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THE SITUATION OF DISABLED WOMEN, THEIR MARGINALIZATION AND MEASURES FOR SOCIAL INTEGRATION IN THE ESCWA REGION

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EXPLANATORY NOTES

The following symbols are used in the tables throughout this study:

Two dots (..) indicate that the data are not available or are not separately reported.

An em dash (--) indicates that the amount is nil or negligible.

A hyphen (-) indicates that the item is not applicable.

The opinions, figures and estimates set forth in this paper are the responsibility of the author, and should not necessarily be considered as reflecting the views or carrying the endorsement of the United Nations.

Bibliographical and other references have, wherever possible, been verified.

INTRODUCTION

Although the status of women varies from one society to another, it has consequences everywhere related to the status of disabled women. Women's unequal status has a negative impact not only on women but on the entire human community. Gender relations and the position of Arab women have been affected by urbanization, industrialization, the expansion of wage labour, political conflicts and warfare in the ESCWA region. Although many countries in the ESCWA region have made significant progress towards improving the general status of women during the last few decades, the tendency is still to exclude disabled women and girls from mainstream development and marginalize them in Arab society. The objectives of this paper are the following:

(a) To outline the major causes of impairments, disabilities and handicaps in the region, particularly those related to women, and especially mothers;

(b) To present and analyse the situation of disabled Arab women on the basis of available disability statistics from seven ESCWA members (Bahrain, Egypt, Jordan, Kuwait, Palestine, Qatar and the Syrian Arab Republic);

(c) To highlight the social problems faced by disabled Arab women by means of several case-studies;

(d) To provide a description of existing services in two countries of the ESCWA region (Bahrain and Jordan);

(e) To assess the role of Arab women (as, *inter alia*, mothers and professionals) in providing services to disabled persons both in informal settings (such as family care) and public settings (such as rehabilitation centres and institutions).

The last chapter contains a summary of the findings of this report and a number of recommendations.

I. THE STATUS OF ARAB WOMEN IN GENERAL AND THE GENDER RELATIONSHIP

State-sponsored education, accompanied by industrialization and urbanization, has played a major role in creating a generation of more assertive and independent Arab women, and increased participation of women in paid employment has led to changes in household decision-making. However, the integration of Arab women in development is still in a formative stage and is rather limited. Annex table 1 indicates that countries of the ESCWA region have made progress in improving the status of women during the last few decades. Life expectancy at birth in 1992 was above 60 in all countries of the region except Yemen and, parallel to the worldwide trend, women's life expectancy tends to be longer than that of men. Life expectancy is shorter than the world average of 64.7[1] in only two countries, Egypt and Yemen (see annex tables 1 and 2). The demographic stage of most countries in the ESCWA region will continue to be transitional. It is still characterized by relatively high levels of fertility combined with relatively low mortality. The birth rate in Arab families remains high as children are considered to be valuable. The reproductive function of Arab women thus remains one of the most important functions. However, high fertility rates coupled with a lack of proper birth spacing may cause different kinds of impairments.

The statistics in annex table 2 indicate that in 1992 illiteracy levels among women in the ESCWA region were still much higher than those for men despite the steady growth of female literacy during the past few decades. Among individual ESCWA member countries, female literacy rates as percentages of male literacy rates (which should be 100 per cent in principle) range from 49 per cent (Yemen) to 87 per cent (Kuwait). The past few decades have witnessed a gradual but steady increase in the participation of Arab women in the labour force.[2] The participation of Arab women in formal employment has significantly changed their status and gender relations. It has improved their status in the family and given them a role in decision-making.

Regarding marriage, the available statistics (see annex table 3) indicate the high percentages of married female youth in the 20-24 age group in the countries of the ESCWA region for 1980. The statistical data indicate that Arab women tend to marry much earlier than their male counterparts; they also tend to marry older men.

The overall impact of the above-mentioned social transformation has been the creation of different segments in the female Arab population. The range of options and opportunities available to Arab women has expanded, particularly in limited social segments. These options and opportunities are open to a small portion of the female population, namely, urban females of the middle or upper middle class. New options and opportunities are related to higher education, later marriage, employment, lower fertility, and participation in cultural and social activities and in decision-making. Although a modern middle class has gradually emerged in a number of urban communities in the region, the majority of disadvantaged Arab women (including the poor, the disabled and the rural female population) do not enjoy equal access to these new options. The extent to which disabled women are excluded from mainstream development and are marginalized in society will be reviewed in detail below.

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[1] *World Population Prospects: The 1992 Revision* (United Nations publication, Sales No. E.93.XIII.7).

[2] ESCWA, "Review and assessment of the progress achieved for the advancement of Arab women in the light of the Nairobi Forward-looking Strategies" (E/ESCWA/SD/1994/WG.3-WOM/3).

II. CAUSES OF DISABILITY IN WOMEN

The countries of the ESCWA region have made progress in channelling human and physical resources into one of the objectives of the World Programme of Action concerning Disabled Persons,[3] namely, the "prevention of disability". The "classic" causes of impairment have been declining in relative terms owing to improved child immunization, improved education, better access to health care, improved water and sanitation facilities, lower fertility rates, and better prenatal and perinatal care for women in some countries. However, there are several hereditary, medical, environmental and developmental factors that have caused impairment, and that are particularly relevant to women in the ESCWA region. Before the causes are outlined, the definitions of "impairment", "disability" and "handicap" must be clearly understood. According to the World Health Organization (WHO), "impairment" is defined as "any loss or abnormality of psychological, physiological or anatomical structure or function"; "disability" is defined as "any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal for a human being"; and "handicap" is defined as "a disadvantage for a given individual, resulting from an impairment or disability, that limits or prevents the fulfilment of a role that is normal (depending on age, sex and social and cultural factors) for the individual".[4] This section examines the causes of "impairment" in purely medical terms and the causes of "disability" and "handicap" in social terms, focusing on those which are particularly relevant to Arab women in the region.

Precise data on the prevalence of impairment at the regional level are scant. Furthermore, recent attempts at surveying impaired individuals are fragmented and incomplete. However, existing data indicate that the figures are high. According to a 1982 ESCWA report entitled "Disabled persons in the ESCWA region: features and dimensions of the problem and a regional plan of action", the number of disabled individuals was estimated at 8 million at the regional level—an estimate that may be well below the current figure.[5] The 1981 Arab Declaration on Action for Disabled Persons estimated that there were 15 million disabled persons in the Arab world.[6] By applying the balanced sex ratio of 50/50, the estimates of female disability/impairment could range from 4 million (using the 1982 ESCWA estimate) to 7.5 million (the 1981 Arab Declaration estimate) in the ESCWA region. It is presumed that out of these 7.5 million disabled women, at least 50 per cent (3.75 million) live in rural and relatively poor communities. Being totally isolated, relatively immobile and homebound, they may be deprived of assistance, rehabilitation, services and basic human rights. WHO estimates that 7 to 10 per cent of the world's population have some kind of disability, and the rate is higher in rural communities. If women who care for a disabled family member are added to the statistics, approximately 14 to 20 per cent of women are affected by disability in one way or another.

The causes of impairment in the region can be grouped into two major subcategories: socio-economic and environmental factors, including medical aspects such as prevention and immunization; and factors related

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[3] United Nations, *World Plan of Action concerning Disabled Persons* (New York, United Nations Department of Public Information, August 1992) (DPI/933/Rev.1).

[4] Quoted in International Labour Office *Vocational rehabilitation and the employment of the disabled: a glossary* (Geneva), ISBN 92-2-002571-X.

[5] ESCWA, "Assessment of the implementation of the World Programme of Action concerning Disabled Persons in the ESCWA region at the end of the United Nations Decade of Disabled Persons and agenda for future action" (E/ESCWA/SD/1992/13).

[6] ESCWA, "Developmental social welfare issues: (a) inter-regional consultation on developmental social welfare policies and programmes" (Note by the Executive Secretary), presented at the fourteenth session of ESCWA, held in Baghdad from 31 March to 5 April 1987 (E/ESCWA/14/7).

to certain cultural values and social barriers. During the ESCWA Regional Seminar on the Role of the Family in Integrating Disabled Women into Society (held in Amman from 16 to 18 October 1994, and hereafter referred to as the ESCWA Regional Seminar), several major causes of disability among women in the ESCWA region were identified by the participants. These include: mothers and children suffering from poverty and malnutrition; inadequate sanitary conditions in homes and the lack of proper medical services; inadequate immunization of mothers and children; improper birth spacing and early or late pregnancies; the practice of kinship marriage and the lack of genetic counselling; the lack of appropriate pre-, peri- and postnatal supervision; accidents; armed conflicts; the longer life expectancy of women in general (old-age disability); and negative social attitudes towards disabled women as a result of the stigma attached to disabilities, leading to social isolation and thereby creating a social "handicap".

A. POVERTY

The most significant socio-economic and environmental factor is poverty. The correlation between poverty and impairment/disability can be proved by the higher prevalence of disability in Arab rural communities, which suffer from poverty, lack of basic services and negative socio-economic and environmental conditions. For instance, according to the *Population Census of the Syrian Arab Republic, 1981*,[7] the prevalence of disabled persons per 100,000 of the total population was 1,034 in rural areas and 1,008 in urban areas. Rural prevalence rates are higher than urban rates particularly for blindness, deafness and mutism, which are often caused by malnutrition and inadequate hygienic standards. The same national census shows that the rates of blindness per 100,000 females was 147 in rural areas and 101 in urban areas, and the rates of female deafness and mutism were 161 in rural and 147 per 100,000 females in urban areas.

In the Gaza Strip, a significant relationship between mental/multiple disability and poverty was found in the Bureij and Al-Shati communities (see table 1).

TABLE 1. CORRELATION BETWEEN DISABILITY AND THE FINANCIAL STATUS OF FAMILIES WITH DISABLED PERSONS IN THE BUREIJ AND AL-SHATI REFUGEE CAMPS, GAZA STRIP, 1993

(Percentage distribution)

Type of disability	Financial status					
	Poor		Middle level		Well-to-do	
	Bureij	Al-Shati	Bureij	Al-Shati	Bureij	Al-Shati
Physical	32	44	41	41	27	15
Mental/multiple	42	50	32	33	26	17

Source: Gaza National Committee for Rehabilitation and DIAKONIA, *Disability and Rehabilitation Needs in the Gaza Strip: A Survey Report on Bureij and Al-Shati Refugee Camps* (Gaza City, 1993).

Notes: Bureij: chi sq. = 8.40324, p = 0.015; Al-Shati: chi sq. = 5.8979, p = 0.05.

[7] Syrian Arab Republic, Office of the Prime Minister, Central Bureau of Statistics, *Population Census of the Syrian Arab Republic, 1981*, quoted from ESCWA, "Social statistics and indicators in the ESCWA region" (E/ESCWA/SD/89/8), developed based on the United Nations, Department of International Economic and Social Affairs, Statistical Office, *Disability Statistics Data Base (1975-1986)* (New York, 1988).

As table 1 indicates, the prevalence of mental and multiple disabilities among the poor (42 per cent in Bureij and 50 per cent in Al-Shati) is significantly higher than that of the well-to-do (26 per cent in Bureij and 17 per cent in Al-Shati). The rate of mental and multiple disabilities tends to decrease from poor to middle level to well-to-do. These disabilities may be a cause of poverty, or poverty may be a determinant of the disabilities. A significant association was also observed between poverty and the number of disabled persons in each family (see table 2).

TABLE 2. CORRELATION BETWEEN FINANCIAL STATUS AND THE NUMBER OF DISABLED PERSONS PER FAMILY IN THE BUREIJ AND AL-SHATI REFUGEE CAMPS, GAZA STRIP, 1993

(Percentage distribution)

Number of disabled within the same family	Financial status of the family in the Gaza Strip, 1993					
	Poor		Middle level		Well-to-do	
	Bureij	Al-Shati	Bureij	Al-Shati	Bureij	Al-Shati
One disabled	31	40	41	42	28	18
Two disabled	32	43	43	43	25	14
Three disabled	48	66	25	23	27	11

Source: Gaza National Committee for Rehabilitation and DIAKONIA, "Disability and rehabilitation needs in the Gaza Strip: a survey report on Bureij and Al-Shati refugee camps" (Gaza City, 1993).

Notes: Bureij: chi sq. = 20.03357, p = 0.005; Al-Shati: chi sq. = 43.35005, p = 0.0000.

Of those families with one disabled member, 31 per cent in Bureij and 40 per cent in Al-Shati are poor, and the number of disabled persons in a family increases parallel to the poverty factor. Of those families with two disabled members in the same family, 32 per cent in Bureij and 43 per cent in Al-Shati are poor. Of those families with three disabled members, 48 per cent in Bureij and 66 per cent in Al-Shati are poor. This reveals a clear correlation between poverty and the number of disabled persons within the same family.

Various manifestations of poverty are related to disability in general and childhood disability in particular. Malnutrition and unsanitary conditions (including inadequate access to clean water, sanitary facilities and basic medical services) pose the greatest dangers to "safe" parenting.

B. MALNUTRITION

Poverty causes malnutrition, which is one of the main factors contributing to disabilities in children and women. Poverty results in the failure of many children to grow to their full mental and physical potential. Over 100 million persons around the world are currently estimated to be disabled as a result of malnutrition.[8] During the ESCWA Regional Seminar, malnutrition in both mothers and children (signified by low-birth-weight babies and deficiencies in vitamins A and D, iodine and iron) was considered a major cause of disability in the region. Malnutrition is more prevalent among girls than among boys in some parts of the ESCWA region. For instance, several studies in Palestine indicated higher malnutrition rates among

[8] United Nations Children's Fund (UNICEF), *The State of the World's Children 1994* (New York, Oxford University Press, 1994).

girls than among boys in many of the Palestinian communities studied owing to the selective neglect of female children.[9]

Vitamin A deficiency (a major cause of blindness) and iodine deficiency (a major cause of goitre and cretinism leading to subnormal mental development, deaf-mutism and paralysis) are recognized as major causes of childhood blindness and mental retardation, respectively.[10] It is estimated that 6 per cent of Jordanian children were suffering from malnutrition in 1991, and that about 20 per cent of them were consuming less than the required amount of nutrients.[11] It has been reported that malnutrition is common among both pregnant Egyptian women and female children.[12] To compensate for the lack of nutrients, the child's metabolism drops, causing low blood pressure. The amount of body fat decreases, and the body draws on its reserves, depleting muscle instead of body fat and delaying bone growth or even causing deformation of bones.

Chronic anaemia (leading to subnormal child development) is caused by iron deficiency. A study conducted by the United Nations Relief and Works Agency for Palestine Refugess in the Near East (UNRWA) in 1992 on morbidity patterns in the refugee camps indicated a high prevalence of anaemia among children who visited the clinics (66 per cent of children older than six months and younger than one year of age, 63 per cent of two-year-old children and 45 per cent of three-year-old children).[13]

The 12 months following birth are crucial to a child's development. During this stage brain development is almost completed, so even if nutrition later improves, the child's physical and mental development will be impaired. Breast-feeding is recommended in the early months of a child's life; however, the quality and quantity of the mother's breast milk are greatly affected by her own nutritional status. A lack of high quality breast milk may impair the child's immune system and expose him or her to illness. The lack of clean water and sanitation in some communities causes diarrhoea and contributes to malnutrition.

Low weight at birth causes various kinds of childhood disabilities and at the same time contributes to malnutrition. It is a major cause of maternal mortality and birth trauma. During the ESCWA Regional Seminar, it was agreed that low birth weight (a manifestation of poverty) was a major cause of childhood disability. The statistics in annex table 2 indicate that, during the period from 1980 to 1992, the proportions of children aged 0 to 4 years who were moderately to severely underweight stood at 30 per cent in Yemen,

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[9] United Nations Conference on Trade and Development (UNCTAD), *Health Conditions and Services in the West Bank and Gaza Strip* (by Rita Giacaman) (UNCTAD/ECDC/SEU/3), 1994.

[10] ESCWA, "UNICEF-assisted programmes and global strategy on childhood disability prevention and rehabilitation" (E/ESCWA/SD/89/WG.1/3), a paper presented by UNICEF at the Conference on the Capabilities and Needs of Disabled Persons in the ESCWA Region (held in Amman from 20 to 28 November 1989). UNICEF has been assisting iodine deficiency control programmes throughout the world through iodization of the local salt supply. It is estimated that 800 million malnourished people are at risk, and cretinism itself affects about 3 million. More than 80 per cent of these individuals are in Asia as a whole.

[11] Fahed Al Fanek, "A battle on the social front", *Jordan Times* (Amman), 10 April 1994.

[12] Heba Hagrass, "Women with disability in Egypt", a paper submitted to the ESCWA Regional Seminar on the Role of the Family in Integrating Disabled Women into Society (held in Amman from 16 to 18 October 1994).

[13] United Nations Children's Fund (UNICEF), "Health services", *Mother & Child in Jordan*, a newsletter about human development issues (Amman, UNICEF and Al Kutba, Publishers, 1994).

23 per cent in Oman, 12 per cent in Iraq, 10 per cent in Egypt and 6 per cent in Kuwait (where per capita GNP is US$ 16,150). In oil-rich Oman, 5 per cent of children were severely underweight.

The ESCWA Regional Seminar identified the delivery of a child without the attendance of proper medical personnel as one of the major causes of disability in women in the region. The infant mortality rates in Iraq and Yemen remain higher than the world average. The traditional midwife is still a popular health practitioner in some countries of the ESCWA region, particularly in rural and Bedouin communities. For instance, in Jordan, there is an acute shortage of nurses with proper training in midwifery. While the number of trained midwives increased from 127 in 1951 to 625 in 1991, the ratio remains low, necessitating the continued dependence on untrained traditional midwives.[14] Assistance in childbirth rendered by such unqualified individuals can result in a number of complications for both mother and child, some of which can lead to permanent disabilities.[15] Asphyxia at birth (which is more common in home deliveries) is a major cause of mental retardation and cerebral palsy. There is an urgent need to introduce measures to eliminate birth-related accidents that lead to disabilities. This can be achieved by supporting safe delivery and mothering practices.

These childhood disabilities are likely to continue through adolescence and into adulthood. As a result of malnutrition, these disabled children tend to suffer throughout their lives. This is particularly true for disabled girls, as they will be given the lowest priority for rehabilitation and other services. Later, they, too, may give birth to underweight babies, and they may not be able to manage early intervention inasmuch as they will most likely be illiterate and ignorant—a vicious circle.

C. Lack of sanitation, immunization and early intervention

Poverty is often manifested by human deprivation. The profile of human deprivation can be measured by the level of unsanitary living conditions, the lack of access to safe drinking water and the lack of access to health services. These factors, combined with insufficient immunization, are causes of infectious diseases leading to the onset of various impairments in some communities of the ESCWA region. In some cases, the aftermath of armed conflicts has aggravated the situation. The ESCWA Regional Seminar singled out inadequate sanitary conditions in homes and inadequate medical services in some communities of the ESCWA region as major causes of disability.

Indeed, the lack of adequate water and safe sanitation frequently causes illness, poor growth and impairment. These factors contribute to the spread of contagious diseases, leading to permanent impairment in some cases. Inadequate hygienic practices are closely related to diarrhoea, which is still the major cause of stunted child growth. According to the UNICEF report, *The State of the World's Children 1994*,[16] during the period 1988 to 1991, 70 per cent of the rural population in Yemen had no access to safe water, and 39 per cent had no access to adequate sanitation. In the Syrian Arab Republic, 42 per cent of the rural population had no access to safe water, and 32 per cent had no access to medical services. In Egypt, half the total population and 74 per cent of the rural population had no access to adequate sanitation. Even in

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[14] Ibid.

[15] Madiha Al-Safty, American University in Cairo, "Women and disability: the role of the family" (E/ESCWA/SD/1994/WG.1/7); and Nazek Nosseir, "Childhood disability: causes and role of family in prevention, early detection and rehabilitation" (E/ESCWA/SD/1994/WG.1/6). Both papers were submitted to the ESCWA Regional Seminar on the Role of the Family in Integrating Disabled Women into Society, held in Amman from 16 to 18 October 1994.

[16] See note 8.

Oman, with its per capita GNP of US$ 6,120 (in 1991), only 40 per cent of its rural population had access to adequate sanitation services. Only 30 per cent of Saudi Arabia's rural population has access to adequate sanitation (per capita GNP in Saudi Arabia was US$ 7,820 in 1991). In some places, the lack of clean water causes water-borne diseases such as river blindness, leading to permanent disabilities.

During the Regional Seminar, inadequate immunization of both mothers and children was singled out as a major cause of disability in the region. Indeed, in recent decades there has been substantial progress regarding immunization for pregnant women and children in most countries of the ESCWA region. However, universal immunization has not yet been fully achieved in the region.

The importance of immunizing women who are or may become pregnant cannot be overstated. The statistics in annex table 2 indicate that the rates of pregnant mothers immunized against tetanus from 1990 to 1992 ranged from 13 per cent (Yemen) to 97 per cent (Oman). For the eight reporting countries, the rate was between 60 and 70 per cent in three countries (Egypt, Qatar and Saudi Arabia), between 30 and 50 per cent in two countries (Iraq and Jordan) and less than 30 per cent in two countries (Kuwait and Yemen).

The vaccination of women against rubella (German measles)[17] prior to child-bearing is among the most important preventive measures against multiple childhood disabilities (blindness and mental retardation). One Palestinian woman living in Saudi Arabia has two totally blind children, the blindness being due to her infection with rubella during her pregnancies. The second time, doctors misdiagnosed her rubella virus as cured despite her persistent inquiries about the risk of having another blind child (see chapter III, section D, case-study 2).

The immunization of newborn children is also important. Meningitis during infancy was found to be a major cause of childhood cerebral palsy (CP) in the sample survey conducted in Jordan.[18] Also, poliomyelitis contracted in childhood often causes permanent paralysis. The immunization of children against poliomyelitis (a disease that can cause permanent physical disability) is not universal in some countries. At the global level, the rate of immunization (by means of a vaccine during the 12 months after birth) has already reached 80 per cent.[19] The percentage of fully immunized children (one year old) against poliomyelitis during the period from 1990 to 1992 was only 62 per cent in Yemen and 64 per cent in Iraq. According to international statistics, in Iraq, the level of poliomyelitis immunization fell significantly from 1990 to 1992 (from 75 per cent to 64 per cent) owing to the aftermath of the Gulf crisis (see annex table 2). According to the latest statistics released by the country, the number of poliomyelitis cases increased by a factor of 7.5 during the period from 1989 to 1993.[20] Even in Jordan, where medical services are relatively

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[17] Maternal rubella frequently causes severe and multiple impairments (blindness combined with mental retardation) in a newborn child. Prenatal vaccination against rubella and a perinatal examination is an effective preventive measure. Women should be cautioned never to be immunized against rubella during pregnancy, however, as a "live vaccine" is used which is very likely to cause fetal impairment/deformity.

[18] Staffan Janson and others, "Severe mental retardation in Jordanian children", *Bulletin of the Consulting Medical Laboratories*, vol. 6, No. 2 (Amman), April 1988.

[19] See note 8.

[20] Iraqi national report submitted to the International Meeting on the Development of a National Plan for Community-Based Rehabilitation, held by the World Health Organization in Beirut from 28 November to 1 December 1994.

extensive, a UNICEF report[21] noted that about 10 per cent of Jordanian children were not yet vaccinated against poliomyelitis, diphtheria, pertussis or tetanus, and 20 per cent were not vaccinated against measles.

D. High fertility rates and the lack of birth spacing

As noted in the previous section, fertility is high in the ESCWA region. High fertility combined with the lack of spacing between births may cause health problems for both the mother and child. During the ESCWA Regional Seminar, the participants agreed that improper birth spacing, often indicating early or late pregnancies, was a major cause of disability in the Arab world, and proper birth spacing was recommended.

Women's level of education is often the key determinant of the fertility level in a given country. Some scholars attribute the absence of a rapid decline in fertility in the Arab world to the fact that traditional values still favour large families. High fertility[22] indicates a lack of spacing, early child-bearing or rearing (teenagers), and late child-bearing or rearing (after age 37). All of these, especially late child-bearing, create a high risk of bearing an impaired child. Pregnancy after the age of 37 entails the high risk of having a child with Down's syndrome (a congenital disorder caused by a chromosomal defect, characterized by mental retardation and physical defects). According to a Jordanian survey in 1993, almost 14 per cent of the mothers surveyed were above age 35 when they conceived their last child. The older the mother, the greater the chance of a high-risk pregnancy.[23]

According to data on disability in Qatar,[24] the number of children with an impairment as a proportion of all children ever born[25] increases with the mother's age. The number of disabled children increases from 2.8 per 1,000 children even born for mothers under 25 years of age, to 6.2 per 1,000 for mothers aged 25 to 29, and to 9.6 per 1,000 for mothers aged 40 to 44.[26] The figures for surviving children with a disability show a similar picture. The *Qatar Child Health Survey 1991* concluded that the risk of certain congenital impairments increased with the mother's age (see table 3).

Late pregnancy frequently causes Down's syndrome in newborns. For instance, according to the survey conducted in Jordan, the mean age of the mothers of newborns with Down's syndrome in the experimental group was 37.[27] The amniocentesis test—especially for relatively older pregnant women (over 36 to 37)—has proven to be an effective diagnostic measure for Down's syndrome. In fact, abortion is permitted in some countries of the region (for example, Bahrain, Iraq, Kuwait and Qatar) in cases of severe fetal

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[21] United Nations Children's Fund (UNICEF), "Infant and child health", *Mother & Child Health in Jordan*, a newsletter about human development issues (Amman, UNICEF and Al Kutba, Publishers, 1994).

[22] Total fertility rates per woman range from 3.6 (Lebanon) to 7.7 (Yemen) in the region, which is much higher than the world average (3.31 per woman).

[23] Jordan, Ministry of Health, Department of Statistics, and the United Nations Children's Fund, *Assessment of the Nutritional Status of Preschool Children in Jordan* (Amman, 1993).

[24] Qatar, Ministry of Health, *Qatar Child Health Survey 1991*, Abdul-Jalil and others, eds. (Doha, Ministry of Health, 1991).

[25] Including those who died.

[26] However, partially, the increase in the mother's chronological age in proportion to the number of disabled children reflects the corresponding increase in the average age of children and their longer and cumulative exposure to risks.

[27] See note 18.

impairment.[28] Aysha (a Palestinian woman now living in Jordan) was merely 20 years old when she became the second wife of Mohammed (then 49 years old) in 1948. Both Aysha's first husband and Mohammed's first wife had been killed by Israeli soldiers in the first Arab-Israeli war. Aysha had 12 (surviving) children with Mohammed, and when she delivered their last child, Abdul Aziz, she was 48 years old. Aysha did not take the amniocentesis test, nor was she aware of the possibility of bearing a mentally retarded baby. Abdul Aziz was born with Down's syndrome. (Further details of this story are provided in case-study 1 in section D of chapter III.)

TABLE 3. NUMBER OF CHILDREN EVER BORN WITH IMPAIRMENT ACCORDING TO THE MOTHER'S AGE, QATAR, 1991

	Children with impairment (ever born)		Live children	
Age of mother	(per woman)	(per 1,000 children)	(per woman)	(per 1,000 children)
Under 25	0.006	2.8	0.004	1.9
25-29	0.020	6.2	0.020	6.3
30-35	0.033	7.7	0.028	6.9
35-39	0.040	7.3	0.038	7.4
40-44	0.058	9.6	0.049	8.6
45-49	0.066	9.2	0.063	9.8
Average of all age groups	0.033	7.6	0.030	7.2

Source: Qatar, Ministry of Health, *Qatar Child Health Survey 1991*, Abdul-Jalil Salman and others, eds. (Doha, Ministry of Health, 1991).

In the early stage of the child's life, breast-feeding constitutes the most important source of nutrition. There is a risk that bottle-feeding may contribute to malnutrition in the child and abnormal development. It is often the case that Arab women who have numerous, closely spaced pregnancies stop breast-feeding and depend instead on powdered milk or alternative nutritional sources. The percentages of mothers breast-feeding at 6 months after birth decrease significantly: 32 per cent in Kuwait, 40 per cent in Lebanon, 45 per cent in Iraq, and 52 per cent in Saudi Arabia (annex table 2). This may lead to health problems for the newborn. The statistics in annex table 2 indicate that the proportion of mothers breast-feeding for the first 3 months after birth range from 47 per cent (Kuwait) and 50 per cent (Lebanon) to 91 per cent (Saudi Arabia) for the period 1980 to 1991. However, the rate drops significantly even in Saudi Arabia at 6 months.

According to the 1990 *Jordan Population and Family Health* (JPFH) survey,[29] 90 per cent of mothers breast-fed their babies during the first 3 months of life, with the proportion falling to 68 per cent from the seventh to the ninth month, and to just 60 per cent from the tenth month to one year after delivery. Surprisingly, the lowest breast-feeding rate was found for mothers in upper-income families, followed by

[28] *Abortion Policies, a Global Review* (United Nations publication, Sales No. E.94.XIII.2).

[29] *Jordan Population and Family Health* survey (1990), as quoted in: United Nations Children's Fund (UNICEF), "Infant and child health", *Mother & Child in Jordan*, a newsletter about human development issues (Amman, UNICEF and Al Kutba, Publishers, 1994).

those living in refugee camps. The most depressing finding is that in some countries of the region (for example, Oman), girls are breast-fed for a shorter period than boys. In Oman in 1989, the average duration of breast-feeding for girls was 7.55 months compared with 8.9 months for boys.[30]

Some Arab scholars[31] argue as well that the mother's attention and energy tend to be scattered if she has too many children; with each child receiving less care, the likelihood of accidents occurring increases. Other international scholars also support the view that high fertility rates reduce the amount of time, care and resources available for each child, which might contribute to increased child morbidity and accident rates.[32]

Proper pre-, peri- and postnatal care is also essential for impairment prevention, and early intervention and rehabilitation can very often either partially or totally prevent or correct childhood impairments. Deliveries should be performed by qualified medical professionals (doctors or qualified nurses/midwives) so that any unnecessary trauma or complications may be avoided. During the Regional Seminar, it was agreed that the delivery of children without the attendance of the proper medical staff constituted one of the major causes of childhood disability in the region. Trauma during delivery may result in the occurrence of disability; the prevalence of deliveries by unqualified, traditional midwives is a serious problem in many countries of the ESCWA region, particularly in rural areas. The figures in annex table 2 indicate that the percentages of births attended by trained medical personnel range from 16 per cent (Yemen) to 99 per cent (United Arab Emirates) for the period 1983 to 1992; the rate is still 50 per cent or below in four countries of the region (Egypt, Iraq, Lebanon and Yemen).

E. Insufficient education and illiteracy among Arab women in general

Although there has been significant general improvement in Arab women's participation in education at all levels and in female illiteracy eradication, the results are not yet completely satisfactory. Many studies have confirmed the positive correlation between women's illiteracy and child mortality and morbidity. Illiteracy is also a major barrier to social integration. The education of women could significantly reduce the incidence of childhood disability, as rates are much higher among the children of illiterate women than among those of mothers who have received even just a basic education.[33] Women's illiteracy is both a cause and a result of underdevelopment, as the mother is most often the key to a child's socialization and human development. In a study on Egypt, female illiteracy was proven to be a significantly relevant variable. An illiterate woman lacks an awareness of health issues, including those related to medical care during pregnancy; among other things, she tends to prefer the traditional practitioner when seeking health services. All of this frequently results in unnecessary problems and complications.[34] During the Regional Seminar,

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[30] United Nations Children's Fund, Regional Office for the Middle East and North Africa, *Sex Differences in Child Survival and Development, 1990*, Evaluation series, No. 6 (1990).

[31] Nazek Nosseir, "Women and disability in the ESCWA region", *Proceedings of the Conference on the Capabilities and Needs of Disabled Persons in the ESCWA Region* (E/ESCWA/SD/1992/2); and Heba Hagrass, "Women with disability in Egypt", a paper submitted to the ESCWA Regional Seminar on the Role of the Family in Integrating Disabled Women into Society, held in Amman from 16 to 18 October 1994 (E/ESCWA/SD/1994/WG.1/3).

[32] Napaporn Havanon and others, "The impact of family size on wealth accumulation in rural Thailand", *Population Studies*, vol. 46 (1992).

[33] See note 8.

[34] See note 12.

the importance of family literacy was stressed; it was agreed that the literacy and overall development of Arab family members, especially women and mothers, should be considered prerequisites for the prevention of and early intervention in disability in the region.

According to the *Qatar Child Health Survey 1991*,[35] illiterate women tend to run a much higher risk of having a child with an impairment or disability. As shown in table 4 below, the number of children with disabilities per 1,000 children ever born to illiterate women is 8.4, compared with only 6.9 for literate women. The difference is significant among women aged 45 plus: 10 compared with 6.3 per 1,000 children ever born. Among women aged 35 to 44, the figures are 9.5 for illiterate mothers and 7.0 for literate mothers. Among women under 35 years of age, however, the incidence of childhood disability is slightly higher for the literate mothers' group. The higher risk of disability among children born to illiterate mothers increases with the age of the mother, as it is presumed that apart from the increased likelihood that disabilities will occur as the result of, for example, illness, home accidents, or the lack of early intervention—all related to the illiteracy of mothers—there is the additional risk of congenital disabilities occurring among the children of older mothers. The higher incidence of disabled children among illiterate women of over 35 age group thus indicates the greater risks of congenital disability—perhaps caused, *inter alia*, by the lack of prenatal care.

TABLE 4. QATARI CHILDREN WITH DISABILITIES PER 1,000 CHILDREN EVER BORN ACCORDING TO THE MOTHER'S AGE AND BACKGROUND, QATAR, 1991

Mother's literacy level	Mother's age			Total (all ages)
	<35	35-45	45+	
Illiterate	5.4	9.5	10.0	8.4
Literate	6.8	7.0	6.3	6.9
Combined average	6.4	8.3	9.2	7.6

Source: Qatar, Ministry of Health, *Qatar Child Health Survey 1991*, Abdul-Jalil Salman and others, eds. (Doha, Ministry of Health, 1991).

Some experimental research conducted in Jordan in 1988[36] involving 203 mentally retarded children and their parents showed that mental retardation was much more prevalent among the children of illiterate and less educated mothers (the overall level of education among the retarded children's mothers was lower than the national average). The same pattern is found here as in the Qatari survey. One third of the mentally retarded children's mothers in the Jordanian sample survey were found to be illiterate; only 1 per cent were university graduates (see table 5).

Furthermore, it has been proved that there is a significant negative correlation between the level of the mother's education and consanguineous marriage, which is considered a major cause of congenital disability in the ESCWA region; this will be reviewed in greater detail below. Annex table 2 indicates that female adult literacy rates (literate females as a percentage of literate males, which should be 100 per cent in

[35] See note 24.

[36] See note 18.

principle) are relatively lower in the ESCWA region, ranging from 49 per cent in Yemen and 54 per cent in Egypt to 83 per cent in Lebanon and 87 per cent in Kuwait.

TABLE 5. EDUCATIONAL LEVELS OF THE PARENTS OF MENTALLY RETARDED CHILDREN IN JORDAN, 1984 TO 1987

(Percentage distribution)

		Education of the mother (national average) in the early 1980s	
Educational level	Father of the retarded child (mean age of 35)	Mother of the retarded child (mean age of 28)	Mother of the average child (mean age of 25.27)
Illiterate	18	33	30.48
Primary	23	16	25.79*
Preparatory	18	15	26.19
Secondary	10	8	11.23
Diploma	10	8	2.96
University	5	1	1.26
Unknown	16	19	

Sources: Staffan Janson and others, "Severe mental retardation in Jordanian children", *Bulletin of the Consulting Medical Laboratories*, vol. 6, No. 2 (Amman), April 1988; and S.A. Khoury and D. Massad, "Consanguineous marriage in Jordan", *American Journal of Medical Genetics*, vol. 43 (1992), pp. 769-775.

* Excluding those who "read and write" (0.35 per cent).

When it comes to the education of disabled women themselves, there is no need to mention that the equivalent literacy rates for disabled women are much lower than those for able-bodied women and disabled men (further details are provided below). Annex tables 4 and 5, respectively, indicate the male-female distributions and ratios of the disabled population relative to the total population in the Syrian Arab Republic in 1981, according to both type or category of disability and literacy status/educational attainment. Illiteracy among disabled Syrian women is 1.32 times that of disabled Syrian men. Only one third (34 per cent) as many disabled women as disabled men hold university degrees. As there is a similar trend within the able-bodied population, this analysis indicates that there is a clear gender-based differentiation regarding literacy for both the able-bodied and disabled Syrian populations (see table 6).

These findings can be summed up by the following vicious cycle: (a) a girl is born with an "impairment"; (b) she is not given priority for rehabilitation or services, so she remains illiterate; and (c) she does not have the means to become economically or socially independent; and this leads to (d) permanent "disability" and the increased likelihood that the girl will become a "handicap" to society. All of this constitutes what is often called the "handicap dynamism".

TABLE 6. PERCENTAGE DISTRIBUTION OF THE ILLITERATE POPULATION AND THOSE WITH UNIVERSITY DEGREES, BY SEX AND DISABILITY, SYRIAN ARAB REPUBLIC, 1981

	Illiteracy among the disabled	Illiteracy among the total population	Disabled population with university degrees (BA or MA)	Total population with university degrees (BA or MA)
Women	80.50	54.53	0.23	0.59
Men	60.51	21.95	0.68	2.48
Both sexes	67.95	37.88	0.51	1.56

Source: Syrian Arab Republic, Office of the Prime Minister, Central Bureau of Statistics, *Population Census in the Syrian Arab Republic, 1981*, quoted from ESCWA "Social statistics and indicators in the ESCWA region" (E/ESCWA/SD/89/8), developed based on the United Nations, Department of International Economic and Social Affairs, Statistical Office, *Disability Statistics Data Base (1975-1986)* (New York, 1988).

F. ACCIDENTS

In many countries today, quite a large proportion of disabilities are caused by accidents and disease. A particularly significant phenomenon in the ESCWA region is traffic accidents: the rates of such accidents are quite high in some countries of the region. In Jordan, for instance, the majority of patients found in emergency rooms are traffic accident victims.[37] In many cases, traffic-related injuries lead to permanent disabilities. Many countries in the region lack the proper infrastructure to absorb the increasing number of automobiles and also lack an effective public transportation system: both problems render them unable to cope with the expanding population. A good public transportation system not only provides an essential service for disabled individuals (to allow them full access), but also constitutes an effective preventive measure against impairment.

During the Regional Seminar, the participants identified various disability-causing accidents among women which occur at home and in the work-place as a result of exhaustion. There is a growing number of working Arab women, and their dual roles have imposed greater psychological pressures on them, as they must now handle work-related responsibilities in addition to their family responsibilities. The lack of proper child-care facilities may aggravate this condition. Good child-care centres are rare in many countries of the ESCWA region, and if they exist, the fees tend to be so high that only privileged women can afford them. In the rural communities of Egypt, for example, some women must work from 12 to 16 hours a day to carry out their domestic, child-care and outside work responsibilities, and often find themselves overloaded and exhausted.[38]

A large number of women in the Gulf countries and some Arab expatriates from the Gulf are dependent upon foreign maids (mainly Asians) to provide child care; their care may not be accompanied by sufficient affection or the proper type of attention, which sometimes leads to accidents in the home and

[37] Association of Japanese Residents in Jordan, "Guidelines for life in Jordan" (Amman, 1989).

[38] See note 12.

childhood impairment. In poor countries and among working-class families, the children in some cases are simply left at home without care when the mothers go to work outside, and the risks of a home accident occurring increase dramatically.

G. ARMED CONFLICTS AND POLITICAL UNREST

The prolonged armed conflicts in some countries of the ESCWA region have increased the magnitude of the disability problem. Although classical warfare itself affects mainly men, the aftermath of war affects children and women even more (see the case-studies on Asma and Aysha in section D of chapter III). During the Regional Seminar, armed conflicts (particularly modern, "high-tech" wars) and their aftermath (in, for example, Lebanon, Iraq and Palestine) were mentioned as key factors related to female disability in the region. As was proved during the Gulf war, high-tech conflicts affect men, women and children without any discrimination; the same is true of urban warfare, exemplified by the plight of Beirut during Lebanon's tragic civil war. The human efforts towards rehabilitation and reconstruction in the countries of the ESCWA region will last for years and years to come.

The magnitude of disability has increased significantly in Palestine owing to the ruthless suppression of Palestinians during the *intifadah*. During the period 9 December 1987 to 1 October 1990, in addition to 855 fatalities, there were 58,000 casualties resulting from the use of live rounds, plastic-coated metal bullets, rubber bullets, and tear gas; beatings and other forms of assault were also reported in the West Bank and the Gaza Strip. Some 25 per cent of these casualties were women and girls, and 10 per cent of all injuries resulted in permanent disability; this constitutes a substantial increase over the pre-*intifadah* figures of about 60,000 persons with some kind of disability.[39]

It has been observed that the aftermath of the Gulf crisis has had the most serious impact on vulnerable groups such as women in general and widows in particular, many of whom have no personal assets to buy food or medicine.

The crisis and ongoing sanctions have placed even greater constraints on the already limited resources available for dealing with disability. According to a report of the Food and Agriculture Oraganization of the United Nations (FAO),[40] the food situation in Iraq after the war was so desperate that people were forced to consume cereals normally used for animal feed. The report added that vulnerable groups such as the disabled had increased by 50 per cent in Iraq. Food shortages and the widespread incidence of gastroenteritis appear to have contributed to a very high level of malnutrition, which has caused a large increase in low birth-weight babies. The incidence of certain diseases has also increased dramatically—particularly meningitis (which can cause cerebral palsy and hearing impairment), preventable diseases such as measles and poliomyelitis, and water-borne diseases such as typhoid. The continuing sanctions have been responsible for higher rates of malnutrition; specifically, numerous impairments have been caused by the lack of sufficient vitamin A and/or iodine.[41] According to the same report, psycho-social trauma has been the most serious effect of the aftermath of the Gulf crisis and war for Iraqi children. Immediately after the war, the mortality

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[39] United Nations Relief and Works Agency for Palestine Refugees in the Near East, report submitted to the Eighth Inter-Agency Meeting on the United Nations Decade of Disabled Persons, held in Vienna from 5 to 7 December 1990.

[40] Quoted from John M. Goshko, "U.S. expects pact this week on permanent truce in Gulf", *International Herald Tribune* (27 March 1991).

[41] Infant and child mortality and nutrition were assessed by means of a survey of 9,034 households in every region of Iraq: the analysis, entitled *Health and Welfare in Iraq after the Gulf Crisis: An In-Depth Assessment* (October 1991), was conducted in 1991 by the International Study Team, and funded by the United Nations Children's Fund and other private foundations.

rate for Iraqi children under five years of age skyrocketed to 380 per cent of its pre-crisis level. It was also estimated that the infant mortality rate rose to 350 per cent of its pre-crisis level. Over 900,000 children—some 29 per cent of all Iraqi children—were reported to be malnourished immediately after the war.

The situation has not improved. By 1994, the aftermath of the war was still affecting the welfare of Iraqi mothers and children, leading to an overall increase in childhood disability. According to the latest statistics released, the number of those malnourished increased by a factor of 17 between 1990 and 1994 (from 102,487 to 1,312,678), and the incidence of poliomyelitis (a possible cause of permanent paralysis) increased by a factor of 7.5 during the period 1989 to 1993.[42]

H. WOMEN AND OLD-AGE DISABILITIES

Annex table 2 indicates that, parallel to the worldwide trend, life expectancy for women tends to be longer than that for men in all countries of the ESCWA region; this appears to be a natural phenomenon. Disability greatly increases with ageing, as has been shown in numerous studies. Disability—characterized by a reduction in one's ability to carry out the functions and activities required for daily living and life's roles, and often connected with the outcomes of disease, injury or trauma—may occur at any time during the life cycle, but is more common later in life.

Parallel once again to the worldwide trend, as Arab women tend to outlive their male counterparts, old-age disability is more serious among women. During the Regional Seminar, the participants stressed the relation between longer life expectancy among women in general and female old-age disability. In the ESCWA region as a whole, the incidence of disability among the elderly—particularly among elderly females—is much higher than the average for all groups combined.

Table 7 illustrates this point as it applies in Qatar. According to the 1986 Qatari national census,[43] of the total number of disabled females, 16.04 per cent are over 80 (compared with 12.03 per cent of Qatari men), and 41.83 per cent are over 65 (compared with 33.24 per cent of Qatari men).

A similar trend is found in Bahrain (see table 8). According to Bahrain's *Census of Population and Housing, 1981*,[44] the incidence of disability per 100,000 of the total female Bahraini population was only 1,020 for the combined average of all age groups, but 5,028 for the age group 60 to 64, 5,963 for the age group 65 to 69, and 13,032 for those 70 and above. In other words, about a quarter (24.32 per cent) of females with disabilities were over 70; as the corresponding figure for men was 15.51 per cent, it can be concluded that the old-age disability trend was (and still is) more significant for women in Bahrain. The

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[42] See note 20.

[43] Qatar, national census, 1986, quoted from *Demographic Yearbook 1993*, special issue, "Population ageing and the situation of elderly persons", special article, "Disability statistics of ageing", prepared by the United Nations Statistical Division, Department for Economic and Social Information and Policy Analysis (New York, 1993).

[44] Bahrain, Cabinet Affairs, Directorate of Statistics, *Census of Population and Housing, 1981*, quoted from ESCWA "Social statistics and indicators in the ESCWA region" (E/ESCWA/SD/89/8), developed based on the United Nations, Department of International Economic and Social Affairs, Statistical Office, *Disability Statistics Data Base (1975-1986)* (New York, 1988).

higher rate of disability among women compared with men in the 65-plus age group is reported for the Bureij camp in Palestine as well.[45]

TABLE 7. NUMBER AND DISTRIBUTION OF DISABLED PERSONS IN QATAR BY AGE GROUP, 1986

Age group	Male disabled		Female disabled		Male and female disabled combined	
	Total number	Age group (percentage distribution)	Total number	Age group (percentage distribution)	Total number	Age group (percentage distribution)
65-69	28	8.86	32	10.06	60	9.46
70-74	18	5.70	22	6.92	40	6.31
75-79	21	6.65	28	8.81	49	7.73
80 plus	38	12.03	51	16.04	89	14.04
Over 65 (subtotal)	105	33.24	133	41.83	238	37.54
All age groups	316	100	318	100	634	100

Source: Qatar, national census, 1986, quoted from *Demographic Year Book 1993*, special issue, "Population ageing and the situation of elderly persons", special article, "Disability statistics of ageing", prepared by the United Nations Statistical Division, Department for Economic and Social Information and Policy Analysis (New York, 1993).

TABLE 8. AGE DISTRIBUTION OF THE DISABLED IN BAHRAIN RELATIVE TO THAT OF THE TOTAL POPULATION BY SEX, 1981

Age group	Number of disabled Bahraini women per 100,000 females	Percentage distribution of female Bahrainis		Percentage distribution of male Bahrainis	
		Disabled females	Total females	Disabled males	Total males
60-64	5 028	8.77	1.78	10.24	2.11
65-69	5 963	5.79	0.99	6.61	1.17
70 plus	13 032	24.32	1.90	15.51	1.85
Over 60 (subtotal)		38.88	4.67	32.36	5.13
All	1 020	100	100	100	100

Source: Bahrain, Cabinet Affairs, Directorate of Statistics, *Census of Population and Housing, 1981*, quoted from ESCWA "Social statistics and indicators in the ESCWA region" (E/ESCWA/SD/89/8), developed based on the United Nations, Department of International Economic and Social Affairs, Statistical Office, *Disability Statistics Data Base* (1975-1986) (New York, 1988).

[45] Gaza National Committee for Rehabilitation and DIAKONIA, "Disability and rehabilitation needs in the Gaza Strip: a survey report on Bureij and Al-Shati refugee camps" (Gaza City, 1993).

In terms of types of disability, blindness and hearing impairment are the most closely associated with ageing (see table 9). According to the *Population Census in the Syrian Arab Republic, 1981*,[46] the prevalence of blind females per 100,000 of the total female population was only 126 across all age groups, compared with 577 for the age group 60 to 64 and 1,368 for those 65 and over.

The rate of deafness among elderly female populations is very high relative to other age groups in the ESCWA region. In Egypt in 1976, the number of deaf women per 100,000 of the female population was only 7 for all age groups, compared with 17 for the age group 60 to 64, 23 for the age group 65 to 69, 38 for the age group 70 to 74 and 58 for those 75 and above. As the medical and social costs incurred by elderly people with disabilities constitute a burden to the State, and as elderly females tend to be more financially dependent than elderly males, appropriate preventive measures should be stressed.

TABLE 9. BLINDNESS AMONG SYRIAN WOMEN (1981) AND DEAFNESS AMONG EGYPTIAN WOMEN (1976), BY AGE GROUP

Blind Syrian women by age group (1981)		Deaf Egyptian women by age group (1976)			
				Age distribution for Egyptian females (percentage)	
Age group	Number of blind Syrian women per 100,000 females	Age group	Number of deaf Egyptian women per 100,000 females	Deaf females	Total females
All	126	All	7	100	100
55-59	226	60-64	17	6.12	2.65
		65-69	23	4.05	1.39
60-64	577	70-74	38	4.07	1.19
65 plus	1,368	75 plus	58	4.93	0.98

Source: Bahrain, Cabinet Affairs, Directorate of Statistics, *Census of Population and Housing, 1981*; and Egypt, Central Agency for Public Mobilization and Statistics, *Population and Housing Census, 1976*, vol. I (Total Republic), Reference No. 93-15111 (Cairo, 1980); both sources quoted from ESCWA "Social statistics and indicators in the ESCWA region" (E/ESCWA/SD/89/8), developed based on the United Nations, Department of International Economic and Social Affairs, Statistical Office, *Disability Statistics Data Base (1975-1986)* (New York, 1988).

The above has touched upon a number of socio-economic and environmental causes of "impairment" in the ESCWA region. While many of those listed affect both men and women, most affect women to a greater extent. The following includes a brief description of some factors related to cultural and social barriers which constitute another type of "disability" or "handicap" and which are especially relevant to women.

[46] See note 7.

I. SOCIAL BARRIERS AND SOCIAL ISOLATION

Most of the societies in the ESCWA region are traditionally male-oriented, and services are more accessible to men. Negative social attitudes towards impaired women constitute just as much of a "disability" or a "handicap" as the impairment itself. Negative social reactions and rejection may create social barriers which further handicap women who are already disabled. Disabled Arab women tend to believe that they are less important or worthy than their male siblings or able-bodied female siblings; later, the lack of formal education, training and employment opportunities aggravates this deep-seated inferiority complex. One of the biggest problems of disabled Arab women and a major cause of this social handicap is their lack of awareness of their own capabilities and talents—a result of their socialization and upbringing. The role and awareness of the mothers of disabled girl are extremely important in this context. During the Regional Seminar, the participants focused on two important social barriers: (a) negative social attitudes towards disabled Arab women, which lead to social isolation and stigma; and (b) low self-esteem and poor self-image.

Negative attitudes and the social isolation they produce are important causes of social "handicaps" among impaired Arab women; their isolation is clearly reflected in the statistics. A 1993 survey[47] found that in the Gaza Strip, the participation of disabled Palestinian women in public life was much lower than that of disabled men (see table 10).

TABLE 10. SOCIAL PARTICIPATION AMONG DISABLED MEN AND WOMEN IN THE GAZA STRIP (BUREIJ), 1993

	Percentage of gender category	
Type of social activity	Males	Females
Move about in community alone	64	44
Do not move about in community at all	13	31
Chi sq. = 36.14959, p = 0.000		
Attend school normally	41	33
Attend school only at a lower level	31	19
Do not attend school at all	28	48
Chi sq. = 10.50871, p = 0.005		
Participate in social activities	49	31
Do not participate in social activities	29	41
Chi sq. = 21.53889, p = 0.000		

Source: Gaza National Committee for Rehabilitation and DIAKONIA, "Disability and rehabilitation needs in the Gaza Strip: a survey report on Bureij and Al-Shati refugee camps" (Gaza City, 1993).

The table above shows that 31 per cent of disabled women do not move about in their communities at all, compared with only 13 per cent of disabled men. Additionally, a much larger proportion of disabled men than disabled women move about by themselves in the community—64 per cent compared with 44 per cent, respectively (chi sq. = 36.14959, p = 0.000).

[47] See note 45.

The table also indicates that 28 per cent of disabled men do not attend school, 31 per cent attend only lower-level classes, and the rest (41 per cent) attend school normally. However, 48 per cent (almost half) of disabled women do not go to school at all, 19 per cent attend only lower-level classes, and 33 per cent attend school normally (chi. sq. = 10.50871, p = 0.005). The same gender-based differences are found regarding participation in other social activities. Some 41 per cent of disabled women do not participate in social activities at all, compared with only 29 per cent of disabled men (chi sq. = 21.53889, p = 0.000). Additionally, a significantly higher number of disabled women than disabled men were found to have psychological problems.

Social integration appears to be a problem affecting both disabled men and disabled women in the Bureij refugee camp, but disabled women seem to have more serious difficulties than their male counterparts in this respect. In Gazan society, these gender-based differences in levels of social integration can be explained by the prevailing social and parental attitudes towards disabled women. Parents may be less inclined to let their disabled daughters go outside the home; families might be more conscious of the social stigma attached to having a disabled female member. Rather than run the risk of letting this stigma affect the marriage potential of their other daughters, they may keep their disabled daughter "hidden" from the community.[48]

There is a significant under-enumeration of the disabled female population in most countries of the ESCWA region. For example, Egypt's *Population and Housing Census, 1976*[49] indicated an unusual sex ratio of handicapped males to handicapped females of almost 3 to 1;[50] for mentally retarded persons the ratio was the same in Egypt (3 to 1), and 2 to 1 in the Syrian Arab Republic, according to the *Population Census in the Syrian Arab Republic, 1981*.[51] This is most likely associated with the cultural and social pressures placed upon females to appear marriageable; having a disabled female family member may make other members of the family (particularly female siblings) less marriageable, a circumstance related to the social stigma attached to disability. In such cases, disabled women are either completely ignored or are overprotected by their families.

A similar gender imbalance was found in both Palestine (Al-Yarmouk camp, 1984-1985) and Jordan (1983), indicating significant under-enumeration with respect to female disability (see table 12). In both cases, the female-male sex ratio of disability was about 0.6 (or in other words, 3 disabled women to 5 disabled men). Even if the probability of a slightly higher rate of male disability is taken into account (related to the long-lasting civil conflict in Palestine), this sex ratio is still too skewed.

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[48] Much of this section is derived from the analysis of the Gaza National Committee for Rehabilitation and DIAKONIA based on their 1993 disability survey (see note 44).

[49] Egypt, Central Agency for Public Mobilization and Statistics, *Population and Housing Census, 1976*, vol. I (Total Republic), Reference No. 93-15111 (Cairo, 1980), quoted from ESCWA "Social statistics and indicators in the ESCWA region" (E/ESCWA/SD/89/8), developed based on the United Nations, Department of International Economic and Social Affairs, Statistical Office, *Disability Statistics Data Base (1975-1986)* (New York, 1988).

[50] Biologically, the female-male ratio of impairment should be about equal (1 to 1). For instance, in 1993, the numbers of disabled males and females (over 16 years old) in Sweden were 106,000 and 135,000, respectively; the corresponding figures for Austria were 149,000 and 138,500, respectively (United Nations, *Demographic Yearbook*, 1993; see note 42).

[51] See note 7.

TABLE 11. THE GENDER IMBALANCE WITH RESPECT TO THE INCIDENCE OF DISABILITY: THE STATISTICAL UNDER-ENUMERATION OF FEMALE DISABILITY IN EGYPT (1976) AND THE SYRIAN ARAB REPUBLIC (1981)

Sex	Egyptian census (1976)		Syrian census (1981)	
	Number of disabled per 100,000 people in Egypt	Number of mentally retarded per 100,000 people in Egypt	Number of disabled per 100,000 people in the Syrian Arab Republic	Number of mentally retarded per 100,000 people in the Syrian Arab Republic
Females	158	10	802	114
Males	443	31	1 232	195
Both sexes	303	21	1 022	155

Source: Bahrain, Cabinet Affairs, Directorate of Statistics, *Census of Population and Housing, 1981*; Egypt, Central Agency for Public Mobilization and Statistics, *Population and Housing Census, 1976*, vol. I (Total Republic), Reference No. 93-15111 (Cairo, 1980); and the Syrian Arab Republic, Office of the Prime Minister, Central Bureau of Statistics, *Population Census in the Syrian Arab Republic, 1981*; all sources quoted from ESCWA "Social statistics and indicators in the ESCWA region" (E/ESCWA/SD/89/8), developed based on the United Nations, Department of International Economic and Social Affairs, Statistical Office, *Disability Statistics Data Base (1975-1976)* (New York, 1988).

TABLE 12. THE GENDER IMBALANCE WITH RESPECT TO THE INCIDENCE OF DISABILITY: THE STATISTICAL UNDER-ENUMERATION OF FEMALE DISABILITY IN JORDAN (1983) AND PALESTINE (1984-1985)

Country	Age group	Number of male disabled per 100,000 males	Number of female disabled per 100,000 females	Female-male ratio
Jordan (1983)	0-14	1 340	941	0.70
	15-59	4 555	2 530	0.56
	60 plus	3 449	2 385	0.69
	All ages	539	344	0.64
Palestine (Al-Yarmouk camp survey, 1984-1985)	0-14	2 406	1 645	0.68
	15-59	17 878	8 493	0.48
	60 plus	14 625	7 841	0.54
	All ages	1 556	921	0.59

Source: ESCWA, *Compendium of Social Statistics and Indicators*, third issue (E/ESCWA/STAT/1993/25), 1993.

During the Regional Seminar, the participants agreed that disabled Arab women were under-enumerated as a result of both prevailing social attitudes and the lack of literature on this subject. It was recommended

that studies on disabled Arab females be promoted, and that the families of these females be encouraged to cooperate in the collection of data for national censuses and other surveys.

J. KINSHIP MARRIAGE

Another cultural and social factor influencing the incidence of impairment is the (often encouraged) practice of marriage between close relatives in the countries of the ESCWA region. In the Arab world the marriage of cousins is commonly practised by all social classes in both rural and urban settings. During the Regional Seminar, the participants all agreed that consanguinity constitutes one of the most significant cultural factors contributing to disability in the ESCWA region.

According to a study conducted by Khoury and Massad (1992), the rate of consanguinity (kinship marriage) in Jordan is about 50 per cent. The observations of several other authors are also included in this study: Khlat and Khudr (1983) indicated that in Beirut, consanguinity (first cousins and more distant relatives) affected a quarter of all marriages; Hafex reported that the level of consanguinity was 28.96 per cent in Egypt; and Al-Awadi and others reported a rate of 54.2 per cent for Kuwait.[52] The genetic disorders caused by consanguinity can result in all types of impairment, including those affecting the mind, the senses and motor skills. Abdallah Al-Khatib, in his national study submitted to the Conference on the Capabilities and Needs of Disabled Persons in the ESCWA Region (held in Amman from 20 to 28 November 1989), stressed the urgent need to draw up legislation to forbid marriage without the necessary medical exams—a first step in preventing hereditary impairments. He also emphasized the need to boost public awareness of the dangers of marriage between close relatives and the consequences of impairment among their offspring.[53] This phenomenon of consanguineous intermarriage is closely related to the status of Arab women in general. The changing role of women has coincided with changes in marriage patterns. With increasing female education and employment, it has become much harder to force a girl into an arranged marriage. In accordance with the improvements in women's education, this traditional form of marriage to kin (particularly the first cousin) is expected to become less common over time. The marriage age of Arab girls has generally risen, and the more contemporary marriages are increasingly based more on mutual understanding and affection between husband and wife than on the family's convenience and perceived interests.

According to a sample survey conducted in Jordan and published in 1992,[54] consanguinity is closely related to the level of women's (wives') education. At the time of the survey, the overall rate of consanguineous marriage in Jordan was about 50 per cent: 32.03 per cent for first cousins, 6.8 per cent for second cousins and 10.5 per cent for more distant relatives (50 per cent of married couples had no blood relationship). The figures were particularly high for rural communities, where the first-cousin marriage rate was reported to be as high as 37.9 per cent. Education and consanguinity showed a negative correlation: the higher the education, the lower the consanguinity. The survey showed women's education to be much more effective than that of men in this regard. As shown in table 13, female university graduates were shown to enjoy much greater freedom in selecting husbands than other, less-educated groups. Eighty per cent of Jordanian college graduates (wives) had avoided consanguineous marriage (compared with 60 per cent of their male counterparts); they tended to choose their husbands based on friendship, generally avoiding the

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[52] The figures and their sources are quoted from a study conducted by S.A. Khoury and D. Massad, "Consanguineous marriage in Jordan", *American Journal of Medical Genetics*, vol. 43 (1992), pp. 769-775.

[53] Abdallah Al-Khatib, "Disability in Jordan", *Proceedings of the Conference on the Capabilities and Needs of Disabled Persons in the ESCWA Region* (E/ESCWA/SD/1992/2).

[54] See note 53.

traditional behavioural patterns in this regard. Interestingly, however, the rate of consanguineous marriage among university-educated Jordanian men is not much different from that of the illiterate group. This might be attributable to a prevailing social factor: there is family pressure on educated Arab men to marry within the family, the general trend being to keep the best males within family boundaries.[55] The overall level of women's education thus appears to be a key factor in reducing the incidence of kinship marriage.

TABLE 13. THE CORRELATION BETWEEN CONSANGUINEOUS MARRIAGE AND THE EDUCATION OF THE SPOUSE

(Percentage)

	Spousal relationship (consanguineous)			
Level of education	First cousins	Second cousins	Distant relationship	No relationship
Illiterate (wife)	31.40	5.45	12.73	50.41
Illiterate (husband)	23.58	4.07	15.45	56.91
Read and write (wife)	38.15	7.13	9.25	45.47
Read and write (husband)	32.97	7.33	8.42	51.28
University (wife)	12.00	4.00	4.00	80.00
University (husband)	25.11	5.94	8.22	60.73

Source: S.A. Khoury and D. Massad, "Consanguineous marriage in Jordan", *American Journal of Medical Genetics*, vol. 43 (1992), pp. 769-775.

There is also a clear correlation between parental consanguinity and the incidence of severe mental retardation among children. The findings of the study conducted by Staffan Janson and others[56] corroborate those of the above-mentioned study, also reporting an overall consanguineous marriage rate of about 50 per cent in Jordan. The study by Janson and others indicated that the overall kinship marriage rate of 67.5 per cent in the experimental group of parents of severely mentally retarded children was significantly higher than the national average (50 per cent), with the breakdown of the former as follows: 35 per cent for first-cousin marriage; 14.2 per cent for second-cousin marriage; and 18 per cent for marriage between more distant relatives. It was also reported that 21 per cent of the sample children had at least one mentally retarded sibling (11.3 per cent had one retarded sibling, 7.9 per cent had two, 1.5 per cent had three, and 0.5 per cent had four)—a clear indication of genetically based mental retardation.

[55] Ibid.

[56] See note 18.

Interestingly, a very similar figure was found in Egypt, where it was reported that 67 per cent of the parents of disabled persons were close blood relatives, and that 20 per cent of all disability cases could be attributed to congenital causes.[57] In the Gaza Strip (Bureij camp), significantly higher rates of mental and multiple disability were reported for the children of parents who were blood relations: 43 per cent of the parents of mentally retarded or multiply disabled children were first cousins, and only 30 per cent of the parents were not related at all. The deep-rooted social practice of marriage between cousins appears to be a contributing factor to the incidence of disability throughout the Arab world.

[57] M.A.S. El-Banna, "The situation of the disabled in Egypt", *Proceedings of the Conference on the Capabilities and Needs of Disabled Persons in the ESCWA Region* (E/ESCWA/SD/1992/2).

III. PROBLEMS OF DISABLED ARAB WOMEN

According to *Women and Disability*,[58] more disabled women are illiterate and fewer are well educated, they have less access to vocational training, they are less frequently and less gainfully employed, and they are less likely and have fewer opportunities to marry and set up a family. With all these factors combined, their social status tends to be the lowest in any given society. Disabled women in Egypt (and elsewhere), being uneducated, untrained, unemployed and unmarried, are dependent on their parents for support. Losing parents and being left alone with no financial support are a real nightmare for elderly disabled women; training and employment are the only solutions to such a problem.[59] In this chapter, the situation of disabled Arab women with respect to education, employment and marital status is briefly reviewed.

A. EDUCATION

During the Regional Seminar, the participants singled out the lack of education as a major problem facing disabled Arab women, and recommended the mainstreaming of these women in education and training. Illiteracy rates among disabled women are high compared with those for able-bodied women and disabled men. Table 14 and annex table 4 indicate that in the Syrian Arab Republic in 1981, 80.50 per cent of disabled women were illiterate, compared with 54.53 per cent of the total female population and 60.51 per cent of the disabled male population. Table 14 and annex table 6 show that in Bahrain in 1981, 88.24 per cent of disabled Bahraini women were illiterate, compared with 41.44 per cent of the total Bahraini female population, 73.71 per cent of disabled Bahraini men, and only 21.18 per cent of the total Bahraini male population. Annex tables 4 through 7 indicate the differences in the levels of educational attainment between disabled men and disabled women in the Syrian Arab Republic and in Bahrain (among Bahraini nationals). The illiteracy rate among disabled women is much higher than that for disabled men; in the Syrian Arab Republic, the rate of illiteracy among disabled women was 1.32 times that of disabled men in 1981 (annex table 5). In both Bahrain and the Syrian Arab Republic, the percentage of disabled women who completed higher education was only one third that of the corresponding male population (annex tables 5 and 7).

The connection between female illiteracy and "disability"/"handicap" forms a vicious cycle, as illiterate women are unaware of and/or do not have access to the means by which they might improve their own economic and social status, and this produces a dependency mentality, which in turn constitutes a social "handicap". Additionally, as illiterate women generally have little idea of the most effective measures for preventing childhood impairment and for early intervention, they are more likely to end up having disabled children themselves.

During their interviews with ESCWA staff (discussed later), Ms. Munira Bin Hindi and Ms. Heba Hagrass (both disabled Arab women) confirmed that family support, particularly support from the mother for education and training, is the most important factor and is a prerequisite for the eventual integration of disabled girls.

B. EMPLOYMENT

Employment and income security are prerequisites for living with dignity. During the Regional Seminar, the lack of employment opportunities and income security were singled out as major problems for

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[58] Esther Boylan, *Women and Disability* (London and New Jersey, Zed Books Ltd., 1991), ISBN No. 0-86232-987-6.

[59] See note 12.

disabled Arab women in particular, in view of their special needs. The mainstreaming of disabled Arab women in training and employment was encouraged.

TABLE 14. PERCENTAGE DISTRIBUTION, BY SEX, OF THE DISABLED AND ABLE-BODIED POPULATIONS WHO ARE ILLITERATE AND WHO HOLD UNIVERSITY DEGREES IN THE SYRIAN ARAB REPUBLIC AND BAHRAIN, 1981

	Illiterate disabled persons as a proportion of the total disabled population		Percentage of the total population (both disabled and able-bodied) who are illiterate		Disabled persons with a university degree as a proportion of the total disabled population		Percentage of total population (both disabled and able-bodied) with a university degree	
	Syrian Arab Republic (SAR)	Bahrain (BAH)	(SAR)	(BAH)	(SAR)	(BAH)	(SAR)	(BAH)
Females	80.50	88.24	54.53	41.44	0.23	0.09	0.59	1.42
Males	60.51	73.71	21.95	21.18	0.68	0.34	2.48	2.47
Both sexes	67.95	79.28	37.88	31.36	0.51	0.23	1.56	1.92

Source: Syrian Arab Republic, Office of the Prime Minister, Central Bureau of Statistics, *Population Census in the Syrian Arab Republic, 1981*, quoted from ESCWA "Social statistics and indicators in the ESCWA region" (E/ESCWA/SD/89/8), developed based on the United Nations, Department of International Economic and Social Affairs, Statistical Office, *Disability Statistics Data Base (1975-1986)* (New York, 1988).

The participation of disabled women in the labour force is very limited in the ESCWA region. For instance, according to the *Population Census of Kuwait, 1980*[60] only 2.03 per cent of the disabled Kuwaiti female population[61] were economically "active", compared with 9.62 per cent of the total Kuwaiti female population, 19.96 per cent of the disabled Kuwaiti male population, and 66.84 per cent of the total Kuwaiti male population. It should be noted, however, that out of the 97.97 per cent of the economically "inactive" disabled female Kuwaitis, 24.86 per cent were homemakers. Disabled women in this category may be involved in various productive activities at home. On the other hand, not one of the disabled or able-bodied men is considered to be a homemaker. This relatively high proportion of homemakers among disabled women may be at least partially attributable to the standard Arab notion that a woman's major role involves taking care of the home and family. In the Gaza Strip (Bureij camp) as well, disabled women were found to participate in household work and other domestic activities to a much greater degree than disabled men; it was found that some 60 per cent of disabled men did not participate at all in household work, compared

[60] Kuwait, Department of Social Affairs, *Populationi Census of Kuwait, 1980* (Kuwait, Kuwait Government Press, 1982), quoted from "Social statistics and indicators in the ESCWA region" (E/ESCWA/SD/89/8), developed based on the United Nations, Department of International Economic and Social Affairs Statistical Office, *Disability Statistics Data Base (1975-1986)* (New York, 1988).

[61] The statistics cited here refer only to Kuwaiti nationals.

with only 32 per cent of women. The participation of disabled women in household work and other domestic productive activities should not be ignored.

TABLE 15. PERCENTAGE DISTRIBUTION OF DISABLED AND ABLE-BODIED KUWAITIS (15 YEARS OLD AND ABOVE) BY SEX AND EMPLOYMENT STATUS, 1980

	Economically active	Economically inactive	Homemakers
Disabled Kuwaiti women	2.03	97.97	24.86
Disabled Kuwaiti men	19.96	80.04	--
Total Kuwaiti women	9.62	90.38	69.86
Total Kuwaiti men	66.84	33.16	--

Source: Kuwait, Department of Social Affairs, *Population Census of Kuwait, 1980* (Kuwait, Kuwait Government Press, 1982), quoted from ESCWA "Social statistics and indicators in the ESCWA region" (E/ESCWA/SD/89/8), developed based on the United Nations, Department of International Economic and Social Affairs, Statistical Office, *Disability Statistics Data Base (1975-1986)* (New York, 1988).

With respect to occupational categories (see table 16), 35.29 per cent of the economically active disabled females in 1980 were employed in professional and technical fields, and 41.18 per cent in the clerical field. Disabled Kuwaiti males tended to be employed in services (32.85 per cent), clerical work (24.78 per cent), and production/labour (16.14 per cent)—very similar to the proportions for able-bodied Kuwaiti males.

TABLE 16. PERCENTAGE DISTRIBUTION OF DISABLED AND ABLE-BODIED KUWAITIS (15 YEARS OLD AND ABOVE) BY SEX AND MAJOR OCCUPATIONAL GROUP, 1980

Field	Disabled women	Total women	Disabled men	Total men
Professional/technical	35.29	51.98	14.99	9.94
Administrative/managerial	0.00	0.50	2.02	2.28
Clerical	41.18	35.11	24.78	22.03
Sales	0.00	0.37	4.03	5.74
Services	11.76	11.13	32.85	40.22
Agriculture related	0.00	0.29	5.19	4.27
Production/labourers	11.76	0.62	16.14	15.51
Not stated	0.00	0.00	0.00	0.00
Total	100	100	100	100

Source: Kuwait, Department of Social Affairs, *Population Census of Kuwait, 1980*, (Kuwait, Kuwait Government Press, 1982). Quoted from ESCWA "Social statistics and indicators in the ESCWA region" (E/ESCWA/SD/89/8), developed based on the United Nations, Department of International Economic and Social Affairs, Statistical Office, *Disability Statistics Data Base (1975-1986)* (New York, 1988).

These gender-based occupational differences may be particularly characteristic of the Gulf countries; the majority of employed disabled Kuwaiti women work in the professional and clerical categories, with a high proportion of them earning good salaries and enjoying social prestige. These relatively "privileged" disabled Gulf women may work for personal satisfaction, intellectual stimulation, social prestige and/or personal development. A disabled Gulf Arab woman with a good academic background is sometimes in a unique position and is able to develop her career on a long-term basis. There seems to be more pressure on disabled men to earn an income, however, regardless of the occupational category.

Annex tables 8 and 9 indicate the differences between disabled men and women in terms of their employment and activity status in Egypt (a non-oil-producing and labour-sending Arab country) in 1976. The tables indicate that, relative to the total disabled Egyptian population, the proportions of students, aged persons, and those unable to work were extremely high for disabled females; the ratio of disabled females to disabled males in the "aged persons" category was 2.75 to 1, and the corresponding ratio for those "unable to work" was 2.43 to 1.

One interesting finding was that although the proportion of self-employed disabled females was much lower than that of self-employed disabled males (the disabled female rate was only 9.05 per cent of the disabled male rate), it was much higher than the corresponding figure for the total female population (only 2.65 per cent of the total male rate). It appears that some disabled women are engaged in certain types of informal but productive income-generating activities to earn a living and simply to survive. Annex tables 10 and 11 also indicate that in 1976 disabled women were less integrated into the major occupational groups than were disabled men, indicating the failure of these women to occupy themselves productively. In the relatively poor countries of the ESCWA region, self-employment and informal employment may be viable solutions for disabled women. In many rural Arab communities, a number of disabled women are engaged in domestic work and help in agriculture. Some are also heads of households, and many have the same family responsibilities as able-bodied men and women—there are even some who become family heads in old age. In the worst case, unless appropriate policies are promptly formulated for them, poverty can lead to old disabled women being deserted or being taken care of by their families, who may have very little affection for them.

During an interview with ESCWA staff, Ms. Amal Nahas (a specialist in the education and training of disabled persons in Jordan) emphasized that the training of disabled Jordanian women should be geared towards the "immediate incentive" of income generation upon completion of the training, in order to invite support and cooperation from their families, many of whom are reluctant to facilitate such training.

C. MARRIAGE

Disabled Arab women face more discrimination and difficulty with respect to marriage. During the Regional Seminar, it was noted that difficulties related to marriage (partially attributable to the practice of arranged marriage) constituted a major problem. The only exception to this occurs in the case of mildly retarded women; while men may accept a young and pretty mildly mentally retarded woman, women tend to refuse marriage with a mentally retarded man. Annex tables 12 and 13 indicate that in Jordan in 1983, the percentages of divorced, widowed, and single disabled women were extremely high compared with the corresponding percentages for able-bodied Jordanian women. According to the 1983 statistics, 62 per cent of all disabled women were single, 18 per cent were widowed, only 16.31 per cent were married, and 3 per cent were divorced (see table 17).

The figures for disabled women were also high relative to the corresponding percentages for disabled men: the female rate was 3.43 times the male rate for the "divorced" category, 5.92 times the male rate for the "widowed" category, and 1.05 times the male rate for the "single" category. This is a fairly consistent

phenomenon for all categories of disabled persons. However, marriage (particularly maintaining a marriage) seems to be more problematic for deaf and mute women than for those in other disability categories. The 1983 statistics indicate that for deaf and mute persons, the proportion of "married" women was less than half that of men, and the "divorced" rate was 8.1 times higher for women than for men. However, in the case of mentally retarded persons, it appears that the gender differences were far smaller.

TABLE 17. PERCENTAGE DISTRIBUTION OF DEAF MUTE AND OTHER DISABLED PERSONS (AGE 13 AND ABOVE) IN JORDAN, BY SEX AND MARITAL STATUS, 1983

Marital status	Disabled women	Disabled men	Total disabled population	Deaf and mute men	Deaf and mute women
Single	62.17	59.26	60.30	67.07	73.20
Married	16.31	36.69	29.37	30.67	14.93
Divorced	3.36	0.98	1.83	0.40	3.23
Widowed	18.17	3.07	8.49	1.87	8.63

Source: Jordan, Department of Statistics, *Statistics on the Disabled in Jordan, 1983*, quoted from ESCWA "Social statistics and indicators in the ESCWA region" (E/ESCWA/SD/89/8), developed based on the United Nations, Department of International Economic and Social Affairs, Statistical Office, *Disability Statistics Data Base (1975-1986)* (New York, 1988).

Some of the related literature has affirmed the statistical trends which reflect the problematic nature of marriage for disabled women in the countries of the ESCWA region. The following account is a prime example:

> "I then had a daughter, Sanna. When she was eight months old she had fever, and I took her to someone who gave her penicillin injections, and lo and behold, instead of recovering she became paralysed. She got polio. I stood her up on my knee one day, and suddenly her leg gave way. I was shocked. My nerves gave way. That this should happen to her and she being a girl and a woman, I knew would have grave consequences. No man would want to marry a cripple."[62]

As the statistics show, disabled women are frequently denied many of the most basic human rights, including those related to love, marriage, and motherhood.[63] It is relatively easier for disabled men to marry, to maintain a marriage, and to fulfil family obligations and responsibilities. Arab societies, like many other societies, often fail to recognize disabled women as "women" with emotional and biological needs, desires, rights and duties. During the Regional Seminar, almost all of the disabled female participants emphasized society's failure to recognize the importance of marriage and motherhood to disabled women. The disabilities and/or appearance of these women often cause them to be rejected by society and deprived of the opportunity to enjoy the rights and privileges accorded the able-bodied (as an example, 62.17 per cent of disabled women were single in Jordan in 1983). Many parents tend to overprotect a disabled girl, discouraging her from aspiring to goals which may not be achievable in the Arab world at present.

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[62] Nayra Aitya, *Khul-Khaal: Five Egyptian Women Tell Their Stories* (Cairo, American University in Cairo Press, 1988).

[63] See note 31.

During an interview with ESCWA staff in 1993, Ms. Heba Hagrass and Ms. Hala Awad related that they found marriage to be one of the most serious social barriers for disabled women, and shared their belief that disabled women faced more difficulty than disabled men in finding partners.

Hala Awad, who suffers from progressive muscle atrophy, emphasized that marriage for a disabled Arab woman was particularly problematic when there was some question about the genetic linkages and trends associated with a disease (such as hers), as marriage in the Arab world was mainly undertaken for the purpose of producing offspring.

In general, disabled women find it difficult both to get married and to stay married. As noted above, the gap between disabled men and disabled women appears to be narrower in cases of mental retardation. This is thought to be attributable to the fact that a man might agree to marry a mildly mentally retarded or borderline disabled woman if she is young and pretty; however, it is not easy for a mentally retarded man to marry, as men are expected to take primary responsibility for providing a secure family income.

D. INTERVIEWS

In 1993 and 1994, ESCWA staff undertook a series of interviews with a selection of disabled Arab women for the purpose of drawing up profiles which would highlight their particular problems and circumstances. Much of what was said in these interviews reaffirms or reiterates what is written in the earlier chapters and sections of this study concerning the female-related causes of disability and the major problems of Arab disabled women. A summarized version of each of the interviews is provided below.

A feeling emerged from the interviews that disability was the direct result of inadequate human development in the region. There is in fact a positive correlation between poverty and fertility rates, and a negative correlation between educational level (particularly among women) and fertility rates. Further, the belief in and/or practice of family planning (one effective preventive measure against disability) correlates positively with the level of education and the quality of life. Disability is a developmental issue which for much of the population is even more closely connected with the development of women: the issues relating to disabled women—particularly the prevention of childhood disability—should be tackled within the framework of the overall advancement of women.

As noted above, very late pregnancy (particularly after age 36 or 37), a direct result of the extremely high fertility rate in Arab society, is one medical cause of childhood impairment. Some Arab States are taking practical legal measures, permitting abortion if proof exists of any serious mental or physical foetal abnormality or disability. One dimension of the problem of late pregnancy is the lack of awareness among parents and conventional medical practitioners, and another is the lack of proper facilities for perinatal medical diagnosis.

The text and table below provide a brief introduction to cases 1 and 2. Mr. and Mrs. Mailesh are a Palestinian Jordanian married couple who are originally from Hebron (West Bank).[64] In 1964, they moved to Zarqa, Jordan, because of the economic recession in Palestine. The two cases of childhood disability described below occurred within their family, but under very different circumstances and with very different outcomes. Table 18 shows how these two cases of congenital childhood disability affected the lives of two Arab mothers within the same family—one of the old generation and one of the new—and also provides an idea of how they responded to the challenges presented by these disabilities.

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[64] Mr. and Mrs. Mailesh are the landlord and landlady of the author of this study (an ESCWA staff member), and live in Um-Uthayna, an area in west Amman.

Case 1: A childhood disability caused by an extremely high fertility rate (very late child-bearing), combined with the failure to have an amniocentesis test done to detect Down's syndrome

This case features Mrs. Mailesh's stepmother, Aysha. Aysha's first husband was killed by Israeli soldiers in 1948 during the first Arab-Israeli war, as was Mrs. Mailesh's natural mother. Aysha, at 20 years of age, married Mrs. Mailesh's father, Mohammed (then aged 49). At that point, Mohammed already had seven children (three boys and four girls) from his first wife, including Mrs. Mailesh herself. After he married Aysha, he had another 15 children with her; 3 died and 12 survived. When Aysha delivered the last child (Abdul Aziz), she was 48 years old. Before Abdul Aziz was born, Mohammed already had 18 children of his own. Was it really necessary, then, to have a nineteenth child, to risk the occurrence of congenital mental retardation? Of course, Mohammed (whose educational attainments are limited to reading and writing) was not aware of the risk himself; neither was his wife (who is totally illiterate). It appears that, instead of seeking to practice any form of birth control, Mohammed was encouraging his 48-year-old wife to have another child. They are in the lower-middle-income bracket,[65] and regard having a lot of children as a form of security. In addition, Mohammed is very proud of his reproductive capabilities.

Aysha did not have the amniocentesis test done,[66] nor was she aware of her increased risk of bearing a disabled baby. The most depressing part of this story is that Aysha still does not understand the connection between her son's severe mental retardation (Down's syndrome) and her very late pregnancy—perhaps she will never understand it fully. This story supports the relation between an extremely high fertility rate (a very late pregnancy) and disability, and underlines the importance of "family literacy" in preventing disability. This particular case could easily have been prevented through the use of birth control, or at least discovered at an earlier stage through the amniocentesis test. Mr. Mailesh (a well-educated, self-made man)[67] hopes that this type of tragedy, common in his father's generation, will occur less frequently in the next generation, given the higher levels of education and awareness.

The only positive aspect of this story is that Aysha loves Abdul Aziz and cares as much about his welfare as that of her other children. However, the extent of Aysha's understanding of Abdul Aziz's mental disability is questionable; she simply believes that "Abdul Aziz is different from other children". Abdul Aziz went to a special primary school for mentally retarded children in Zarka for six years. His parents love him and want to send him to a vocational school; however, there is the problem of transportation, as the school is located in Russeifa (between Amman and Zarka). Abdul Aziz (shown in the photograph below with his mother at their home in Zarka) is now 14 years old and enjoys dancing and music.

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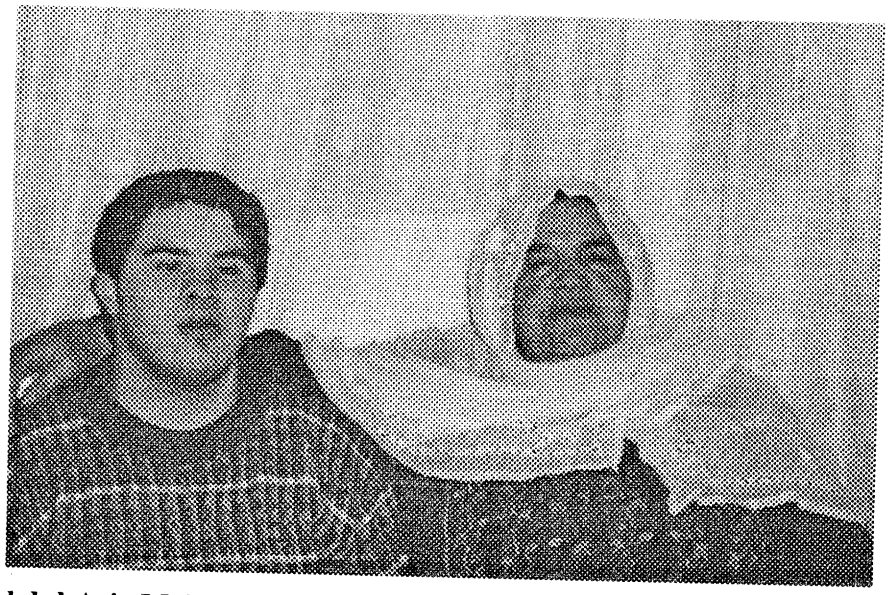
[65] Mohammed once owned his own grocery shop in Palestine, but after migrating to Jordan, he worked in construction as a stonemason.

[66] In many developed countries, this examination is mandatory for pregnant mothers over the age of 36 or 37 to detect Down's syndrome (which can cause mental retardation and physical abnormalities). The test requires that a skilled medical professional extract fluid from the pregnant mother's amniotic sac.

[67] Mr. Mailesh and Mrs. Mailesh are also cousins; however, their children are all able-bodied and well educated.

TABLE 18. A COMPARISON OF THE DATA RELATED TO TWO CHILDHOOD DISABILITY CASES WITHIN THE MAILESH FAMILY

Name of the mother; residence; origin; age	Aysha; Jordan; Palestinian; 64 years old	Inam; Saudi Arabia; Palestinian; 38 years old
Relationship within the Mailesh family	Mrs. Mailesh's stepmother	Sister of Mr. Mailesh's son-in-law
Child's disability	Mental retardation (Down's syndrome)	Total blindness (two sons)
Cause of the childhood disability	Very late pregnancy (48 years old); failure to have an amniocentesis test done	Maternal rubella virus acquired during pregnancy; incorrect pre- and perinatal diagnoses
Total number of children	15 born, but only 12 (6 boys and 6 girls) surviving	3 boys (2 blind and 1 able-bodied)
Mother's level of education	Illiterate	College graduate (a two-year associate's degree and teaching credentials) from the United States of America
Father's level of education	Reads and writes only	College graduate (a two-year associate's degree and teaching credentials) from the United States
Occupation of parents; income level	Mothers is a housewife, father is a stonemason; lower-middle income	Teachers (both wife and husband); upper-middle income
The child's education/ training and the mother's attitude	Primary school only—now totally home-bound; loves the child	Emphasizes the need for training/rehabilitation; wishes to send the blind boys to schools in the United States; positive attitude
Awareness of the mother	Not aware of the cause or the need for rehabilitation; knows very little even about Down's syndrome itself	Fully aware of the risks, leading to her decision to abort



Abdul Aziz Mailesh and his mother, Aysha, in their home in Zarqa

Case 2: Congenital blindness caused by the fact that the mother was never immunized against rubella

This account relates another disability-related tragedy in Mr. Mailesh's family. Ms. Inam Rashed Hussein, the sister of Mr. Mailesh's son-in-law, is a Palestinian-Jordanian originally from Nablus. An educated woman, she is currently living in Abha, Saudi Arabia, and working as a primary school teacher.[68] She and her husband have three sons; the eldest is unimpaired, while the two younger boys are totally blind.[69] She appears to have been infected by the rubella virus during her last two pregnancies, not having been properly vaccinated against the disease prior to either of them. As mentioned before, rubella during pregnancy is one of the major causes of congenital multiple disability (for example, blindness combined with mental retardation) in children. During her third pregnancy (after she had delivered the older blind boy), Inam went to a few hospitals for some very detailed pre- and perinatal medical exams, as she was aware of the possibility that she might still have the virus, or that it might recur. Though she was, in fact, still infected with rubella, the doctors failed to detect it; they thought she was just being overly anxious. As a result, she delivered another blind boy (her third son). Inam has some very serious misgivings about the quality of pre- and perinatal medical care in Saudi Arabia in spite of the state-of-the-art medical facilities and equipment available there. After bearing her three sons, she became pregnant again, but this time decided to abort the foetus, as she was too afraid of having another blind child. Inam considers herself a religious, moral woman; however, she confirms that she is guilt-free with respect to her abortion, as she believes that preventing congenital disability is the right thing to do. Regarding rehabilitation and training, Inam emphasizes the importance of "normalization" for the two blind boys, and hopes to send them to a good school in the United States where they can receive the best possible education and training. The message here is clear: the failure to follow a proper immunization programme, coupled with inadequate pre- and perinatal medical care, can add substantially to the incidence of disability in the region; every effort must be made to remedy both problems.

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[68] Inam has an associate's degree in teaching from a junior college in the United States of America.

[69] So far she has not noticed any signs of mental retardation in either of her two blind boys.

Case 3: Difficulty in marriage for disabled Arab women (two cases)

As indicated in previous sections of this study, the difficulties surrounding marriage for disabled Arab women constitute a serious barrier to their social integration; most will remain single for their entire lives. Ms. Hala Awad is a Jordanian who returned to her country from Kuwait after the Gulf crisis. She has been suffering from progressive but very mild muscular atrophy since birth. Her disability appears to be genetic, (inherited),[70] as her brother is in a wheelchair with the same disease, and two of her cousins suffer from muscular atrophy as well. While she was in Kuwait, she completed her university studies, receiving a bachelor's degree in accounting/business from a university in Beirut (through correspondence courses). Hala believes that correspondence courses provide a wealth of opportunities for physically disabled women. She is currently working at the Union Bank for Savings and Investment in Jordan. Her physical disability affects her movements only minimally—she can walk and drive—but she still faces the difficulties related to genetic disability in Jordan. The most serious problem for her is marriage. As mentioned before, marriage in the Arab world is contracted mainly for purposes of reproduction; this is particularly important in Jordan for the security of the country. Hala believes that another negative element in Jordan relates to the strong influence the parents have in the selection of a bride; marriage among Arabs is regarded as a social institution, and relatively less importance is attached to the component of mutual affection between husband and wife. Both of Hala's disabled cousins (women) are married to Westerners and reside outside Jordan; Hala expresses her intention to migrate from Jordan as well, and to find a spouse who will accept her regardless of her genetic tendencies with respect to disability.[71]

Ms. Heba Hagrass, an Egyptian businesswoman with rheumatoid arthritis who is dependent on crutches and a wheelchair, confirms that there are numerous marriage problems faced by disabled Arab women. She believes that disabled Arab women have a much more serious problem than disabled men in finding marriage partners. Heba still remembers that her own parents almost gave up on her prospects for marriage, and were very annoyed when they found out that she was going to marry her cousin (her current husband). When her cousin proposed, she decided to take the risk and accept. "As [even] a number of able-bodied women are getting divorced today, why not take such a risk?" She smiles, remembering that her own father was very bewildered when she became pregnant (as Heba is "disabled"), although he congratulated her later on. Currently, she is effectively carrying out her duties as wife, mother and career woman.

Case 4: A female war-related disability in Palestine

Asma is a victim of the first Arab-Israeli war; her case illustrates the role armed conflict plays in female disability in the Arab world. Asma completely lost her eyesight in 1949 (during the first Arab-Israeli war), when she was one and a half years old. At that time, displaced Palestinians did not have access to proper medical care or facilities; when Asma's parents took her to a hospital, the doctor gave her the wrong prescription, and she suffered permanent loss of vision. She stresses that the aftermath of armed conflict is responsible for significant increases in the incidence of female and childhood disability, and confirms that "peace" is the most important prerequisite for reducing disability in the ESCWA region. A war itself may involve men more directly, but its aftermath has more impact on women and children, especially in the areas of medical care, nutrition, and maternity-related issues.

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[70] An occupational therapist with the King Hussein Medical Centre in Amman confirmed that the majority of patients with muscle atrophy under rehabilitation there are hereditary cases. She attributes this phenomenon to the practice of kinship marriage in Jordan.

[71] A few months later after this interview, both Ms. Hala Awad and her disabled brother migrated to the United States.

Asma received a diploma after completing a two-year teaching programme and is currently a Braille teacher at the Regional Centre for the Rehabilitation and Training of Blind Girls in Jordan. She went through mainstream education up to college, though she depended totally on her peers to read texts to her in high school. In college, she used a tape recorder for lectures. She singled out the lack of Braille texts as one of the main problems of visually disabled students in the region.

Asma highlights two major problems of disabled women: employment and marriage. Concerning marriage, she believes that even disabled Arab men prefer to marry able-bodied women—at least partly for reasons of convenience, as they can expect assistance and care from their spouses. However, there is almost no chance for a blind Arab girl to marry an able-bodied man. The attitude of parents is another problem: there is a tendency to overprotect disabled girls. They may be closed up in the house and totally isolated from society. With respect to employment, at the school where Asma teaches, the training of telephone operators is the most successful area in terms of eventual placement. Teaching may also be considered suitable for blind women, but the lack of Braille texts poses a problem in Jordan. Recent technological developments, including the computerization of texts and the use of Braille printers and speech synthesizers, may relieve this problem somewhat in the future.

Case 5: The important role of the family (particularly the mother) in the rehabilitation and social integration of disabled Arab women (two cases)

As noted in chapter IV below, it is generally Arab women—mothers, sisters and daughters—who are directly involved in the care of disabled family members in the home. The role of the mother is particularly important, and her influence over the child's future development and social integration is incalculable. The importance of the mother's role in the rehabilitation and social integration of disabled girls was endorsed by all disabled women participants at the Regional Seminar.

The story of Ms. Heba Hagrass (mentioned earlier) exemplifies the validity of this concept. Heba is a successful businesswoman and fashion designer who owns two retail shops for women's clothing and accessories in Garden City, Cairo. She also actively participates in counselling disabled children's parents for an Egyptian non-governmental organization (NGO) affiliated with the Integrated Service Society. This NGO provides referral services to the parents of children with various types of disabilities; approximately 90 per cent of the clients are the parents of mentally retarded children. Heba is a wife and the mother of two children (a 13-year-old girl and an 8-year-old boy). At the age of nine years, Heba was struck with rheumatoid arthritis; since then, she has had difficulty walking, and must use either crutches or a wheelchair.

Heba received family support; most important was the unlimited support from her well-educated mother in the areas of education and training and in preparing Heba for financial independence. Heba believes that family support (particularly a mother's support) is the most important factor—in fact a prerequisite—for the integration of disabled persons in the future. Heba is most grateful for the support given to her by her own mother.

Heba's family encouraged her to attend regular (public and private) schools throughout her education. At first, her peers' reaction was negative, as she was one of only a few disabled children at her school. She attributes this initial negative reaction, which she encounters even now on various occasions, to the image that able-bodied persons have of the disabled and particularly of disabled women, and to the tendency of human beings to base their judgements of peoples' capabilities on their first impressions. At school, however, as Heba demonstrated and convinced others of her capabilities, and as her academic performance proved outstanding, her peers gradually started accepting her. During her adolescence, when she encountered emotional and social problems as a young disabled Arab woman, her mother always emphasized her

capabilities, creativity and excellent qualities, and stressed the importance of self-confidence and self-esteem. Later, she obtained a bachelor's degree in business administration from the American University in Cairo.

Heba attributes her success and achievements to her mother's support during her childhood and adolescence. She thinks that family background and the parents' level of education and social class are all important, as these factors tend to determine the value system. However, she emphasizes that a high educational level *per se* is not sufficient unless it is accompanied by "genuine understanding", as she has come into contact with so many well-educated parents who do not know how to cope with their disabled children, and who tend to perceive a disabled child as a failure.

Heba highlights the following as the major problems affecting disabled women in Egypt:

(a) Physical restrictions on mobility in public (which prevent disabled women from actively participating in daily activities) and poorly designed and maintained infrastructural facilities (public transportation, buildings, sidewalks and so on);

(b) A negative image of disabled persons, and particularly of disabled women;

(c) Marriage-related difficulties and the mythical image of the oversexed disabled woman;

(d) A negative self-image and lack of self-esteem among disabled women.

Ms. Munira Bin Hindi of Bahrain, another successful disabled woman, confirms the importance of the mother. Munira is President of the Bahrain Centre for International Mobility, a social worker/counsellor for disabled persons and their families in the Social Rehabilitation Section of the Ministry of Labour and Social Affairs, a member of the Bahrain National Committee for Disabled Persons,[71] a member of the Bahrain National Committee for the International Year of the Family (IYF), and a businesswoman.

At the age of one and a half, Munira caught poliomyelitis, and since that time has been confined to a wheelchair. She has received plenty of family support—particularly from her mother (who is illiterate) in the areas of early intervention and rehabilitation, education and training. Immediately after contracting poliomyelitis, she was sent to India for six months for physiotherapy and other training. Her father died when she was 10 years old. Munira believes that family support is the most important factor in the integration of disabled persons; she agrees that the role of the mother is of particular importance, and is most grateful for the support given to her by her own mother.

Munira's mother encouraged her to attend a regular (public) school throughout her education. At first, her peers' reaction was not very positive, as she was the only disabled child at her school. Soon, however, she distinguished herself through her outstanding academic performance, and her peers started accepting her and respecting her academic achievement and creativity; she was active not only in academic pursuits, but also in acting, poetry composition, school broadcasting, and other extracurricular activities.

Munira sometimes encountered negative attitudes from her peers and teachers, and was forced to overcome the social barriers they created. For instance, when she wanted to join Girl Scouts, her teacher told her to forget the idea, as she would not be able to fully participate in the activities and the uniform would

[71] Munira Bin Hindi is the only disabled member of the Bahrain National Committee for Disabled Persons, and is one of six females on the Committee (composed of 13 members).

not fit her. However, she insisted on her normalization, and her classmates finally supported her and helped her convince her ignorant teacher that she could manage.

Munira later completed her education, obtaining a degree in psychology from Cairo University. She has participated in a number of disability-related fellowship programmes in the United States of America, Canada, the United Kingdom of Great Britain and Northern Ireland, Austria, Egypt, Kuwait, and other countries.

At present, Munira is very active in promoting "accessibility"—namely, barrier-free architecture and transportation for disabled citizens in Bahrain—in her capacity as the President of the Bahrain Centre for International Mobility. She is working hard to get new regulations for barrier-free design passed in Bahrain.

Munira believes that it is her strong will and determination that have enabled her to achieve success in spite of her disability and gender. She encourages other disabled women to work hard at building their self-esteem and confidence: "You must have confidence in yourself before society can have confidence in you". Munira is also very pragmatic, however, she strongly believes that family wealth and financial support is a prerequisite for achievement among disabled female children in Bahrain.

Also active in her private life, Munira is currently involved in writing an autobiography, composing poems, and collecting Bahraini proverbs; for the last project, she is visiting various villages on the island with the help of her mother. She has also recently opened her own shop for women's accessories. She believes that such retail businesses are good for disabled women, as some of them have a wide range of contacts, and their friends may wish to patronize the shops.

Disabled persons are almost exclusively cared for by women in many parts of the world. Family care (for dependants) has become increasingly preferred all over the world for a number of practical and financial reasons (such as the world recession). In the countries of the ESCWA region, the great majority of family care-givers are women. Arab society takes it for granted that caring for disabled family members, children and the elderly is a family responsibility—one that falls mainly to women. However, Arab women also contribute significantly to the disability-related services provided in the public sector (rehabilitation centres, institutions, special education and so on) in both professional and supporting capacities.

IV. THE ROLE OF WOMEN IN THE FORMAL SETTING IN JORDAN AND BAHRAIN

Arab women play a significant role in the formal institutional setting for the rehabilitation and social integration of disabled persons.

VISITS OF ESCWA STAFF TO THE REHABILITATION SERVICE CENTRES, AND INTERVIEWS WITH ARAB WOMEN WORKING WITH DISABLED PERSONS

Having covered the major causes of impairment and some of the problems related to disabled women, the focus of this study now shifts to an investigation of the services provided for disabled women and to the role women play in providing "public" services. To this end, field visits were made to various facilities in two countries (Jordan and Bahrain), and some interviews with professional Arab women working in the field were carried out. The present chapter focuses on the contribution of professional Arab women within the more formal service settings, including centres affiliated with NGOs and public institutions; the role of women as care-givers in the informal setting will be discussed in detail in chapter V.

1. Services for disabled persons and the role of women in Jordan

It is worth mentioning that the person in charge of the delivery of services for disabled persons at the Ministry of Social Development in Jordan is a woman; Ms. Amal Nahas is the Director of the Ministry's Department of Special Education. Amal obtained a bachelor's degree in psychology and a master's degree in special education for mentally retarded persons at the University of Jordan, where she also completed an intensive training course for educating the deaf. After finishing her bachelor's degree, she worked as a regular schoolteacher for three years, gradually coming to the realization that some of the students enrolled in regular schools required additional assistance and a special curriculum.

Amal's current responsibilities include supervising the operation of all public special education schools and social rehabilitation centres in the country. She is also responsible for the development of programmes and budgets in accordance with the urgent needs of these facilities. Further, she provides consultative and referral services to parents of disabled children and organizes training courses and meetings for special education teachers and other professional staff.

There are a total of 30 governmental rehabilitation facilities in Jordan: 1 for the blind, 11 for the deaf, 1 for the physically handicapped, 10 for mentally retarded persons, 1 for those with multiple disabilities, 3 for other handicapped groups, and 3 for vocational rehabilitation and training. Nearly the same number of rehabilitation facilities (a total of 31) are run by non-governmental and voluntary societies, broken down as follows: 2 for the blind, 4 for the deaf, 1 for the physically handicapped, 15 for mentally retarded persons, 1 for those with multiple handicaps, 1 for other handicapped groups, and 7 for vocational rehabilitation.

Amal believes that the most serious problems confronting disabled women in Jordan parallel those faced by women in general; these include the lower priority given to girls and women by the family in all areas and aspects of life, a higher illiteracy rate, lower enrolment ratios in higher education, the lack of access to various services, and the fact that they generally receive an unequal share of benefits. She emphasized the necessity of tackling women's disability issues within the overall framework of Jordanian women's advancement and development. According to her, the social barriers created by traditional values and the lack of access to specialized services are among the major problems of disabled women in particular. She strongly believes that the concept of "independent living" should be gradually introduced and applied (in an

appropriately modified form) to the next generation of disabled women in Jordan, in a manner consistent with the country's cultural patterns and dynamic value systems. A group of disabled women living within a self-help cooperative (or a similar type of arrangement), with active community support, would constitute a good initial challenge. Another important point should be reiterated here: because the training of disabled women is given such low priority, there should be a direct incentive such as gearing the training towards immediate opportunities for income generation upon completion of the training programme in order to invite the support and cooperation of the family.

(a) Regional Centre for the Rehabilitation and Training of Blind Girls

Jordan has one governmental and two non-governmental institutions for the blind; one of the latter is the Regional Centre for the Rehabilitation and Training of Blind Girls, a facility run by a female Jordanian specialist. Ninety-five per cent of the Centre's funding is provided by the Regional Bureau of the Middle East Committee for the Affairs of the Blind (located in Riyadh), and 5 per cent by the Jordanian Government. The Centre is currently providing training and rehabilitation services for 36 blind girls and women aged 15 to 35. The head of the Centre, Ms. Hala Jawhari, was formerly employed as a teacher in Saudi Arabia; her academic background is in education and psychology. Except for the resident medical doctor, the Centre's entire staff is made up of women—including a special education teacher, a physical education teacher, four handicrafts teachers, a music teacher, a Braille teacher, a mobility trainer/maths teacher, a librarian, some nurses, and some telephone switchboard operators who are graduates of this Centre. The Centre also has boarding facilities for resident students which are run entirely by Jordanian women.

(b) Young Muslim Women's Association (YMWA) Centre for Special Education

Another NGO run by a female specialist in Amman is the YMWA Centre for Special Education. Located in a suburb of Amman, the Centre is a voluntary organization offering its services to mentally retarded boys and girls aged 3 to 18, and includes preschool, school, and vocational training sections, as well as an attached sheltered workshop. The activities of this Centre constitute a good example of parent and community involvement. Those at the Centre believe that parental involvement in the education of a child is crucial to the comprehensive development of the individual; therefore, the Centre hosts an open day for parents once a week. Parents can use the time to observe their children in the classroom and consult with teachers regarding their children's progress. Parents of the first-year preschool students and of children with severe behavioural problems are invited to attend the classes for a minimum of one day per month. The Centre has also established a parent-teacher association (PTA), which aims at providing informative programmes on issues related to the children and at organizing fund-raising activities.

The Centre provides various services to the community as well; it has, for example, participated in a literacy programme for the Bunayat area, and has organized an "open day" programme for any parents in the community who might need counselling or referral services. The Director of the Centre, Ms. Ghusoon Kareh,[72] participated in the development of *A Parent Guide to Dealing with Mentally Handicapped Children*, published under the auspices of the United Nations Children's Fund (UNICEF) and the Queen Alia Jordanian Social Welfare Fund.[73]

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[72] Ms. Ghusoon Kareh also contributed to efforts leading to the enactment of the 1993 Law on the Handicapped in Jordan.

[73] Much of this section is derived from an article entitled "YMWA marks 20 years of service to the disabled", *Jordan Times* (11 October 1994).

2. Services for disabled women and the role of women in Bahrain

First, it is worth noting that the Director of the Social Rehabilitation Section within the Ministry of Labour and Social Affairs is a woman, Ms. Hanan Kamal. Hanan is in charge of social rehabilitation for disabled persons in Bahrain, and is also the Vice-President of the Bahrain National Committee for Disabled Persons.

(a) Al-Amal School for Disabled Children of the Association for the Welfare of Children and Mothers

In Bahrain, there are a number of centres for disabled persons run by NGOs. Al-Amal School for Disabled Children of the Association for the Welfare of Children and Mothers, a voluntary association of Bahraini women located in the town of Issa, was established in 1982 (having previously been known as Al-Amal House School, founded in 1977). The change in name and focus was a direct response to the urgent need for services in the field of special education; it also reflects the importance that the Association for the Welfare of Children and Mothers attaches to providing services for disabled children. The School has units for curriculum development and research, special education, pre-vocational training, evaluation and diagnosis, and staff training. During the visit of an ESCWA staff member in 1993, the School was offering services to 131 mildly mentally retarded children (61 boys and 70 girls, 126 of them Bahraini and 5 from other Arab countries).

The School's curriculum development and research unit offers a special education curriculum which was developed in Jordan and is geared towards providing an Individually Designed Instructional Educational Programme (IDIEP) for each mildly handicapped student. The unit has also developed a Bahraini version of the American Association of Mental Deficiency Adaptive Behavior Scale for use in all special education schools. Curriculum development is supervised by the Ministry of Education.

Within the special education unit, the aforementioned curriculum is offered to mildly mentally retarded children (those within the intelligence quotient [IQ] range of 50 to 70) between the ages of 6 and 15. The pre-vocational unit conducts several training courses which are particularly geared towards girls, offering them instruction in sewing, cooking, home economics and daily living skills.

It is worth noting that the Director of this School is a woman, and that out of 14 special education teachers, 13 are women (1993 statistics). The teachers studied at the Arabian Gulf University, which offers a graduate-level programme in special education, as well as an advanced diploma programme in special education for regular teachers.

(b) The Children's Rehabilitation Home

In 1970 the Ministry of Labour and Social Affairs set up the Children's Rehabilitation Home (prior to the establishment of Al-Amal School, mentioned above. The Home provides free services for children between the ages of 6 and 17 suffering from severe mental and/or physical disabilities. Today, the Home caters to young people whose more serious disabilities preclude them from being admitted to Al-Amal School—more specifically, those who are afflicted with cerebral palsy, Down's syndrome or autism, and/or are severely mentally retarded. The Home includes a permanent residential care unit, a day-care unit and a physiotherapy unit. This is a place for severely disabled individuals where governmental services are provided free of charge; as might be expected, the facilities are not in totally satisfactory condition.

During the visit of an ESCWA staff member in 1993, the permanent residential care unit was accommodating 22 severely disabled young people (5 males and 17 females) whose families were either unable or unwilling to take care of them.

The Home also offers short-term residential care to children who need temporary shelter when their families are travelling abroad and cannot care for them properly. Day care is provided within the same unit for commuting students. During the 1993 visit, this unit was providing services for 131 students (62 girls and 69 boys). Last is the physiotherapy unit, which was providing services to 13 students during the 1993 visit; the two certified physiotherapists working there are both women.

The services provided by the Home include medical and health examinations, the treatment of illness, psychological treatment, education, rehabilitation, physiotherapy and recreation. Because of the severity of the children's disabilities, the Home employs a large staff; 52 of the 59 employees are women, including the Director of the Home and the special education teachers, physiotherapists, social workers, nurses, care-givers, secretaries and other administrative staff.[74] The few men working at the Home are either drivers or manual labourers. According to the Director, working conditions are very tough; there is a shift system, as the Home is operational 24 hours a day.

All of the Home's services are offered free of charge. However, after reaching the age limit (17), each child must leave the Home. This is problematic, as most of the graduates are too severely handicapped to join Al-Amal School's pre-vocational rehabilitation or special education unit. In concluding this subsection, it is worth noting that the role played by Bahraini women here is more "significant"; it can even be concluded that this Home is run entirely by a team of such women.

(c) Bahrain Centre for International Mobility

The Bahrain Centre for International Mobility, an NGO founded in 1979, works at removing physical barriers and facilitating the transportation and movement of disabled citizens in Bahrain. It also facilitates the participation of disabled persons in cultural exchange programmmes at the local, regional and international levels.

The Centre has an elected Board of Directors consisting of disabled members and volunteers. The Chairman of the Board and President of the Centre is a physically disabled woman, Ms. Munira Bin Hindi (the subject of case-study 5 in chapter III). According to her, there are a number of successful disabled women in the Arab region, but there are very few disabled women who are heads of organizations. Munira is also a member of the Bahrain National Committee for Disabled Persons, whose objectives and tasks include drawing up general policies for the rehabilitation of the disabled, proposing and introducing legislation, preparing studies, and implementing preventive schemes in accordance with the World Programme of Action concerning Disabled Persons after the end of the United Nations Decade of Disabled Persons (1983-1992). Within the institutional frameworks of both the Committee and the Bahrain Centre for International Mobility, Munira is working hard to promote the development and enactment of new legislation which would guarantee free access for disabled citizens and set barrier-free architectural requirements.

[74] In Bahrain, most of the care-givers who are directly responsible for disabled persons at residential centres are women; the working conditions and financial incentives may not be sufficient to attract men.

V. THE ROLE OF WOMEN IN THE INFORMAL SETTING

The role of women is very important in the areas of impairment prevention, early intervention and medical treatment, rehabilitation, and social integration. Theoretically, women should not be the only ones responsible for dealing with the challenges of disability; the care of disabled persons should be a cooperative effort shared by all members of society. However, in the Arab world, society supports the role of women as care-givers, and many women are proud of being able to assume responsibility for the care of a disabled family member. Within this context, Arab women generally end up providing the bulk of both informal and public services for disabled persons.

In the area of disability prevention, women play an extremely significant role. An impairment or disability involves costs which must be borne not only by the disabled person, but also by his or her family and community—and ultimately by the State; it therefore stands to reason that investing in prevention is the wisest course to follow. The mother's role is vital in this area. Arab women should be educated and informed about the importance of both appropriate birth spacing and physical recovery between pregnancies, and should be encouraged to breast-feed as much as possible, especially during the child's first few months. Arab women should also be made aware of the possible consequences of kinship marriage; young, unmarried women should be encouraged to assert themselves in this regard to contribute towards preventing the worst possible congenital cases. Public nurses, community-health workers and birth attendants play an essential role in primary health care programmes, as they are trained to detect a number of disorders which are curable if treated at the early stages, but which may cause permanent disability if timely intervention is not undertaken. Preventive measures should be developed within the framework of the overall development of Arab women. For instance, with regard to one of the major contributing factors to severe disability in the ESCWA region, many experimental studies have indicated that female education is more effective than male education in lowering the rates of kinship marriage. The training and education of women (especially mothers) also have a significant impact on their ability to detect symptoms. During an interview with ESCWA staff, the mother of Hala Awad said that she had noticed abnormality in her son's development six months after his birth.[75] Although a number of doctors (general practitioners) in Kuwait failed to diagnose her son's symptoms, she continued observing his abnormal movements and insisted that something was wrong; finally, a specialist concurred, and diagnosed the illness as muscular atrophy. Both Hala and her disabled brother expressed their appreciation for the support, dedication and affection given to them by their mother during their upbringing.

As mentioned repeatedly in this study, it is generally the women in the Arab world who are directly involved in the treatment, rehabilitation and care of disabled persons, whether at home or in institutions; at home, it is usually the mother, sister or daughter who cares for a disabled relative. In addition, with all of the Arab women interviewed for this study confirming that marriage is much easier for disabled Arab men, it appears quite likely that a great many single disabled women may have to take care of themselves after their parents die. Taking these circumstances into consideration, it seems appropriate to conclude that priority for training should be given to women. Community-based rehabilitation (CBR) should be encouraged, as this approach offers greater advantages in terms of both the costs involved and the utilization of available human resources.

[75] Hala's elder brother had also realized by that point that something was wrong with the boy.

Finally, it should be emphasized once again that responsibility for the disabled should be shared among all family members—supplemented by professional guidance and financial and moral support where available—so that Arab women do not have to shoulder the burden of family care alone.[76]

The following comprises those recommendations of the Regional Seminar that concern the role of the family or certain of its members.

1. The importance of the family's role in preventing childhood disability should be emphasized. Literacy and the overall development of Arab family members—especially that of women and mothers—should be encouraged, as these factors constitute prerequisites for early intervention and the prevention of disability in the region.

2. Families should keep abreast of new developments related to the treatment of disability and should make use of new methods and appropriate technologies.

3. Proper birth spacing should be practised, and very early and very late pregnancies should be avoided.

4. Breast-feeding and proper weaning practices should be encouraged, and both mothers and children should have a balanced diet.

5. Health authorities should assume responsibility for the primary health care of mothers and children, providing the necessary immunizations and appropriate pre-, peri-, and postnatal care, but also concerning themselves with the prevention and early detection of disability and early intervention. Primary health care should also be directed towards the treatment of disabling conditions and should involve careful monitoring of the validity of vaccines. It should be stressed that the family plays a significant role in ensuring the implementation of an effective primary health care programme.

6. Unhealthy or dangerous practices such as smoking, the use of drugs and alcohol, and exposure to X-rays should be avoided during pregnancy.

7. The family's role in helping a disabled child to overcome psychological barriers should be recognized.

8. Families should involve their disabled children in family and community activities.

9. Appropriate technical, moral and financial support, including family counselling, should be provided where possible to families caring for disabled members; such support should be offered from the beginning (when the disability first occurs or is first diagnosed).

10. Rehabilitation institutions and centres for disabled persons should work together with the family in order to ensure the fullest integration of disabled persons (especially women).

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[76] Separate ESCWA documents on the role of the family (particularly mothers) in caring for the disabled are also available. These include: "Women and disability: the role of the family" (E/ESCWA/SD/1994/WG.1/7); "Childhood disability: causes and role of family in prevention, early detection and rehabilitation" (E/ESCWA/SD/1994/WG.1/6); and "The role of the family and popular action associations in disability prevention, early detection and rehabilitation in Lebanon" (E/ESCWA/SD/1994/WG.1/5 [in English and Arabic]).

11. Family-support programmes should be instituted which provide short-term relief for families with disabled children.

12. Economic support should be provided by Governments to the families of disabled persons as a means of providing some relief in the home (for example, to facilitate the employment of a helper or maid).

13. Free, compulsory education should be made available for all children, including those that are disabled.

14. The family and the community should promote the integration of disabled persons in recreation programmes.

VI. CONCLUSION AND RECOMMENDATIONS

The present study finds that in most countries of the ESCWA region, women do not have access to the same resources and opportunities available to men. Many disabled Arab citizens and regional experts believe that the World Programme of Action concerning Disabled Persons failed to achieve its objectives during the United Nations Decade of Disabled Persons (1983-1992). It is widely recognized that a new set of long-term strategies is needed to sustain efforts to achieve the objectives of the World Programme of Action in the ESCWA region, particularly with respect to the more disadvantaged group—women—of the most disadvantaged population group—the disabled.

ESCWA has organized a number of forums for discussion, including the Conference on the Capabilities and Needs of Disabled Persons in the ESCWA Region (held in Amman from 20 to 28 November 1989), the Cultural Event for Disabled Persons in the ESCWA Region: An Event to Mark the End of the United Nations Decade of Disabled Persons (1983-1992) in the ESCWA Region (held in Amman on 17 and 18 October 1992), and the ESCWA Regional Seminar on the Role of the Family in Integrating Disabled Women into Society (also held in Amman, from 16 to 18 October 1994). All of these meetings singled out disabled women as the most disadvantaged group, and recognized the need to provide them with special attention. The findings of this study, which are based on available statistics and interviews, have empirically supported the recommendations of the three meetings.

The following suggestions are based on the recommendations of the above-mentioned meetings, on the results of this study, and on comments made by disabled Arab individuals and their families. The suggestions are not absolute, as they need to be adapted and modified in accordance with the conditions in each country and each community of the ESCWA region and with the rapid social and technological change in the area.

1. Disabled women in the ESCWA region have the same problems as disabled men; however, many of these difficulties are compounded for disabled women, and there are characteristics of these problems which apply only to them. Among other things, disabled Arab women's participation in education, training and employment is very limited compared with that of disabled men and able-bodied women—a circumstance which is attributable to the position of Arab women in general. The issues relating to disabled women should be dealt with within the overall framework of women's development in the Arab world. In particular, the mainstreaming of disabled Arab women in education, training and employment should be promoted.

2. Although the majority of disabled Arab women are not formally employed, a number of them are engaged in home-based or other such income-generating activities. The contributions made by disabled women in the informal sector should be recognized. Concerned institutions should develop programmes to train disabled women to perform various types of home-based income-generating tasks, and should also provide them with the necessary aid for that purpose. It is also necessary to facilitate the means for adapting the physical environment inside the home to the needs of disabled women. Finally, it is vital that disabled women be offered psychological counselling and practical training that will enable them to take better care of themselves and their children.

3. In the Arab world, disabled women face more discrimination and difficulty in marriage than do disabled men. As a substantial proportion of disabled Arab women are single, widowed or divorced, appropriate marriage counselling services should be provided for them. Further, efforts should be made to change negative public opinion regarding marriage for or to disabled women.

4. The importance of the role of women and mothers in preventing childhood disability should be emphasized; particular stress should be placed on community-based rehabilitation. The statistical data in this

study affirm that there is a significant correlation between the mother's illiteracy and the incidence of childhood disability. Literacy among Arab women and their overall development constitute prerequisites for effective disability prevention and early intervention efforts in the region. Efforts should also be made to deal with other causes of disability such as poverty, malnutrition, traffic accidents, home accidents and armed conflicts.

5. It is clear from the census data that disabled women are under-enumerated—a manifestation of prevailing negative social attitudes. Another, related problem is that the available literature on this subject is limited. Public awareness of the capabilities and needs of disabled women should be boosted, and every effort should be made to facilitate and promote their social integration. Practical efforts should concentrate on the rehabilitation of disabled women and on breaking down social barriers that stand in the way of both their active participation in economic life and their fulfilment in private and public life.

6. Kinship marriage, a prevailing practice in the ESCWA region, is a negative socio-cultural factor affecting the incidence of hereditary disability. It is important to alert the public about the dangers and possible consequences of intermarriage among close relatives. As a related issue, women's education should be given more attention, as it has been shown to have more of an impact than men's education on discouraging kinship marriage and other detrimental practices. Proper genetic counselling should also be made available to couples.

7. Arab women play a significant role in the formal setting; some rehabilitation centres are run entirely by these women. Rehabilitation in the institutional setting should be recognized as a field which can absorb many well-qualified and well-educated Arab female labour-force candidates.

8. A number of new technologies (computer-based Braille and computer synthesizers), items (large-print texts), and fields (informatics), as well as the adaptation of the physical environment (through barrier-free design), greatly enrich the lives of disabled persons and should be promoted as powerful instruments which facilitate the fullest possible integration of disabled Arabs—especially women—in daily life.

9. All national, regional and international programmes and projects for the advancement of women should be designed to accommodate the needs of disabled women as well.

Annex

DISABILITY-RELATED TABLES FOR SELECTED COUNTRIES IN THE ESCWA REGION

ANNEX TABLE 2. INDICATORS RELATED TO WOMEN AND DISABILITY IN THE ESCWA REGION

	Life expectancy for females as a percentage of males		Adult literacy rate: females as a percentage of males	Percentage of pregnant mothers immunized against tetanus		Maternal mortality rate (per 100,000)		Percentage of children underweight (0-4 years)			
								1980-1991		1980-1992*	
	1990	1992*	1990	1989-1990	1990-1992*	1980-1990	1980-1991*	Moderate/severe	Severe	Moderate/severe	Severe
Bahrain	..	..	..	..	..	..	..	..	..	..	..
Egypt	105.1	104	54	63	70	320	270	13	3	10	3
Iraq	103.1	105	70	67	45	120	120	..	..	12	2
Jordan	106.2	106	79	23	32	48	48	..	..	6	1
Kuwait	105.6	106	87	22	22	6	6	6	..	6	..
Lebanon	106.3	106	83	..	..	..	..	..	..	..	..
Oman	106.3	106	..	97	97	..	..	..	..	23	5
Qatar	..	..	..	..	..	..	..	..	..	..	..
Saudi Arabia	104.8	104	66	62	62	..	41	..	..	..	..
Syrian Arab Republic	106.3	106	65	84	63	140	140	..	..	..	..
United Arab Emirates	107.2	106	66	..	..	..	..	..	..	..	..
Yemen	102.9	102	49*	8	13	..	..	53	..	30	4

ANNEX TABLE 1. BASIC INDICATORS FOR THE ESCWA REGION

	Mortality rate for children under age 5 (per 1,000)			Infant mortality rate (per 1,000)			Total population (thousands)		GNP per capita (US dollars)		Life expectancy at birth		Adult literacy rate (percentage)		Total fertility rate (per woman)	
	1960	1990	1992*	1960	1990	1992*	1990	1992*	1989	1991*	1990	1992*	1970 M/F	1990 M/F	1990	1992*
Bahrain	208	17	16	130	14	13	516	533	6 360	7 130	71	71	..	..	..	..
Egypt	301	85	55	179	61	55	52 400	54 800	640	610	60	61	50/20	63/34	4.3	4.2
Iraq	222	86	80	139	63	64	18 900	19 300	2 340	1 500	65	66	50/18	70/49	6.1	5.7
Jordan	217	52	30	135	40	25	4 000	4 300	1 640	1 050	67	68	64/29	89/70	5.8	5.7
Kuwait	128	19	17	89	17	17	2 000	2 000	16 150	16 150	73	75	65/42	77/67	3.7	3.7
Lebanon	91	56	44	68	44	35	2 700	2 800	2 150	2 150	66	68	79/58	88/73	3.6	3.1
Oman	378	49	31	214	37	24	1 500	1 600	5 220	6 120	66	69	..	..	7.1	6.8
Qatar	239	36	33	145	29	27	368	453	15 500	14 770	69	70	..	..	..	..
Saudi Arabia	292	91	40	170	65	35	14 100	15 900	6 020	7 820	65	69	15/2	73/48	7.1	6.4
Syrian Arab Republic	217	59	40	135	44	34	12 500	13 300	980	1 160	66	67	60/20	78/51	6.5	6.2
United Arab Emirates	289	30	22	145	24	18	1 600	1 700	18 430	19 860	70	71	24/7	58/38	4.6	4.5
Yemen	378	187	177	214	114	107	11 700	12 500	650	520	51	52	14/3	47/21	7.7	7.2

Sources: United Nations Children's Fund (UNICEF), *The State of the World's Children 1992* (New York, Oxford University Press, 1992); and *UNICEF, *The State of the World's Children 1994* (New York, Oxford University Press, 1994).

ANNEX TABLE 2. *(continued)*

	Percentage of one-year-old children fully immunized against poliomyelitis			Percentage of mothers breast-feeding, 1980-1991			Percentage of children (1986-1992)* who were:			Percentage of births attended by trained health personnel		Secondary school enrolment ratios 1986-1991 (percentage)	
	1981	1989-1990	1990-1992*	3 months	6 months	12 months	Exclusively breast-fed (0-3 months)	Breast-fed with complementary food (6-9 months)	Still breast-feeding (20-23 months)	1983-1990	1983-1992*	Male	Female
Bahrain	..	..	..	..	..	..	..	..	..	..	..	..	..
Egypt	84	87	89	90	83	68	38	52	..	47	41	92	71
Iraq	16	75	64	76	45	19	..	..	..	50	50	58	37
Jordan	87	92	97	93	80	61	32	48	13	83	87	79	73
Kuwait	76	94	92	47	32	12	..	..	..	99	99	93	87
Lebanon	..	82	85	50	40	15	..	..	..	..	45	57	56
Oman	9	96	97	75	55	20	..	..	..	60	60	59	48
Qatar	..	..	...	..	..	..	..	..	..	..	..	..	..
Saudi Arabia	52	94	96	91	52	..	..	..	..	88	90	55	41
Syrian Arab Republic	14	90	89	81	72	..	..	..	..	61	61	60	43
United Arab Emirates	45	85	86	..	..	..	..	..	26	99	99	63	72
Yemen	21	53	62	74	66	34	15	51	..	12	16	47	10

Sources: United Nations Children's Fund (UNICEF), *The State of the World's Children 1992* (New York, Oxford University Press, 1992); and *UNICEF, *The State of the World's Children 1994* (New York, Oxford University Press, 1994).

ANNEX TABLE 3. PERCENTAGE OF MALES AND FEMALES CURRENTLY MARRIED IN SELECTED COUNTRIES OF THE ESCWA REGION, BY AGE GROUP AND SEX, LATEST AVAILABLE YEAR

Country	Year	Percentage currently in the age group 15-19			Percentage currently in the age group 20-24			Percentage currently in the age group 25-44			Percentage currently in the age group 45-59			Percentage currently in the 60-plus age group		
		Males	Female	Total	Males	Female	Total	Males	Female	Total	Males	Females	Total	Males	Females	Total
Bahrain	1989	0.23	5.48	2.82	8.40	35.31	21.50	69.36	61.42	65.26	93.71	71.56	82.43	85.50	36.18	63.08
Egypt	1986	3.39	16.67	9.61	17.15	58.32	36.79	79.64	85.88	82.78	94.64	68.26	81.50	85.11	28.42	57.40
Iraq	1987	5.77	19.97	12.58	27.24	53.36	39.53	78.27	82.11	80.12	94.84	77.21	86.29	88.60	50.03	68.23
Jordan	1991	0.58	8.86	4.55	11.63	39.68	24.89	74.40	81.59	77.99	98.42	82.77	90.97	92.74	47.56	72.94
Kuwait	1988	0.62	8.90	4.79	19.23	42.57	31.79	84.28	82.30	83.48	98.46	79.11	92.02	93.12	32.64	67.97
Lebanon	1970	1.01	12.91	6.82	11.76	48.44	29.72	72.65	81.20	76.95	91.41	76.33	84.08	85.67	45.08	65.69
Oman	1988-1989	3.83	36.00	20.42	37.45	83.66	63.21	80.98	75.11	78.39	93.10	73.84	84.08	83.71	29.20	61.87
Qatar	1987	3.44	14.09	8.28	25.04	58.24	35.69	78.11	83.37	79.34	95.96	75.13	91.01	92.56	34.27	70.13
Saudi Arabia	1974	5.68	40.64	21.73	31.64	78.66	51.81	79.60	89.25	84.06	90.78	69.07	81.60	82.50	27.78	58.62
Syrian Arab Republic	1981	3.77	24.55	13.85	25.14	63.50	44.05	84.13	87.54	85.83	96.65	82.52	89.83	88.55	49.56	69.70
United Arab Emirates	1987	2.18	17.39	9.87	26.13	49.30	39.23	83.32	79.12	80.93	95.33	65.91	81.08	86.21	29.12	60.21

Sources: Bahrain, Ministry of Health, *Bahrain Child Health Survey, 1989*; Egypt, Central Agency for Public Mobilization and Statistics, *Population Census, Final Results, 1986*, Population Characteristics, Total Republic; Iraq, Central Statistical Organization, *Population Census Results*, Total Republic, 1987; Jordan, Department of Statistics, *Labour-force, Unemployment, Returnees and Poverty, 1991*; Kuwait, Central Statistical Office, *Final Results of Labour-force Sample Survey, 1988*; Lebanon, Central Bureau of Statistics, *Labour-force Survey in Lebanon, Demographic Characteristics 1970*; Oman, Ministry of Health, *Oman Child Health Survey, 1988-1989*; Qatar, Central Statistical Organization, *Population and Housing Census, 1987*; Saudi Arabia, Central Department of Statistics, *General Population Census, Detailed Results*, 1974; Syrian Arab Republic, Office of the Prime Minister, Central Bureau of Statistics, *Population Census of the Syrian Arab Republic, 1981*; and the United Arab Emirates, Ministry of Health, *United Arab Emirates Child Health Survey, 1987*.

ANNEX TABLE 4. PERCENTAGE DISTRIBUTION OF THE HANDICAPPED POPULATION (10 YEARS OLD AND OVER) IN THE SYRIAN ARAB REPUBLIC, BY SEX, EDUCATIONAL ATTAINMENT AND TYPE OF HANDICAP, 1981

Table A. Percentage distribution of the handicapped male population (10 years old and over) in the Syrian Arab Republic, by educational attainment and type of handicap

Educational attainment	Blind	Deaf and mute	With one arm	Without arms	With one leg	Without legs	Paralysed	Mentally retarded	Other	Handicapped population	Total population
Illiterate	74.35	74.14	38.37	34.37	44.52	28.64	49.56	81.10	49.02	60.51	21.95
Read and write	14.03	16.09	31.44	29.01	30.05	29.95	24.74	10.71	27.79	20.96	31.52
Subtotal	**88.38**	**90.22**	**69.80**	**63.38**	**74.57**	**58.59**	**74.31**	**91.80**	**76.82**	**81.48**	**53.47**
Primary	6.44	6.63	18.10	18.03	14.79	25.37	16.52	4.88	14.83	11.56	26.35
Intermediate	2.33	1.62	6.10	5.92	4.79	7.20	5.38	1.64	4.17	3.58	9.32
Secondary	1.79	0.78	3.77	7.32	3.70	4.75	2.70	1.02	2.86	2.21	6.63
Vocat./tech. diploma	0.20	0.20	0.93	2.82	0.87	1.80	0.36	0.26	0.56	0.42	1.63
Bachelor's or master's	0.79	0.46	1.24	2.54	1.28	2.13	0.63	0.36	0.67	0.68	2.48
Doctorate	0.03	--	--	--	--	--	0.05	0.01	0.03	0.03	0.09
Subtotal	**11.59**	**9.70**	**30.14**	**36.62**	**25.43**	**41.24**	**25.65**	**8.17**	**23.13**	**18.48**	**46.50**
Not stated	0.03	0.07	0.05	--	--	0.16	0.04	0.03	0.05	0.04	0.03
Total	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**

Table B. Percentage distribution of the handicapped female population (10 years old and over) in the Syrian Arab Republic, by educational attainment and type of handicap

Educational attainment	Blind	Deaf and mute	With one arm	Without arms	With one leg	Without legs	Paralysed	Mentally retarded	Other	Handicapped population	Total population
Illiterate	87.60	85.60	65.45	62.08	71.93	53.60	74.63	90.62	75.39	80.50	54.53
Read and write	5.88	8.90	15.53	17.42	12.94	19.41	12.00	5.16	12.03	9.70	20.17
Subtotal	**93.48**	**94.49**	**80.98**	**79.49**	**84.86**	**73.01**	**86.62**	**95.78**	**87.42**	**90.20**	**74.70**
Primary	4.25	3.68	12.04	13.20	8.28	16.08	8.63	2.37	7.90	6.19	15.16
Intermediate	1.27	1.00	3.65	2.53	3.10	5.91	3.04	0.99	2.41	2.02	5.53
Secondary	0.76	0.67	2.22	2.81	2.07	2.96	1.28	0.47	1.47	1.09	2.88
Vocat./tech. diploma	0.08	0.06	0.48	0.84	0.91	0.92	0.18	0.21	0.31	0.22	1.09
University and master's	0.13	0.06	0.63	1.12	0.78	1.11	0.21	0.17	0.31	0.23	0.59
Doctorate	--	--	--	--	--	--	--	--	--	--	0.01
Subtotal	**6.50**	**5.47**	**19.02**	**20.51**	**15.14**	**26.99**	**13.33**	**4.22**	**12.40**	**9.75**	**25.27**
Not stated	0.02	0.04	--	--	--	--	0.04	--	0.18	0.05	0.03
Total	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**

ANNEX TABLE 4. *(continued)*

Table C. Percentage distribution of the total handicapped population (10 years old and over) in the Syrian Arab Republic, by educational attainment and handicap

Educational attainment	Blind	Deaf and mute	With one arm	Without arms	With one leg	Without legs	Paralysed	Mentally retarded	Other	Handicapped population	Total population
Illiterate	79.96	79.01	45.03	48.24	51.67	40.36	58.95	84.44	57.82	67.95	37.88
Read and write	10.58	13.03	27.52	23.21	25.58	25.00	19.97	8.76	22.53	16.77	25.97
Subtotal	**90.54**	**92.04**	**72.55**	**71.45**	**77.25**	**65.36**	**78.92**	**93.20**	**80.35**	**84.72**	**63.85**
Primary	5.51	5.38	16.61	15.61	13.09	21.01	13.57	4.00	12.52	9.56	20.88
Intermediate	1.88	1.36	5.50	4.22	4.35	6.60	4.51	1.41	3.58	3.00	7.47
Secondary	1.35	0.73	3.39	5.06	3.27	3.91	2.17	0.83	2.40	1.79	4.80
Vocational/ Tech. Diploma	0.15	0.14	0.82	1.83	0.88	1.39	0.29	0.24	0.48	0.35	1.36
University and master's	0.51	0.29	1.09	1.83	1.15	1.65	0.47	0.29	0.55	0.51	1.56
Doctorate	0.02	--	--	--	--	--	0.03	0.01	0.02	0.02	0.05
Subtotal	**9.43**	**7.90**	**27.41**	**28.55**	**22.75**	**34.55**	**21.04**	**6.78**	**19.55**	**15.23**	**36.12**
Not stated	0.03	0.06	0.04	--	--	0.09	0.04	0.02	0.10	0.05	0.03
Total	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**

Source: ESCWA, "Social statistics and indicators in the ESCWA region" (E/ESCWA/SD/89/8), p. 147, developed based on the United Nations, Department of International Economic and Social Affairs, Statistical Office, *Disability Statistics Data Base (1975-1986)* (New York, 1988).

ANNEX TABLE 5. THE HANDICAPPED SYRIAN POPULATION (10 YEARS OLD AND OVER): FEMALES AS A PERCENTAGE OF MALES, BY EDUCATIONAL ATTAINMENT AND TYPE OF HANDICAP, 1981

Educational attainment	Blind	Deaf and mute	With one arm	Without arms	With one leg	Without legs	Paralysed	Mentally retarded	Other	Handicapped population	Total population
Illiterate	118	115	171	181	162	187	151	112	154	132	248
Read and write	42	55	49	60	43	65	49	48	43	46	64
Subtotal	**106**	**105**	**116**	**125**	**114**	**125**	**117**	**104**	**114**	**111**	**140**
Primary	66	56	67	73	56	63	52	49	53	54	58
Intermediate	55	62	60	43	65	82	57	60	58	56	59
Secondary	42	86	59	38	56	62	47	46	51	49	43
Vocational/ Tech. diploma	40	30	52	30	105	51	50	81	55	52	67
Bachelor's or master's	16	13	51	44	61	52	33	47	46	34	24
Doctorate	--	..	..	..	..	..	--	--	--	--	11
Subtotal	**56**	**56**	**63**	**56**	**60**	**65**	**52**	**52**	**54**	**53**	**54**
Not stated	67	57	--	..	..	--	100	--	360	125	100

Source: ESCWA, "Social statistics and indicators in the ESCWA region" (E/ESCWA/SD/89/8), developed based on the United Nations, Department of International Economic and Social Affairs, Statistical Office, *Disability Statistics Data Base (1975-1986)* (New York, 1988).

Note: ".." signifies that a figure is not available mathematically because of a 0% value for males in the original table.

ANNEX TABLE 6. PERCENTAGE DISTRIBUTION OF THE HANDICAPPED BAHRAINI POPULATION (10 YEARS OLD AND OVER) BY EDUCATIONAL ATTAINMENT, TYPE OF HANDICAP AND SEX, 1981

Table A. Percentage distribution of the handicapped male Bahraini population (10 years old and over) by educational attainment and type of handicap

Educational attainment	Blind	Deaf and dumb	Deaf	Amputee	Paralysed	Mentally handicapped	Other	Handicapped population	Total population
Illiterate	87.84	65.14	65.57	68.84	63.49	73.29	60.78	73.71	21.18
Read and write	7.36	17.43	22.95	18.09	20.63	13.35	21.57	14.78	28.58
Primary	2.23	11.01	7.38	4.52	9.13	6.53	8.33	5.81	19.45
Intermediate	0.68	4.59	1.64	4.02	3.57	3.56	2.94	2.55	12.49
Secondary	0.68	1.83	1.64	3.52	3.17	2.67	3.43	2.16	12.71
Diploma	0.51	--	0.82	0.50	--	0.59	1.47	0.55	3.09
Bachelor's degree	0.34	--	--	0.50	--	--	0.98	0.28	2.12
Master's degree	0.17	--	--	--	--	--	--	0.06	0.31
Ph.D. or equivalent	--	--	--	--	--	--	--	--	0.04
Not stated	0.17	--	--	--	--	--	0.49	0.11	0.02
Total	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**

ANNEX TABLE 6. *(continued)*

Table B. Percentage distribution of handicapped female Bahraini population (10 years old and over) by educational attainment and type of handicap

Educational attainment	Blind	Deaf and dumb	Deaf	Amputee	Paralysed	Mentally handicapped	Other	Handicapped population	Total population
Illiterate	93.52	84.13	91.55	85.71	81.50	88.17	78.49	88.24	41.44
Read and write	3.89	7.94	2.82	3.17	10.00	8.88	13.98	6.68	23.79
Primary	2.38	3.17	2.82	3.17	2.50	1.18	4.30	2.50	13.41
Intermediate	0.22	4.76	2.82	1.59	3.00	1.78	1.08	1.52	8.26
Secondary	--	--	--	4.76	2.50	--	2.15	0.89	9.44
Diploma	--	--	--	--	0.50	--	--	0.09	2.24
Bachelor's degree	--	--	--	1.59	--	--	--	0.09	1.31
Master's degree	--	--	--	--	--	--	--	--	0.07
Ph.D. or equivalent	--	--	--	--	--	--	--	--	--
Not stated	--	--	--	--	--	--	--	--	0.04
Total	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**

ANNEX TABLE 6. *(continued)*

Table C. Percentage distribution of the total handicapped Bahraini population (10 years old and over) by educational attainment and type of handicap

Educational attainment	Blind	Deaf and dumb	Deaf	Amputee	Paralysed	Mentally handicapped	Other	Handicapped population	Total population
Illiterate	90.35	72.09	75.13	72.90	71.46	78.26	66.33	79.28	31.26
Read and write	5.83	13.95	15.54	14.50	15.93	11.86	19.19	11.68	26.20
Primary	2.29	8.14	5.70	4.20	6.19	4.74	7.07	4.54	16.45
Intermediate	0.48	4.65	2.07	3.44	3.32	2.96	2.36	2.15	10.38
Secondary	0.38	1.16	1.04	3.82	2.88	1.78	3.03	1.67	11.08
Diploma	0.29	--	0.52	0.38	0.22	0.40	1.01	0.38	2.67
Bachelor's degree	0.19	--	--	0.76	--	--	0.67	0.20	1.71
Master's degree	0.10	--	--	--	--	--	--	0.03	0.19
Ph.D. or equivalent	--	--	--	--	--	--	--	--	0.02
Not stated	0.10	--	--	--	--	--	0.34	0.07	0.03
Total	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**

Source: ESCWA, "Social statistics and indicators in the ESCWA region" (E/ESCWA/SD/89/8), developed based on the United Nations, Department of International Economic and Social Affairs, Statistical Office, *Disability Statistics Data Base (1975-1986)* (New York, 1988).

ANNEX TABLE 7. THE EDUCATIONAL ATTAINMENT OF THE DISABLED BAHRAINI POPULATION* (FEMALES AS A PERCENTAGE OF MALES), 1981

Educational attainment	Blind	Deaf and dumb	Deaf	Amputee	Paralysed	Mentally handicapped	Other	Handicapped population	Total population
Illiterate	106	129	140	125	128	120	129	120	196
Read and write	53	46	12	18	48	67	65	45	83
Primary	107	29	38	70	27	18	16	43	69
Intermediate	32	104	172	40	84	50	52	60	66
Secondary	--	--	--	141	79	--	63	41	74
Diploma	--	..	--	--	..	--	--	16	72
Bachelor's degree	--	..	..	318	..	..	--	32	62
Master's degree	--	..	..	..	..	..	..	--	23
Ph.D. or equivalent	..	..	..	..	..	..	..	..	--
Not stated	--	..	..	..	..	..	--	--	200

Source: ESCWA, "Social statistics and indicators in the ESCWA region" (E/ESCWA/SD/89/8), developed based on the United Nations, Department of International Economic and Social Affairs, Statistical Office, *Disability Statistics Data Base (1975-1986)* (New York, 1988).

Note: ".." signifies that a figure is not available mathematically because of a 0% value for males in the original table.

* Bahraini national only.

ANNEX TABLE 8. PERCENTAGE DISTRIBUTION OF THE HANDICAPPED EGYPTIAN POPULATION (6 YEARS OLD AND OVER) BY EMPLOYMENT/ACTIVITY STATUS, TYPE OF HANDICAP AND SEX, 1976

Table A. Percentage distribution of the handicapped male Egyptian population (6 years old and over) by employment/activity status and type of handicap

Employment/activity status	Blind	One-eyed	Deaf and mute	Deaf	Mute	Without arms	Without legs	Mentally disabled	Other	Handicapped population	Total population
Self-employed	8.82	22.13	10.91	16.21	11.30	19.53	16.42	--	9.65	12.59	12.83
Employer	3.28	9.09	3.59	6.52	3.56	11.75	4.61	--	2.90	4.90	5.48
Paid employee	10.81	49.27	46.02	47.17	39.31	45.00	37.97	0.21	55.60	36.07	39.20
Unpaid family worker	0.79	0.87	3.55	2.12	6.07	0.48	0.45	0.53	3.31	1.74	3.64
Other unpaid worker	0.01	0.03	0.02	--	0.04	--	--	--	0.02	0.02	0.02
Unemployed	1.05	0.39	1.07	0.48	1.05	0.53	1.34	--	2.06	1.02	0.23
Newly unemployed	1.67	0.55	2.51	1.37	5.06	1.05	2.37	0.53	1.87	1.60	3.39
Student	27.58	8.71	14.58	8.30	13.52	4.19	7.29	1.97	7.99	12.97	28.24
Housewife	--	--	--	--	--	--	--	--	--	--	--
Retired	--	--	--	--	--	--	--	--	--	--	0.83
Unwilling to work	--	--	--	--	--	--	--	--	--	--	2.52
Aged (elderly)	19.61	3.66	2.15	6.42	1.59	2.98	4.99	2.86	2.14	7.08	2.45
Unable to work	26.19	4.00	11.29	7.97	17.87	10.75	23.92	93.55	12.06	20.32	0.22
Not stated	0.19	1.29	4.32	3.44	0.63	3.72	0.63	0.34	2.40	1.71	0.95
Total	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**

ANNEX TABLE 8. *(continued)*

B. Percentage distribution of the handicapped female Egyptian population (6 years old and over) by employment/activity status and type of handicap

Employment/activity status	Blind	One-eyed	Deaf and mute	Deaf	Mute	Without arms	Without legs	Mentally disabled	Other	Handicapped population	Total population
Self-employed	0.21	2.08	0.60	1.07	0.59	2.91	3.42	--	4.62	1.14	0.34
Employer	0.11	0.36	0.14	0.46	0.47	1.36	--	--	0.35	0.22	0.09
Paid employee	1.13	14.28	13.24	7.29	11.70	17.28	5.13	0.06	29.69	8.41	3.84
Unpaid family worker	0.10	0.10	0.11	--	0.47	0.39	0.34	0.17	1.16	0.23	0.37
Other unpaid worker	0.02	0.02	--	--	--	--	--	--	0.04	0.01	0.01
Unemployed	0.06	0.17	0.92	0.08	0.24	--	--	--	0.18	0.19	0.04
Newly unemployed	1.46	0.60	1.55	0.92	1.42	0.58	0.51	0.62	0.88	1.17	1.93
Student	23.62	12.31	22.31	26.69	13.71	25.24	10.77	2.71	12.57	18.93	17.50
Housewife	--	--	--	--	--	--	--	--	--	--	71.25
Retired	--	--	--	--	--	--	--	--	--	--	0.03
Unwilling to work	--	--	--	--	--	--	--	--	--	--	--
Aged (elderly)	31.52	13.99	5.02	19.25	4.49	8.54	12.99	4.97	9.46	19.49	4.48
Unable to work	41.77	54.86	52.37	43.87	66.55	41.75	66.67	91.46	39.53	49.32	0.09
Not stated	0.02	1.22	3.73	0.38	0.35	1.94	0.17	--	1.52	0.88	0.02
Total	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**

Table C. Percentage distribution of the total handicapped Egyptian population (6 years old and over) by employment/activity status and type of handicap

Employment/activity status	Blind	One-eyed	Deaf and mute	Deaf	Mute	Without arms	Without legs	Mentally disabled	Other	Handicapped population	Total population
Self-employed	5.47	17.63	7.85	12.26	8.45	18.25	15.08	--	8.90	9.68	6.70
Employer	2.05	7.14	1.58	4.96	2.73	10.96	4.14	--	2.52	3.71	2.84
Paid employee	7.06	41.38	36.33	36.78	32.06	42.88	34.58	0.17	51.78	29.04	21.85
Unpaid family worker	0.52	0.69	2.52	1.57	4.58	0.48	0.44	0.45	2.99	1.35	2.04
Other unpaid worker	0.01	0.03	0.02	--	0.03	--	--	--	0.03	0.02	0.01
Unemployed	0.66	0.34	1.03	0.38	0.83	0.49	1.20	--	1.78	0.81	0.13
Newly unemployed	1.60	0.56	2.21	1.25	4.12	1.01	2.17	0.56	1.72	1.49	2.67
Student	26.06	9.59	16.96	13.11	13.82	5.81	7.65	2.14	8.66	14.48	22.97
Housewife	--	--	--	--	--	--	--	--	--	--	34.95
Retired	--	--	--	--	--	--	--	--	--	--	0.44
Unwilling to work	--	--	--	--	--	--	--	--	--	--	1.28
Aged (elderly)	24.21	5.98	3.04	9.74	2.36	3.41	5.82	3.36	3.22	10.23	3.45
Unabled to work	32.23	15.40	23.30	17.30	30.47	13.13	28.34	93.06	16.12	27.69	0.16
Not stated	0.12	1.27	4.16	2.66	0.55	3.59	0.58	0.26	2.27	1.50	0.50
Total	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**

Source: ESCWA, "Social statistics and indicators in the ESCWA region" (E/ESCWA/SD/89/8), developed based on the United Nations, Department of International Economic and Social Affairs, Statistical Office, *Disability Statistics Data Base (1975-1986)* (New York, 1988).

ANNEX TABLE 9. THE EMPLOYMENT/ACTIVITY STATUS OF DISABLED PERSONS IN EGYPT (FEMALES AS PERCENTAGE OF MALES), 1976

Employment/activity status	Blind	One-eyed	Deaf and mute	Deaf	Mute	Without arms	Without legs	Mentally disabled	Other	Handicapped population	Total population
Self-employed	2.38	9.40	5.50	6.60	5.22	14.90	20.83	..	47.88	9.05	2.65
Employer	3.35	3.96	3.90	7.06	13.20	11.57	--	..	12.07	4.49	1.64
Paid employee	10.45	28.98	28.77	15.45	29.76	38.40	13.51	28.57	53.40	23.32	9.80
Unpaid family worker	12.66	11.49	3.10	--	7.74	81.25	75.56	32.08	35.05	13.22	10.16
Other unpaid worker	200.00	66.67	--	..	1 175.00	..	..	..	200.00	50.00	50.00
Unemployed	5.71	43.59	85.98	16.67	22.86	--	--	..	8.74	18.63	17.39
Newly unemployed	87.43	109.09	61.75	67.15	28.06	55.24	21.52	116.98	47.06	73.13	56.93
Student	85.64	141.33	153.02	321.57	101.41	602.39	147.74	137.56	157.32	145.95	61.97
Housewife	..	..	..	..	..	..	..	..	..	..	..
Retired	..	..	..	..	..	..	..	..	..	..	3.61
Unwilling to work	..	..	..	..	..	..	..	..	..	..	..
Aged (elderly)	160.73	382.24	233.49	299.84	282.39	286.58	260.32	173.78	442.06	275.28	182.86
Unable to work	159.49	1 371.50	463.86	550.44	372.41	388.37	278.72	97.77	327.78	242.72	40.91
Not stated	10.53	94.57	86.34	11.05	55.56	52.15	26.98	--	63.33	51.46	2.11

Source: ESCWA, "Social statistics and indicators in the ESCWA region" (E/ESCWA/SD/89/8), developed based on the United Nations, Department of International Economic and Social Affairs, Statistical Office, *Disability Statistics Data Base (1975-1986)* (New York, 1988).

Note: ".." signifies that a figure is not available mathematically because of a 0% value for males in the original table.

ANNEX TABLE 10. PERCENTAGE DISTRIBUTION OF THE TOTAL HANDICAPPED EGYPTIAN POPULATION (15 YEARS OLD AND OVER) BY MAJOR OCCUPATIONAL GROUP, TYPE OF HANDICAP AND SEX, 1976

Table A. Percentage distribution of the handicapped male Egyptian population (15 years old and over) by major occupational group and type of handicap

Major occupational group	Blind	One-eyed	Deaf and mute	Deaf	Mute	Without arms	Without legs	Mentally disabled	Other	Total population
Professional and technical	17.43	5.99	7.48	4.43	2.83	9.37	4.06	6.86	0.11	8.42
Administrative and managerial	--	0.67	1.45	1.01	0.58	4.85	0.43	0.99	--	0.98
Clerical and related	--	4.15	10.62	4.19	1.79	3.91	5.66	5.74	0.07	3.95
Sales	3.11	7.92	4.6	6.39	3.12	0.01	9.51	6.02	--	5.52
Services	0.01	8	7.37	11	4.16	9.46	9.62	9.72	0.02	6.34
Agriculture, fishing and related	9.25	38.67	23.88	30.17	40.31	31.2	14.94	21.39	0.02	22.35
Production and related and labour	0.02	18.79	22.64	23.44	17.93	15.56	18.19	23.8	0.09	14.82
Not stated	1.69	2.05	4.48	2.66	5.84	3.03	4.49	7.46	0.14	3.56
No occupation	68.49	13.77	17.49	16.72	23.42	15.61	33.11	18.01	99.54	34.06
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**

ANNEX TABLE 10. *(continued)*

Table B. Percentage distribution of handicapped female Egyptian population (15 years old and over) by major occupational group and type of handicap

Major occupational group	Blind	One-eyed	Deaf and mute	Deaf	Mute	Without arms	Without legs	Mentally disabled	Other	Total population
Professional and technical	1.38	4.5	2.68	2.46	5.34	8.62	1.05	7.71	--	2.9
Administrative and managerial	--	0.21	0.25	0.21	1.03	1.72	--	0.66	--	0.2
Clerical and related	--	4	12.63	1.28	2.93	4.43	1.47	5.51	--	2.87
Sales	0.2	1.96	0.29	1.18	0.34	3.2	2.1	2.29	--	0.86
Services	--	3.11	2.55	3	1.55	3.69	0.42	6.08	--	1.68
Agriculture, fishing and related	0.17	2.41	1.63	1.82	2.41	5.17	0.42	2.6	--	1.18
Production and related and labour	--	1.88	2.72	2.03	3.97	2.22	4.19	5.73	--	1.53
Not stated	0.18	1.33	1.42	0.96	1.55	0.49	0.42	12.12	--	1.81
No occupation	98.07	80.59	75.83	87.04	80.86	70.44	89.94	57.29	100	86.96
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**

ANNEX TABLE 10. *(continued)*

Table C. Percentage distribution of the total handicapped population (15 years old and over) by major occupational group and type of handicap

Major occupational group	Blind	One-eyed	Deaf and mute	Deaf	Mute	Without arms	Without legs	Mentally disabled	Other	Total population
Professional and technical	11.03	5.67	6.17	4.01	3.56	9.35	3.79	0.09	7.11	3.3
Administrative and managerial	--	0.59	1.12	0.83	0.73	4.66	0.38	--	0.95	0.5
Clerical and related	--	4.12	11.21	3.53	2.06	3.97	5.37	0.05	5.74	3.2
Sales	1.96	6.63	3.45	5.21	2.4	6.75	8.83	--	5.55	2.87
Services	0.01	6.91	6.04	9.24	3.48	9.07	8.76	0.02	9.16	3.71
Agriculture, fishing and related	5.62	30.68	17.79	23.8	30.6	29.5	13.57	0.02	18.65	18.34
Production and related and labour	0.01	15.08	17.3	18.65	14.29	14.69	16.9	0.07	21.2	9.35
Not stated	1.09	1.9	3.68	2.28	4.72	2.87	4.1	0.11	8.12	2.56
No occupation	80.29	28.43	33.23	32.45	38.15	19.14	38.3	99.65	23.52	56.17
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**

Source: ESCWA, "Social statistics and indicators in the ESCWA region" (E/ESCWA/SD/89/8), developed based on the United Nations, Department of International Economic and Social Affairs, Statistical Office, *Disability Statistics Data Base (1975-1986)* (New York, 1988).

ANNEX TABLE 11. DISTRIBUTION OF MAJOR OCCUPATIONAL GROUPS OF DISABLED PERSONS IN EGYPT (FEMALES AS A PERCENTAGE OF MALES), 1976

Major occupational group	Blind	One-eyed	Deaf and mute	Deaf	Mute	Without legs	Without arms	Mentally disabled	Other	Total population
Professional and technical	8	75	36	56	189	92	26	112	--	34
Administrative and managerial	..	31	17	21	178	35	--	67	..	20
Clerical and related	..	96	119	31	164	113	26	96	--	73
Sales	6	25	6	18	11	46	22	38	..	16
Services	--	39	35	27	37	39	4	63	--	26
Agriculture, fishing and related	2	6	7	6	6	17	3	12	--	5
Production and related and labour	--	10	12	9	22	14	23	24	--	10
Not stated	11	65	32	36	27	16	9	162	--	51
No occupation	143	585	434	521	345	451	272	318	100	255

Source: ESCWA, "Social statistics and indicators in the ESCWA region" (E/ESCWA/SD/89/8), developed based on the United Nations, Department of International Economic and Social Affairs, Statistical Office, *Disability Statistics Data Base (1975-1986)* (New York, 1988).

Note: ".." signifies that a figure is not available mathematically because of a 0% value for males in the original table.

ANNEX TABLE 12. PERCENTAGE DISTRIBUTION OF THE HANDICAPPED POPULATION (13 YEARS OLD AND OVER) IN JORDAN (EAST BANK), BY MARITAL STATUS, TYPE OF HANDICAP AND SEX, 1983

Table A. Percentage distribution of the handicapped male population (13 years old and over) in Jordan (East Bank), by marital status and type of handicap

Marital status	Visual	Deaf and mute	Physical	Mental	Multiple	Total
Single	29.42	67.07	45.96	87.35	69.53	59.26
Married	63.11	30.67	50.20	9.93	25.15	36.69
Divorced	1.22	0.40	0.69	2.06	0.44	0.98
Widowed	6.25	1.87	3.16	0.66	4.88	3.07

Table B. Percentage distribution of the handicapped female population (13 years old and over) in Jordan (East Bank), by marital status and type of handicap

Marital status	Visual	Deaf and mute	Physical	Mental	Multiple	Total
Single	37.39	73.20	54.13	82.58	64.36	62.17
Married	25.00	14.93	21.30	6.82	9.94	16.31
Divorced	1.83	3.24	2.44	6.63	2.76	3.36
Widowed	35.78	8.63	22.12	3.98	22.93	18.17

Table C. Percentage distribution of the handicapped male population (13 years old and over) in Jordan (East Bank), by marital status and type of handicap

Marital status	Visual	Deaf and mute	Physical	Mental	Multiple	Total
Single	32.60	69.68	48.65	85.77	67.73	60.30
Married	47.89	23.97	40.66	8.90	19.85	29.37
Divorced	1.47	1.61	1.27	3.57	1.25	1.83
Widowed	18.04	4.75	9.42	1.76	11.18	8.49

Source: ESCWA, "Social statistics and indicators in the ESCWA region" (E/ESCWA/SD/89/8), developed based on the United Nations, Department of International Economic and Social Affairs, Statistical Office, *Disability Statistics Data Base (1975-1986)* (New York, 1988).

ANNEX TABLE 13. DISTRIBUTION OF THE HANDICAPPED POPULATION IN JORDAN (EAST BANK): FEMALES AS A PERCENTAGE OF MALES, BY MARITAL STATUS AND TYPE OF HANDICAP

Marital status	Visual	Deaf and mute	Physical	Mental	Multiple	Total
Single	127	109	118	95	93	105
Married	40	49	42	69	40	44
Divorced	150	810	354	322	627	343
Widowed	572	461	700	603	470	592

Source: ESCWA, "Social statistics and indicators in the ESCWA region" (E/ESCWA/SD/89/8), developed based on the United Nations, Department of International Economic and Social Affairs, Statistical Office, *Disability Statistics Data Base (1975-1986)* (New York, 1988).

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