutional Development in Ethiopia (PwDs Perspective)**

In Ethiopia government offices, NGOs, service providers, DPOs constitute the institutional environment in the disability sector, as normally occurs these stakeholders create the cooperation and competition among themselves. The main government organ responsible for persons with disabilities is the Ministry of Labor and Social Affairs, other Federal level Ministries mainstream disability issues in their program. In the regions, the responsibility falls under the Social & Labor Affairs Bureaus. By and large, government offices focus on legislation, policy formulation and coordination matters while service delivery is shared by all stakeholders, nongovernmental organizations taking the major part.

**6.1 Disabled Persons Organizations**

Historically, it is almost five decades since the DPOs movement started in Ethiopia. The two time honoured founders are the Ethiopian Blind Association (January 1960) and the Ethiopian Deaf Association (1970).

The DPOs organizational development at the different times echo the socio economic and political picture of the Ethiopian society, the dynamism within the associations, reflected the changes in the purpose and function they stood for. Retrospectively, services that started with basic needs along with primary education took a developmental perspective in the form of educational, vocational and employment opportunities after 1975.

In the 1990th, three disabled peoples organizations were established namely, Ethiopian National Association of Persons Affected by Leprosy, Ethiopian National Association of the Physically Handicapped and Ethiopian National Association for Intellectual Disability which gave momentum to the disability movement in the country.
In the course of time, DPOs suffered from recurrent internal conflict which contributed in regressing DPOs at different periods. On this line of discussion, the interview with key informants including association leaders pointed out, the cause for the frequent conflict to be low capacity of the elected leaders and drive for personal benefit which created division among members (Annual reports 1999, 2000 & 2001 ENAD).

Despite the internal problems, the aspiration to strengthen DPOs continued giving rise to an idea that the struggle for self representation and rights will be more effective when all disabilities get united under an umbrella organization, because a stronger voice can succeed than each disability group speaking out separately. As a result and with the help of the Rehabilitation Agency (MoLSA) and Save the Children (UK) the Federation of Ethiopian National Associations of People with Disabilities (FENAPD) was formally established in February 1996.

At the same time the national associations increased their representation in the regions, by collaborating with NGOs and creating links with international disabled organizations. This contributed towards the visibility DPOs in the public. Table below describes the respective association’s international links, regional expansion and member’s coverage in the last decade.

**Table - 6A DPOs, their international link, Regional Branch offices and Membership**

<table>
<thead>
<tr>
<th>Association</th>
<th>Membership to International Organization</th>
<th>Regional Coverage</th>
<th>No of Branch offices</th>
<th>Estimated Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>FENAPD(1996)</td>
<td>DPI</td>
<td>Federal</td>
<td>-</td>
<td>5 National Associations</td>
</tr>
<tr>
<td>ENAB(1960)</td>
<td>AUB, DPI</td>
<td>9 regions 2 AT</td>
<td>29</td>
<td>10,631</td>
</tr>
<tr>
<td>ENAD(1960)</td>
<td>WFD, WFD/RESESA</td>
<td>6</td>
<td>14</td>
<td>1997</td>
</tr>
<tr>
<td>ENAPAL(1996)</td>
<td></td>
<td>9 regions 2 AT</td>
<td>63</td>
<td>15,000</td>
</tr>
<tr>
<td>ENAPH(1993)</td>
<td></td>
<td>9</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>ENAID</td>
<td>Inclusion International II, Inclusion Africa</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>ENABD(2006)</td>
<td></td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>
The six national associations have made their visibility across nine regional states with a total of 106 branch offices. So far Gambella, Afar and Somalia regions are not covered by any of the associations. In addition the Ethiopian Women with Disabilities National Association (EWDNA) established in 1995, has 800 members in Addis Ababa and five branch offices in the regions (Mekele, Bahirdar, Awasa, Nazareth and Diredawa)

5.4.2 Services Providers

With the exception of hospitals grass root preventive and rehabilitation programs are mostly implemented by nongovernmental organizations and religious charities. (International Labour Office). Nongovernmental organizations are international donor agencies providing technical & financial support to local partners and indigenous organizations directly involved in service delivery.

The major international NGOs involved for over decades are ILO, UNICEF, WHO, the German Leprosy and Rehabilitation Association (GLRA) The Christofffer Blind Mission (CBM), Handicap International (HI) Save the children UK, Swedish Save the Children (RÄDDA BARNEN) and Light for the World.

Among the indigenous groups Cheshire Services Ethiopia, Cheshire Foundation Ethiopia, Addis Development Vision, Arbaminch Rehabilitation Centre, Handicap National, POC are the major ones. Ethiopian National Disability Network established in 2004 serves as an umbrella organization for disability focused organizations. CBR Network Ethiopia is also a legally registered organization to facilitate experience sharing and coordination among organization who implement CBR programs. In addition, a recent publication on the number of referral institutions stated there are 196 government and non government organizations engaged in different types of rehabilitation programs. The following table shows description of service providers by regions and type of services.
Table – 6B Description of Service providers by Type of Services and Regional Location

<table>
<thead>
<tr>
<th>No</th>
<th>Regions</th>
<th>Physiot</th>
<th>Appliance</th>
<th>Special Needs</th>
<th>Eye care</th>
<th>Awareness/counselling</th>
<th>Audiometer/sign language</th>
<th>Braille/ mobility training</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Tigray</td>
<td>6</td>
<td>9</td>
<td>5</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>27</td>
</tr>
<tr>
<td>2</td>
<td>Amhara</td>
<td>6</td>
<td>9</td>
<td>5</td>
<td>4</td>
<td>4</td>
<td>5</td>
<td>4</td>
<td>22</td>
</tr>
<tr>
<td>3</td>
<td>Oromia</td>
<td>6</td>
<td>10</td>
<td>5</td>
<td>5</td>
<td>7</td>
<td></td>
<td></td>
<td>33</td>
</tr>
<tr>
<td>4</td>
<td>SNNP</td>
<td>3</td>
<td>5</td>
<td>3</td>
<td>4</td>
<td>3</td>
<td>3</td>
<td></td>
<td>24</td>
</tr>
<tr>
<td>5</td>
<td>Harar</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>6</td>
</tr>
<tr>
<td>7</td>
<td>Dire dawa</td>
<td>4</td>
<td>2</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>9</td>
</tr>
<tr>
<td>8</td>
<td>Addis Ababa</td>
<td>16</td>
<td>12</td>
<td>5</td>
<td>26</td>
<td>11</td>
<td>5</td>
<td>75</td>
<td>196</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>37</strong></td>
<td><strong>46</strong></td>
<td><strong>18</strong></td>
<td><strong>19</strong></td>
<td><strong>44</strong></td>
<td><strong>21</strong></td>
<td><strong>13</strong></td>
<td></td>
<td><strong>196</strong></td>
</tr>
</tbody>
</table>

It can be observed that all the services are located in major towns in the country where 38% are in the capital Addis Ababa. (Directory of special Needs Education Services, equipment and materials, Directory of Institutions providing services For Persons with Disabilities)

VII. The African decade of Disabled persons

7.1 Background

The African decade of Disabled persons pronounced for 1999 - 2009 was initiated by the Labor and Social Affairs Commission of the Organization of African Unity (OAU) in April 1999 in Windhoek, Namibia. It was adopted by the 35th session of the OAU Assembly of heads of states and government held in Algiers in July 1999. The period 1999 to 2009 was formally proclaimed “the African Decade of Disabled Persons” at the 36th session of the OAU heads of states and governments in Lome, Togo in July 2000.

February 4-7 2002, African Union’s Labour and Social Affairs Commission along with the African Rehabilitation Institute (ARI), ILO, PAFOD, AFUB and other regional organizations of persons with disabilities organized the Pan-African Conference to develop a "Plan of Action for the Decade". The conference ended by adopting the draft plan and referring it for final endorsement. Later the Action Plan was formally endorsed by the seventy-sixth ordinary session of the OAU Council of Ministers, held at Durban.

The continental Plan of action demand the OAU member States and Governments to study the situation of persons with disabilities and take measures in line with equalization of opportunities, full participation and independence of disabled persons in their respective societies. The document advises member States and Governments to:

- Prepare policies and national programme that encourage the full participation of persons with disabilities in the socioeconomic development;
• Set up national disability coordination committee by the full representation of disabled persons organizations;
• Support community-based rehabilitation programs to collaborate with international development agencies and organizations;
• Enhance the society in developing positive attitudes towards children, youth, women and adults with disabilities to ensure their access to rehabilitation, education, training and employment, as well as to cultural and sports activities and access to the physical environment;
• Develop programmes that alleviate poverty amongst disabled people and their families;
• Mainstream disability on the socioeconomic and political agendas of African governments;
• Spearhead the implementation of the UN Standard Rules on the Equalization of Opportunities for people with disabilities, and ensure the use of the Standard Rules as a basis for policy and legislation development;
• Apply all UN and OAU human rights instruments to promote and monitor the rights of persons with disabilities.

As a measure of operationalizing the decade plan, the Secretariat of the African Decade of Disabled Persons (SADDP) was established on October 2003. Albeit it’s late emergence the secretariat was given a focal role that include serving as an institutional framework in the coordination and implementation of the decade’s plan of action in Africa. It was legally set up and began working in Cape town in March 2004 (Reg. No 2003/027026/08) almost half way through the pronouncement of the decade.

7.2 The Ethiopian Perspective
As described in the introduction, out of 25 African countries where the secretariat has been active, Ethiopia is chosen (along with Rwanda, Senegal, Kenya, and Mozambique) for this study. The foregoing discussion on Ethiopia’s legal, institutional, policy and program implementation on issues of PwD show that the country is undertaking progressive steps in the right direction. The timing in which most of the policy and program actions have come into force coincides with the time of the African decade. However the study has not found any substantial evidence to suggest that these actions are induced (influenced) by the decade declaration or with the support of the
African decade secretariat. In appreciation of the terms of reference, the study has attempted to
gauge the effectiveness of the “African decade” pronouncement (and/or the effort of the
secretariat) in influencing domestic policy and program by seeking information from various
individuals and committees who had direct working link with the secretariat.

For assessing the extent of the decade’s influence on the development of national policies and
program for PwD, the study has looked into three broad areas of engagement, namely entry &
conceptual clarity, institutional arrangement or functionality of NDSC and the role of SADDP.
These points are assessed based on information mainly from members of the Ethiopian national
decade steering committee and other key government officials who took part in various workshops
and meeting sponsored by the secretariat.

7.2.1 Entry & Conceptual Clarity

The first decade familiarization workshop was conducted in Ethiopia at the beginning of 2006 at
Gion Hotel, in the presence of DPOs, disability focused NGOs and government representatives. At
that time there was ambiguity as to who should take responsibility for the decade activities in
Addis Ababa. The idea of entrusting the duty to the disability forum (ENDAN) was not accepted
instead consensus was reached to make the institutional link through MOLSA and FENAPD.

In November 2006 a tripartite agreement was signed between MOLSA, the secretariat and the
Federation of Ethiopian National Associations of People with Disabilities (FENAPD). In the
agreement MoLSA and FENAPD agreed to become the chair and secretary of the national decade
stirring committee respectively. All other parties who were represented in the meeting shared
responsibility to facilitate the implementation of the decade through a focal umbrella committee
named as National Decade Steering Committee (NDSC). Among other things, the committee was
tasked with a duty of formulating an adopted national decade plan of action. SADDP took
responsibility to provide technical and advisory support and to help the NDSC hook up with
potential sources of financial resource that would help the implementation of disability focused
programs in the country.
The NDSC was formally established on March 2007. It consisted of 16 representatives drawn from line Ministries\(^{30}\), DPO representatives, disability forum and CBR network. A core management was also appointed to play a lead role in coordinating the committee actions and to serve as primary contact with the SADDP. This was the procedure undertaken to formally introduce the pronouncement of the decade and establish a link between Ethiopia and SADDP. According to some key informants from within the NDSC, this process has been passive, indistinct and most of all way late to the time span of the decade.

Most members of the NDSC and other stakeholder contacted as key informants to this study found it difficult to recall the above events because the decade activities in Ethiopia did not follow an interlinked set of activities. Nearly all of them do not recall receiving the continental plan of action or any decade related documents. According to their response, knowledge about the decade has not passed beyond those who attended the few workshops organized by the Secretariat. There was no awareness creation strategy adopted to familiarize the relevant stakeholders and the public at large. Neither the Secretariat nor the NDSC have devised clear strategy to lay down an operational plan for reaching the entire regions of Ethiopia. Labour and Social Affairs Bureaus of Oromia regional state and Addis Ababa City Administration confirmed to have no information about the decade which proves that no effort is made to introduce the “African Decade” in the regions.

For the most part of the interview and FGD with stakeholders, this study found it difficult to get direct response neither to the questions related neither to the entry and conceptual clarity of the African decade pronouncement nor to the contribution of SADDP. In their views, the decade lacked conceptual clarity, no entry strategy (awareness raising) was devised, SADDP’s effort was limited to only facilitating few workshops that had unclear objectives and no follow up actions. For most respondents the decade pronouncement never occurred as a serious and relevant instrument and they never contemplated to streamline their activities in the decade framework. Mostly stakeholders consider the decade as lost opportunity. In the words of one respondent:

“The ADDP was an opportunity that has come and (probably gone) before we knew much about it. I am not sure if this has to do with their failure to come forward and create awareness about their work or if it is our inaction in taking the opportunity. It can be a combination of both. But, on the balance, it is fair to label the decade as “a missed opportunity”

\(^{30}\) The line ministries mainly consisted of representatives from Ministry of Labour and Social Affairs, Ministry
On the other hand, considering the time in which the SADDP is established and the time it took to launch the national steering committee in Ethiopia, it is premature to expect to get information by which one can assess the overall performance of the decade plan. However at this point it is fair to expect that at least clear entry strategy is in place and that all stakeholders are on board with a common conceptual understanding on the decade objective and the strategy by which it aims to attain those objectives. Failure to attain the least of these expectations is something that amounts to lack of any meaningful control over the whole vision.

### 7.2.2 Institutional Arrangement & Functionality of NDSC

Even though the NDSC was established to work closely with SADDP for implementing the mission of the decade, it has failed to deliver in all its commitments. Despite clear statement in the tripartite agreement, it has not taken any step to adopt the decade plan of action for Ethiopia (ToR is not drafted, action points are not drawn, institutional arrangement is not thought thoroughly). Apart from those that are represented in NDSC or those few who were present in its launching workshop, most stakeholders who responded to this study are not aware of the existence and functioning of the NDSC.

Member of the NDSC also admit the failure of the committee in meeting the purpose for which it is created. They attribute the failure to the voluntary nature of the assignment. Since all member of the NDSC are full time employees (leaders) of their own organization and that there is no technical working group that is created for coordinating routine activities on a daily basis, the committee has been less responsive to take initiative and follow up activities. In the words one NDSC member: “I can only recall a couple of (or more) meetings we had as NDSC and the trip we made to Rwanda and Kenya from where we came back with some enthusiasm but nothing happened afterwards. I can certainly say the decade has lacked ownership in Ethiopia”

In view of these shortcomings MOLSA and FENADP have come up with an idea of revamping NDSC by creating a core implementation unit at national level. The unit was meant to handle the routine operational aspects of the decade providing for the “missing link” between the NDSC and SADDP. All parties including the SADDP have initially welcomed the idea and some actions went underway to hire technical persons for the unit. However the action did not go further as resources for sustaining the cost of the unit could not be secured either from the SADDP or with in the country.

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7.2.3 Inputs of SADDP

To determine the involvement of the SADDP in Ethiopia (such as providing technical assistance and/or capacity building of domestic institution as it is clearly stipulated in the purpose of the SADDP), the study collected information from member of the NDSC. In general the study found it difficult to get concrete and accurate information on the actions that have been taken so far. Based on the feedback from participants, the following workshops have been conducted in various occasions in which different institutions and individuals from Ethiopia have been represented:

- Training/workshop organized for DPOs in Ethiopia on the concept of the Logical Framework analysis from July 21-22, 2008 followed by a practical on service training on the same concept from July 23-25, 2008

- Training/workshop organized for DPOs in Ethiopia on “advocacy and lobbying” from July 21-22, 2008

- Members of the Ethiopian NDSC attended skill enhancing training on “project design & preparation” in South Africa in 2007

- An Ethiopian team (that included the vice minister of MOLSA and some members of NDC attended) have attended an experience-sharing workshop in Rwanda in 2008

- An Ethiopian journalist attended a regional workshop held in AA on disability reporting.

- Members of the Ethiopian NDSC attended a workshop on “reporting major decade activities in selected five pilot countries” in 2008 in Kenya

The feedback from the workshop/training participants varies from one group to other. In general those who took part in the DPO capacity building training expresses relatively higher level of satisfaction to the conduct of the training. Notably they agree on the relevance of the topics selected and the professional approach in the coverage and mix of the presentations. On the other hand members of the NDSC expressed disappointment on the same trainings because they were conducted without the knowledge and involvement MOLSA or FENAPD. According to informants, the trainings were conducted directly by the SADDP people who have come to the country with out the knowledge and involvement of NDSC (or even with out the knowledge of the most relevant ministry for disability such as MOLSA and FENAPD). In the words of one NDSC member:
“We heard that a group of SADDP people comprising of trainers and a treasurer were in the country to organize DPOs capacity building workshop. We are not consulted or heard information about the event. We cannot say if the training was good or bad but we know that everything had happened in the way they (the SADDP) wanted it. I think this kind unilateral action is not helpful for achieving the good intentions of the decade declaration. Most of all it is a breach of our tripartite agreement”

On the other hand those participants that have taken part in the continental workshops in Rwanda and South Africa have little (if any) appreciation to the way the workshop/trainings are conducted. They appreciate the effort of SADDP for creating the platform for experience sharing but in general expectation outweigh what has happened in those events. In all cases the study could not find any written records of the workshops and trainings.

7.3 Conclusion about the Decade
The African Decade of Disabled Persons, as good as it may sound, had limited (if any) positive influence on the situation of persons with disabilities in Ethiopia. Even though there were some notable efforts made towards the later years of the decade, they were not good enough to generate the minimum stimulus threshold to influence the development of legislation & policy, enhance participation of DPOs or improve the accessibility of services to people with disabilities. The following are summary of key problem areas associated in the implementation of the African decade of Disabled persons in Ethiopia.

1. The implementation of the African decade of disabled persons suffered from late and gradual emergence responsible institutions at both continental and national level. SADDP started to work after 2004 and began launching the decade pronouncement in Ethiopia late 2006 when only three years was left to finalize the decade plan of action.

2. There was no adequate familiarization about the mission, purpose and activities of decade at federal, regional or organizational levels. Knowledge about the pronouncement of the decade remained in the minds of individuals who were involved in workshops organized at the launching stage.
3. The relation between the African Secretariat, MOLSA and FENAPD lacks transparency and accountability as exhibited in the DPOs workshop conducted without the knowledge and involvement of MOLSA/FENAPD.

4. As commented by most stakeholders the African decade of disabled persons lacks ownership in terms of having a relatively autonomous institutional mechanism to implement the decade plan of action. The major partners MOLSA and FENAPD were not proactive to take timely remedial measure that can fill the necessary leadership gap.

7.4 **Recommendation (decade only)**

The African decade of disabled persons is an opportunity, effective familiarization and mainstreaming of the decade pronouncement into the plan and strategy of line ministries, DPOs and disability-focused organizations would be an added value to the disability movement in the country.

Thus the consultants would like to forward the following points to contribute towards the proper utilization of the upcoming decade pronouncement:

1. The African Decade of Disabled persons can be used as an instrument to implement the UN convention on the rights of persons with disabilities. By so doing stakeholders can directly work on legislation, policy framework and empowerment of DPOs.

2. Develop an effective awareness strategy to familiarize the concerned bodies, the regions and public at large about the mission and purpose of the decade pronouncement.

3. Set up a practical structural unit to coordinate the national implementation of the decade plan of action.

4. Prepare an inbuilt M&E system to gauge the implementation of the decade plan of action

5. Prepare a national decade action plan with the necessary budget through the participation of major stakeholders.

6. Use the overall activities of the decade as an instrument to participate and empower DPOs.
7. Follow an inclusive approach in stakeholders’ participation; never limit the partners to the primary stakeholders but rather to larger group of secondary stakeholders including the private sector

VIII. Recommendation

The situation of PwD in Ethiopia is not properly documented and periodically updated. Any effort (such as this study) that is aimed at examining the current situation of PwD is likely to suffer from lack of basic statistics on the prevalence, social, economic, and many other circumstantial situations of PwDs. With this limitation in hand, this study understands that the legal and policy environment for PwD is undergoing fast and progressive steps while their implementation can be considered as lagging or as yet awaiting the quick emergence (and/or transformation of the existing) institutions, political commitment of leaders and putting in place various enforcement mechanisms.

At the policy and legislative level, there is a need for creating more progressive participation for PwDs. The involvement of PwDs in awareness creation is one key area of improvement over the years. While these are encouraging steps taken towards increased participation, there is a need for **further boosting the engagement of PwDs to a genuine participation level where they become major actors in negotiating the laws and policies directly by themselves**. The case of disability is gaining increased airtime in media and the depiction of disability message is showing major stride shifting from social welfare towards to a right-based approach. However, the effort in this regard needs to be carefully documented for research and for planning further improvement.

To get the gist of PwD’s situation in Ethiopia, the study sought information both at policy and implementation level. In doing so it has following key sectoral lines (education, health and employment) that are thought to be crucial in determining the social and economic wellbeing of PwDs. The study highlighted that sectoral policies, albeit different from one another, have incorporated disability issues across their long-term strategic plan. However the sectors are not equally progressive in devising clear strategy or putting in place the necessary checks and balance to ensure the implementation of policies. Based on this finding the study would like to forward the following recommendations for future consideration by the different stakeholders.
8.1 Government

At the government level there is a “missing link” that serves not only as a central coordinating unit for national plans and program but also one that plays lead roll in ensuring that multi-sectoral plans are synchronized and that all are advancing in similar pace. The challenge faced in the implementation of the African Decade visibly demonstrated the absence of this role at a government level.

In this regard the government has to establish a focal point, preferably at the centre of government. Ideally the focal point must be at the highest level of government such as an inter Ministerial coordinating body in the office of the President or Prime Minister.

 Ministry of Health on the other hand has to review its policy and service delivery guideline to give disability more space & consideration. At present there is no clear strategy, even in document, that shows how the health service will reach out (become more accessible) to the PwDs. The sector needs to put in place clear strategy that shows the steps that will be taken to make the service accessible to PwDs. The health institutions should have the readiness and proper accommodation to provide primary and special care to all types of disabilities. A capacity building action such as human resource development, communication/ attitudinal and physical accessibility need to be carried out in a way that enables the sector to provide adequate and professional service to the PwDs.

Similar to the health sector, the education sector, has to step up accessibility of schools and training centres to the CwDs. Even though there are encouraging steps taken so far, the MoE need to work more in creating conducive physical environment particularly in vocational training centres and school facilities both in quality and magnitude that is commensurate with the growing need from PwDs.

8.2 Disabled Persons Organizations (DPOs)

DPOs participation is the key both for generating useful policies and laws and for ensuring their implementation in various sectors. To boost their level of participation a concerted effort has to be made to build their capacity such as investing in their negotiating skills, enhance their exposure through experience sharing, encourage intellectual PwDs to take active part in DPOs. By so doing DPOs need to strive for higher level of participation in policy and
program design. The government also need to pay attention to providing more space and seeking genuine counsel of the DPOs in all matters that are pertinent to the PwD.

DPOs in Ethiopia (at all levels) are also characterized as less cohesive and internally weak organizations. Maintaining internal strength and creating strong horizontal link is the first step that will help boosting their profile for higher-level engagement. As a national umbrella association, EFNAPD must take a proactive role to give a lasting solution to the recurrent internal disputes or conflict in the associations’ leadership.

8.3 Program Implementation (all stakeholders)

There is a growing number of development organizations (mainly NGOs) that are showing interest to work in the disability sector. The government needs to recognize the growing interest and resource as an opportunity to promote and mainstream and the disability inclusion policy into the broader development strategy. NGOs and donors interested to work in disability need to follow a coordinated approach one that avoids duplication of efforts, ensures fair distribution of services across the country and one that allows complementary (rather than competing) with each other.

A national level disability survey has to be organized to get a reference to the disability situation in the country, to serve as a tool for planning and evaluation. The national census is so far the only source of information for referring the issues related to PwD. The census, as good as it is for a sole source of information, is by no means adequate source. It is believed that the 1994 census has largely underestimated the prevalence of PwDs, not to mention that there is not another census result since then. It is increasingly recognized that each country need to have its own specialized disability focused survey that provide in-depth information regarding the situation of PwDs.

There is a need for national strategy that will help to coordinate the different programs implemented by DPOs, prosthetic orthotic centres, CBR programs, health and educational institutions etc. The coordination can be both at national and regional level. Similar to other crosscutting development programs (food security, HIV/AIDS etc), stakeholder working in disability must strengthen their own networking through which they can exchange information, success stories, new approaches and project ideas.
References


3. Easterly & Levine 1997


16. GLRA/DAHW Fifty years in Ethiopia, 2008


23. THE THREE YEARS STRATEGIC PLAN, NATIONAL VIOLENCE AND INJURY
PREVENTION AND EMERGENCY MEDICAL SYSTEM STRATEGY, 2007/8 – 2009/10
24. TUBERCULOSIS, TB/HIV AND LEPROSY CONTROL, STRATEGIC PLAN, 2007/8 –
2009/10 MoH, August 2007,
25. Bright Hope, No. 13, December 2009, FENAPD
26. The Truth, ENAPAL No. 9, January 2009
27. Directory of Special Needs Education Services, equipment and materials, MoE, April 2007,
Addis Ababa
29. Directory of Institutions Providing Services for persons With Disabilities, CBR Network
Ethiopia, November 2007, Addis Ababa
30. Annual report of ENAB, ENAPAL, ENAD.....etc
31. የአካል ምዳት ማቶቹ ይወጆ እንወር, February 2008