



SINTEF Health Research

Address:
NO-7465 Trondheim/
P.O.Box 124, Blindern, NO-0314 Oslo,
NORWAY

Telephone:
+47 40 00 25 90 (Oslo and Trondheim)
Fax:
+47 22 06 79 09 (Oslo)
+47 930 70 500 (Trondheim)

Enterprise No.: NO 948 007 029 MVA

SINTEF REPORT

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This is my life - Living with a disability in Yemen

A qualitative study

AUTHOR(S)

Lisbet Grut and Benedicte Ingstad

CLIENT(S)

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ABSTRACT

This report is a contribution towards describing the lives of people with disabilities in Yemen. The report is a result of field work conducted during two weeks of May, 2006, on behalf of the World Bank. A family perspective is necessary to understand the questions of disability in a culture where social and cultural life is family based. Disabled people and their families faces many challenges in a country like Yemen. Families with a disabled family member have to reorganize their resources of time, labour capacity and capital in order to meet the new challenges that the care for a disabled member places upon them. The families risk falling out of the social and economic relations within which they understand themselves and there is a risk of losing access to the resources that are necessary to manage as a family group. As they have difficulties in performing the income generating tasks that are considered normal in their community there are very few job opportunities for disabled people. Disabled children almost as a rule do not go to school. Even when the parents care about sending a disabled child to school, the schools do not necessarily accept the child because of inaccessible buildings, lack of adapted teaching materials, unqualified teachers, and lack of transport to and from school. There is an absence of a developed and locally adapted health care system. Health care services are centralised and institution-based and practically inaccessible to the rural population - in Yemen a majority of the people. This field work has shown a need for actions on several levels to secure disabled people's equal access to public services and to participate in the social and communal life.

KEYWORDS	ENGLISH	NORWEGIAN
GROUP 1	Living conditions	Levekår
GROUP 2	Disability	Funksjonshemming
SELECTED BY AUTHOR	Poverty	Fattigdom

Preface

This report is a contribution towards describing the lives of people with disabilities in Yemen. The report is a result of field work conducted during two weeks of May, 2006. The work was done on behalf of the World Bank and we hope that this report will contribute to the work of improving the living conditions for people with disabilities in Yemen. We also hope it will be useful for actors in Yemen, whether governmental authorities or NGOs working for the benefit of people with disabilities.

Many people have contributed to this report:

Ms. Afrah Alawi Al-Ahmadi, responsible for disability issues at the World Bank office in Yemen, for answering all our questions and facilitating the field work in an excellent way, for providing background information on Yemen, and especially for contributing to chapter three “Country background”.

Our team members: Dr. Mahdi Nasser and Dr. Arwa Baider. Mahdi for doing the preparatory work for the field visit and for participating in the field work as well as for providing background information on Yemen on statistics and the situation for disabled people. Arwa for participating in the field work at very short notice, and particularly for her generosity and hospitality by opening her home to us.

The local professionals in the areas we visited. Without their cooperation in identifying and recruiting informants we could not have completed this study within the time limits we had.

Mr. Peter Coleridge for giving valuable comments during the writing on the content and the language.

But most of all we would like to underline our thankfulness to our informants, the people themselves, who opened their homes to us and shared their everyday life with us.

A satellite picture of Yemen which shows the mountain range along the coast in the west and south with the desert area behind:



Map showing the cities, illustrating that most of the population lives in the mountains:



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1 Abbreviations

CBR	Community Based Rehabilitation
CSO	Central Statistical Organisation
DF	Disability Fund
DPO	Disabled People's Organisation
ICF	International Classification of Functioning
MoE	Ministry of Education
MoPHP	Ministry of Public Health & Population
MoSAL	Ministry of Social Affairs and Labor
NGO	Non-Governmental Organisation
PRS	Poverty Reduction Strategy
SFD	Social Fund for Development
SWF	Social Welfare Fund
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organisation
YER	Yemen Rial

2 Introduction

2.1 The Problem

The objective of this study as formulated by the World Bank is to gain more knowledge on how human functioning affects people's living conditions. People's functioning levels vary significantly, whether in relation to physical and intellectual capabilities, sensory abilities (hearing and vision), or the impact of mental health. There is a growing awareness of the necessity to account for these differences in order to secure the effectiveness of programmes designed to promote economic and social well-being.

When individuals with different levels of functioning encounter barriers to health services, education, employment, public services, and infrastructure, they are disabled. That is, disabled in the sense that their ability to participate in economic activities and lift themselves from poverty suffers. Disability is thus to be understood as an interaction between human functioning and an environment which does not account for different levels of functioning. In other words, people with physical or mental limitations are often disabled not so much because of their functioning level, but because they do not have access to education, labour markets, and public services. This exclusion leads to poverty, and in a vicious circle, poverty can lead to more disability by making people more vulnerable to malnutrition, disease, and unsafe living and working conditions.

The effects of disability go beyond those with functional impairments themselves as this report will demonstrate. Family members must often absorb extra responsibilities that inhibit their participation in the economic and social life of their communities. And of course, the less productive any citizen is, the less economic growth is possible.

Unfortunately, due to limited research in this area, we do not have good knowledge of the relationship between poverty and disability. At present there is a growing effort to obtain quantitative data that can provide prevalence estimates and general links between poverty and disability. However, there is scant information on the dynamics of how the presence of impairments affects the economic and social life of disabled people in developing countries. A qualitative study could thus provide us with important information on the daily reality of the lives led by disabled people, and how their functional status interacts with the physical and policy environments they face.

Based on this background, the purpose of this study has been to uncover the key barriers – e.g. cultural factors, inaccessible infrastructure, lack of resources – that prevent people with various mental, physical, and sensory impairments from participating in the economic and social lives of their communities.

2.2 The team participants

The field work was carried out by Dr. Benedicte Ingstad, Professor of Medical Anthropology at the University of Oslo, and Lisbet Grut sociologist and Senior Researcher at SINTEF Health Research, in cooperation with Dr. Mahdi Nasser, medical doctor and consultant at Interaction, Yemen, and Dr. Arwa Baider, paediatrician at the University Hospital and director of Child Health Directorate at the Ministry of Health and the National Coordinator of IMCI (Integrated Management of Childhood Illness, American Red Cross).

2.3 The Governorates visited for the field work

The field work was carried out in Yemen. The team visited three Governorates: Sana'a, Dhamar and Aden.

In the capital city Sana'a we visited 4 zones:

- Asser and Madhbah on the outskirts
- Hassabah and Misaik in the city

The city of Dhamar and surroundings:

- The Old city
- A village near Dhamar: Rakhamah

Aden governorate:

- The main towns in Aden governorate:
 - Sheikh Othman and Memdarah
 - Khor Makser,
 - Crater
 - Mansourah
- Two villages near Aden:
 - Bir Ahmed – an agricultural area
 - Khaisah – a fishing village

Governmental organizations visited:

1. Ministry of Social Affairs - Disabled Care and Rehabilitation Fund
2. Ministry of Education - Inclusive Education Directorate
3. Supreme National Committee for Disabled Care
4. Social Fund for Development

NGOs (Non Governmental Organisations) and Centres visited:

1. Al Noor Association of Blind girls, Sana'a
2. The Challenge Association of Disabled Girls, Sana'a
3. Yemeni Association of Physically Disabled, Sana'a
4. Vocational Training Centre for People with Special Needs, Aden

3 Concepts and methods

The concepts of disability and poverty are core concepts to this study. The concepts are open to interpretation and can be perceived in different ways. It is important to be aware that the understanding and application of the concepts can vary from one socio-cultural context to another (Whyte and Ingstad 1998).

3.1 Disability as limitation of functioning and participation

The concept of disability has in the past twenty years developed from a medical model focusing on the individual's impairment to a social model of functioning and participation, focusing on limitations in activities and restrictions in social participation. One has seen a shift in terminology and an increasing tendency towards viewing the disability as a complex process involving a number of different elements at individual and societal level.

A recent model of disability is WHO's Classification of Functioning, Disability and Health: ICF - The Model of Functioning¹. According to ICF disability arises when an individual's ability to do daily activities, carry out social roles and participate in communal activities that are considered normal or common by the individual and the community, is limited or hindered because of a bodily, sensory, mental and/or intellectual reduced function and environmental barriers.

Within this model understanding disability is to understand both the individual and the social consequences of the impairment. The interaction between the individual and his/her environment in the wide sense of the word is in focus, taking physical, personal, social and environmental aspects into consideration. Thus, to understand disability it is necessary to focus not only on the individual but also on the family and/or the social group within which the individual co-exists, and how the individual, the family and the society functions and copes within their particular social and cultural setting. Within the Model of Functioning both the individual and the environment is in focus.

However, the ICF-model is sometimes criticised for being too individualistic and for placing too heavy a focus on the individual's limitations (Oliver 1993, Yeo and Moore 2003 among others); it does not direct the focus of understanding towards the society's exclusion mechanisms against people with certain bodily, sensory, mental and/or intellectual qualifications (Barnes 1999). To understand the full consequences of a disability one should consider that both the medical model (which focuses on the impairment) and the social model are relevant.

The ICF-model is designed to be culturally neutral and applicable in cross-cultural connections. The question is, is such neutrality possible, and does this make the model too general? Because disability is a social construct, the perception of 'normality' and 'disability' has a cultural dimension. The personal, practical and social consequences of impairment will differ depending on factors such as gender, economic and social class, culture, caste and remoteness. Different kinds of impairments are understood differently and will have different consequences in different cultures. The perception of, for example, blindness or whether the impairment is congenital or acquired later in life, will vary according to different cultural circumstances.

3.2 Poverty - a multidimensional concept

The understanding of poverty as well as international policy for alleviating poverty has broadened during the last decades. Development thinking has moved toward a new paradigm characterized by broader and better integrated understanding of development (Wolfensohn & Bourguignon 2004). The understanding of poverty has changed from a narrow focus on income and consumption to cover education, health, social and political participation, security and freedom, environmental quality, and lately also social justice and human rights (Wolfensohn & Bourguignon 2004). Clearly this has led to increased interest in micro-level decisions and instruments and measures intended to improve poor peoples' access to food, shelter, education, and health care. Furthermore, focus has been directed towards improving service delivery to poor people and to ensure increased influence on important decisions affecting their lives.

Understanding poverty requires a focus on peoples' living conditions in a comprehensive way. The concept of poverty as well as the concept of living conditions is complex and multi-dimensional. The understanding of living conditions have developed from a relatively narrow economic and material definition to a concern with human capabilities and how individuals utilise their capabilities. An individual's level of living is defined not so much by his or her economic possessions, as by the ability to exercise choice and to affect the course of his or her life (Loeb and Eide 2004). Similarly the perspective on poverty has developed from a focus on the economy and material welfare in a narrow sense, to include human capabilities and how individuals utilize these capabilities. The World Bank Report *Attacking Poverty* (2000) focuses on opportunity, empowerment and security as key words in understanding poverty. Poverty arises when the individual is being deprived of the necessities of material well-being and the denial of the opportunities for living a tolerable life.

Poverty is affected by many aspects in the individual's life:

- Lack of income/subsistence and material welfare.
- Lack of basic needs such as food, clothing and housing.
- Lack of health and access to health services.
- Lack of education and occupational training.
- Lack of capability - seen as the opportunity to achieve acceptable levels of basic functioning.
- Lack of opportunity to participate and/or decide in organisational and political matters.
- Lack of knowledge about civil rights
- Lack of participation in leisure and community activities.
- Lack of experience of respect and self-respect.

In other words poverty arises when the individual is deprived of the opportunity to lead a healthy life, does not enjoy a decent standard of living, is not able to participate in social and political life and/or lacks respect and self-respect. Connecting poverty to deprivation involves comparing living conditions to a defined standard or way of living. It would be necessary to consider both global standards (for instance standards set by the UN: 'people surviving on less than one US dollar a day') and local standards held by the individual's community and society.

3.3 The relationship between disability and poverty

Although there is a close linkage between poverty and disability, little research has been carried out into analysing the mechanisms behind this relationship (Elwan 1999). An abundance of literature has shown living conditions among individuals with disabilities in high-income countries to be low compared with non-disabled. While less focus has been on this relationship in

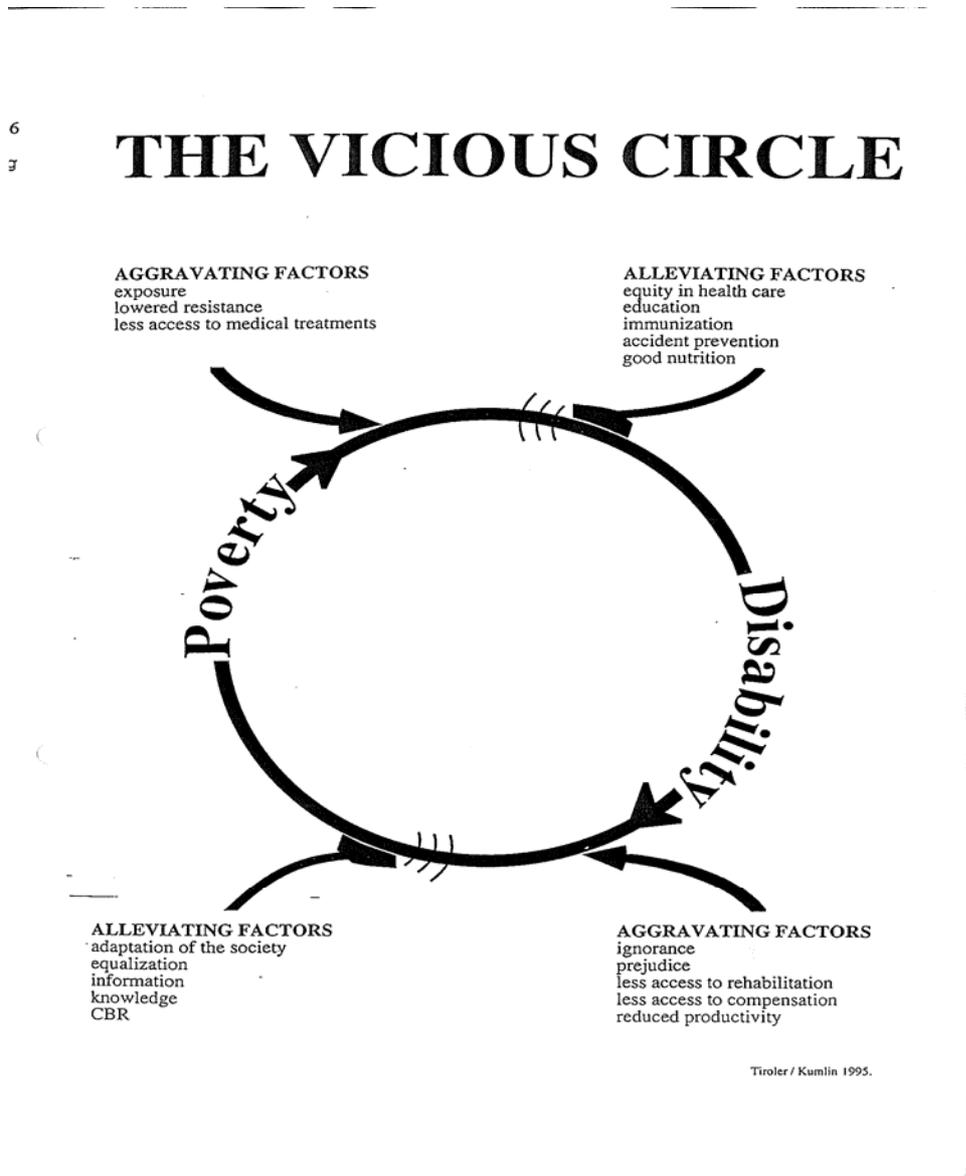
low-income countries, a few recent studies and reviews have documented the same pattern also in Africa in particular (Eide, van Rooy & Loeb 2003; Loeb & Eide 2004).

The relationship between disability and poverty is bi-directional as poverty often leads to disability and disability often leads to poverty (Yeo and Moore, 2003). Even though disability does not necessarily cause poverty, and poverty does not necessarily cause disability, the relationship is strong. There is scant information on the dynamics of how the presence of impairments affects the economic and social life of people as well as how poverty affects the occurrence of disability in developing countries; however, there is sufficient knowledge to conclude that people with disabilities are at risk of being and remaining among the poorest. At an individual level the relationship depends on the social and economic circumstances under which the individual is living. Among the most prevailing exclusion mechanisms are low education or illiteracy; unemployment and limitation in social contacts; exclusion from political and legal processes; low priority for access to limited resources such as food, clean water and land; lack of support for high costs associated with the impairment. (Elwan 1999, Yeo and Moore 2003)

Lack of bodily and/or mental functioning may deprive the individual of access to income and subsistence, education and social participation. In this way people with impairments are hindered in obtaining a good living standard, or may be deprived of an already achieved standard of living. Among the environmental conditions connected to poverty causing disability are: lack of access to proper nutrition; lack of necessary health care and medication; absence of sanitary installations; contamination of the air, soil and drinking water.

The relationship between disability and poverty is complex, as this figure by Tiroler/Kumlin (1995) illustrates. The bi-directional connection between disability and poverty traps people in a vicious circle as a poor living standard leads to (untreated) sickness or impairment, which leads to disability, which again leads to exclusion from education, job opportunities, social and political participation.

Figure 1: 'The vicious circle of poverty'



3.4 Methodology

The study was undertaken in line with a manual of qualitative methodology in studies of the relationship between disability and poverty, developed by Ingstad and Grut (2005).

The research questions founding the basis in this study call for a qualitative methodological approach. A qualitative approach is likely to be chosen when the focus involves an interpretive approach in which the aim is to understand and interpret the meaning the different experiences have to the individuals. The intention of a qualitative approach is to develop a fuller understanding of the phenomenon and to enlighten or revise the analytical point of departure of a study. Further, a qualitative study gives access to people's own experiences and may give access to the meaning they place upon these. It offers a method to enlighten people's experiences, their view of the different aspects in their lives, and how a phenomenon arises. In addition a qualitative study could be useful if the phenomenon is sensitive and delicate and therefore difficult to investigate. (Wadel 1973, Denzin and Lincoln 1994, Ryen 2002) In this matter confidence and respect are important factors in the relation between the interviewer and the informant. A qualitative approach involves more or less structured conversations, collecting data which is verbal or metaphorical. This implies an interactive approach as communication between interviewer and informant is fundamental.

Our focus was the everyday life and family life of disabled people in Yemen. This required a glimpse of people's private lives. Because of this we considered a qualitative approach to be appropriate. It was vital that the informants trusted us and that they liked to talk about themselves. It was important for us to be sensitive to the informants' responses on the themes and topics we introduced. We let the informant's associations dominate the interview situation but at the same time we had to see to that the conversation covered the topics and themes we had listed in the interview guide. At the opening of the interviews we introduced ourselves to the informants by name and who we represented, and explained the purpose of the study. The informants were informed that participation was voluntary and that they had the right to be anonymous and a right to choose not to answer or talk about particular subjects. They were also informed that they had a right to withdraw from the interview at any time.

In qualitative studies the type and size of the sample will usually be based on existing knowledge of the research topic and knowledge of the place where one wishes to collect information. The size of the sample is often difficult to assess at the onset of the study and very often one must reconsider both the number and the types of informants during the data collection depending on the information gained in the interviews. The sampling is strategic. That is, one must try to pick informants that are most likely to have much information to share on the topics in question and represent a wide variety of life situations as possible. (Miles and Huberman 1993, Kvale 1997)

The identification of the informant was undertaken by local partners with first hand knowledge of Yemen: the two participants of the team in co-operation with health and social workers in the areas visited. They cooperated with local personnel who worked with either disability issues or with health and social issues. These personnel knew the communities well, and even if they did not necessarily direct services to the informants they were aware of them and their situation. They addressed our request for an interview on behalf of us. They were asked to identify informants in different life situations considering variables such as gender, age, type of disability, family situation, social and cultural setting. The sample as a whole should reflect these different variables.

We conducted all in all 28 interviews. Some of the interviews were with one informant, others were done in families with more than one disabled family member. In these families we talked about the situation for all the family members. We visited an institution for disabled girls and did a group interview there. The participants in the group interview were young girls, most of them with a physical impairment, but some were hearing impaired siblings with both brothers and sisters staying at the orphanage.

The sample consisted of 38 individuals or groups:

Children: 15

Adults: Women: 8

Men: 12

Group interview: 1

DPOs with services: 2

The sample covers different kinds (and different degrees) of impairments: physical, visual, hearing and intellectual. When interviewing persons with intellectual impairment, the person with the impairment was present but the interview was mostly done with the mother and/or father.

We visited three centres that provide services for people with disabilities. At one centre we did individual interviews, at the other ones we were shown around by the manager or by someone from the staff.

3.5 Constraints of sample and method

The field visit was limited in some ways. Our visit to Yemen was restricted to 12 days and this meant we could not visit every governorate in Yemen. It must be considered a possible bias that some areas were omitted from the study. Some areas were for various reasons difficult to visit. We had to choose accessible places and at the same time obtain as complete data as possible. We could not interview every person in each area visited but had to pick a sample that could give us information covering as many relevant aspects of the research questions as possible. Due to the limitation in time we chose not to visit the more remote places.

As we were dependent on local assistance to identify informants, we had to choose places with organisations working for the benefit of people with disabilities. This implies a possible bias in only reaching people benefiting from these activities and services. Thus, it was a risk of not meeting the really poor ones - those who do not benefit from any kind of assistance. On the other hand we discovered that many of the informants, even if they were known by the organisations, did not benefit from any services and were not informed of the possibilities of assistance and every informant told a story about impairment leading to economic and social challenges for themselves and the family. Most of the informants belonged to the so called lower layer of the population, and many, but not everyone, could be considered to belong to the poorest of the poor.

When identifying informants the facilitators looked for people they considered severely challenged by the impairment; this may have led to a somewhat higher number of families with hereditary conditions and more than one impaired family member in the sample.

One group of disabled people this study does not include is mentally ill people. We do not know why we did not meet families with mentally ill members. A possible reason could be that mentally ill people are not seen as disabled people. However, there is reason to believe that mentally sick people are among the most vulnerable ones in Yemen as in many other countries.

4 Country background

4.1 Yemen - the country and the people

Yemen is located in the south-west corner of the Arabian Peninsula bordering the Arabian Sea, the Gulf of Aden, the Red Sea, the south of Saudi Arabia and the west of Oman. Today's Republic of Yemen was established with the merging of the former North and South Yemen in 1990. The former North Yemen became independent of the Ottoman Empire in 1918. The British, who had set up a Protectorate in the hinterland of the southern port of Aden in the 19th century, withdrew in 1967 from what became South Yemen. Three years later, the southern government adopted a Marxist orientation. The two countries were formally unified as the Republic of Yemen in 1990. The total population is about 20 million (2004 census). The capital city Sana'a with about 1,7478,000 citizens (2004 census- preliminary report) lies on a highland plain 2286 meters above sea level in the former North Yemen. The country is divided into 21 governorates each composed of several districts. Among the most populated are Ibb, Ta'iz, and Hudeidah governorates.

The language spoken is Arabic. The religion is Islam. In addition, there are very small numbers of Jews, Christians and Hindus. The population is mainly Arab, but there are also minorities of Afro-Arab and South Asian origin. There was, prior to the establishment of Israel in 1948, a Jewish community, but most have left since that date. The few Europeans are not indigenous and occupy positions in commerce and aid and development.

The climate is extremely hot in the desert interior in the east, mostly hot and humid along the west coast, and temperate in the western mountains. Yemen is for the most part a very mountainous country. Going from west and south to east a relatively small strip of tropical and partly desert-like climate turns into a very mountainous landscape with deep fertile valleys; highland plantations where crops are grown in terraces (between 1600 and 2700 metres) and high peaks with the highest mountain Nabi Shuayb at 3760 metres. In some places, like around Sana'a, there are mountain plateaus at an elevation of around 2000 metres and towards the east it becomes more desert like again. It is very beautiful, but for the most part a very difficult country for a person with a disability to move around in as the topography makes accessibility extremely challenging. The many villages and towns are scattered throughout the steep and rocky highlands and coastal regions. In the highlands, small villages cling to the top of mountains. Historically this provided security and made the villages inaccessible to enemies. It also left the hillsides free for terraced cultivation. At the same time this settlement pattern makes mobility, travel and transportation very problematic.

Yemen is facing rapid urbanisation and a growing economy, but is still rated as the poorest country in the Arab world and one of the poorest nations in the world. Based on estimates from 2003, the 2005 Human Development Report ranks Yemen at 151 out of 177 with a GDP of \$889 per capita. (UNDP Human Development Report 2005). The annual percentage increase in industrial production is estimated at 3 % (2003), with some small-scale production of textiles, food processing and handicraft. (<http://en.wikipedia.org>).

Historically Yemenis have been dependent on subsistence sedentary agriculture. Estimates from the 2004 census state that 75 % of the population lives in rural areas, scattered in over 110,000 populated areas and the main source of income is agriculture and herding. Services, construction, industry, and commerce account for less than one-fourth of the labor force (CIA-The World

Factbook) Lack of infrastructure poses a big problem for the people living scattered in the mountains.

Women are traditionally secluded even though there has been some change over the last few years. There are women in key positions and women with higher education. (The Labour Bill provides opportunities and equal rights without discrimination because of gender, age, race, colour, religion and language. The General Election Bill grants women full rights to candidacy in elections. The Education bill grants girls full access to free education.)

A major factor that influences the lives of women is a cultural tradition based on gender segregation. This places a woman in a subordinate position regarding her participation as well as her control over important aspects of her life such as reproduction. The traditional patterns of fertility characterised by early, many, close and late pregnancies and deliveries impact on a woman's health status, as well as her social opportunities, and the opportunity to develop her potentials. Recent data indicated a fertility rate of 6.2 (Yemen Family Health survey 2003). The fertility rate ranges among the highest in the world and the region. Although infant mortality is high the annual population growth rate is high (of 3.02 according to the 2004 census).

Table 1 summarises the main socio-demographic indicators and references:

Indicator	Value	Source
Total residential population	19,721,643	Yemen 2004 census
Median age of the total population	16.5 y.	WB Factbook of Yemen, 2005
Population under 15 years	46,5 %	WB Factbook of Yemen, 2005
Population 65 years and over	2,7 %	WB Factbook of Yemen, 2005
Birth rate	43/1000	WB Factbook of Yemen, 2005
Life expectancy at birth (years)	60.6	UNDP, Human Development Index, 2005
Total fertility rate	6.2	Yemen Family health survey, 2003
Family size	7.1	Yemen 2004 Census
Population annually growth rate	3,02 %	Yemen 2004 Census
Infant mortality rate	75/1000	Yemen Family health survey, 2003
Under five mortality rate	102/1000	Yemen Family health survey, 2003
Maternal mortality rate	570*	2000 WHO
Literacy rate 10+ years	50 %	MOE, Education Report 2004
Literacy among females:	30%	MOE, Education Report 2004
Literacy among males:	71 %	MOE, Education Report 2004
GDP per capita (USD)	565	UNDP-human development index, 2005
Population with access to safe drinking water	36%	WHO, Country profile, Yemen, 2005
Population with adequate excreta disposal	41%	WHO, Country profile, Yemen, 2005
Health services coverage	50%	WHO, country profile, Yemen, 2005
Population under poverty line	16%	UNDP-human development index, 2005

* Per 100000 live births.

4.2 Governmental policies

Yemen does not have a disability strategy but is planning to developing one with support from the World Bank. There is a **disability law** that guarantees rights to access social services and employment opportunities, but this is not enforced according to our informants. Under the law (61/1999) 'Concerning the care and rehabilitation of disabled persons' disabled people are accorded all the rights due to them under the constitution. The law allocates responsibility for this sector to the Ministry of Social Affairs and Labor (MoSAL) and to the Disability Fund (DF).

MoSAL is enjoined to coordinate and cooperate with all other relevant bodies offering services to disabled people. The law makes provision for the rehabilitation of disabled people and for the employment of disabled people according to their abilities under the relevant ministries. The law implies that disabled people should be integrated into tertiary education where possible. However, there is no mention of disabled people in the *Education for All* strategy document dealing with basic (i.e. primary) education. (Coleridge 2004). Both government institutions, corporations and private sectors are required to employ at least five percent of qualified disabled personnel according to the law (Law no 19/1991 and 5/1995).

The government has established a National Council for disability with a coordination and policy enforcement mandate, but this council is not operative according to some of our informants.

The **Social Fund for Development (SFD)** is an autonomous governmental institution established in 1997 as a main component of the Social Safety Net. The SFD's mandate is to respond directly to local communities' needs for social services (e.g. health, education, rural roads, water, microfinance), following a demand-driven approach through which local communities compete for SFD funds. The SFD has expanded its programmes and has developed a special programme to target vulnerable groups in society that may not have the capabilities to compete for its resources, especially the extremely poor, and seeks to reduce poverty by improving living conditions and providing income generating opportunities.

SFD's policy is to encourage community driven development by responding to local demands. In many cases SFD initiates and encourages local NGOs to take action. SFD has compiled a database of social, economic, and population indicators in order to address issues related to income, poverty and living conditions. Because of lack of information on disability magnitude in the country, SFD has agreed with the Central Statistical Organisation to include questions on disability in the 2004 Census. The database is maintained by SFD and is shared with other organisations working on development. SFD's aim is to contribute to implementation of services and improving the quality of services by funding equipment, training of supervisors and teachers, and school transport for children with disabilities.

People with disabilities are one of the groups targeted in addition to children at risk (orphans, street children, children in conflict with the law, children of imprisoned women, children engaged in child labour), women at risk (women in prison and women coming out of prison) and the socially marginalised (e.g. people in psychiatric hospitals, isolated elderly people, returnees living in shanty dwellings) (www.sfd-yemen.org).

The disability programme works with MoSAL, NGOs, and DPOs. Although SFD has a key role in supporting the disability agenda in Yemen, disability is not the focus of this institution as it represents only about 2% of SFD's expenditures. However, the SFD plays a key role in mobilizing national organizations responsible for disabled people towards establishing and implementing a national disability strategy. The first steps in this regard consist in analyzing the disability situation and thereafter developing some concrete guidelines to be followed by SFD in its interventions to meet the needs of disabled people. MoSAL is asking the World Bank for support for SFD-facilitation and funds to develop the national disability strategy. The role of the World Bank with SFD is to be one of a number of donors funding SFD (through credits to the government of Yemen). The World Bank has been involved extensively in providing SFD with technical support.

There is a **Disability Fund (DF)** under Ministry of Social Affairs and Labor (MoSAL) established by the government. The responsibilities of the DF are (Law 2/2002):

1. To provide funds to support projects for the rehabilitation of disabled people.
2. To coordinate with and support the other funds involved in provision of a safety net for vulnerable people with a particular focus on disabled people.

The DF has public financing to provide financial assistance to people with disabilities for health care, education, and assistive devices (e.g. hearing aid, artificial limbs, medications). The financial resources of the DF fluctuate as they come from taxes, mainly through cigarettes and flight tickets. DF is active but is considered to have weak capacity which makes it biased to the urban population. DF does not operate a micro-credit scheme. Students can apply for a scholarship to cover accommodation, food and transport. The DF carries out need assessments and is available for disabled men, women and children. However, men take the largest portion of the benefits. The DF does not do outreach activities but supports other NGOs.

There is also a Social Welfare Fund (SWF), also under MoSAL, which is a cash transfer mechanism for poor groups in society including: poor women headed household, people with disability, orphans etc. The very needy (whether disabled or not) can get a monthly allowance to survive through the SWF. This is available to anyone who applies for monthly payments. However, very few know about the possibility and individual payments are very limited (1000 YER/month, or about \$5). This fund is now going through a reform and is considering whether to shift into conditional cash transfer.

In addition to these funds the MoSAL has a **Disability Directorate**. The mandate of this directorate is to support NGOs/DPOs initiatives, build their capacity, supervise public centres that provide services to disabled people in collaboration with DPOs. In the past they implemented a CBR-programme with support from international NGOs (among the most influential was the Swedish Rädna Barnen (Save the Children)). The programme was unsustainable and stopped with the withdraw of the NGOs. The capacity of the Directorate is weak as it has no financial resources.

The government's **Poverty Reduction Strategy (PRS)** identifies disability under the Social Protection issues. The PRS tackles the needs of disabled people from three sides: training of persons with disabilities in vocational training centre (covering 5,430 persons according to SFD, 2005), absorption of disabled persons in the formal educational system (covering 5,430 persons, SFD 2005), provision of job opportunities for disabled people (covering 4,190 persons, SFD 2005). However what the PRS has in terms of a plan unfortunately seems to be cut and pasted from SFD annual reports and annual plans.

4.3 Disabled People's Organisations

During the last few years, several disabled peoples' organisations (DPOs) have been established. Among the more than 80 NGOs and governmental organisations that address disability issues, only a few of them are actively involved in service provision for disabled people, and that with an exclusively urban focus (SFD Disability Guide 2005). What services should be provided, how, by whom and which beneficiaries among each disability category are questions that have no clear answers in the available services. Moreover, most of these centres are not well staffed, lack disabled access and face severe shortages in human and financial resources. Some of them do promotions and have a recruitment policy, but most of them do not. In general goals and strategies are poorly developed. With scarce resources they reach only a minority of the people in need of services. Post-training follow up of disabled graduates is not done.

4.4 Health and health care

The health care system in Yemen delivers services at 3 levels; primary, secondary and tertiary levels. The primary level is peripheral and combines Health Units. Secondary level is a first referral level and includes the rural, district and governorate hospitals. The tertiary level is referred to the central and educational hospitals and specialized ones. Health services cover only half of the population with clear urban/rural discrepancy: health services cover 80% of urban population compared to only 25% of rural population which represents 75% of the country population. According to our informants many of the health care facilities do not function well because of shortage of staff, lack of equipment and/or medical supply. Because the health care seeker needs to travel long distances in order to reach the public health facilities, transportation cost and rough roads are some of the access barriers in addition to unaffordable costs of health services. Therefore, rural dwellers and poor people are most likely to underutilise health services.

Modern maternity care is poorly developed. Difficult topography, low accessibility to health services, lack of female health workers, lack of awareness and knowledge and a high illiteracy rate are among the most commonly identified reasons for low coverage. Most childbirths occur at home and are usually not attended by a trained birth attendant. As an example, neonatal tetanus (death risk between 70 - 100 %) is still a risk for newborn babies in Yemen due to unhygienic delivery practices and is considered the cause of 20.3 % of all neonatal deaths. According to WHO estimates more than 3000 cases occur annually in Yemen. (UNICEF, WHO, UNFPA Maternal and neonatal tetanus elimination by the year 2005: Strategies for achieving and sustaining elimination. UNICEF Publication 2000). About 35 % of the population are considered under nourished and 45 % of the children underweight (UNA Norway 2006).

Yemen still has incidents of polio. The consequences for the individual are various degrees of paralysis. Globally a total of 1,831 cases of wild polio virus were registered in 2005 in a total of 16 countries (WHO). Yemen was the second after Nigeria, with 478 new incidents:

1. 727 Nigeria (endemic)
2. 478 Yemen (importation)
3. 299 Indonesia (importation)
4. 154 Somalia (importation)

Malaria and HIV/AIDS are two of the most devastating global health problems of our time. Together, they cause more than 4 million deaths a year. Malaria accounts for more than a million deaths each year, of which over 80% occur in tropical Africa, where malaria is the leading cause of mortality in children under five years of age. The HIV/AIDS epidemic claimed 3.1 million (2.8–3.6 million) lives in 2005, more than half a million (570 000) were children.. Both are diseases of poverty, and both are causes of poverty. To a considerable extent, both are concentrated in the same geographical regions. Children who have suffered episodes of severe malaria are at risk of developmental impairments. In Yemen malaria is a problem especially in the coastal areas; however HIV/AIDS prevalence in Yemen is not known but is expected to be low. (WHO 2004 and 2006)

4.5 Disability prevalence in Yemen

There is uncertainty about the prevalence of disability in Yemen as for many other poor countries. Coleridge (2004) mentions several reasons for lack of reliable disability statistics:

- The institutions targeting people with disabilities have limited technical and administrative capacity.

- Centres for people with disabilities are concentrated in the capital cities of some governorates.
- Rural and scattered communities that are hard to reach makes it difficult to visit every community or household.
- High illiteracy rates make it difficult to do surveys where people need to read and/or write.
- There is a suspected tendency to under-report disabled girls and women partly for fear of damaging marriage prospects of siblings and partly due to gender 'blindness'.
- It is suspected that families tend to hide the mentally disabled family members regardless the sex. Several cases in psychiatric hospitals are hospitalised for years without being visited by their families. It is not rare to see the mentally disabled in the streets (homeless) both in urban and rural settings. Such cases (hospitalised and homeless disabled) are not asked about in household surveys.
- Having a disabled family member may be considered shameful.
- The general problem of defining 'disability' makes the identification difficult.

The Yemen Family and Health Survey 2003 included questions on disability¹. (MoPHP 2003) An average of 2.9 % had problems that prevented them from practicing their daily activities, more in rural areas than urban (3.1 - 1.9), more prevalent among males than females (3.3 - 2.3).

The 2004 census (by the Central Statistical Organisation (CSO)) included questions on disability. This was based on request and finance from SFD who analysed that data according to disability distribution by governorate and district, types of disability by gender, reasons of disability at country level. According to SFD the main causes for disabilities among adults are:

- Accidents
- Injuries
- Participation in hard manual labour such as constructions
- Infections, diseases and epidemics.

Data on children with disabilities are scarce but according to a Family Health Survey in 2003 most of the disabled children are exposed to the impairment during their first five years of life.

Different estimates have suggested a disability prevalence ranging from 0.4 % to 12 %. Estimates from the 2004 census indicate that there are about 380,000 (1.9 % of the population) people with disabilities in Yemen. In a 2005 survey, the Disability Fund registered 33,000 females with disabilities (both adults and girls). According to informal estimates by our informants at the Disability Fund there are about 15,000 new incidents of permanent impairment in Yemen each year due to traffic accidents. Unfortunately we have not been able to confirm these figures.

In the recent years local surveys have indicated different prevalence rates:

- A house to house survey in Crater, Aden, (1999) indicated a rate of 6.2 % people with disabilities under 18 years (MoSAL and Rädde Barnen, Sweden).
- A house to house survey in Ta'iz and Lahej (1994) indicated a rate of 1.4 % and 1.7 % under 18 years (Mansour).

Yemen is in line with many African countries where the disability prevalence rate has been reported to be well under 5 %. This is far below the rates observed in some western countries, where it sometimes is indicated to be more than 15 % (Loeb and Eide 2004). A low prevalence

¹ All interviewed household members were asked if they had "any physical or mental state or any health condition that has lasted or expected to last for six months or more which limits one's ability to practice any daily life in a normal way compared to another person of the same age."

rate does not justify complacency about disability neither Yemen nor in other poor countries. On the contrary, it can be a sign of low survival rates which in turn are an indication of poor health care and other serious poverty factors (Coleridge 2004).

Several factors may explain low prevalence:

- In low income countries/developing countries there is a tendency to relate disability to visible impairments. In this context many impairments (e.g. learning disabilities and rheumatism) will not necessarily tend to be considered as impairments leading to disabilities.
- As the concept of disability is normative and often attached to a certain stigma there will be a tendency not to report some kinds of impairments. For the same reason one should expect a tendency to deny the presence of some impairments.
- Mortality, especially infant mortality, is in general higher in low income countries than in high income countries where people with severe impairments will tend to have a longer life expectancy.
- The accessibility and quality in diagnostics and treatment is poorer in low income countries than in high income countries.
- Different social structures will place different kinds of demand upon people. Thus a modern and/or urban society will demand other types of qualifications than a traditional and/or rural society.

In Yemen, people live in family groups and one family member's destiny is likely to affect the situation of the rest of the family. The presence of a disabled family member will therefore affect the whole family, thus the number of people affected by the disability is much larger than the prevalence data might indicate. Because of this it could be useful to focus upon the number of families with a disabled family member as well as the number of individuals with a disability. The 2004 census included questions on type of disability. This was based on request and finance from SFD; the CSO conducted the census. The SFD analysed the raw data and delivered tables on disability distribution by governorate and district, types of disability by gender, reasons of disability at country level.

Table 2: Types of disability as registered by the 2004 census raw data and analysed by SFD (%):

	Country	Governorates visited for our study		
		Sana'a city	Dhamar	Aden
Total Disabled (N)	379,822	24,676	27,527	10,517
Disabled % among population:	1.9	1.4	1.5	1.8
Type of disability:				
Sight	0.5	16.3	16.3	17.1
Hearing	14.3	9.9	10.6	8.7
Speech	14.6	5.4	3.9	4.7
Both Hearing and speech	4.7	5.0	4.0	4.3
Walking	6.8	23	22.6	24.7
Body mobility	21.4	7.5	7.4	7.1
Difficulty in catching	4.1	5.5	5.7	3.1
Mental	4.7	17.8	13.9	18.9
Multiple	10.8	14.1	15.8	13.5
Not identified	19.3	1.2	0.4	0.8

4.6 Education and training

Illiteracy is a severe challenge in Yemen, especially the high rate among females (about twice as high as among males). Estimates from the World Bank indicate that 87 % of the poor people in Yemen are illiterate or do not complete primary school. Girls are more likely not to attend school at all or they drop out earlier than boys. Especially in the rural areas parents do not send the girls to school. A major factor that may influence girls' enrolment in schools is the low expectancy about the possibility of employment for educated women; education is not generally seen as an investment in a girl's future or in increasing her ability to contribute to the household. Especially in rural areas education does not necessarily increase a girl's attractiveness as a potential wife. Parents tend to consider a daughter useful at home where she will assist in housekeeping, care giving and work on the family farm instead of spending time in school.

Primary education is still not compulsory. Schools are in theory free, but parents have to pay for transport, clothing and school materials, which many claim they cannot afford. In the last few years, girls' participation in education has increased dramatically. However, it is still far below global norms. The number of children enrolled in primary education was about 70 % (88 % for boys and 51 % for girls) in 2000. The schools are characterized by under-qualified teachers and over-crowded classrooms. Because of this, many children drop out before completing primary school. The graduation rate for primary school was 22 % in 2000. (Education for All, strategy document, undated, MoE).

Not every village has a local school and children may have to walk long distances to reach school. Transport facilities are available in the cities but are seen as too expensive by poor people. School transport for children with disabilities is theoretically free but, where it exists, few know about this opportunity.

There is a severe lack of skilled teachers in general. In some cases the classes consist of as many as one hundred children. Teachers with special needs skills are very few.

Within this picture there are signs of a major effort to improve the education both when it comes to the National Budget (increase of 3 % in ten years according to 'Education for all' Strategy document, MoE) and the number of students enrolled in primary school (however, it is higher for boys than for girls).

There are signs of a will for inclusive education as a principle by the Ministry of Education, - evident in the strategy document Education for All (Coleridge 2004). However, there is no information available on the actual rate of children with disabilities enrolled in ordinary local schools ('inclusive education'). Estimates from SFD suggest about 5000 children with disabilities are integrated in ordinary schools in the main cities.

Special schools for children with disabilities exist only in the cities and they are few. To some degree, the SFD finances provision of vehicles for transportation to some schools attended by children with special needs as well as to some schools with integrated children. This assistance only reaches a small proportion of those who need it (only urban schools).

In the institutions for disabled people education is limited to the basic level without extending to higher educational levels. There are institutions offering training in handicrafts. These are limited to one single craft or a few skills that do not correspond to the needs of the job market. (General Information on Disability Work in Yemen, SFD 2005)

5 The field work

5.1 Religion and the meaning of disability

Yemen is a Muslim country and religion plays a large part in people's lives. It organizes the day into five prayer times and it gives meaning to everything that happens in life, such as having a disabled child or becoming disabled oneself. People in Yemen strongly believe that everything that happens to them or their loved ones is because of God and that he will help them and give them the strength to cope with any problem and that they will be rewarded for being patient with what they get. The Quran has a verse that says “great and good things will happen to enduring people”.

Disabled persons are considered to be vulnerable and looking after them and being kind to them is a religious duty which people will also be rewarded for. Teasing people with disabilities is forbidden. There is a story in the Quran about a blind man who called on the prophet but the prophet was busy and did not pay him much attention. The blind man went away unhappy and that made God angry. There is also a saying that one is blind when his heart is blind, not his eyes. There are many examples in our sample of how religion plays a role in giving meaning to a life with a disability/disabled child:

A family that already had a girl with a visual impairment one day found an abandoned newborn baby on their doorstep. They took the child in and kept it as their own. The fact that the child turned out to have hydrocephalus, cerebral palsy and had become somewhat intellectually impaired (because they could not afford an operation) made no difference. According to the father: "God gave this responsibility to us, we have never even thought about not taking him into our family. God put mercy in our hearts".

While this seemed to be the most prevalent attitude within families with disabled members there was however, as in many areas of life, often a gap between learning and practice especially when it came to people outside the family. Many of our informants told us that it was a common occurrence for people with disabilities to be teased and even have thrown stones at them. Several parents therefore chose to keep their disabled children at home and away from school. One mother had complained to one of the teachers, but was told that “*they are just children and nothing can be done about it*”. We were told by one informant that the interaction between children in school is generally rough, which may easily lead to teasing and violent behaviour. All the same, for a child with a disability such experiences are particularly painful and may lead to withdrawal from other children, and in the long run a feeling of being worth less than others.

Amar, 17 years old and deaf, finds it very painful when other people express negative attitudes towards him and his deaf friends when they speak sign language on the street. He can feel people staring at them and that makes him angry. His dream for the future is to work with electricity or to be a photocopier - professions that do not entail speaking to customers. He is looking for a job, but no one wants to hire him because of the communication problems.

Fear of ridicule or mistreatment may also keep disabled individuals and their families from seeking help from family members outside the immediate family. Such is the case of a teenage girl, who is deaf in one ear and a slow learner, and her divorced mother. They live under very

poor conditions but the mother is afraid of moving back to her own parents because she thinks they may mistreat the disabled girl. She says she cannot bear the thought of anyone causing harm to her children. Many of the parents we met kept their children from meeting strangers in order to protect them from negative reactions. These children were either mentally handicapped and unable to protect themselves, or had CP resulting in involuntary and uncoordinated movement or polio resulting in limping. The girls at the orphanage we visited preferred to spend most of the day inside the house in each other's company. The reason they gave was that strangers call them names and shout at them when they go out to walk the streets, which is embarrassing and wounding.

5.2 Gender relations

One of the main pillars around which the Yemeni society is organised is the segregation of men and women. There is also a strong emphasis on beauty and bodily fitness for both men and women. Thus an impairment which affects the beauty and working ability of a woman is seen as an impediment to marriage (see below). Similarly, men with an impairment may risk being considered inferior. Two disabled men (one blind and one in a wheelchair) explained that they did not like to visit their home villages because there they were seen and treated as lesser men even though one of them is the only one in his village with a higher education (he is a lawyer).

After puberty, men and women are only allowed to see those of the opposite sex with whom marriage is unthinkable, i.e. siblings, parents and children. Outside the house most women dress in long black cloaks and black veils that cover everything but the eyes. Thus men and women move in separate spheres; the women's sphere is public seclusion, and private closeness and unveiled companionship with other women at home. The man's sphere is being seen in public with an emphasis on strength and manliness. Thus, the fact that disabled girls and women often spend a large part of their lives inside the house is partly a function of the tradition of female seclusion, partly because of protection and partly because they have no tasks outside the home and therefore no reason to go out. But if they do go out, then it is necessary to be accompanied by a male relative (*mahram*). Consider the differences in life situation between these two cases:

A young woman, dependent on a wheelchair because of polio in her youth, lives with her parents and two other adult siblings who are also disabled. Since she has no particular assignments outside the household she says that she only gets out twice a year when her brother takes her to festivals. When asked why she does not go to the day-centre for disabled people like her older disabled sister, we are told that the bus stops a bit too far from the house (due to bad roads), and her father and brother do not want to get up early enough to take her there. There was no point, according to the father.

A young man has quite severe Cerebral Palsy which affects his arms, legs and to some extent his speech but not his ability to understand and communicate. The family has arranged to have three beds for him; one in the living room where he can spend the time with the family as well as sleep at night, one in the yard outside the house so he can be with them when they work or just sit outside, and one outside the fence where he can communicate with neighbours and passers by. One married sister has a paid job in Aden and a car, and once in a while she comes and picks him up and takes him to her house for a couple of days.

It would be wrong to deduce from this that this disabled woman is "hidden" in the house. Obviously her existence is well known by neighbours and relatives outside the immediate household. However, the custom of gender segregation combined with the constraints of the

physical surroundings and a somewhat unconcerned father makes her situation far worse than that of the man with a much more extensive disability.

Even in marriage this segregation is upheld: the bride and groom celebrate separate weddings with their gender-mates and same-sex family members. Only on the last day of the wedding are they allowed to see each other. Thus any relationship before marriage is highly unlikely. In practice, adult men (besides his sisters and mother) are only allowed to see, unveiled, the women they are married to.

What was striking with the interviews we did was the fact that none of the disabled women (or parents of disabled girls) seemed to have even considered the possibility of being married and the question about this released spontaneous laughter among the young physically disabled women at the orphanage we visited. They said it was something which they had not considered at all. One young woman, in a wheelchair due to polio, said jokingly that she would marry if they could find a rich man for her - one who could afford to keep a maid. Her sister, also a polio victim, said that a man who was even more disabled than her had proposed to her father to marry her. She had refused however, and said: *“He is even more disabled than I am and does not have a job. What would we live on? It is not enough to like each other.”* Disabled men on the other hand, seem to expect marriage and preferably to a non-disabled woman regardless of how severe their impairment is. This is also the expectation of parents for their disabled sons. We asked a young non-disabled woman who was married to a disabled man if she had been in any way hesitant to do so. Her answer was that he would be able to give her children which would be the main thing in her life anyway so she did not mind.

Even though disabled girls are not considered marriageable it must be remembered that not being a candidate for marriage has given some of them a freedom which most other girls of their social class do not have: the freedom to get an education and pursue a career if helped by an organisation, or in some cases also a by a concerned father.

Divorce seems to be relatively easy to obtain for both men and women, provided the bride price is returned to the man's family. Separated women usually move back to their father's household. We did however see a few examples, as in the case mentioned above, where separated women managed the care for a disabled child alone, if possible with the help of their older unmarried daughter(s). Interviews with young girls from the orphanage for physically disabled girls showed however that many of them came from broken homes. Thus in a situation of divorce the disabled child, and in particularly the girls, seem to be vulnerable, especially if the mother remarries. As one of the girls in the orphanage said: *“First I was kicked out by my father, then by my mother and then told to go by my grandmother.”* She feels unwanted by her family and prefers to live in the institution among her disabled friends.

Segregation of the sexes is an issue in all parts of community life, as illustrated by the situation of Mahmud, 17 and mentally handicapped. Two years ago his mother took him to a centre that teaches illiterate adults. But after a short while the teacher, who is female, rejected him because she did not teach male students. The mother is very sad about this, because he was beginning to learn for the first time in his life: *“He is a child inside and a man on the outside.”*

5.3 The household

At marriage the wife moves to the household of the husband's family. In well-off families space is often created by adding a new floor to the paternal house. In poor families however, marriages of several sons may make the small houses very crowded especially if there are daughters who do not get married and move out. Reasons for this may be a disability or that a daughter is kept from

marriage by the parents in order to remain at home and help with the task of caring for a disabled family member. This is quite a common way for the families with disabled members to solve the need for care. Thus the disability does not only affect the impaired person, but also the sister/daughter. Two case stories may illustrate different outcomes of such a solution:

A married woman who already had several children gave birth to an obviously brain damaged baby girl. Immediately after the birth, her younger sister took over the baby and raised her as her own. The disabled girl is now four years old and has severe cerebral palsy, epilepsy and mental impairment. The aunt says she expects to remain unmarried to take care of the girl, whom she loves as her own, for the rest of her life. She does not seem to mind this solution. They live in the home of her parents while the biological mother lives with her husband in his family's house.

A family has three disabled boys with an undiagnosed muscular disease. One son with a similar condition died some time ago when he was not able to move away from a lorry fast enough and was run over. The father is weak from diabetes and a heart condition. The mother is the only one with an income from selling qat, however the 3 boys get 1000 YER a month (about \$5) from the disability fund. At Ramadan, the community donates a little money to them. They also receive a little charity from a rich man. A non-disabled young daughter is taking care of the whole family and doing all the housework. She went to school for 5 years but quit. The father says there is no possibility for her to marry since she has to remain home and take care of them all.

It is useful to analyse the situation of the families from the perspective of a “disabled family” (Ingstad 1997). When an impairment occurs in a family, whether from birth or by accident later in life, the family has to reorganise their resources of labour, time and capital in order to meet the new needs. Thus in this way we may say that the whole family becomes disabled, and therefore rehabilitation of the disabled individual should also be concerned with the family unit. In some cases the best help a “disabled family” may get could be for the (non-disabled) household member to get a job. There seems to be a tendency for the non-disabled boys to leave school early in order to contribute to the family's income. We see from the cases above how poor Yemeni families, with no money to hire help, have few other ways of meeting the new demands on their time and working capacity but to keep adult daughters from continuing school and/or getting married and involving them as life-time carers for disabled family members.

Amin is 14 years old, hyperactive and may be hearing impaired. Amin is totally dependent on his daily rituals. Life has to be very regular otherwise he becomes aggressive. The whole family is involved in caring for Amin. To keep him calm, the father comes home in the lunch break every day and takes him for a ride on the moped. He repeats the same procedure every afternoon. His mother and an elder sister have the main responsibility for him during the day. Amin needs help to dress, wash himself and eat. The two younger sisters take their turn as well. Amin's aunt comes every now and then to take him for a walk so that the family can get some rest.

To acquire a disability as an adult is especially painful for a woman who thereafter is no longer able to fulfil her duties as a woman and a housewife:

Noha is a woman in her fifties who is married as a second wife and has 10 children, four boys and six girls. The husband has a small business which they live from. About a year before we met her, she had been run over by a truck and had one leg amputated at the hip

after numerous infections and hospitalisations. She sits in a wheelchair and has not tried to use crutches (which she has got) or get a prosthesis for walking. She never goes out but spends her day in the family's common-room which is nice and has a big window. She has to be carried down to her original quarters which are half way down in the basement. Her household duties have been taken over by a young daughter who as a consequence is not likely to be married off. Noha is very depressed and cried throughout most of our interview. She says her heart has died (meaning she is not interested in anything) and that she herself only wants to die. She feels useless, her husband has lost all interest and concern for her and the first wife does not want her to occupy the common room as much as she does these days. Noha has a sewing machine but says she only knows how to mend clothes. With some training in sewing perhaps her life could be made more meaningful to her. But there is no such training around and it is quite unlikely that anyone in the family will take it upon themselves to bring her to a training centre in Sana'a.

In this case we see that though Noha's household duties are taken care of and she still has small children who love and depend on her, it is not enough for her to feel accepted and worthy as a woman. The fact that she feels that her husband rejects her (because of her destroyed body), and that the co-wife is unsupportive, is an added pain to the physical phantom pains she has to live with daily.

We also met people with disabilities that did not live in large family households. In these cases the break-down of (or physical distance to) the supportive family network was part of the reason for living in poverty. The forced return of Yemeni families from Gulf countries after the first Gulf war was one example. Some of these families had only weak family networks remaining in Yemen, and with a person with a disability to care for they easily ended up alone. In other cases they preferred to live on their own for various reasons as in the families below:

Ahmed is in his forties and has been blind since the age of two when he got a high fever. His parents believe this was caused by the evil eye from an old woman in the village but he does not think so himself. He is married to a seeing woman and they have six children. They live alone as a nuclear family in a rented house. Neither he nor his wife have got a job. He says he has never considered the possibility even though he has finished basic education at the school for the blind. They live from the support they get from his father and brother who run a farm up-north. Although he struggles to pay the house rent, he says he prefers to live in town because it is easier to move around, and he has other blind friends from the years at the school for the blind. In the village he feels he is considered a lesser man because of his disability. He says he cannot consider a life without blindness: "This is my life, I do not want to be normal. This is my usual life".

Hani is in her sixties. She is physically disabled and uses a wheelchair. She lives with one of her two sons under very poor conditions in a very small room (about 20 sq.m.). This son is married but his wife refused to take care of his mother and moved back to her family. The other son works at a farm. He supports them by providing food and some money from time to time. It seems that her main income comes from begging, and this is the reason why she and her son remain in Sana'a and rent a room in a relatively expensive area. There are many rich people living in this area.

These two cases demonstrate two of the main reasons for some disabled Yemeni people living in smaller households, the social reason and the economic reason. To beg is considered shameful in Yemeni society but at the same time it is considered a religious duty to give to the needy. Thus

begging may give an income worth sacrificing other ways of life for – as in the case of Hani and her son.

Since marriage often take place between close-cousins, moving to the husband's family house does not mean moving to strangers, but to people one is related to and has known throughout life. The genetic implications of (close) cousin marriages are discussed among medical specialists, but is not a big public issue in Yemen. We met several families where the disabling condition was frequently seen in the family (blindness, deafness and muscular dystrophy), but they did not seem to be aware of the fact that cousin marriages might increase the risk considerably. As for other types of knowledge about disability issues there seemed to be a mixture of traditional and more modern belief. Older people we talked to would sometimes give "the evil eye" as an explanation for the impairment, while younger ones tended to rely mostly on the understanding they had got from talking to modern medical doctors.

5.4 Rural and urban life

A majority of the people in Yemen live in villages scattered in the mountains. Village life in the rural areas is based on agriculture which produces both cash crops such as qat² and crops for home consumption. The household duties are the women's responsibility, but both men and women work in the fields. Since services (especially health care and schools) are most developed in the towns, few people have access to these services in the rural areas. Long distances and transport costs make these services inaccessible for the majority.

A father of six small children used to work in a stone quarry and used to be a respected man in the village. Probably due to his work he suffered from thrombosis in both legs with amputation as a result. Similar symptoms have started to develop in his hands as well. As a result of the amputation he has phantom pains and is not able to move around any more. He has no assistive devices such as crutches or a wheelchair. The family has no income and survives on charity from the villagers. We asked him if he had heard of the possibility to get financial support from the Social Welfare Funds or the Disability Foundation, which he has. But no one is willing to take him the long way to Sana'a to apply for the grant, so this opportunity is out of the question.

To apply for financial support one has to go to the offices in the city to fill in the forms and get the necessary signatures. One needs to go to the office several times during the applications process which can take up to two years with several visits to the office. This means a long way to travel for the people living in the rural and sometimes remote areas.

A father in a village outside Dhamar had been striving to raise money from the Disability Fund to pay for hospital treatment for one of his sons. He worked for three years to get the application through. Finally he got a reply saying that he had to wait till the boy got older. He has given up the application process because it is too demanding.

² Qat is a leaf from the Catha Edulis tree and is cultivated in the highlands between 1600 and 2700 m. Qat is said to have an amphetamine-like effect followed by a quiet mood. Qat chewing has become common by all sections of society, both men and women. It is not an exaggeration to say that all men participate in the qat chewing every after noon. The long term consequences is debated. There are different opinions in Yemen whether qat is considered positive or negative to the Yemen society. Much land is devoted for its production as qat is many times more profitable than for instance coffee production. Relevant to the question of poverty is that qat costs money and that chewing qat severely reduces people's productivity.

Not every village has a school and children in small distant villages will have to walk long distances to get to the school. Transport facilities, if available, cost money and most families can not afford this. A disabled child is therefore not likely to be sent to school if the child is not able to get there by itself. The families we met had hesitated to send their disabled children away to boarding school even when the boarding school is free. For some families, then, the solution was to leave the village and settle in the city. We met families in Sana'a who had moved from the village – and thus left the daily life within the extended family – because they wish for help for their disabled children.

A father who used to work as a carpenter in the city passed from time to time a centre for children with disabilities without giving it further thought. As it happened, some of his sons developed a muscular disease, and he remembered this centre and realized that the only possibility for his children was for the whole family to leave the village and move to the city. In this way the children could get day care at the centre and at the same time be taken care of within the family.

There are boarding institutions for disabled children, and we visited two of them; one for blind girls and one for girls with physical impairments and hearing impairment. Many of the girls at the institutions came from remote areas but some came from areas near by as well. Some of them told us that sending them to this institution was the best option the parents could give. Others however, seemed to be depressed from the feeling that the family had abandoned them. The contact with the family had almost ceased and they considered the institution their new home and the others there as their new family group.

Some of the parents kept their disabled child from playing with other children outside the family. The reason for this, we were told, was the desire to protect the child. One mother mentioned that she was afraid for her child to be kidnapped, without wanting to give further reason for this worry. But this was not always a problem in rural areas where the community life is transparent and children with disabilities could socialize with the others. The parents there told us that the village neighbours were kind to the children because everyone in the village knew each other well. If the child had stopped going out of the house to play with other children, the disability was given as the reason for this.

The father of a boy with a muscular disease told us that the boy used to play with the other children in the village, but had stopped as he became incapable of going out. Gradually he had lost the energy to play with other children. On the other hand no one visited him and the father told us the boy was lonely.

The mother of Mahmud, a mentally handicapped young boy, told us he liked to play with the children in the village. The other children as well as the adult neighbours treated him well. Because of this he moved freely around in the village and had a social life. On the other hand he was not always treated well by strangers. Because of this the mother did not allow him to go far from the neighbourhood or to talk to strangers.

Also adults can prefer to spend most of the time at home because of the disability:

Nasser lives in the city. He is blind due to measles as a child. He tells us that children call him names when he goes out, but he does not care even if it hurts his feelings. He says to them "May God forgive you". He goes to the shop and to the mosque to pray and he communicates with neighbours and knows them all, but most of the time he does not go out because of epileptic fits, for which he has no medication.

In some respects it seems that the close community life in the village sometimes makes life easier for a family with a disabled family member than the life in the city. But village life has challenges of its own. Accessibility to resources such as water, firewood and food is important to manage daily life. Inaccessible terrain is also a major factor; life in rural areas is laborious when it comes to moving around and fetching water and food. In this respect Yemen's mountainous topography and sparse infrastructure make living difficult for people with disabilities.

A widow lives in the city with her two adult children. The three of them live in a small room of about 15 square meters. The room is at street level at the back side of the block facing the district's waste deposit. The eldest child is a mentally handicapped daughter that needs to be looked after constantly. Because of this the mother can hardly leave the room. When she has to go out she must clear up the room to prevent the daughter from harming herself, and then the daughter is locked in. If the daughter manages to come out of the room she will refuse to go inside again. If let out the other children will throw stones at her and call her names, which is very wounding to the mother, and the daughter can approach other people and cling to them. The mother finds this very embarrassing. The son has quit school and is a day worker to support his family. This is their only income. Occasionally neighbours give them food and fuel for cooking. Questioned why she does not move to her family in the north where she can get assistance to take care of the daughter, she replied that life is even harder there. In the village she would have to go and fetch water and find food herself. In the city the water is right outside the door, the son can get work and kind neighbours will come with food. Because of this they can survive in the city but not in the village.

The mother seems to care very much for her daughter but has no assistance during the day to take care of her. Neither has she received any kind of guidance on how to deal with the daughter's social behaviour. The consequence is social isolation for both of them and a total dependency on the brother's contribution. This makes them extremely vulnerable.

People without income living in the city sometimes manage because they receive help from family members living in the countryside. The help is mostly in the form of food supplies, but some receive money from time to time as well. These examples show that family members will help even if they are poor themselves. It illustrates the importance of the extended family in Yemeni society.

5.5 Work and employment

In general microfinance seems not to be used as a tool to help people with disabilities to set up a business of their own. We were informed that the Social Fund for Development gives such support, but on a very small scale. We did not meet anyone that benefited from this possibility.

Some of our informants had been enrolled in schools and rehabilitation centres run by DPOs where they were taught different kinds of handicraft. However after completing the training none of them received any assistance to start a business for themselves. It seems that no infrastructure is established to assist them in making a living out of what they had learned at the centre. We did not find "job hunting" included as a taught skill in any of the training centres visited to help those who have been trained get access to the labour market. Some skilled disabled people, especially females, stay at home, dependent on their poor families. For those who lack initial capital or a resourceful network there is a risk that the training is in vain, as we saw in the example of Aisha who had learned basket work but had no resources to start a business of her own:

Aisha had the opportunity to learn basket work at a training centre. During this period, which lasted for three years, she could sell her products at the school's shop. When finished she was shut out from this opportunity. As she has no resources to start a business of her own, she is back to the same situation she faced before the training. She is now totally dependent on her parents again, a situation that increases her feeling of being useless.

The case of Nahala illustrates that the situation can sometimes be complex. To make a choice may involve taking financial risks which can not even be considered by a person without resources. Because of this Nahala is not able to benefit from the training and assistance she has received:

Nahala was paralyzed in her right leg after vaccination at the age of six months. She was operated on several times. At 17 she was offered an operation which was said to make her walk normally. However, the operation and the cast she got in her right leg ended with gangrene and worms coming out of her foot, so a part of the leg was amputated. The leg never healed and Nahala was in great suffering for years; she even tried to commit suicide. After six years of open wounds she went to the doctor and asked him to amputate her leg. He cut off the leg up to the knee. It took two years for her wounds to heal. Nahala joined the disabled society and was trained there for sewing. Now she is teaching disabled people sewing. She receives no salary for her work at the workshop but is given some money whenever they have work to do, but it is not much. When asked why she does not get a loan to start her own sewing business, she said "I already got one to buy the sewing machine but I had to sell the sewing machine for my treatment. Now if I get another loan I am not sure I will be able to pay it back because most of my neighbours have sewing machines themselves and I do not think I can work outside the neighbourhood".

In other cases it was obvious that other people's attitudes destroy the job opportunities for the disabled person, as is the situation of Amar, the young deaf boy. He is clever with electricity and has a particular interest in computers, but no one wants to hire him in spite of his skills because of his deafness.

Mahmud helps his mother with the family business. In spite of his mental handicap there are a lot of things he is able to do, but still the mother cannot have him to help her with the shop - and in this way relieve her work burden - without supervising the whole business, even if the boy himself is trustworthy. When she tells him what to do he will do exactly what he is told, and this is their problem. Customers cheat him when they discover that they can fool him. Because of this he cannot help his mother as much as he might be able to.

Self-employment requires some saved capital through previous work, inheritance or micro-finance support.

In Sana'a, by coincidence, we ran into two young physically impaired brothers, and did an interview with them which had not been pre-planned by our organisers. They both had polio since childhood, one walked with crutches and one used a wheelchair. One brother was going to school and one was running a small family business from a window in the basement, selling cigarettes, matches, soft drinks and sweets. They had inherited a small house when their father died, thus had no rent to pay, and lived there with their mother, unmarried sisters and the wife and children of the eldest brother. Their economy is quite marginal but they manage and are hoping for better days when the younger brother

finishes school. He has a friend in a wheelchair who works in a factory and hopes to get a similar job himself.

5.6 Health care

People generally try hard to raise the necessary money to seek treatment in hospitals. For many families with a disabled member this turned out to be money spent in vain. They hope for a cure for the impairment or a treatment, which is at best only available abroad, - out of the question for poor people. The result is a lot of money spent gaining nothing. Facilities like physiotherapy, occupational therapy, behavioural therapy barely exist, so training and guidance on how to improve the person's level of functioning is hardly given. Some of the informants had been through operations without results, and sometimes even with a worse condition than before the operation, as in the case of Noor, who most likely is a victim of bad medical practice:

Noor, 17 years, suffered from child paralyses as a baby. Some time back she went to the doctor who offered to operate on her and fix her hip in a stiff position. He promised this would make it possible for her to walk. The operation however was not a success. It was painful and she could not walk. After some time they asked that the nails should be taken out. When taking out the screws they lost one inside her body (it shows up on x-ray). It gives her pain sometimes but she does not tell her mother because it makes her unhappy.

Many parents mobilize the extended family to raise money for medical help for their disabled children. In many cases they are referred to one hospital after another. Too often the only result seems to be a diagnosis describing symptoms that already are obvious - for instance that the person is weak sighted or partly paralyzed.

The father of three disabled boys managed to raise money to take his boys to the hospital in Sana'a when he realized that they developed muscular dystrophy that he had seen in an older child who died. The doctors at the hospital did nothing but referred them to medical specialists at the military hospital. The doctors at the military hospital advised him to see a medical specialist who was expected to visit Yemen from abroad. The father was then advised to go abroad to seek treatment, which the family could not possibly afford. He has given up seeking treatment and now they do nothing about the situation but try to manage their daily life. The father is not young any more and has developed heart disease. The doctor tells him that he needs regular medication at the cost of 5000 YER per week (about \$25). Sometimes he can afford this but usually not.

Many told us they suffer from partial paralysis after a fever as a little child. Not everyone could give a precise explanation for the cause - and maybe this has never been explained to them. Some of them described their condition as polio, others only as 'partial paralyses'. Several informants with partial paralyses explained to us that the sickness - and the following impairment - came after an injection, as was the case for many of the girls at the orphanage. In some cases blindness and deafness as well was explained as a consequence of a fever as a little child. Thus children's diseases such as measles and polio, under control in countries in the western world, are still a threat to children's health in Yemen and a cause of disability.

During the field work we met very few that told us they had tried to cure the impairment by traditional medicine. This however must not be taken as an indication that traditional medicine does not exist in Yemen, only that we met few who voluntarily told us they had actively tried

traditional medicine to minimize the impairment. The fact that two of the team were Yemeni medical doctors might have led the informants to hold back such information. On the other hand, even if few told us they used traditional medicine, some replied (when we asked about the causes of the impairment) that the family members had different opinions on the causes.

Yahir was in his thirties, paralysed in one leg since childhood by what he believed had been polio, but which his family explained as the evil eye: “If you ask my mother she will say I fell down, if you ask my aunt she will say it is the ‘evil eye’ from a neighbouring woman, if you ask me I think it is polio” - The parents had taken him to a traditional healer as a little child, but without help.

Some of the people we met in Aden told us they had been sent abroad for treatment, but not necessarily with success. We met a man who had cancer of the bone marrow 15 years ago. He was sent to India and operated upon at the expense of the (communist) government. According to the father the result was that he lost his equilibrium and now he walks like a drunk. Another man got measles at the age of 4. The family took him everywhere, even to Russia (paid by the communist state), to Chinese doctors and traditional doctors. Nothing had helped and he has never been given any training.

5.7 Education

Basic education is still not compulsory for children in Yemen. However there is a major effort to increase the enrolment rate. An example of this is the possibility for uneducated adults to join primary school. Some of the young disabled people we met went to special classes for adult illiterates. They had not been accepted by the school as a child, but now - with the efforts of inclusive education and the possibility for adults to go to school - they got a second chance. In spite of this many of the children we came across in the families we met did not attend school. This was the case for non-disabled children and even more so for the disabled ones. The parents give several reasons for not sending the disabled children to school. Some children with disabilities are not accepted at the local school because very few schools practise inclusive education. And even if the child is accepted, the school buildings are not accessible to the impairment, there are no adapted teaching materials, the teachers do not know how to teach and handle a disabled child and there are no transportation facilities.

However, there was a clear awareness of the advantages an education could give in life and there were examples of fathers who had struggled to see their child with a disability through school precisely because he or she was disabled. The thought behind this was that if a boy could not do physical work – and a girl could not marry – their best chance in life was to be educated.

As mentioned, special schools for children with disabilities are few and located in the cities. Many families do not wish to send their children away from home - disabled or not, and especially not the girls. The consequence is that the disabled children are kept at home with no education.

Sahra, 13 years, is practically blind due to a genetic condition. Her grandfather, her mother and a brother are weak sighted as well. She lives with her mother and brother in her uncle’s house. Her mother is surprisingly open on the point that girls with a disability are considered worthless. Her wish for Sahra is that she be educated and independent. Sahra goes to school as there is a special class for blind children near by. The special class was established two years ago. This opportunity at the local school is the reason why she is at school at all. The school does not teach mathematics, however, as they lack both

proper teaching materials and the skills to teach blind children maths. The family tried at first to enrol her in the ordinary school but she was only accepted as a listener. She was not granted any kind of adaptations and was not permitted to disturb the class by asking questions. Her mother tells us she would never send Sahra away to a boarding school. Before the special class was set up the only possibilities for Sahra was to be a passive listener in the ordinary school or to stay at home without education at all.

Yahir wanted to go to school and was accepted in the local school. The father supported him in this although he came from a farming village where no one previously had gone for education. He crawled on his hands and knees back and forth every day, one kilometre each way with no help from others, not even his brothers or his father. After finishing secondary school he wanted to study and was encouraged by his father. He was accepted at Sana'a University to study science. The only problem was to afford to live in Sana'a. The father found a solution by buying a second hand car so that Yahir could drive back and forth to his home village every day. After a while he had to quit his science studies because he could not stand up long enough to do the laboratory work. He applied to the Ministry of Education to be allowed to continue but got the answer that he should rather do law study because the Law school was accessible for him. After he got his diploma he waited for a year to get a job, which is not unusual for non-disabled either. He is married to a non-disabled woman and has many children. They live in his family home in the village where everyone else is a farmer. He is a member of the village council, but when he says something the other men tend to degrade him by saying "you are not a proper man". He has also experienced being chased away from village ceremonies because he was not considered a proper man since he is not physically fit and strong like the other men.

The case of Yahir is illustrative of many important points. It shows us the effort it takes for him to get to school although being lucky to have one in his home village. It shows the importance of support from his family, and especially being encouraged by his father. It shows that even a relatively small disability (he can walk with crutches) may be a hindrance if there is not a will to make classrooms accessible (he could probably have managed the lab exercises by getting a high chair to sit on). It also illustrates other's attitudes to people with disabilities and the difference in values between traditional and modern society. While quite successful in Sana'a, he was not able to achieve the position of a fully respected man in the village community because he could not perform the tasks from which a man gained recognition.

In considering the possibilities for children and young people with disabilities in Yemen to get education there are several important points to be made about the mainstream schools:

- Not every village has a school and transport is most often not available or too expensive for those who are poor and cannot afford to pay for it.
- The terrain is rugged and often inaccessible for a wheelchair and people with crutches.
- The teachers are not trained or given any special motivation to include a disabled child.
- The classes are very large, so it is hard to give a child with special needs any extra attention.
- Adapted teaching materials are almost non-existent and special equipment like tape recorders and hearing aids are rarely available.
- The physical lay-out of the schools does not take the special needs of children with disabilities into consideration.

- Although schools are in principle free, children more and more have to wear school uniforms and shoes, which is a big cost for a poor family with many children. Some do also require school fees, even if the amount is small.

As inclusive education in mainstream schools only reaches very few children with disabilities, educating children with disabilities takes place in special schools and training centres, some of which we visited. Some of the special schools we saw were boarding schools for the children living far from the school, thus taking the disabled child away from the home community almost to the point of (in some cases) making them into orphans (contact with the family almost stopped). The centres were daytime-only with buses picking up the children at home and delivering them in the afternoon. Such establishments are usually very costly and reach only a very limited number of those in need. We also saw a few examples of people who had finished their training at such a centre, but afterwards were left without any job or materials to continue using their skills to make a living – only unfulfilled dreams.

Some of these cases, however exceptional, show an interesting paradox that disability can be a way out of poverty and misery.

Nohra is blind, comes from a small village and is the eldest daughter of a worker. She became blind suddenly at 18 years old. After the blindness she stayed home for two years, doing nothing. 'I was nothing' she says, 'I was a thing'. A friend of her father told him about a special school for blind girls. The father applied for her as the school is flexible when it comes to school fees. To be accepted she had to learn Braille (the tactile alphabet). She did this the summer before the school started guided on the telephone by the headmistress. She was accepted as she proved herself to be a hard working student. Now she is the first girl in her family and the village with a degree. She is married and a mother. Her husband has a visual impairment as well. She tells us that in contrast to being a burden to her family she contributes. She considers herself as a role model for other blind girls as well as for her sisters and the neighbours in the village. Her parents would never have been able to give her this education without the contribution from the institution. She would definitely not have become a psychologist - which she desired - if she had not become blind because her parents would never have been able to afford a higher education at all.

One could ask what it is that makes some people succeed. Obviously it is a story about bright, clever and hard working students. But this seems only to be a part of the whole story. It is as well a story about encouraging and supportive parents and important mentors. It is of course a question about economic resources, but just as much about the ability to seek alternative solutions. The blind woman did not come from a well-off family at all. But she has a caring father who searched for the best opportunities for his bright daughter. They were lucky to meet a headmistress who is dedicated to encouraging and stimulating her students. The story of Yahir, who was educated as a lawyer, tells us about a caring father eager to seek practical and economic arrangements within the scarce family resources for his son so he could make a future for himself when the traditional option, farming, was impossible.

5.8 Disability services

We visited three centres that provided services to people with disabilities. They all seemed to be well managed, but as they are small and with scarce resources they reach only a minority of the people that are in need of services. Some of the centres run kindergartens and schools for the children, and skill training programmes for adults. A few centres provide assistive devices as well.

Assistive devices – such as wheelchairs, crutches, mobility sticks and/or hearing aids - are not very often seen in Yemen. The reason for this is manifold. Due to the difficult terrain wheelchairs are not useful outside the main cities. Neither are they useful inside the houses because of the many floors and steps. Most people live one floor up from the street level. One must as well consider that there is a certain stigma connected to the use of assistive devices in Yemen as in many other countries. But most important for poor people is that devices are expensive, difficult to obtain and seldom individually adapted. Some of the children at one of the centres we visited had a wheelchair. However, the chairs were designed for adults and too heavy for them to operate by themselves. Because of this they were dependent on others to be pushed around. When a child is placed in a wheelchair which is too big and too heavy he/she will not be stimulated to develop his/her own potentials and there is a risk of increasing dependency as an unintended result. The cases mentioned here illustrate the point that it is not enough to provide an aid if the aid is not adapted or if there is no follow up if the aid breaks down:

Aisha lives in one of the hilly quarters of Aden. She has a wheelchair from the Social Development Fund. The chair is heavy to operate and she is only able to move around on the ground floor inside the house. Outside she is dependent on the father or the brothers to push her. As no one is willing to push her the chair is of little use to her. As a result of this she is unable to get to school even if she is accepted at the local school.

The brother of Sahra is weak-sighted due to the same genetic visual impairment as Sahra and her mother, but his sight is a bit better. The extended family – his uncles – bought him glasses which was a considerable expense for the family. One day he had an accident, the glasses broke and there is no money to buy new ones.

5.9 Physical and environmental barriers

As described in the introductory chapter Yemen is for the most part a very mountainous country. It is very beautiful, but a very difficult country for a person with a disability to move around in.

The villages on the mountain tops and the mountain side look very picturesque to the passer by, but create a very difficult life situation for a person with a physical impairment. *“The villages are not friendly to us”* said the girls in the orphanage for physical disabilities. They referred to the problem of getting around with a wheelchair or with crutches as a reason for not planning to move back after finishing their education.

Another problem is the lay-out of the houses. Most houses for those who can afford it are quite large, providing space for a large family of unmarried daughters and married sons. On the ground floor however there are only usually storages rooms and only after ascending a steep stairway does one get up to the living quarters one or more floors up. This of course creates another problem for people with physical impairments. Many of the houses of poor people that we visited had the same layout, although on a much smaller scale and more crowded, while some of the poorest lived in only one or two rooms on the ground floor.

Official buildings and pavements did not seem to be made accessible for wheelchair users, and on the whole there seems to be much left to do in order to accommodate the needs of people with disabilities into physical planning. A visit to the office of the Disability Fund illustrated this: the courtyard is overcrowded with disabled people, many of them in wheelchairs or with crutches, waiting while the person who assists them is attending the office inside the building that is only accessible for those who can climb the stairs.

6 How disability generates and increases poverty and the other way around

In focusing on the links between disability and poverty there are some obvious ways in which people and their families may end up in (even worse) poverty if a family member becomes disabled or a disabled child is born.

Income

The first point that has to be made is that disabled people in a country like Yemen have difficulties in performing the income generating tasks that are considered normal in their community. For people who are poor from the start, as well as for people living in the rural areas, these tasks most often involve manual labour and thus are difficult to perform with a disability compared to the jobs occupied by the better-off classes of the society. There is also a real chance of losing ones job when becoming disabled and no longer being able to perform the necessary tasks. This was clearly demonstrated in the case of the father who had both his legs amputated as well as in the case of the carpenter with a rheumatic disease.

Even when the disability is no hindrance in doing the actual tasks required by the job, there are very few job opportunities for disabled people, as we have seen in the case of the deaf boy, Amar. Employers are not likely to hire people with impairments. A general lack of adaptations and low expectations on the capability of disabled people is a part of this picture. Thus the chances for poor persons with a disability being employed are small, in spite of the law saying that 5% of any workforce in 100 or more are employed should be a disabled person.

Education

We have seen that disabled children almost as a rule do not go to school. Not attending school is the case for many children, but even more for disabled children. This implies that children are hindered from developing their abilities and the possibility to qualify themselves for a profession and in this way provide for themselves and their family in the future. One must consider as well that parents in rural areas do not necessarily see school and education as useful. Even when the parents care about sending a disabled child to school, the schools do not necessarily accept the child. Reasons for this are inaccessible buildings, lack of adapted teaching materials, unqualified teachers, and lack of transport to and from school.

Education in special skills for self-employment or non-manual work may be a solution for a person with a physical impairment and could give the person a chance to be independent, and possibly a career which he or she is not likely to have had as a person without the impairment. Thus impairment may for those few lucky and/or clever people become a way out of poverty. As we have seen, to get education usually takes a dedicated father and a resourceful mentor to help.

Family life

We have seen that daughters with a disability almost as a rule do not get married. This may represent both a practical and an economic burden for a poor family. As unmarried she will not eventually move out of the household and thereby she becomes one more mouth to feed after the age when marriage would normally be expected. If a non-disabled sister remains unmarried in order to help with the care this will double the costs.

Health care

The absence of a developed health care system is striking. As health care services are centralised and institution-based they are practically inaccessible to the rural population - in Yemen a majority of the people. Primary health care and rehabilitation services that could have improved the person's ability to participate are poorly developed. We noticed that there is also a general lack of qualified health care workers, for instance medical and rehabilitation specialists, and of sufficient and regular supplies of medication. Even when it is available, poor families do not have the economic resources to pay for health services and medical treatment, and in many cases neither the capability nor competence and knowledge to demand such services. Lack of resources is therefore not only a matter of the ability to pay but as well about knowledge and competence on how to change a difficult situation.

The consequence of a poorly developed health care system has to be stressed. Health care services are absent in the local communities as well as skilled health care workers in general. People acquire impairments from diseases and injuries that would have been minimized or prevented in developed countries, but are not dealt with in Yemen.

Poor midwifery seems to be a risk factor that leads to impairments that could have been prevented, for instance Cerebral Palsy and intellectual impairment due to poor obstetric aid. One also has to take malnutrition into consideration as a threat to children's health and a cause of impairments. Counseling on hygiene and nutrition should therefore be considered important to prevent impairment. In a society where close cousin marriage is common one should also consider the necessity of genetic counseling especially for families where hereditary impairments are frequent, even if this might be controversial.

Although to some extent produced in Yemen, assistive devices that could minimize the consequences of the impairment and open opportunities for participation are rare, especially among poor people. The devices that exist are rarely adapted to local situations and to the person's functional ability. A system for production, adaptation and distribution of assistive devices (wheelchairs, walking aids, hearing aids etc.) suited to local technologies and economic conditions of the users could improve this situation.

The complexity of disability and poverty

The field work has shown that to understand the relationship between disability and the social and economic situation for those involved one has to understand the complexity of family and social life. When a family member becomes disabled or a disabled child is born, the family as a unit has to reorganize their resources of time, labour capacity and capital (salary/property/live stock/land) in order to meet the new challenges that the care for a disabled member places upon them. In this way, families with a disabled family member risk falling out of the social and economic relations within which they understand themselves and there is a risk of losing access to the resources that are necessary to manage as a family group. As the infrastructure is poorly developed in the rural areas there is a growing tendency to move to the cities and seek better opportunities there. We met families with disabled family members that had moved to the city to seek help. Doing this there is a risk of losing the ties to the extended family and the community within which the family exists, and thus making the disabled person even more vulnerable. In a family based social system one is extremely vulnerable when the family group, and the individual's ties to the family, are weakened; this would happen if one or several family members are unable to contribute so that the family can keep the economic and social standard they are used to. For most families in low-income countries, who already live on the lower limit, this could have dire consequences. In order to contribute under such social and economic circumstances one should consider helping the family as a group and not only focus on the disabled family member.

As shown in this field work poverty is a complex phenomenon and economy is only one dimension among many others. In developing assistance and services it is important to focus upon how people (and the family) utilize their capabilities – what kind of opportunities they have and how society could strengthen and facilitate this.

In Yemen it is considered a duty to take care of a disabled person and in general people with disabilities are taken care of within the family. We met families that cared a lot for their loved ones within their limited resources (both economic and knowledge). However, we could sometimes see that ‘caring’ in too many cases led to passivity, as the family members rarely encouraged the disabled family member to do things by themselves. But we met exceptions such as the mother of Mahmud, the intellectually impaired boy. Denial of opportunity is mentioned as an aspect of keeping people in poverty. Keeping people with disabilities at home and caring for them by doing things for them can create a paradox: disability is increased because of the will to help.

To improve a difficult situation is also a matter of having self-confidence and gaining respect. Strengthening DPOs is one way to do this. People with disabilities know themselves best what they need and what they are capable of. Within DPOs they can act as role models for others, as some of the people we met working in the DPOs considered themselves.

7 Concluding remarks

People with disabilities and their families encounter many barriers in daily life due to the disability because of:

- reduced ability to contribute to the family's income, because of reduced ability to perform job tasks and reduced access to jobs and/or labour market;
- reduced opportunity to attend school, education and/or vocational training;
- reduced access to health and social services;
- limited ability to participate in public and communal life compared to other community members.

In short, an impairment restrains the individual's possibility of filling the expected social role both within the extended family and in the community and society.

This field work has shown a need for actions on several levels to secure disabled people's equal access to public services and to participate in the social and communal life. To improve this there is a need both for further research and further policy development. A family perspective is necessary in order to understand the questions of disability in a culture where social and cultural life is family based. A consequence of this should be that research should enlighten both how the disability affects the individual as well as the family group. Likewise policy and assistance should be directed towards the individual as well as the family unit in order to assist them in coping with the (new) situation.

7.1 Suggestions for further research

There is a need for further research to build a knowledge base for policy development and further developments of programmes and activities.

One should consider doing studies similar to this in the parts of Yemen not covered by this study, as one has little knowledge of the situation for people with disabilities in these areas.

There is particularly a need for research to enlighten the situation and gain more knowledge of how to improve the situation for people with mental illness. There is also a need for more knowledge on the circumstances of disabled children and a need for more knowledge to improve maternity care, birth control and infant care.

There is a need for general knowledge and methods on how to teach people how they themselves can take care of their health.

A situation analysis of the services provided to disabled people should be carried out as well as post training follow-ups of graduates after vocational training. There is further a need for a deeper knowledge of rehabilitation, especially of methods that could facilitate individually adapted practices. There is also a need for research to see how knowledge is or could be translated into good practice. In this regard CBR could be a useful tool in developing user tailored rehabilitation. One should seriously consider restarting the former CBR-programme and extend it to focus on home-based counselling. CBR-programmes should focus on participation in social/community life as well as in work in addition to training.

There is a need for knowledge based evaluation of the tools (concepts and methods for data collection) that are used to produce statistics on disability. Likewise there is a need for knowledge based evaluation of ongoing programmes and activities directed towards people with disabilities. This could improve the accuracy of the programmes.

7.2 Suggestions for policy and programmes

- **The programmes:**

There is a need for a national policy and a national plan of action on inclusion and rehabilitation.

The delivery of disability programmes serving disabled people needs improvement.

There is a need of awareness campaigns so that disabled people know about these programmes. Further there is a need of developing application procedures that accommodate the functional capabilities of disabled people.

It is vital to link new strategies, programmes and activities with already existing programmes to strengthen the effectiveness and the economic viability of those programmes.

There is a need for a strategy to create an inclusive environment to ensure that public buildings will be accessible for disabled people.

Considering the very limited resources for the DPOs, they appear to play a significant role in the services to disabled people. The resources - economy and competence - of DPOs should be strengthened.

- **The family:**

This field work has identified a need for programmes of specific outreach to families with disabled members to improve the family members' knowledge and attitudes on disability. Programmes should also be developed on education and training of parents and other family members on how to contribute in improving their disabled relatives' functional capacities.

There is a need for support to family members in order to lessen the responsibilities that affect decisions to attend school and find employment.

- **The community:**

There is a need for programmes of community awareness building concerning the situation for people with disabilities in order to sensitise the communities on disability issues and stimulate the positive signals of inclusion that are seen.

- **Education:**

Improvement of a population's educational level is of vital importance in the struggle against poverty in every society. Because of this schools should be compulsory for all children regardless of disability or gender.

There should be a particular focus on inclusive education (instead of establishing special schools) as inclusive education could improve disabled children's access to education.

There is a need for development of knowledge and initiatives for special education within the ordinary schools. Within this there is a need for adapted teaching materials as well as a need for accessible school buildings.

Schools should be free, including school uniforms, teaching materials and transport for children who need this.

- **Health care and rehabilitation:**

Health care and rehabilitation is fundamental in improving disabled peoples' living conditions and well-being. Because of this one should focus on outreach health care and rehabilitation services as this could improve the access to treatment, training and provision of assistive devices. Likewise training and rehabilitative programmes should be developed according to local needs.

- **Employment:**

People with disabilities must be granted equal access to employment and job opportunities. One way of facilitating this could be extensive use of micro-credit for self-employment.

The authorities should consider financial incentives to stimulate the design of adapted workplaces.

8 References

- Albu M: *Improving Business Development Services with Disabled People in Northern Uganda. Evaluation of an action-research project by NUDIPU and APT Enterprise Development.* Evaluation of NIDIPU Programme in Uganda, July 2004
- Barnes C, Mercer G, Shakespeare T: *Exploring disability : a sociological introduction.* Polity Press, Cambridge, Mass. 1999.
- Beatty S: *Yemen Population Development Policy Review (draft).* Washington DC: World Bank 2005.
- Brock K: *a review of participatory work on poverty and well-being. Consultations with the poor.* World Bank DC 1999 in: Elwan A *Poverty and disability a survey of the literature 1999.*
- CIA - The World Factbook, July 2006 (<https://www.cia.gov>)
- Coleridge P: *The Social Fund for Development. A review of its disability programme.* March 2004
- Eide A H, Loeb M E: *Living conditions among people with activity limitations in Namibia. A National representative study.* SINTEF Report no. STF 78 A034503. Oslo: SINTEF Unimed 2003
- Elwan A: *Poverty and Disability. A Survey of the Literature.* Social Protection Discussion Paper Series No. 9932. Washington D.C: the World Bank. 1999.
- HIV/AIDS & disability: *Capturing hidden voices.* The World Bank and Yale University Global Survey on HIV/AIDS and Disability, 2004.
- Ingstad B: *Community-based rehabilitation in Botswana: The myth of the Hidden Disabled.* Edwin Mellen Press, N.Y. 1997.
- Kvale S 1997: *InterViews. An Introduction to Qualitative Research Interviewing.* Thousand Oaks: Sage.
- Loeb M, Eide A H: *Living Conditions among People with Activity Limitations in Malawi.* SINTEF Report no. STF78 A044511. Oslo: SINTEF Health Research. 2004
- Miles and Huberman 1993: *Qualitative Data Analysis: an expanded sourcebook.* (second ed.) Thousand Oaks, California: Sage.
- MoH 2003: *The Yemen Family and Health Survey.* Ministry of Public Health and Population, Sana'a 2006.
- Social Fund for Development 2005: *General Information on Disability Work in Yemen.*
- UNA Norway (The United Nations Association of Norway): www.Globalis.no, July 2006

WHO: *Malaria and HIV interactions and their implications for the public health policy*. Report of a Technical Consultation, Geneva, June 2004. ISBN 9241593350.

WHO: *AIDS Epidemic Update*: December 2005. ISBN 929173439X.

WHO: *Guidelines for the treatment of malaria*. Global Malaria Programme (GMP), 2006. ISBN 92 4 154694 8

Wolfensohn J D, Bourguignon F: *Development and Poverty Reduction. Looking Back, Looking Ahead*. Washington D C: The World Bank. 2004.

Yeo R, Moore K: Including Disabled People in Poverty Reduction Work: “Nothing About Us, Without Us”. *World Development*, vol. 31, No. 3, 571–590:2003. Great Britain Elsevier Science Ltd.

Yeo R: Disability, poverty and the new development agenda. Disability KaR, 2005 www.disabilitykar.net, August 2006.

<http://en.wikipedia.org/wiki/Yemen> June 30th 2006.
