directing council

PAN AMERICAN HEALTH ORGANIZATION

XXVIII Meeting

regional committee

WORLD HEALTH ORGANIZATION

XXXIII Meeting

Washington, D.C.
September-October 1981

Provisional Agenda Item 35

CD28/29 (Eng.)
29 July 1981
ORIGINAL: ENGLISH

INTERNATIONAL YEAR OF DISABLED PERSONS, 1981

This document is an attempt to draw attention to the problem of disability with particular reference to the situation in the Region of the Americas in the year 1981, the "International Year of Disabled Persons."

The document also refers to PAHO's contribution to the solution of the problem through measures to prevent disability from occurring and by extending programs to provide wider coverage. Methods are suggested for the strengthening of programs for disabled persons, with particular emphasis on primary rehabilitation care at the community level.

INTRODUCTION

1. The year 1981 was proclaimed by Resolution 31/123 of the United Nations General Assembly of 1976 as the "International Year of Disabled Persons (IYDP)," with the theme "Full Participation." At its 34th Session in 1979 the General Assembly expanded this theme to "Full Participation and Equality" (Resolution 31/154).

2. In 1979 the Thirty-first World Health Assembly requested the Director General to contribute as extensively as possible, within the approved budget of WHO, to the success of the Year (Resolution WHA31.39). The Thirty-fourth World Health Assembly, in May 1981, recommended continued efforts for the success of the Year, and the establishment of permanent programs for the disabled as part of health for all by the year 2000. It also requested the development of disability programs within the primary health care context and enhanced cooperation with UN agencies and intergovernmental and nongovernmental organizations in planning and implementing the above programs.

3. The purpose of IYDP is to call the attention of health and welfare authorities to disability as a health and social "problem," to increase general understanding of disability by all people, and to increase services for the disabled, particularly for those who, for economic or geographic reasons, do not have access to existing facilities.

DISABILITY AND THE DISABLED*

The changes in functions and social roles that accompany a disease, accident, congenital condition, or other pathological process have been described as Impairment/Disability/Handicap, where Impairment is any loss or abnormality of psychological, physiological or anatomical structure or function; Disability is any restriction or lack of ability to perform an activity in the manner or within the range considered normal for a human being; and Handicap is a disadvantage for a given individual, resulting from an impairment or disability, that limits or prevents the fulfillment of a role that is normal, depending on age, sex, and social and cultural factors, for that individual.

Examples of the use of the above terms are given in Annex I.

It has been estimated that from 7 to 10 per cent of the world's population have some type of physical or mental disability and that about 1.5 per cent of the population is, at any given moment, in need of assistance. This means that a country of 10,000,000 inhabitants can expect to have a disabled population of from 700,000 to 1,000,000, of whom 15,000 are in active need of some type of rehabilitation service.

The principal causes of disability and approximate numbers on a world basis are given in Annex II.

PREVENTION OF DISABILITY

First-level prevention is applied after the accident or disease has occurred which might lead to impairment and attempts to prevent that impairment from taking place; second-level prevention is an attempt to prevent the impairment from becoming a disability; and third-level prevention includes those actions designed to prevent the disability from becoming a handicap.

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*Adapted from "Training the Disabled in the Community," WHO DPR/80.1

EVOLUTION IN THE DEVELOPMENT OF SERVICES FOR THE DISABLED

During the past decade the emphasis in finding solutions for the problem of disability has shifted from the provision of traditional rehabilitation services in an institutional setting towards programs for the prevention of disability and the provision of primary rehabilitation services at the community level.

Rehabilitation services were originally provided in Europe and the United States of America to people who had suffered severe war injuries, and such cases were of necessity cared for in hospital surroundings. From this developed the concept of the rehabilitation center which became more and more sophisticated in its technology, both with regard to equipment and human resources. From the years 1950 to 1980, most countries in Latin America developed one or more centers along these lines, with PAHO frequently cooperating in the preparation of appropriate personnel. The medical rehabilitation centers were usually equipped to serve paraplegics, hemiplegics, amputees, and neuro-muscular problems, whereas special centers were provided for children with cerebral palsy or speech and hearing problems, and special education centers developed for the mentally retarded.

About ten years ago, concern began to be felt that although these centers were serving well for a limited number of people, they were costly to construct and maintain, and their capacity was limited to those who lived close to them and who could either meet the costs themselves or have them met by some government or insurance agency. It was estimated that possibly some 2 per cent of disabled persons were actually able to use the world's existing facilities and, hence, to continue developing these approaches only along institutional lines would be an economic impossibility for most countries.

It was considered that at least some of the services required could be carried out in simpler surroundings and by less highly trained personnel, and it was decided, therefore, to investigate up to what point it would be feasible to provide basic services at home.

In 1979, a manual was prepared by WHO, Geneva, entitled "Training the Disabled in the Community," and a Spanish version was prepared for Latin America. It consists of 20 individual handbooks written in very simple Spanish, with illustrations designed to be easily understood by the users. The booklets cover general rehabilitation problems such as social, domestic, and educational difficulties; specific problems such as those of movement, sight, hearing, and speech; and there are three further guides for those in the community who are principally involved--the local authorities, schoolteachers, and community health workers.

The application of these techniques by community health workers in peoples' homes has added a new element in the field of disability prevention and rehabilitation, and opens the way for a much greater coverage for the world's disabled population.

THE SITUATION CONCERNING SERVICES TO THE DISABLED IN THE REGION, 1981

The situation in this Region at the moment is that most rehabilitation of disabled people is being carried out in institutions. Highly developed countries such as the United States of America and, to a lesser extent, Canada, by virtue of having many specialized centers and hospital departments have a greater coverage than most countries in Latin America. However, even in these two countries coverage is far from complete.

In Latin America, where there are far fewer rehabilitation facilities, coverage of disabled persons is very poor, and available only to those who live close to one of the few existing centers or departments, and even then financial restrictions may prevent their use.

Rehabilitation centers do, of course, have a useful part to play in assisting disabled persons, but their usefulness could be far more widely felt if they were used not only as service centers but as training centers for community health workers in rehabilitation activities, as supervisors of work being carried out at the community level, and as referral institutions for disabilities too severe to respond to assistance at the community level.

For the past 20 years PAHO has been involved in the preparation of personnel for the provision of rehabilitation services. Training courses and fellowships have been given for doctors, physical and occupational therapists, speech therapists and prosthethists/orthotics. During the 1960's and early 1970's, a series of study groups were held concerning the appropriate training required for each of these disciplines, with the aim of enabling relatively uniform training to be provided for such personnel throughout the Region. In 1981 work along these lines is continuing in Argentina, Chile, Mexico, Peru, and Venezuela.

During 1981 PAHO has also been collaborating with government and non-government agencies in implementing rehabilitation programs, and has been represented at both national and international meetings concerned with IYDP.

Training schools for doctors and therapists in rehabilitation work have been set up in most countries in the Region, which has become largely self-sufficient in this area. For those countries still requiring outside assistance, the use of short-term consultants can usually fill

the need. However, the fact that most countries are providing training for conventional rehabilitation personnel unfortunately does not solve the problem of disability in the Region. As pointed out earlier, the sheer number of disabled persons requiring assistance means that, if all the services required are to be provided by specialized staff, they will be needed in such large numbers that the cost of maintaining them will be totally unrealistic. Other complimentary methods must be found.

PROPOSALS FOR FUTURE PROGRAM DEVELOPMENT

The International Year of Disabled Persons has increased the awareness of many people of the magnitude of the problem of disability throughout the world. It is a propitious moment therefore for re-emphasizing the need for the prevention of disability and rehabilitation of the disabled to be included in all public health programs and for the reorientation of some of the ways in which this may be achieved.

The document, "Health for All: Plan of Action for the Implementation of Regional Strategies," refers to four main areas of action for the disabled:

a) Development of policies and programs;

b) Development of technologies;

c) Promotion of community participation;

d) Development of human resources and research.

A. Policies and Programs

To create a policy leading to programs which will provide national coverage requires that the matter be considered from several points of view. First some kind of estimate should be made of the number of people needing rehabilitation assistance. A rough guide is the 1.5 per cent quoted above, but surveys should also be made at least in selected areas. A further estimate should then be made of how many of these are moderate disabilities which can be assisted at the community level, and how many need institutional help. A survey in Mexico suggests that 41 per cent can be helped at the community level, rising to 59 per cent if therapists or other specialized personnel are available, and that 12 per cent cannot be assisted without institutional help, but these figures will vary in accordance with the availability and sophistication of existing facilities. This gives a guide as to how much community activity will be needed and the minimum of institutional care which should be provided.

Consideration has to be given to effective multisectoral cooperation, particularly with regard to health education and labor.

Provision of services has to be made for the following categories of disabled persons:

1. Mild disabilities which can be improved at the community level.

2. Moderate to severe disabilities which need:

   a) evaluation and early care at an institution providing surgery and physical therapy; or

   b) evaluation and early care at an institution providing appropriate rehabilitation services (physical therapy, speech and hearing therapy, therapy for visual problems or therapy for mental problems);

   c) provision for education in the case of disabled children; and

   d) provision for job-training in the case of disabled adults.

3. Very severe disabilities which are not susceptible to rehabilitation and require custodial care.

The provision of appropriate services for all the disabled population, including programs for the prevention of disability, can, in most countries, only be accepted as a long-term goal. The people that can be assisted at the community level (group 1) the greater, of course, will be the coverage. An analysis of disabled persons in group 2 and of the existing specialized services in the country will indicate whether more specialized institutions or hospitals are needed. Further assessments could be made as to whether existing facilities are being used to provide the fullest possible coverage.

Institutional facilities staffed by specialized personnel should only be provided to cover the real needs of the country. Wherever possible, the problems of the disabled should be solved at the community level.

B. Technologies

The conventional technologies must continue to be taught so that they are available when required. Every country must have its cadre of well-trained rehabilitation personnel. However, more and more it will become part of the jobs of these specialized persons to train and supervise community health workers so that as much as possible of the proposed assistance can be given at home, using the technology mentioned previously in this paper. In fact it is to be hoped that techniques for helping the disabled at the community level will include the training of all community

health workers, and it would be of great value if, at least, the concept of helping disabled persons in relatively simple ways were to become part of the training of all health personnel, especially doctors.

C. Community Participation

In addition to having suitable technology to be applied at the community level, it is equally important that the community as a whole be oriented in its attitudes toward the disabled. Disabled persons should be encouraged to move around in the community as much as possible, and to take part in community activities both socially and politically.

Community leaders should be closely involved in the organization of these services, and schoolteachers should be asked to cooperate in both identifying disabled schoolchildren and accepting them wherever possible in the regular classes.

The community should also be encouraged to assist disabled persons to find employment, however simple such employment may be. The more involved the community can become, the less disability will prove to be a handicap.

D. Human Resources and Research

Support should be given, therefore, to training programs at all levels. Where still required, training should be provided for medical rehabilitation doctors and rehabilitation therapists, (physical and occupational therapists, speech therapists, prosthetists/orthotists and vocational workers). However, at the same time, provision must be made for community work, preferably giving training in simplified rehabilitation to existing community health workers.

Further research is needed both to improve this basic technology and to find ways for its implementation on a large scale. The technology has been shown to work when there are permanent appropriate local staff to apply it. It appears that more and more countries are training community health workers for various aspects of health care, and it would seem that this would be the key to extended coverage for the disabled on a wide basis. When it becomes possible to ensure that all community health workers are also capable of giving basic rehabilitation services, then health authorities will be in a better position to give disability the attention it requires.

CONCLUSIONS

The International Year of Disabled Persons is of value in calling the world's attention to the problem of disability, but it will only be of lasting value if use is made of this awareness to create policies which will continue long beyond the Year itself.

Conventional rehabilitation services should be strengthened in those countries which have not yet sufficiently developed them, and training provided for appropriate personnel to provide such services; however, all countries should consider complimenting these services with additional programs to provide primary rehabilitation services at the community level.

Annexes

EXAMPLES OF IMPAIRMENT/DISABILITY/HANDICAP

Example 1: A 16-year-old boy is involved in a traffic accident and one leg had to be amputated above the knee.

Impairment: Loss of leg.

Disability: Decreased ability to walk.

Handicaps: Decreased ability to work, to enjoy normal social activities (sports, dancing) and to have social relationships.

Example 2: A 50-year-old male, who has had hypertension for several years, suffers a stroke resulting in a right-side hemiparalysis and dysphasia.

Impairment: Hypertension.
Disturbance of brain function.

Disabilities: Decreased ability to talk.
Decreased ability to walk and use right hand.
Fatigue through low physical endurance.

Handicaps: Inability to work, partial inhability to look after himself, and reduced ability to interact with surroundings.

Example 3: A 3-year-old girl is left with severe scars on her face and her entire left arm after burns.

Impairments: Burn scars.
Abnormal appearance.

Disabilities: Decreased mobility of arm.
Decreased interest in and contact with surroundings.

Handicaps: Decreased capacity to take part in household work, disturbed social relationships (rejected by family and community members), and marriage prospects greatly decreased.

Example 4: An adult married female, with two children, with a two-year history of "schizophrenia."

Impairments: Auditory hallucinations.
Lack of volition (i.e., normal drive and interest).
Disturbance of thought processes.

Disabilities: Inability to maintain drive and interest in daily tasks.
Poor attention and grasp of information.
Lack of contact with reality.

Handicaps: Failure to care for children, perform housework, maintain personal hygiene and appearance, and relate to family members and friends.

Example 5: A 50-year-old married man with daily intake of 300 ml absolute alcohol in the form of distilled spirits owing to an inability to abstain from alcohol, withdrawal symptoms each morning (tremor, anxiety, and butterflies in stomach, which are supressed by further alcohol intake), and episodes of amnesia.

Impairments: Inability to abstain from alcohol intake (note: may also have disturbance of brain function, impaired sensation in hands and feet, liver damage, etc.)

Disabilities: Lack of judgement and motor skills.
Drive and motivation disturbed by need to obtain alcohol.

Handicaps: Marked decreased in working efficiency (increased errors, decreased output, absenteeism) leading to inability to work, inability to maintain economic necessities of life, and disturbed social relationships.

Example 6: A 15-year-old mentally retarded boy with no education.

Impairment: Abnormally low intelligence.

Disabilities: Slowness in acquisition of skills and knowledge.
Inability to read, write, or make simple calculations.

Handicaps: Unable to work, and disturbed social relationships.

Example 7: A 40-year-old woman with leprosy for several years.

Impairments: Loss of tissue from hands and feet.
Loss of sensory function in several areas.
Ulceration of skin.
Rash.

Disability: Decreased mobility and motor skills.

Handicaps: Unable to perform household and family duties and to have normal social relationships.

THE CAUSES OF DISABILITY AND APPROXIMATE NUMBER OF DISABLED PEOPLE IN THE WORLD

Medical cause	Estimated disabled people (world population 4,000 million)	
	Million	%
Congenital disturbances:		
Mental retardation[1/]	40	7.7
Somatic heriditary defects	40	7.7
Non-genetic disorders	20	3.9
Communicable diseases:		
Poliomyelitis	1.5	0.3
Trachoma	10	1.9
Leprosy	3.5	0.7
Onchocerciasis	1	0.2
Other communicable diseases	40	7.7
Noncommunicable somatic diseases	100	19.3
Functional psychiatric disturbance	40	7.7
Chronic alcoholism and drug abuse	40	7.7
Trauma/injury:		
Traffic accidents	30	5.8
Occupational accidents	15	2.9
Home accidents	30	5.8
Other	3	0.6
Malnutrition	100	19.3
Other	2	0.4
	Total 516	100.0
Correction for possible double accounting (-25%)	- 129	
	Total 387	

1/ Not all of these are congenital cases

PREVENTION OF DISABILITY[1/]

Measures to diminish disability and handicap area of great importance, and should be given priority whenever possible.

As defined by WHO[2/], prevention may be seen operating at three different levels:

MALNUTRITION
DISEASE
ACCIDENTS
CONGENITAL CONDITIONS
OTHER CAUSES

FIRST LEVEL PREVENTION

IMPAIRMENT

SECOND LEVEL PREVENTION

DISABILITY

THIRD LEVEL PREVENTION

HANDICAP

a) First level prevention includes all action taken to reduce the occurrence of impairment.

b) Second level prevention includes all action taken to reduce the transition of impairment into disability.

c) Third level prevention includes all action taken to reduce the transition of disability into handicap.

Some details regarding these three levels follow.

1/ As given in "Training the Disabled in the Community," WHO DPR/80.1
2/ A29/INF.DOC/1, World Health Organization, Geneva, 1976.

a) First Level Prevention

Examples of what can be done to prevent or limit occurrence of impairment.

SUMMARY OF THE MOST IMPORTANT MEASURES TO PREVENT DISABILITY

PROBLEMS	EXAMPLES OF MEASURES
Nutrition	Improved agriculture to increase and diversify output, to improve distribution of foodstuffs, provision of fertilizers and training of rural population in appropriate agricultural techniques, irrigation, etc., public education to improve composition of meals and cooking habits, better control of gastrointestinal infections, supplementary feeding, e.g. vitamins and iodine.
Communicable diseases	Provision of proper water and sewage systems, public education to improve hygiene and avoid transmission of disease, vaccination.
Road accidents	Public education for drivers and pedestrians, better supervision of children at accident-prone age, technically improved roads and safer vehicles, legislation and improvement of traffic regulations.
Home accidents	Community education, better supervision of children, improvement of housing and home installations (e.g., cooking stoves and use of dangerous fuel), legislation and enforcement of rules to prevent accidents.
Occupational accidents and diseases	Education of workers, improved tools and machinery (including agriculture), monitoring of accidents and environmental hazards, use of safety devices (e.g., when climbing houses and trees), legislation to protect against hazardous agents, safety committees.
Genetic disorders	Counselling to discourage consanguinous marriages, child spacing to reduce natality in high risk families. Contraception, pregnancy termination, sterilization, if culturally acceptable.

PROBLEMS	EXAMPLES OF MEASURES
Perinatal diseases (e.g. cerebral palsy and brain damage)	Improved perinatal care.
Child neglect and abuse	Community education, improved level of schooling, legislation and law enforcement.
Alcohol and drug abuse	Legislation and law enforcement to reduce supply, public education to understand consequences of abuse.
Impairment caused by medicines	Better control of drug import and manufacture, legislation to forbid potentially hazardous drugs.

It may be estimated that measures such as those mentioned may reduce the incidence of disability/handicap by about one-third. As most of the preventive action suggested will have an impact on disability in infants and children, this means that life-long disability/handicap, and excessive mortality in infants and children, may be substantially reduced.

b) Second Level Prevention

When an impairment has already appeared, it is necessary to try to prevent any long-term disability from occurring and to do so requires measures specifically in three areas.

1. Ability to identify those impairments that might lead to disability e.g., to recognize a person with mental retardation, to make a simple test of visual and hearing acuity, to diagnose leprosy, tuberculosis, a fracture, epilepsy, psychosis, etc.

2. Proper care of impairments in the acute stage to avoid subsequent disability, e.g. skills to administer first aid, to splint a fracture and to advise on suitable exercise during its treatment, to sterilize or avoid infection of wounds and burns, to effectively treat persons with acute otitis, trachoma and other eye infections, to manage a patient with an epileptic fit, or one with acute symptoms of psychosis, etc.

3. Proper care of impairments in a chronic stage; drug, surgical and other treatment of patients with epilepsy, leprosy, tuberculosis, psychosis, high blood pressure, diabetes, chronic arthritis, bronchial asthma, chronic skin lesions, cataracts, etc.

The above involves mainly improvements in the delivery of primary and secondary health care. If fully effective, the occurrence of disability/handicap may be reduced by about 20-30 per cent. When planning the development of health services, most attention is presently paid to acute diseases, and less to measures that are effective in prevention of disability.

Thus, it is important that the planning for health care is revised with the aim to ensuring the provision of the care mentioned.

c) Third Level Prevention

Once a long-term disability has developed, one should try to institute measures aimed at the prevention of handicap.

The incidence of disability/handicap can be reduced by at least 50 per cent, possibly even more, if appropriate, effective primary and secondary level prevention is implemented in developing countries.

The preventive effects would be most obvious among infants, children and young people, thus avoiding long-lasting disabilities.

INTERNATIONAL AGREEMENTS AND POLICIES RELEVANT TO THE DISABLED

1. Excerpts from the Universal Declaration of Human Rights
Adopted and proclaimed by the U.N. General Assembly, Resolution 217 A (III) of 10 December 1948

Preamble

Whereas recognition of the inherent dignity and of the equal and inalienable rights of all members of the human families is the foundation of freedom, justice and peace in the world,

Whereas the peoples of the United Nations have in the Charter reaffirmed their faith in fundamental human rights, in the dignity and worth of the human person and in the equal rights of men and women and have determined to promote social progress and better standards of life in larger freedom,

Whereas Member States have pledged themselves to achieve, in cooperation with the United Nations, the promotion of the universal respect for and observance of human rights and fundamental freedoms,

Whereas a common understanding of these rights and the freedoms is of the greatest importance for the full realization of this pledge,

Now, therefore,

The General Assembly

Proclaims this Universal Declaration of Human Rights as a common standard of achievement for all peoples and all nations, to the end that every individual and every organ of society, keeping this Declaration constantly in mind, shall strive by teaching and education to promote respect for these rights and freedoms and by progressive measures, national and international, to secure their universal and effective recognition and observance, both among the peoples of Member States themselves and among the peoples of territories under their jurisdiction.

Article 1

All human beings are borne free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood.

Article 2

Everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, color, sex, language, religion, political or other opinion, national or social origin, property, birth, or other status.

Article 22

Everyone, as a member of society has the right to social security and is entitled to realization, through national effort and international cooperation and in accordance with the organization and resources of each State, of the economic, social and cultural rights indispensable for his dignity and the free development of his personality.

Article 23

1. Everyone has the right to work, to free choice of employment, to just and favorable conditions of work and to protection against unemployment.

2. Everyone, without any discrimination, has the right to equal pay for equal work.

3. Everyone who works has the right to just and favorable remuneration ensuring for himself and his family an existence worthy of human dignity, and supplemented, if necessary, by other means of social protection.

4. Everyone has the right to form and to join trade unions for the protection of his interests.

Article 24

Everyone has the right to rest and leisure, including reasonable limitations of working hours and periodic holidays with pay.

Article 25

1. Everyone has the right to a standard of living adequate for the health and wellbeing of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

2. Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection.

Article 26

1. Everyone has the right to education. Education shall be free, at least in the elementary and fundamental stages. Elementary education shall be compulsory. Technical and professional education shall be made generally available and higher education shall be equally accessible to all on the basis of merit.

2. Education shall be directed to the full development of the human personality and to the strengthening of respect for human rights and fundamentals freedoms. It shall promote understanding, tolerance and friendship among all nations, racial and religious groups, and shall further the activities of the United Nations for the maintenance of peace.

3. Parents have a prior right to choose the kind of education that shall be given to their children.

Article 27

1. Everyone has the right freely to participate in the cultural life of the community, to enjoy the arts and to share in scientific advancement and its benefits.

2. Everyone has the right to the protection of the moral and material interests resulting from any scientific, literary or artistic production of which he is the author.

Article 28

Everyone is entitled to a social and international order in which the rights and freedoms set forth in this Declaration can be fully realized.

Article 29

1. Everyone has duties to the community in which alone the free and full development of his personality is possible.

2. In the exercise of his rights and freedoms, everyone shall be subject only to such limitations as are determined by law solely for the purpose of securing due recognition and respect for the rights and freedoms of others and of meeting the just requirements of morality, public order and the general welfare in a democratic society.

3. These rights and freedoms may in no case be exercised contrary to the purposes and principles of the United Nations.

2. Declaration on the Rights of Disabled Persons
Adopted by the U.N. General Assembly, Resolution 3447 (XXX), 9 December 1975

The General Assembly,

Mindful of the pledge made by Member States, under the Charter of the United Nations, to take joint and separate action in cooperation with the Organizations to promote higher standards of living, full employment and conditions of economic and social progress and development,

Reaffirming its faith in human rights and fundamental freedoms and in the principles of peace, of the dignity and worth of the human person and of social justice proclaimed in the Charter,

Recalling the principles of the Universal Declaration of Human Rights, the International Covenants on Human Rights, the Declaration of the Rights of the Child and the Declaration on the Rights of Mentally Retarded Persons, as well as the standards already set for social progress in the constitutions, conventions, recommendations and resolutions of the International Labour Organization, the United Nations Educational, Scientific and Cultural Organization, the World Health Organization, the United Nations Children's Fund and other organizations concerned,

Recalling also Economic and Social Council resolution 1921 (LVIII) of 6 May 1975 on prevention of disability and rehabilitation of disabled persons,

Emphasizing that the Declaration of Social Progress and Development has proclaimed the necessity of protecting the rights and assuring the welfare and rehabilitation of the physically and mentally disadvantaged,

Bearing in mind the necessity of preventing physical and mental disabilities and of assisting disabled persons to develop their abilities in the most varied fields of activities and of promoting their integration as far as possible in normal life,

Aware that certain countries, at their present stage of development, can devote only limited efforts to this end,

Proclaims this Declaration on the rights of Disabled Persons and calls for national and international action to ensure that it will be used as a common basis and frame of reference for the protection of these rights:

1. The term "disabled person" means any person unable to ensure by himself or herself, wholly or partly, the necessities of a normal individual and/or social life, as a result of a deficiency, either congenital or not in his or her physical or mental capabilities.

2. Disabled persons shall enjoy all the rights set forth in this Declaration. These rights shall be granted to all disabled persons without any exception whatsoever and without distinction or discrimination on the basis of race, color, sex, language, religion, political or other opinions, national or social origin, state of wealth, birth or any other situation applying either to the disabled person himself or herself or to his or her family.

3. Disabled persons have the inherent right to respect for their human dignity. Disabled persons, whatever the origin, nature and seriousness of their handicaps and disabilities, have the same fundamental rights as their fellow-citizens of the same age, which implies first and foremost the right to enjoy a decent life, as normal and full as possible.

4. Disabled persons have the same civil and political rights as other human beings; paragraph 7 of the Declaration of the Rights of Mentally Retarded Persons applies to any possible limitation or suppression of those rights for mentally disabled persons.

5. Disabled persons are entitled to the measures designed to enable them to become as self-reliant as possible.

6. Disabled persons have the right to medical, psychological and functional treatment, including prosthetic and orthetic appliances, to medical and social rehabilitation, education, vocational training and rehabilitation, aid, counselling, placement services and other services which will enable them to develop their capabilities and skills to the maximum and will hasten the process of their social integration or reintegration.

7. Disabled persons have the right to economic and social security and to a decent level of living. They have the right, according to their capabilities, to secure and retain employment or to engage in a useful, productive and remunerative occupation and to join trade unions.

8. Disabled persons are entitled to have their special needs taken into consideration at all stages of economic and social planning.

9. Disabled persons have the right to live with their families or with foster parents and to participate in all social, creative or recreational activities. No disabled person shall be subjected, as far as his or her residence is concerned, to differential treatment other than that required by his or her condition or by the improvement which he or she may derive therefrom. If the stay of a disabled person in a specialized establishment is indispensable, the environment and living conditions therein shall be as close as possible to those of the normal life of a person of his or her age.

10. Disabled persons shall be protected against all exploitation, all regulations and all treatment of a discriminatory, abusive or degrading nature.

11. Disabled persons shall be able to avail themselves of qualified legal aid when such aid proves indispensable for the protection of their persons and property. If judicial proceedings are instituted against them, the legal procedure applied shall take their physical and mental condition fully into account.

12. Organizations of disabled persons may be usefully consulted in all matters regarding the rights of disabled persons.

13. Disabled persons, their families and communities shall be fully informed, by all appropriate means, of the rights contained in this Declaration.