UNITED NATIONS E

ECONOMIC AND SOCIAL COUNCIL

Distr.
LIMITED
E/ESCWA/SDD/2015/IG.1/4(Part II)
18 February 2015
ORIGINAL: ENGLISH

Economic and Social Commission for Western Asia (ESCWA)

Committee on Social Development
Tenth session
Rabat, 8-9 September 2015

Item 5 (b) of the provisional agenda

Priority issues in achieving social development in the Arab region

Extending social protection to persons with disabilities and informal workers in the agricultural sector

Summary

This document provides an overview of social protection in Arab countries and focuses on the difficulties faced by certain groups, in particular agricultural workers in the informal sector and their families and persons with disabilities, in obtaining adequate cover. It notes that women are even less likely than their male counterparts to have adequate social protection and health insurance. The main forms of social protection in the Arab region are described: contributory social insurance schemes for workers in the formal sector, universal subsidies (such as for fuel and food) and non-subsidy targeted social assistance, such as cash transfer schemes.

Noting that social protection is a universal right and at the heart of the post-2015 sustainable development agenda, the document points out that the failure to provide adequate social protection, pensions and health care to marginalized groups constitutes a threat to social cohesion. It recommends that Governments should involve all stakeholders in policymaking on the provision of social protection and a national dialogue on reform. They should tackle structural disadvantages, secure adequate funding for social protection, eliminate duplication and fragmentation of services and work on collecting more reliable disaggregated data. It is argued in the document that Governments need to do more to make sure that legislation and policies on social protection are actually implemented.

CONTENTS

Introduction

1. Social security is a universal human right, as set forth under articles 22 and 25 of the Universal Declaration of Human Rights. Extending social protection to all is a key policy tool for alleviating poverty, vulnerability, inequality and inequity, and making societies more cohesive and stable.

2. Achieving social protection is at the core of the post-2015 development agenda, as detailed in the Report of the Open Working Group of the General Assembly on Sustainable Development Goals (SDGs) (A/68/970). Target 1.3 of the proposed SDGs calls on States to implement "nationally appropriate social protection systems and measures for all, including floors, and by 2030 achieve substantial coverage of the poor and the vulnerable". Target 3.8 calls on them to "achieve universal health coverage, including financial risk protection, access to quality essential health-care services, and access to safe, effective, quality and affordable essential medicines and vaccines for all".

3. In the Arab region, the risk of exclusion from social security coverage is high among certain social groups. Most agricultural workers are poor, work in the informal sector and lack access to health care. Persons with disabilities also face significant barriers to social services and employment, which ultimately leads to higher rates of poverty and poorer access to health care and education. Arab Governments are committed to achieving equality and equity as a prerequisite for security, peace and social cohesion, as is made clear in paragraphs 1 and 16 of the 2014 Tunis Declaration on Social Justice in the Arab Region.

4. In the report on its ninth session (E/ESCWA/SDD/2013/IG.1/6/Report), held in Amman on 12 and 13 October 2013, the Committee on Social Development requested that the secretariat of the Economic and Social Commission for Western Asia (ESCWA) "support the efforts of member countries by focusing research on the achievement of social inclusion, especially for persons with disabilities, and the means to extend social protection to those working in the informal sector". The present document reviews research on current protection structures extended to those two groups in the Arab region and presents policy recommendations from an inclusive and rights-based perspective.

I. SOCIAL PROTECTION FOR VULNERABLE GROUPS

5. The term *social security* generally includes the basic income security and access to adequate health care that should be guaranteed to all as a matter of public responsibility. *Social protection* is sometimes understood to encompass more traditional assistance provided on the family or community level. In this document the terms are used interchangeably.

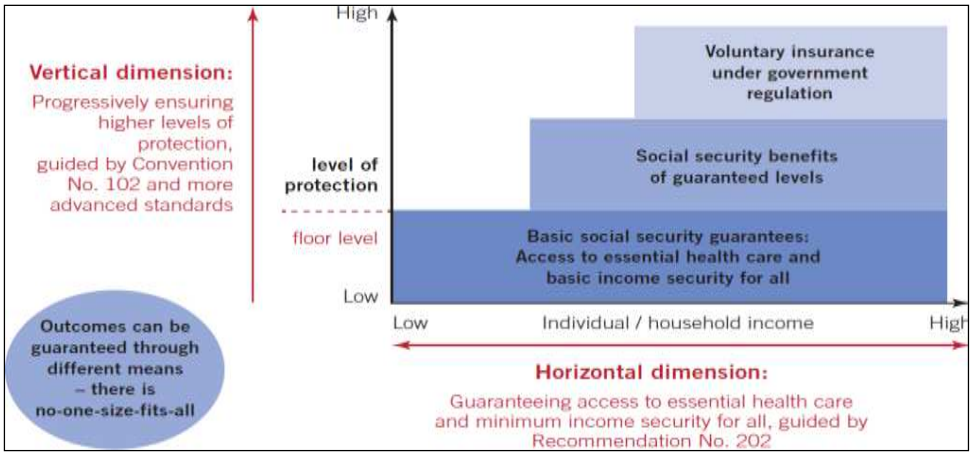
6. The core objectives of social protection are risk mitigation and poverty alleviation. *Social insurance* is the primary vehicle used to mitigate risk and is usually organized through compulsory contributory schemes tied to formal employment. They provide various benefits in the event of illness, old age and unemployment. *Social assistance* is mainly intended to alleviate poverty and can consist of various measures, including general subsidies, cash or in-kind transfer programmes and workfare schemes. *Social services,* such as public health care and education, contribute towards the realisation of social protection objectives by, for example, mitigating the risk of illness and providing skills that help people to achieve income security.

THE SOCIAL PROTECTION FLOOR

7. The United Nations Social Protection Floor initiative calls for the most fundamental aspects of social security, namely income security and access to health care, to be universally guaranteed. The goal is to achieve universal coverage of basic social protection, which should then be complemented by more advanced levels of protection, such as higher benefits and voluntary insurance programmes (figure I). The Social Protection Floors Recommendation of the International Labour Organization, 2012 (No. 202) calls on member States to identify impediments to the extension of social protection and to broaden participation in social insurance by, among other things, encouraging employers to formalize employment. Extending basic

social security guarantees to vulnerable groups should be considered a means of achieving comprehensive and universal social protection.

Figure I. The two-dimensional strategy for the extension of social security



Source: International Labour Organization, 2012b, p. 3.

II. THE STATE OF SOCIAL PROTECTION IN THE ARAB REGION

8. Arab Governments have relied on various approaches to social protection. From the 1950s to the 1970s, extensive welfare systems were established. Social insurance and universal health care were established as pillars of nation-building and national cohesion. However, population growth and an increasingly difficult economic climate drained resources and, except in Gulf Cooperation Council (GCC) countries, welfare systems were stretched beyond their limits. Considerable economic growth in some States did not, contrary to the expectations of Governments, result in equivalent social development.[1]

9. The informal sector has expanded significantly since the 1980s, largely due to rapid labour force growth and a decline in public sector employment.[2] Only around one third of the labour force in Arab countries contributes to social security.[3] Unemployment is persistently high but labour force participation rates are low. Women are especially affected: in 2010, 26 per cent of women in the Arab region, as compared to 76 per cent of men, participated in the labour force. Of those who did, 17 per cent were unemployed, whereas the unemployment rate for men was 8 per cent.[4] In many Arab countries, however, employed women are more likely than their male counterparts to hold formal jobs – particularly in the public sector – and to contribute to social security.[5] This does not hold true for rural areas, as will be shown in the following section.

10. Despite the relative decline in formal employment, the main pillar of social protection in the Arab region remains contributory social insurance, that is pension and health-care schemes tied to formal employment.[6] Certain professional groups, such as the self-employed, household workers, agricultural workers and fishermen, are mostly excluded. The coverage of people not in the labour force (such as

[1] ESCWA, 2014b, pp. 8-9; Karshenas and others, 2014, pp. 727-729.

[2] Angel-Urdinola and Tanabe, 2012, p. 3. For the purposes of this paper, informal workers are defined as those who do not contribute to social insurance.

[3] ESCWA, 2014b, pp. 18-19.

[4] International Labour Organization (ILO), 2012a, pp. 50-52.

[5] World Bank, 2013a, pp. 94-99, 109-111; Angel-Urdinola and Tanabe, 2012, p. 11.

[6] ILO, 2012a, pp. 85-96.

housewives) differs from country to country, as certain schemes include allowances for members of the insured person's family. Unemployment insurance is gradually being introduced by several countries, including Bahrain, Jordan and Saudi Arabia.[7]

11. The second pillar of social protection, at least until recently, has involved extensive universal subsidies. They used to account for a large part (about 85 per cent) of social assistance budgets, with fuel being by far the most heavily subsidised commodity.[8] In 2011, Arab countries accounted for almost half of the world's energy subsidies,[9] and spent on average 3.6 per cent of gross domestic product (GDP) on petrol subsidies – 12 times the world average of 0.3 per cent.[10] However, making use of the steady decline of oil prices, some countries have begun to cut such subsidies. Egypt, for example, did so on a significant scale in 2014 and aims to abolish all fuel subsidies by 2019.[11] It has been recognized that energy subsidies, despite their cost, are not necessarily effective in reducing poverty. Fuel subsidies, in particular, often benefit people who are not poor. In Egypt, Jordan, Morocco and Yemen, for example, the richest quintile of the population in recent years captured 40 to 70 per cent of all diesel subsidy benefits, given its higher consumption of energy.[12]

12. After energy, food is the most subsidised commodity. In 2011, the cost of food subsidies ranged from almost nothing (the United Arab Emirates) to more than 3 per cent of GDP (Iraq), averaging around 1 per cent of GDP across the region.[13] They appear to be less regressive than energy subsidies, since a larger proportion of them benefit the poor.[14] They also help to cushion price shocks in a region heavily reliant on food imports.

13. Abolishing general subsidies outright would in many instances most severely affect vulnerable groups, as only a small weakening of their purchasing power would push them below, or further below, the poverty line.[15] The fiscal space gained by reducing subsidies should therefore be used to create more inclusive social protection systems to mitigate the impact on the poor.

14. A third pillar of social protection in the Arab region is non-subsidy social assistance, which tends to target specific social groups and receives on average around 0.7 per cent of GDP.[16] By far the most common instruments are cash transfers to recipients.[17] Such programmes can be made conditional, meaning that beneficiaries are provided money on condition that, for example, their children regularly attend school or health check-ups. In 2007, Morocco piloted a conditional cash transfer scheme – the Tayssir Programme – which led to higher rates of school attendance, particularly among girls. After the pilot phase, however, the programme continued without hard conditions. Educational attendance is now encouraged rather than required, because evaluations had shown the "labelled" version, which demands far less costly administration than the conditional one, to be at least as effective.[18] Yemen has also implemented a conditional cash transfer

[7] International Social Security Association, Social Security Country Profiles.

[8] Silva and others, 2013, pp. 110-112.

[9] International Monetary Fund (IMF), 2013, p. 11.

[10] Calculation based on IMF, 2013, pp. 50-51. No statistics were available for Palestine and the Syrian Arab Republic.

[11] World Bank, 2015, p. 7.

[12] ESCWA, 2014a, p. 88.

[13] Sdralevich and others, 2014, pp. 11-12.

[14] Ibid., pp. 13-18.

[15] See, for example, Zaid and others, 2014.

[16] ESCWA, 2014b, p. 21.

[17] Silva and others, 2013, p. 140.

[18] Benhassine and others, 2014.

programme with similarly positive results.[19] Several countries, including Egypt, Morocco, Palestine, Tunisia and Yemen, have also introduced workfare programmes, which provide jobs to those in need.[20] The following section includes a closer look at the implementation of one workfare programme.

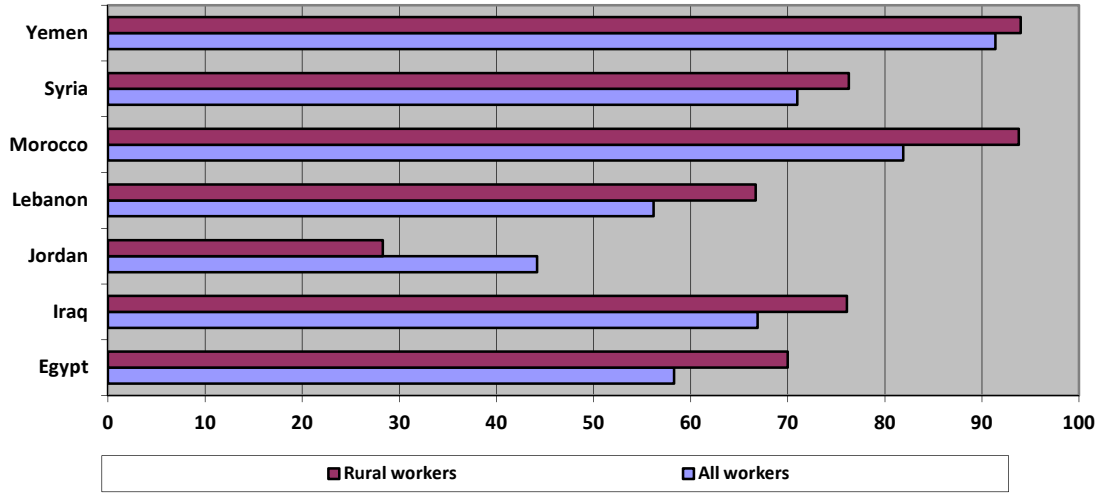
15. Problems such as fragmentation and duplication indicate that non-subsidy social assistance programmes in the Arab region need to be reviewed and consolidated. Inadequate targeting and coverage leads to leakages of benefits to the non-poor. According to some estimates, these programmes reach on average just one third of those in the poorest quintile. Some Arab countries, however, compare favourably to the rest of the world.[21] One regional success story is Palestine. In 2010, it merged its two existing cash transfer schemes into the Palestinian National Cash Transfer Programme, which uses a unified database to evaluate applicants' eligibility. It has been widely praised for its accuracy in targeting those most in need of assistance.

III. INFORMAL WORKERS IN AGRICULTURAL AREAS

16. Around one fifth of the Arab region's labour force works in agriculture.[22] The oil-exporting, predominantly urban, GCC countries generally have much smaller agricultural sectors than the oil-importing, more rural ones. According to available statistics, the size of agricultural employment as a percentage of total employment is highest in Morocco, at 39.4 per cent (2013), and lowest in Bahrain, at 1.1 per cent (2010).

17. Data is lacking on labour markets in the region but the size of the agricultural sector is clearly a key contributor to informality, given that most agricultural workers do not contribute to social security (figure II). In countries such as Morocco and Yemen, where agricultural employment accounts for a large proportion of the labour force, the informal sector also tends to be large. Countries with small agricultural sectors typically have fewer informal workers. In GCC countries, the informality rate in 2010 stood at 6.4 per cent - a tenth of the regional average. Countries of the former category will thus be the focus of this section. Large numbers of women work in agriculture so female workers are more likely than men to work informally, with possibly far-reaching consequences for their social protection.

Figure II. Informality among workers in the Arab region
(Percentage)



Source: Data are from Angel-Urdinola and Tanabe, 2012, pp. 10, 14.

[19] World Bank, 2013b.

[20] ESCWA, 2013.

[21] ESCWA, 2014a, pp. 86, 88.

[22] World Bank, 2011, pp. 39-40.

18. The vulnerability of informal agricultural workers is illustrated by the fact that poverty in many Arab countries is twice as prevalent in rural areas as in urban ones. Upper Egypt, which is largely rural, accounts for about half of the country's population, but 80 per cent of its severe poverty.[23] In Egypt, Jordan and Morocco, low-skilled rural workers are by far the likeliest to live in poor households and the least likely to have high-paying or protected jobs.[24] The level of education is generally lower in rural areas and school dropout rates are high, particularly among girls.[25] Skills-enhancing initiatives typically do not reach informal workers in remote locations.[26]

A. PENSION INSURANCE

19. Most social security systems in the Arab region exclude certain groups, such as the self-employed, temporary workers, household workers, fishermen and agricultural workers. In many countries, there is no pension scheme for agricultural workers. It is true that determining the extent of coverage for them is complicated by the fact that they often fall within different or several categories, such "self-employed" or "employees in agriculture". In Yemen, only 6.4 per cent of men and 1.8 per cent of women in the labour force contributed to a pension scheme in 2011. In the Sudan, the aggregate number of contributors in 2008 was 4.9 per cent. In Algeria, Egypt and Tunisia, where there are separate schemes for agricultural workers and other previously uncovered categories, total coverage rates exceed what could be expected based on national levels of income.[27] An evaluation of social security schemes must, however, take into account not only their coverage but also the level of benefits. The case study in box 1 illustrates how social insurance cover has been provided to previously excluded workers in the agricultural sector in Tunisia.

Box 1. Social insurance for informal agricultural workers in Tunisia

In 1981, the Tunisian Government established a social insurance scheme for full-time agricultural workers, and the year after another scheme for the self-employed in agriculture. Between 1989 and 1999, participation rates among full-time and self-employed agricultural workers increased from 20.7 per cent to 46.6 per cent and from 13.9 per cent to 56.1 per cent respectively. The schemes entitled participants, from the age of 60-65, to pensions of 30 to 40 per cent of the agricultural minimum wage or, in the case of the self-employed, of the inter-trade minimum wage. Sickness and maternity benefits amounted to 50-75 per cent of the wage or salary, the latter for a renewable period of one month. The insured were also entitled to health care at public hospitals and polyclinics under a co-payment arrangement.

The schemes made Tunisia a regional leader in social protection provision. However, the facts that agricultural labourers often work in remote locations and workplaces are scattered over wide areas create challenges in terms of enforcement. Furthermore, small-scale employers and employees cannot always afford the contributions. The relatively low rate of participation in the scheme for the self-employed may partly be due to the lack of a family allowance component. Equivalent schemes in Algeria and Egypt include a family allowance and have higher enrolment rates, in spite of higher contribution fees.

Sources: Chaabane, 2002, pp. 3, 6, 12, 25-28; Loewe, 2014, pp. 92-93.

[23] Ghanem, 2014, pp. 4-5.

[24] Gatti and others, 2013, pp. 7, 81.

[25] Silva and others, 2013, p. 76: ESCWA, 2014b, p. 28.

[26] Gatti and others, 2011, pp. 30.

[27] Robalino and others, 2005, p. 56.

B. HEALTH CARE

20. The exclusion of informal agricultural workers from social security systems means that they are ineligible for social health insurance.[28] In Egypt, only 57 per cent of the population was covered by the Health Insurance Organization in 2008-2009.[29] Public health care is far less accessible to agricultural workers and their dependants. Government spending on health hovers around 2 per cent of GDP in Arab countries, but most goes to urban areas and well-equipped specialist hospitals, leaving rural health stations and village clinics underfunded.[30] Hospitals and other facilities in rural areas have trouble recruiting and keeping qualified personnel. In Egypt, Morocco and Yemen, 59 per cent, 40 per cent and 10 per cent, respectively, of births in rural areas in 2012 were attended by skilled personnel. In urban areas the respective numbers were 87 per cent, 85 per cent and 46 per cent.[31] People living in rural areas spend a disproportionately large part of their income on health care.[32]

C. SOCIAL ASSISTANCE

21. Countries with large numbers of informal agricultural workers have generally not deviated from the pattern of spending considerable sums on subsidising energy. Yemen, for example, devoted virtually its entire social assistance budget in 2008 to keeping down the price of fuel but failed to make a significant impact on poverty.[33] That said, when fuel costs rise in Yemen, the rural poor are the most severely affected. Tractors and generators for water pumps become unaffordable for many farmers when the price of diesel increases, causing incomes to fall as food and drinking water become scarcer. Transportation becomes more costly or even unavailable, making it impossible for vulnerable people in remote areas to access health centres and hospitals.

22. Food subsidies tend to benefit the non-poor and be biased towards urban areas. In Egypt, Cairo dwellers have historically gained disproportionately from food subsidies,[34] which in 2011 were available through ration cards to 70 per cent of the country's population, but not to one fifth of poor households.[35] Nevertheless, households in rural Upper Egypt spent almost twice as much of their total food expenditure on subsidised food (8.7 per cent) than did urban households (4.7 per cent), indicating the detrimental impact that abrupt cuts to food subsidies would have on people in rural areas living on the poverty line.[36]

23. The extent to which non-subsidy social assistance goes to the poor, and hence to informal agricultural workers, varies. Many cash transfer programmes are targeted by category, meaning that, for example, widows or older persons receive benefits irrespective of their economic situation.[37] Other programmes target specific geographical areas, which should be of greater help to informal agricultural workers, provided that they are mostly concentrated to particular locations. Targeting can also include a participatory element, meaning that those most in need are identified through dialogue with local communities. Workfare programmes tend to have an element of self-targeting, which can be an appropriate method for reaching

[28] See Loewe, 2013b, pp. 147-149, for an overview of social health protection arrangements in Arab countries.

[29] ESCWA, 2014b, p. 24.

[30] Loewe, 2013a, pp. 200-201.

[31] Silva and others, 2013, p. 75.

[32] Loewe, 2013b, p. 152.

[33] Silva and others, 2013.

[34] Mahfouz and others, 2014, pp. 89-90.

[35] World Food Programme, 2013, pp. 25, 28.

[36] Ibid., 2013, pp. 26-27.

[37] Silva and others, 2013, p. 106.

informal agricultural workers. The Labour Intensive Work Programme in Yemen (box 2) shows that different targeting methods can be combined to reach the most vulnerable.

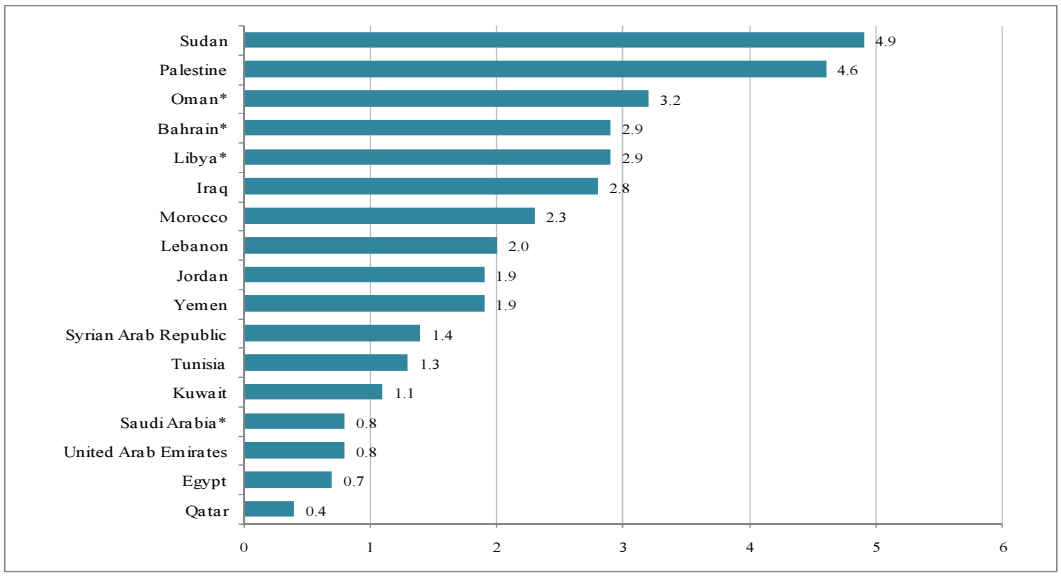
Box 2. The Labour Intensive Work Programme in Yemen

Unemployment and underemployment are rampant in rural Yemen, where many combine seasonal agricultural work with other forms of temporary labour. In 2008, Yemen launched the Labour Intensive Work Programme, which guarantees a certain amount of work every year to targeted households. Targeting is largely geographical, as the poorest villages are selected for participation. The most vulnerable households are identified partly through self-selection, as the wage rate for workers in the programme is set below the average one, and partly through household surveys and community participation. Local communities are consulted about potential projects. Most income earned through the programme is spent on food. In addition to direct employment opportunities, many also appear to be indirectly created as villages receive economic stimulus. Moreover, assets created through the projects often improve efficiency in the agricultural sector. The cost of the programme in 2012 amounted to 0.056 per cent of Yemen's GDP. In comparison, more than 13 per cent of GDP was spent on subsidies during 2008-2011.

IV. PERSONS WITH DISABILITIES

24. Around 15 per cent of the world's population (1 billion people) is estimated to have some form of disability. The prevalence of disability in the Arab region ranges from 0.4 per cent in Qatar to 4.9 per cent in the Sudan (figure III), but these figures are likely to be underestimates, given risk factors such as armed conflict, environmental risks, traffic accidents and poverty. In some countries, the collection, analysis and dissemination of disability data are inadequate. Persons with disabilities are not sufficiently integrated into labour markets in the Arab region, meaning that they are more likely to experience poverty, a trend exacerbated by added financial burdens, such as the need for assistive devices and specialized medical interventions. Conversely, people living in poverty are more liable to incur disabilities, as they often work long hours in hazardous conditions and do not have access to basic services such as preventive health care and decent sanitation. Persons with disabilities thus need to be targeted for social protection.

Figure III. Disability prevalence in the Arab region
(Percentage of the total population)



Source: ESCWA and League of Arab States, 2014, p. 10.

* Signifies that data pertains to nationals only.

A. THE LEGAL AND POLICY FRAMEWORK

25. Over the past decade, a strong rights-based framework, including measures to ensure social protection for persons with disabilities, was developed at the international, regional and national levels. During the Arab Summit in 2004, the League of Arab States launched the Arab Decade for Persons with Disabilities. In 2006, the Convention on the Rights of Persons with Disabilities, the first human rights convention focusing on disability, was adopted (box 3). To date, 15 ESCWA member States have ratified or acceded to the Convention, most recently Palestine in April 2014.

Box 3. Social Protection and the Convention on the Rights of Persons with Disabilities

The Convention on the Rights of Persons with Disabilities contains a number of articles related to the achievement of social protection:

Article 25 on health enshrines the right to enjoy the highest attainable standard of health without discrimination on the basis of disability. It outlines the obligations of States parties, including: the provision of the same range, quality and standard of free or affordable health care as provided to other persons; the provision of specialized health services for persons with disabilities, including early identification and preventative services; and the prohibition of discrimination against persons with disabilities in the provision of health insurance.

Article 28 on adequate standard of living and social protection enshrines the right of persons with disabilities to an adequate standard of living for themselves and their families, including adequate food, clothing and housing. It sets forth the right to social protection and obligates States parties to undertake measures aimed at, for example: ensuring access to social protection and poverty-reduction programmes, especially for women and older persons with disabilities; ensuring access by persons with disabilities and their families living in poverty to assistance from the State with disability-related expenses; and ensuring equal access to retirement benefits and programmes.

26. Arab countries have taken significant steps to protect the rights and address the needs of persons with disabilities. At least 15 ESCWA member States have adopted overarching laws on disability, 12 have established national coordination mechanisms on disability, and at least 10 have or are developing national strategies on disability. Most disability laws in Arab countries set forth the rights of persons with disabilities to education, health care, employment, psychological and social care, and the right to be provided with devices that facilitate learning, movement and transportation. The law in countries such as Oman, Palestine and Qatar sets forth the responsibility of the State to provide many such services free of charge. Bahrain, Jordan and Kuwait offer free health insurance to persons with disabilities. In other countries, especially GCC countries, provision is made for such services but there is no explicit mention of them being free of charge.

27. In some countries, the minimum age requirement for pension entitlement has been waived for persons with disabilities. In Kuwait, for example, a beneficiary of social insurance who is a person with a disability, or a beneficiary caring for a person with severe or moderate disability, is granted a pension amounting to 100 per cent of salary if the accumulated years of service reach 20 years for males and 15 years for females. In Bahrain, the same exception applies to persons with disabilities only, but with a reduced requirement for the minimum years of service (15 and 10 years respectively). In Bahrain and Kuwait, employed women with disabilities have the legal right to special leave with pay in case of pregnancy and whenever it is deemed a medical necessity.[38]

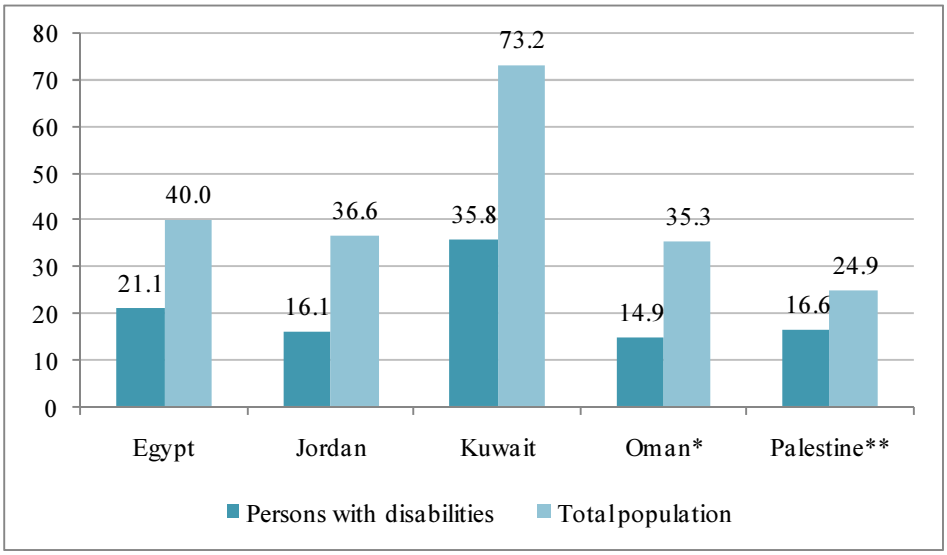
28. Legal and policy advances have not always been accompanied by timely implementation. Two stumbling blocks to implementing policy are the lack of reliable and sufficiently disaggregated data and the failure to define disability clearly.

[38] Act No. 8 of 2010 on the rights of people with disabilities, articles 41 and 42 (Kuwait); Order No. 6 of 2011 on conditions and rules concerning the entitlement to retirement pensions for caregivers of disabled persons (Kuwait); Act No. 74 of 2006 on the welfare, rehabilitation and employment of persons with disabilities, article 6 (Bahrain).

B. Social insurance and social assistance

29. Although at least 16 ESCWA member States have some form of employment quota system, available statistics indicate that employment rates among persons with disabilities are conspicuously low (figure IV). The discrepancy between men and women with disabilities tends to be greater than that between men and women without disabilities, indicating that disability augments the disadvantages already faced by women in the labour market.[39]

Figure IV. Employment rates of persons with disabilities and total populations (15 years and above) in selected Arab countries
(percentage)



Source: ESCWA and the League of Arab States, 2014, p. 18.

* Signifies that data pertains to nationals only; ** signifies that data refers to persons 10 years of age and above.

30. Given their low participation in the labour force, persons with disabilities in the Arab region tend to be excluded from social insurance schemes (including disability pensions), which are primarily accessed through formal employment. For those in formal employment, coverage of disability pensions can be limited by eligibility requirements, as many social insurance schemes require high levels of disability or incapacity to work (often 100 per cent) in order for applicants to be eligible for total disability pensions. In some countries, however, partial disability pensions apply.[40]

31. Persons with disabilities who are unable to obtain work have to rely on social assistance programmes, which tend to encompass cash transfers, exemptions from certain taxes and fees, and in-kind assistance such as assistive devices. In almost all Arab countries, the law provides for an umbrella of social assistance services ranging from customs and fees exemptions to the provision of monthly allowances. In Bahrain, Jordan, Kuwait, Oman, Qatar and Saudi Arabia, the exemption from customs and fees includes all habilitation, prosthetic, and assistive tools, devices and equipment that are used to facilitate learning, movement and transportation. In other countries, exemptions are extended to cover the fees for buying a specially equipped car (such as in Jordan and Kuwait), or to recruit a domestic helper or a driver to assist persons with disabilities (such as in Jordan and Oman). Monthly allowances are paid to persons with disabilities or their caretakers in a number of countries, such as Bahrain and Qatar. In Kuwait, social assistance covers the provision of residential grants. Soft loans are granted to persons with disabilities to start

[39] ESCWA and League of Arab States, 2014.

[40] International Social Security Association, 2013a and 2013b.

their own businesses under disability legislation in Saudi Arabia, and in Qatar the authorities are mandated to provide persons with disabilities with housing designed according to their needs.[41]

32. Information on the impact of social assistance schemes remains limited and more research is needed on their coverage, quality and implementation.

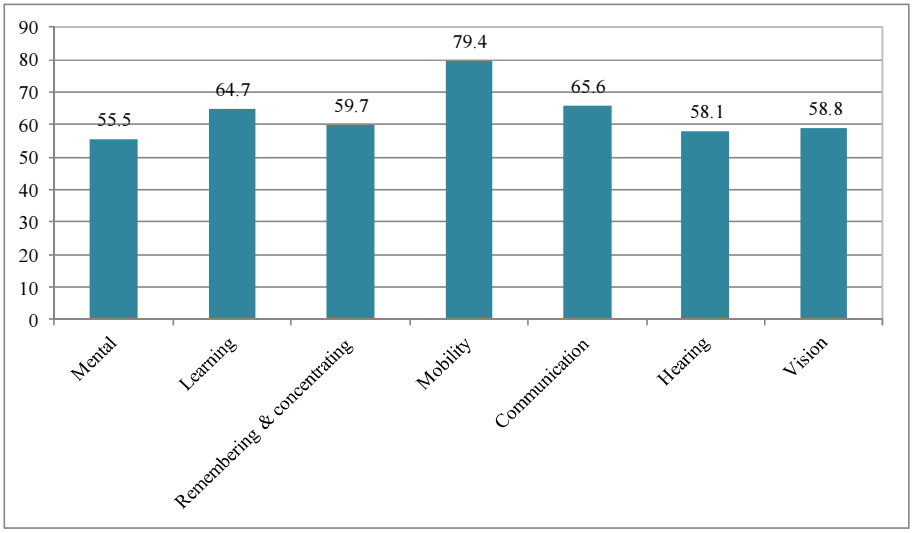
C. HEALTH CARE

33. Persons with disabilities face multiple difficulties in obtaining health care. Access to primary health care is often limited by a lack of accessible facilities and trained staff. Persons with disabilities often need long-term rehabilitation and specialized care related to their disability or additional needs associated with secondary conditions. Without adequate health insurance, they face a heavy financial burden; according to the World Health Survey, persons with disabilities in low-income countries are 50 per cent more likely to face catastrophic health payments than persons without disabilities. Government efforts to provide access to health care to persons with disabilities are therefore critical.

34. The little data available seems to confirm that the Arab region does not deviate from the global pattern of persons with disabilities lacking access to suitable health services. A 2006 study carried out in Morocco showed persons with disabilities voicing a strong need for better health care and rehabilitation services (55.3 per cent) and medications (21.3 per cent).[42] In Palestine, the 2011 Disability Survey found that most persons with disabilities (regardless of disability type) faced difficulties in accessing medical services (figure V). Access to health care and rehabilitation services becomes even more dire in situations of armed conflict and displacement, when facilities and services may be damaged or destroyed and medical personnel is lacking. In a study by Handicap International, 88 per cent of internally displaced persons with new injuries related to the conflict in the Syrian Arab Republic reported that access to rehabilitation services was unsatisfactory.[43]

Figure V. Persons with disabilities (18 years of age and above) experiencing some or a lot of difficulty accessing medical services, by disability type, Palestine

(Percentage)



Source: Palestinian Central Bureau of Statistics and Ministry of Social Affairs, 2011, p. 43.

[41] Act No. 74 of 2006 on the welfare, rehabilitation and employment of persons with disabilities, article 3 (Bahrain); Act No. 31 of 2007 on the rights of persons with disabilities (Jordan); Act No. 40 of 2010 amending article 7 of Act No. 74 (Bahrain); National Strategy for Persons with Disabilities Phase 2, 2010-2015 (Jordan); Act No. 8 of 2010 on the rights of people with disabilities (Kuwait); Decree No. 63/2008 promulgating the Care and Rehabilitation of the Disabled Act (Oman); Disability Code issued by Royal Decree No. 37 of December 2000 (Saudi Arabia); Act No. 2 of 2004 on persons with special needs (Qatar).

[42] Silva and others, 2013, p. 94.

[43] Handicap International, 2014, p. 2.

35. Most legislative frameworks in the Arab region guarantee the right of persons with disabilities to adequate health care and rehabilitation services. Act No. 31 of 2007 in Jordan and Act No. 38 of 2013 in Iraq, for example, guarantee free health insurance for persons with disabilities. Act No. 220/2000 in Lebanon and Act No. 29/2006 in the United Arab Emirates outline a range of health care and rehabilitation services that persons with disabilities are entitled to at the expense of the State. However, high levels of exclusion and marginalization of persons with disabilities in the region highlight the challenges of translating these principles into practice. Coverage gaps can be caused by a variety of factors, including the use of narrow definitions of disability and stringent eligibility requirements, the existence of physical obstacles and barriers in terms of communication or attitudes in the health sector, and deficiencies in monitoring and enforcement mechanisms.

V. THE WAY FORWARD

36. Agricultural workers in the informal sector and persons with disabilities are just two social groups insufficiently covered by social protection systems. Others include the unemployed, informal workers in urban settings and day labourers. In certain circumstances, divorced women are highly vulnerable if protective legislation is not properly enforced.

37. The many disadvantages of the informal sector, including precarious conditions, low wages, and insufficient income support or access to education and health care, leave societies divided, not only in terms of income distribution and social protection, but also in terms of human capital. Such welfare dualism is not sustainable and makes societies highly vulnerable with regards to social cohesion and economic and social development.

38. The post-2015 development agenda emphasizes that policies and strategies must consider not just inequality of income or wealth, but also inequality of opportunity and structural disadvantages faced by some social groups. SDGs underline the need for Governments to look to the quality and not just the quantity of social services. Public social services are often stretched too thinly, limiting availability to vulnerable groups and/or proving to be of inadequate quality. For example, attention must be paid not merely to whether there are health centres in rural areas, but also to whether they provide adequate and affordable care, especially for persons living in poverty.

39. Non-material impediments like prejudice, stigma and discrimination often present additional barriers to equal access to social services. In order to prevent stigmatization, children with disabilities are sometimes not registered by their families. Deep-seated cultural factors have a major impact on the life chances of, for example, the nomads in the Sudan, the Akhdam in Yemen and the Bidun in some GCC countries.

40. It is therefore recommended that Governments:

(a) *Establish clear policy priorities for improving basic protection and services*

This includes clarifying the role of the State vis-à-vis other service providers, be they private sector providers, non-governmental organizations or faith-based organizations. The State may choose to focus on providing good quality basic assistance and services across regions and social groups, as envisaged in the Social Protection Floor Initiative. This will assist people to form human capital, regardless of their social background. Once basic coverage is secured, more diverse, extended and advanced services may be provided by the private sector or civil society groups.

(b) *Address structural disadvantages*

Marginalized social groups often suffer from multiple disadvantages such as underemployment, poverty, social stigma, housing problems and a lack of social capital. Social inclusion and equalization of opportunities for those groups should be accompanied by targeted assistance, such as school support for children, housing support or health-awareness training. Persons with disabilities may need assistive devices, specialized assistance, and support for families and caretakers.

(c) *Launch a national dialogue on social protection reform*

Under any reform of the social protection system, issues of privilege and exclusion must be reviewed. Phasing out privileges is especially difficult, as pension reform in some countries has shown. Explaining, in open discussion with stakeholders, the objectives and rights-based motivation of reforms, limits on State provision of social protection and services, and benefits in terms of social justice and cohesion, will increase acceptance of necessary cuts. Such national dialogue could result in a social protection strategy and plan of action, agreed by all stakeholders.

(d) *Secure sufficient funding for the expansion of social protection*

Taking advantage of historically low oil prices, many countries, including Egypt, Kuwait and Oman, have started to cut energy subsidies. Resources thus freed up should be used to expand social protection. Governments might consider using part of them to (temporarily) subsidize social insurance systems. Such a move might not only help small and medium enterprises, in particular, to register employees for social security, but also support their expansion.

(e) *Eliminate fragmentation and duplication in services*

The sheer number of social protection actors, including government agencies, faith-based organizations, civil society and private sector institutions, make it difficult to assess the overall level of coverage and identify gaps. By consolidating public programmes, applying coherent eligibility criteria and establishing systems of data and information sharing, efficiency can be enhanced. Unified databases are a good first step.

(f) *Expand the production of timely and reliable data for social protection*

There is an urgent need for more accurate, timely, comparable, disaggregated national data to inform programme and policy development, allocate resources, and better monitor whether services reach those who need them. Clear and harmonized indicators based on standard definitions are also required to enable effective monitoring of progress and comparisons between countries. The six short questions developed by the Washington Group on Disability Statistics, which have been incorporated into the census instruments of many ESCWA member States, provide a good starting point for the collection of more comparable and reliable disability data.[44] In addition, in-depth research is needed on social barriers, whether environmental, cultural or of attitude, in order to break them down. Governments could consider enhancing cooperation, including capacity-building and exchange of good practices, in order to strengthen national capacities for the collection, analysis and dissemination of data on vulnerable groups in line with international standards.

(g) *Expand and refine policy infrastructure*

Since many informal sector workers move in and out of poverty depending on the availability of work, Governments need to become more adept at tracking the status of people, assessing their needs and identifying gaps. Better statistical data is a prerequisite, as are broader training of civil servants and an expansion of access points. Concerted efforts are needed to ensure the implementation of laws and policies on persons with disabilities. Available data indicate that advances in legislation and policy have not been matched by real change for persons with disabilities. Arab Governments should continue to harmonize their institutional, legal and policy frameworks with the Convention on the Rights of Persons with Disabilities and improve implementation and monitoring of the impact of such frameworks on the ground. In addition, further research and policy measures are needed to eliminate environmental, societal, cultural and attitudinal barriers that restrict the participation of persons with disabilities and in particular limit their access to social protection.

[44] See Centers for Disease Control and Prevention, 2009.

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