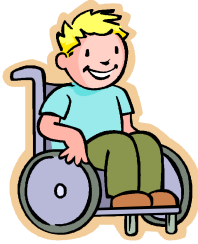


CHILDREN AND DISABILITY IN MOLDOVA

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Children and the Problem of Disability in the Republic of Moldova

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Introduction

Since 1990 the Republic of Moldova has been suffering from the problems typical of economies in transfer from centralized planning to the market, which become apparent through economic stagnation, growing disparity of income and aggravating financial situation and living standards of families and children. It should be pointed out that a number of positive patterns became prominent in the economy in the last year (such as arrested inflation rates and a slow-down in further decline of the living standards and welfare of the population; more efficient utilization of the available resources, etc.). Moldova's per capita GDP, however, is still among the lowest in the Eastern Europe – it makes about USD 400. The analysis of the situation for the last decade has demonstrated that the respective 2000 figure amounts to as little as 34% of the 1990 level.

According to the 2002 Human Development Report, the Republic of Moldova rates 105th (its Human Development Index, or HDI is 0.701), whereas Moldova's neighbor countries Romania and Ukraine rate respectively 63rd and 80th. Furthermore, Moldova rates the one before last among the former Soviet Union Republics (NIS countries), ahead only of Tajikistan (with its HDI of 0.667). Moldova was given that rating based on the indices of longevity (measured by life expectancy at birth) and educational attainment (measured by coverage with school education). If we take into account the GDP index alone, then Moldova is rated among underdeveloped countries.

The economic decline has resulted in the aggravation of living standards, devaluation of salaries and wages and other types of income, coupled with the narrowed employment possibilities. Thus, in 2001 the average salaries sufficed to finance a little more than a half of the minimum consumption basket (the respective figures made MDL 544 and MDL 1053). In the last years the migration (mainly emigration) with the aim of finding employment abroad became a means to supplement family income (the total number of legal and illegal emigrants has reached by now approximately 600 thousand persons). Resultantly, the children are left quite often in the charge of their elderly grandparents, neighbors or distant relatives, devoid of parental care and means of subsistence. Many such children suffer from lack of food, they quit going to school or become waifs due to general abandonment. The continuing economic crisis results, among other problems, in insufficient financing of the social sector, which leads in its turn to limited availability and poor quality of the social services provided to children and families. Thus, in the last 5 years allocations from the budget to finance education and health care fell from 46.7% of the total budgeted expense (1997) down to 33.8% (2001).

Furthermore, the transfer to the market has brought to life considerable demographic changes. In the period of 1990 to 2001 birth rate per 1000 persons fell from 17.7 down to 9.6 whereas death rate grew up to 11.2.

All the above is an indication of the crisis in social values existing with broad public, which can be stated next to the economic crisis. Alcoholism (dipsomania), drug addiction and drug

dependence, prostitution, trafficking in people, and violence in the family have a steadily growing negative impact upon the integrity and living standards of the family, which can be defined as the primary cell of the society. At the same time, the combined impact of poverty and inadequate investments in the social sphere has resulted in the decreasing affordability to support and protect children in a family, in particular where the children in question have certain aberrations or disfunctions requiring specialized care, or disabilities.

The problem of ensuring the efficient social and legal protection for the family and children in conformity with the international norms and provisions of the national constitution is of particular importance for the Republic of Moldova. Such protection is based on the statutory and constitutional principles. According to Article 48 to 51 of Moldova's constitution, the state protects the interests of the family, the mothers, orphaned children, children with disabilities and teenagers. Moldova, similar to other countries, acceded to the UN Convention on the Rights of the Child as early as 1990, and the norms and principles of the above convention are implemented in the national legislation.

Thus, in 1994 the Parliament of Moldova adopted the law on the rights of the child, and in 1995-2002, based on that law, the country's President and the Moldovan Government approved a number of vitally important national programs and regulations designed to protect the interests of the family and the child as well as orphaned children, children with retarded development and disabled children. Article 24 *of the Law on the Rights of the Child* secures the principal rights and responsibilities of the state in respect of children with disabilities or with physical, mental or psychic aberrations or deficiencies. Such guarantees include free medical services, specialized psychological assistance, attainment of general and vocational education, employment according to one's skills, social rehabilitation, and provision of social pensions to the disabled. All the above is aimed to ensure adequate living conditions for children with disabilities and to facilitate their active integration in the social life.

One of the major social problems is the problem of social protection and reintegration of persons with aberrations and disfunctions. The basic document, which regulates such activities, is *the Law on Social Protection of Persons with Disabilities* No. 821-XII of December 24, 1991, setting the underlying social assistance principles, objectives, forms and services designed to observe the rights of the persons falling into the above social category, and to facilitate their integration in the society. In the Republic of Moldova persons with disabilities enjoy a whole range of social, economic and personal rights and freedoms secured in the Declaration on the Rights of Persons with Disabilities, as adopted by the UN General Assembly, the Constitution of the Republic of Moldova, this Law and other legislation. Discrimination of persons with disabilities is prohibited and prosecuted by law.

As mentioned above, the transfer to the market has an additional aggravating effect on the social situation and living standards of the broad public in general and in particular of persons with disabilities, thus bringing to life the necessity of introducing special measures for their protection. The Resolution of the Moldovan Government No. 1153 of November 16, 2000, adopted *the National Program of Social Protection, Rehabilitation and Integration of Persons with Disabilities for 2000-2005*. The goal of the above program is to approve principal directions for measures to be taken in that sphere with account of the government's realistic financial and economic possibilities. The Program specifies certain measures intended to secure equal opportunities for persons with aberrations, disfunctions and disabilities by way of decreasing their dependence on other persons and removal of eventual limitations and restrictions via development of rehabilitation mechanisms within the framework of de-centralized social centers and services. Thus, the most important objectives of the above program are:

- ✓ Development of a positive social attitude towards persons with disabilities and promotion of the positive image of persons with disabilities among the general public;
- ✓ Actions and measures designed to prevent disability and to improve medical assistance to persons with disabilities;
- ✓ Measures aimed at rehabilitation and education of persons with disabilities, providing them access, and organizing their recreation time through specialized cultural, sports, touristic and other events.

Worth mention in the sphere of child protection is *the National Concept on Protection of the Child and the Family* (Resolution of the Moldovan Government No. 51 of January 23, 2002), aimed primarily at:

- ✓ Families with children in risk of neglect;
- ✓ Families in children in extreme poverty;
- ✓ Orphans and children left without parental care;
- ✓ Children with aberrations, deficiencies and HIV/ AIDS infected children;
- ✓ Children and teenagers with behavioral aberrations;
- ✓ Children accommodated in the various social institutions as well as other socially vulnerable categories of children.

A number of regulations were developed and adopted last year directly in respect of orphaned children (*Pilot Program “Orphaned Children”* approved by Government Resolution No. 1321 of October 9, 2002), children with aberrations, deficiencies and disabilities (*Pilot Program “Children with Aberrations and Deficiencies”* - currently under consideration in draft). The main goal of the program “Children with Aberrations and Deficiencies”, which is currently under development, is the improvement of living standards and quality of rehabilitation for such children via social services and actions to be taken at all levels: centralized and local as well as on the level of foreign experts, donors and civil society.

It is evident without any doubt, however, that the existence of the relevant legal environment cannot guarantee by itself the solution of such problems. It would be possible solely as the result of implementation and actual application of the existing regulations, i.e. implementation of the relevant policies and fulfillment of pre-set objectives, and it is extremely difficult for an economy in transfer to the market due to lack of economic stability and financial problems.

1. Children with Disabilities: The General Profile

According to the Law on Social Protection of Persons with Disabilities, a person with disabilities is *the person in need of social assistance and protection due to limited vital functions caused by certain physical or mental deficiencies*. Limited vital functions become apparent through a full or partial loss of the person’s ability to service himself/ herself, move around, get his/ her bearings, communicate, control his/ her behavior and sell his/ her labor. A person may be formally acknowledged a person with disabilities by the relevant governmental authorities acting within their powers and following specified procedures. The authorities in question are: medical consultative commissions operating by certain treatment or preventive treatment facilities within the healthcare system subordinated to the Ministry of Health - in respect of children and teenagers under 16 (i.e. aged fifteen-plus inclusive), and consultative medical examination commissions on vital human functions operating within the system subordinated to the Ministry of Labor and Social Security – for persons aged 16 and older.

A stable growth pattern can be traced in Moldova in respect of the above category of persons. Thus, the total number of persons with disabilities grew nationwide 1.5-fold, or from 91.6 thousand persons up to 133.8 thousand persons in 1991-2000, and the respective disability rate calculated as the number of the disabled per 1000 persons increased from 21 up to 31. At the same time, practically every tenth person with disabilities is a child or a teenager under 16.

Let us examine the problem of child disability in more detail. 863.5 thousand children aged under 16 were registered in Moldova as of January 1, 2002. The authorities within the Ministry of Health had on their records, as of the above date, 13.3 thousand children registered as children with disabilities. Children of school age (aged 7 to 15) accounted for the major portion – 80% of the children with disabilities - due to a number of reasons. Next to the current demographical situation (where the children aged up to 6 inclusive account for 33% of the total age group under 16, and respectively the children aged 7 to 16 account for the remaining 67%), a number of diseases and illnesses are first discovered only when the children undergo an obligatory medical examination by specialists prior to joining school (in Moldova according to the Law on Education the children are covered by obligatory school education starting at the age of 7).

It is impossible to analyze historical statistics on the dynamics in the total number of children with disabilities for any significant period of time due to a number of reasons. One of such reasons is the age group issue: up to 1997 the totals used to be reported for the age group of children under 15 (i.e. aged 0 to 14-plus inclusive), and beginning in 1998 the totals started being reported for the age group of children under 16 (i.e. aged 0 to 15-plus inclusive). Furthermore, beginning in 2001 the totals representing the number of children with disabilities could not be considered comprehensive any longer because no information was available on the situation in Transnistria – the part of Moldova on the left bank of the Dniester. Therefore it would be reasonable to use for the purposes of comparison only the indices where a stable growth pattern can be traced without any doubt.

	1991	1993	1994	1995	1996	1997	1998	1999	2000	2001
Child disability rate (number of disabled children per 1000 children in the respective age group)	8.0	10.3	11.4	12.1	12.7	13.3	14.9	14.9	15.6	15.4

Child disability rate grew 1.9-fold in 1991 to 2001, reaching the level of 15.4 disabled children per 1000 children of the respective age group. The pattern has been brought to life by the increased percentage of congenital anomalies and a higher rate of diseases (such as psychic disfunctions, nervous system diseases, deafness, blindness, etc.) and traumas with children. At the same time, a number of other causes can be pointed out next to the above, such as: a revised list of diseases, illnesses and pathologies entitling a child aged under 16 to the status of a disabled child (according to the Resolutions of the Moldovan Government No. 300 of June 12, 1991, and No. 1065 of November 11, 1999), higher allowances and benefits for the disabled children providing a better incentive to have such children reported, and general improvements in child disability reporting system.

In order to characterize ‘the population’, i.e. the total number of the disabled children reported as of certain date (in Moldova’s case it is December 31), the following causes can be listed as the principal disability causes: nervous system diseases – practically every fourth child is suffering of them; psychic disfunctions and behavioral aberrations – they account respectively for 22% of the disability cases. Congenital anomalies rate third with 16% of the total number of cases. The latter circumstance causes acute anxiety for it testifies – next to genetic diathesis (predisposition)

– to a direct link with the mother’s state of health. Thus, in 2001 every second woman suffered of anemia out of the total number of women reaching the end of pregnancy (via delivery, premature delivery or abortion). Furthermore, toxicosis, urinogenital system diseases, diseases of circulation organs and other diseases and illnesses caused delivery and post-delivery complications with two of each three women in childbirth. Where every sixth child was born sick or became sick in the maternity hospital in 1990, the respective figures made for Moldova: every fifth child in 1993, and as many as every third child in 2001.

Thus, the statistics analysis has demonstrated that nervous system maladies, mental and behavioral aberrations, and congenital anomalies can be named as the principal cause of child disability for the last decade. On the total, the above illnesses, diseases and disorders cause jointly about 64% of all the disability cases.

Furthermore, it should be noted that many aggravating indicators, which are characterizing general state of health with children, such as congenital anomalies and child trauma rate, reveal the pattern towards growing number of new disability cases.

In the context of the child disability problem it would be interesting to analyze in more detail the data characterizing “the flow”, i.e. the total number of children reported disabled during the year where the cause for disability was diagnosed for the first time: that number makes 2.5 to 3 thousand children annually. In 2000 3.1 thousand children were reported as disabled for the first time, as compared to 2.1 thousand in 1991. Due to the reasons that have been already pointed out in the above (i.e. due to impossibility to compare absolute figures), let us examine the specific rates.

	1991	1993	1994	1995	1996	1997	1998	1999	2000	2001
Children reported disabled during the year where the cause for disability was diagnosed for the first time (per 1000 children in the respective age group)	1.8	2.3	2.3	2.2	2.1	2.3	2.4	2.3	3.5	3.3

When calculated per 1000 children in the respective age group, child disability rate grew 1.8-fold in the years of 1991 to 2001. The principal disability causes identified in the “flow analysis” are similar to the ones identified in the “population analysis”, although slight changes can be noticed in the rating. Thus, psychic disfunctions and behavioral aberrations caused the highest percentage (22%) of all the disability cases among the children reported for the first time as disabled in 2001, including mental deficiency (retardation) in two thirds of cases. Nervous system diseases rated second (causing 17% of all cases), including infantile cerebral paralysis (palsy) in about a half of all cases. Congenital anomalies (affecting every sixth child with disabilities) rated a stable third after psychic disfunctions and nervous system diseases.

In addition to the data available from the Ministry of Health, the Ministry of Labor and Social Security statistics can be used as another source of information, because that ministry has to register and report on the persons receiving pensions, benefits and allowances, including the children with disabilities. The current changes in the laws and regulations on pensions require creation of a flexible reporting system on the various categories of beneficiaries. Thus, children with disabilities were paid social pensions up to 1999, and then the transfer of such children to another category of beneficiaries to financial assistance – social allowances beneficiaries –

started in 1999 (it should be noted that the average amount of such allowance is approximately 25% higher than the average disability pension payable to children). The above circumstance makes it impossible to analyze the information for the year 1999 when active re-registration and transfer to another category of social assistance beneficiaries was taking place. The ultimate transfer of the above category of persons to social allowance beneficiaries requires a certain period of time, so the portion of children with disabilities receiving social pensions is becoming less with every year, and currently the disabled children paid the disability allowance account for the absolute majority (97%) of the total children with disabilities registered with the social assistance authorities.

A stable growth pattern has been traced for a number of years in respect of the total number of children receiving disability pensions and allowances. Where in 1992 such children totaled 8.9 thousand, they made about 12.3 thousand persons as of January 1, 2002. Unfortunately, the generalized data on such children available from the Ministry of labor and social security does not provide comprehensive information presented as breakdowns by sex or age group, disability cause and type, place of residence, etc. At the same time certain information is included in the so-called 'personal account file' opened for each child at the time of awarding him/ her social payments, which circumstance makes possible its utilization in the database on the above category of persons to be created for the purposes of more comprehensive analysis.

More about the structural breakdown of the children receiving disability allowances: in 2001 practically every second child in the above category had disabilities of the second degree (moderate graveness), such as mental retardation (arrest of mental development), grave motor or psychic disorders and speech disturbances, epilepsy and epileptic syndrome without psychic disorders, etc.; 35% of the disabled children had first degree (grave) disabilities, such as progressing malignant tumors, extremely grave neuromotor or psychic disorders and speech disturbances (resulting in inability to move around without external assistance), etc.; the remaining 14% of children had third degree (so-called minor) disabilities, such as deficient (arrested) motor, psychic and speech development, deafness combined with muteness, etc.

Next to continuous medical observation, additional expense is required to prevent aggravations of the general state of health with the disabled children. It must be emphasized that the amounts received as such payments are not sufficient to cover the costs of supporting an ordinary (healthy) child, to say nothing of the specific needs existing with the disabled children. Thus, in the beginning of 2002 an average monthly pension payable for a disabled child made MDL 46 (about USD 3), and the disability allowance amounted to MDL 59 (about USD 4), making respectively 8% and 11% of the average monthly salary of an employed person (MDL 544, or about USD 40). At the same time, according to the 2001 data available from the Ministry of Finance, the expense of the state was about MDL 5000, or approximately MDL 400 in a month (round USD 30) per child cared for in a specialized institution for children with mental or physical development deficiencies, which is 7 times higher than the allowance payable to the respective beneficiary category. In essence, in the Republic of Moldova families with disabled children fall into the category of not sufficiently provided for, or the poor, as the financial assistance received by them is not sufficient to cover the additional expense arising in connection with the care for such children.

The lack of finance to buy foodstuffs and first necessity items contributes to the development of problems due to malnutrition, and adequate nutrition is one of the factors contributing to normal physical and mental development of children. The statistics on sick children aged under 5 indicates that half of the children with endocrine diseases, gastro-intestinal disorders and metabolism problems suffer from hypotrophy, and practically all the remaining ones – from rachitis (rickets).

According to the data gathered in the Household Budget Survey, the situation in respect of nutrition was aggravated in the last years in low-income families, typically having many children. A stable pattern became evident towards decreased consumption of animal origin foodstuffs (meat, milk, eggs). Expensive foodstuffs are replaced with cheap food due to low per capita income, thus contributing to additional misbalance in diet even where calorific consumption is maintained at the same level. It is one of the causes contributing to growth in the number of cardiovascular, oncologic and chronic diseases. It is evident without any doubt that chronic malnutrition is one of the major risks for the adequate physical and mental development of a child, which provokes in its turn decreased capacity for work and insufficient intellectual development.

Preventive medical examinations identify annually the children with deficiencies in physical development (arrested growth, etc.). As compared to 1995, the portion of such children identified during the examination grew from 1.4% to 2% of the total examined children.

The data provided below indicates that a part of the problems existing in respect of the disabled children could be solved, were the necessary finance available. In 2001 the supply of disabled children with specialized devices or aids remained at unsatisfactory level: as little as 5% of the total registered children in need of orthopedic prosthetic devices were supplied with them; the respective percentage was 20% in the case of hearing aids, 26% in the case of wheelchairs and 53% in the case of artificial eyes.

When we compare the figures on the total number of children with disabilities in the Republic of Moldova available from two different sources – the Ministry of Health, and the Ministry of Labor and Social Security, we can notice their correlation, which has been ensured by the improved coordination in the activities of the above authorities. Thus, in 2001 the difference between the total number of children with disabilities under medical observation and the number of such children as beneficiaries to social pensions and allowances was less than 1000 persons for the whole country, which is explainable by the need to formalize all the necessary documents and the respective time span required for registration.

The above figures, however, might be a little lower than the actual number of the disabled children, as the number of formally reported cases depends on whether the parents took their child to the specialized examination or not, and if the medical commission stated the degree (graveness) of disability. It is equally possible that a certain number of children (e.g. children with hearing or sight deficiencies) are not entitled to the disability status according to the provisions of the applicable law.

Let us speak now of sample surveys as the alternative approach to the national child disability analyses. In 1991-1996 a Comprehensive child disability survey was held in Moldova, making it possible to reveal general child disability patterns nationwide and to provide the underlying scientific argumentation for the development of a package of medical, social and organizational measures aimed at child disability prevention and control as well as improved quality of treatment, clinical examination and rehabilitation of children with disabilities. Next to the statistics available from the reports approved by the Ministry of Healthcare, the survey was based on the questionnaires specially developed for the purpose. Let us examine the selective survey results in more detail. The sample size was 4.4 thousand persons. A disabled child aged under 16 was the survey unit. The information was collected by asking questions. The questionnaire of 57 questions touched on the following issues: place of residence and living conditions, sex, age at the time of being recognized disabled for the first time, disability causes, education received, required specialized aids and prosthetic devices, treatment received, etc.

The selective survey demonstrated that 77.3% of the children with disabilities lived in the rural area, and 22.7% - in cities and towns. Boys made more than a half (57.2%) of the sample, and girls accounted for the remaining 42.8%. The majority of the surveyed disabled children fell into the age groups of 6 to 14 (67.4%) and 3 to 6 years of age (22.8%). The above age structure was typical of both the rural area and the urban area.

Congenital anomalies rated first among disability causes (63.0%), followed by pathologies acquired at birth (18.7%), after-effects of various diseases (14.4%) and traumas (3.9%).

Depending on the graveness of pathology, the disabled children were broken down by category into "organized" (i.e. attending various establishments) and "unorganized"; the respective percentages were 34.9% and 65.1%. No significant differences were detected between the rural area and the urban area in that respect. Out of the total "organized" children, 16.9% were attending school, and 83.1% - pre-school.

As regards the age at the time of being recognized disabled for the first time: disability was recognized at birth in 34.8% of cases, during the first year of life in 22.2% of cases, at the age of 1 to 3 in 12.1% of cases, at the age of 3 to 6 in 14.1% of cases, and at the age of 7 to 14 in 18.8% of cases.

Mental diseases prevail in the breakdown of child disability by type (59.1%), with oligophrenia found with every fourth child. It should be pointed out that the above illness is distributed very unevenly among various geographic areas. Thus, the portion of children suffering from oligophrenia in the total number of children with mental disorders varies from 17.4% in the south of Moldova to 37.8% in the northern regions. The neurological disability profile rates second, accounting for 23.3% of cases. It is followed (in the decreasing order) by the surgical disability profile, ophthalmologic disability profile, endocrine disability profile, oncologic profile, otorhinolaryngologic profile, etc.

It should be further noted that children with disabilities, similar to other children, are susceptible to bodily (or somatic) diseases, among which the most widespread ones are acute respiratory viral infections (65.4%), acute bronchitis (10.2%), tracheitis (7.1%), pneumonia (6.1%) and gastro-intestinal infections (11.2%). Resultantly, death rate among the children with disabilities is 10 times higher than the general death rate of all children.

2. Responsibilities of the state in respect of children with disabilities

Trouble always comes unannounced. A child could be absolutely healthy a day before, and currently he or she is destined to stay in the wheelchair due to a disease or an accident, unable to walk or to play, to go to school or to communicate with other children of his or her age.

Doubtless, in the situation where a tiny person suddenly and unexpectedly finds himself or herself facing a multitude of problems, which are very difficult to overcome both physically and morally, that person needs support and assistance from his or her family and relatives, and in the case he or she does not have any the state takes over the role of supporter. It is the state that is responsible for provision of the necessary medical services, social security and education of such children to give them the basic knowledge and skills making possible their subsequent social integration.

When we speak of child disability registration and reporting in the sense of formal confirmation of their status on the force of medical indications, the Ministry of Health has a well defined and established registration and reporting system. We can state a similar situation in respect of registration and reporting of the children who are beneficiaries to social disability allowances allocated by the authorities within the system of the Ministry of Labor and Social Security. We face serious problems, however, trying to make a systematic analysis and determine the general profile of the children accommodated in the various institutions – Homes of Child, orphanages, boarding schools, specialized schools. All those problems have a common cause: the above institutions are subordinated to different ministries; they have different specifics and are intended for bringing up and education of children falling into different categories. They accommodate orphans and children devoid of parental care as well as children coming from socially vulnerable families, families with many children and single-parent families, etc. It is practically impossible to single out the information regarding specifically the disabled children from the total statistics. Next to children with disabilities, such institutions accommodate children with arrested development and behavioral aberrations and deficiencies as well as absolutely healthy children. That issue will be presented in more detail in the next section, and this section concentrates on general living conditions and problems of all the children accommodated in such state institutions. The only source of data in that case is the selective survey on the situation of the institutionalized children, which was held in Moldova under the auspices of UNICEF in 1999-2000.

The survey covered 67% of all the specialized state institutions in operation at that time. Out of the 45 institutions covered by the survey, the overwhelming majority – 41 (or 91%) were subordinated to the Ministry of Education, 2 – to the Ministry of Health and 2 more – to the Ministry of Labor and Social Security. At the time of the survey the above 45 institutions accommodated 9105 children, including only 14 children sent there temporarily; all the other children were living there permanently. The sample (the children under survey) was broken down by sex as 62% (boys) and 38% (girls); the breakdown by age was: 10% (children in the first years of life and pre-school age), 88% (children of school age) and 2% (persons aged 18 and older).

The analysis of the financial situation found with the institutions under survey revealed that 67% were receiving financing from the centralized state budget, and 33% were financed from the local budgets. The management indicated in 11% of the institutions that they had certain extra-budgetary financing. The actual financing of such institutions accounted for as little as 55% of the planned budget allocations, and the finance received was utilized to cover the current expense: costs of foodstuffs, salaries and wages to the employees, maintenance. In addition, almost all the institutions (96%) were receiving humanitarian aid (foodstuffs, clothing, footwear, stationery and personal hygiene items) from various religious organizations, public agencies and NGOs, charity foundations, etc.

The survey demonstrated that 45% of the facilities were constructed in 1945-1970, 33% - in 1971-1980, 11% - in 1981-1990 and another 11% - in 1991-1999. 71% of the facilities were designed initially for different purposes. Financial problems and insufficiency of cash available to pay for maintenance made capital repairs and running refurbishments impossible, so their resultant sanitary and hygienic state did not conform any longer to the norms and regulations for accommodation, treatment and education of children with specific needs.

Heating problems, low temperatures indoors (about +8° to +14° C in wintertime), the deplorable state of floors, doors and windows, overcrowded dormitories, lack of furniture, old-type beds

contributing to spinal column deformations, poor lighting in rooms; – this list of the problems daily faced by children in state institutions is far from complete, although those children are in need of special care and attention from the society. Practically every second institution had no running water or plumbing, or they were not functioning. The critical state of shower rooms, outdoor lavatories, lack of detergents and disinfectants as well as personal hygiene items had a general negative impact upon the children's state of health.

The survey revealed that 73% of the children were suffering of various chronic diseases, and about 83% of the children had 2 or 3 diseases at the same time. Typically a child got medical treatment only for acute conditions of chronic diseases. As the result acute diseases tended to become chronic, and chronic diseases and disabilities were progressing. Preventive medical examinations were held in as little as 50% of the institutions under survey.

In case of an emergency or acute condition of a chronic disease medical assistance was provided to children in such institutions by specialists of the respective territorial healthcare facilities, thus giving rise to the problem of children's entitlement to free medical aid. The law on the minimum package of free medical services guaranteed by the state (approved by Government Resolution No. 749 of August 04, 1999) does not provide for free medical services to children older than 5 years of age, excepting orphans, children devoid of parental care and disabled children.

As the result, the above problems present an obstacle for securing a decent living to the children, which should correspond to their growth and development requirements. It is a very sad issue, because disabled children in families are in a situation similar to that of the institutionalized children.

Furthermore, it is evident that disabled children trying to exercise and enforce their rights are facing personalized problems next to the problems brought to life by Moldova's general economic situation. An acute problem of that type is the problem of social integration, i.e. the **problem of access to normal social environment and information for children with disabilities**. Here I would like to quote a disabled person. Ten years ago Oxana became unable to walk and therefore she refused all the contacts with the world outdoors. She says, "I was unable to face the problem of finding myself in the street in a wheelchair. You know how problematic it is for a handicapped person to enter or to exit any building. It is the same story with public transports. Even when I went to a polyclinics I had to implore some strangers to carry myself and my wheelchair inside the building ..."

A year ago, on October 29, 2001, a communication center for children and teenagers was opened in Chisinau, the capital city of Moldova, under the auspices of such agencies as the Swedish Branch of "Save the Children", UNICEF and Center of Information and Documentation on the Rights of the Child. Mainly the children visiting that communication center are coming in wheelchairs, but some of the visitors are healthy children as well. "Motivation" (an association with branches in various countries) has helped gather them under one roof for the purposes of communication, joint training and games. Almost all the disabled children coming to that center have an experience of more than one year of reclusion in their apartments. They are mostly children with cerebral palsy and teenagers with spinal column traumas. Psychological support is an effective first aid for them. Newcomers are taught to communicate with other children of their age, to move around in a wheelchair, to observe basic rules of personal hygiene and food consumption, to develop the skills of managing without external assistance. Unfortunately, that center is but a small oasis available only to those living in the capital city. The others would have to stay patient overcoming their daily problems typically faced by children with disabilities. Although certain changes to the best can be pointed out (special ways of access for the disabled

have been constructed recently in Chisinau in the Opera House and in the Organ Music Hall), libraries, stores, educational establishments, medical facilities and public transports are still inaccessible for the disabled.

3. The Disabled Children in Boarding Schools and in Specialized State Institutions

Similar to the other former republics of the Soviet Union, after World War II the Republic of Moldova created the system of specialized institutions designed to accommodate and take care of the children with deficiencies in development and children from families in crisis. The system was financed from the state budget and it was ensured the necessary staff to provide a set of services specified in the relevant documents (regulations or statutes) on such institutions.

The contribution of the state to social security of the children has somewhat decreased since the 1990-ies rather than increased. The economic crisis contributed to severe under-financing of the social sphere in general and the institutional system in particular.

The grave financial situation in the family and deformation of the family as the social institute was the principal cause for the growing number of children left without parental care. The children not cared for and not covered by the educational system, children with derogations and health problems.

Unfortunately, hardly any mechanism has been developed in Moldova till nowadays as an alternative to the highly undesirable institutionalization approach.

Children in a particularly severe crisis, orphans and disabled children are accommodated, cared after and educated in the various institutions subordinated to the Ministry of Health, the Ministry of Labor and Social Security or to the Ministry of Education. About **12 thousand** children were in the care of such institutions in 2001.

The **Ministry of Health** is in charge of so-called homes of the child, which accommodate children with various diseases or psycho-physical disfunctions as well as orphans and abandoned children. The above institutions provide accommodation, treatment and rehabilitation for the children aged 0 to 7.

As of January 1, 2002, there were 3 such homes of the child in Moldova, with the capacity to accommodate 475 children; the actual number of children accommodated in such institutions made **415**. The breakdown of those children by age was as follows: children in their first year of life – 26%, aged 1 to 3 – 41%, aged 3 to 4 – 11%, and older than 4 – 22%.

The actual situation is that every child is sick at least three times in a year, and acute infections of upper respiratory tracts account for the majority of cases. Preventive medical examinations taking place in those institutions demonstrated that the children in the age group under 3 were the most vulnerable to diseases: anemia was found with a half of them, every fourth child was suffering from indigestion problems, and every seventh child had rickets. Out of the total number of children, 82 children (20%) had physical disfunctions and 52 (13%) had mental aberrations.

After the children in the above institutions become 7 years of age, a certain portion (typically the children with aberrations in their mental or neuro-physical development) is transferred to the institutions subordinated to the Ministry of Labor and Social Security. That ministry is in charge of boarding houses for the children with grave diseases, such as cerebral paralysis (palsy), epilepsy or schizophrenia, or with serious aberrations in mental development. The remaining

children are transferred to the institutions subordinated to the Ministry of Education, including boarding schools for orphaned children and children left without parental care, boarding schools for children with sensory-motor or mental aberrations, and specialized boarding schools for children with the various physical or mental development anomalies. The principal goal of the above institutions is to ensure proper accommodation, general care and healthcare for the children till they reach 16 or 17 years of age.

The **Ministry of Labor and Social Security** is in charge of two currently operating boarding houses for mentally retarded children with the capacity to accommodate 720 children. As of the beginning of 2002, the actual number of children accommodated in the above institutions was **517** (300 boys in the Orhei boarding house, and 217 girls in the Hincesti boarding house). For the last 10 years (i.e. 1992 to 2001) the actual number of children accommodated in boarding houses remained approximately at the same level, making about 70 children per 100 berths. Every fourth child among the children accommodated in boarding houses is unable to move around, which circumstance creates additional problems of caring after them and requires considerable efforts on the part of the auxiliary staff; however, low salaries offered and difficult labor conditions for the junior medical personnel are not appealing for those in search of employment (the above institutions are understaffed: the actual staffing makes only 82% of the required staff levels). Training of the children in basic work skills rates among the most important objectives in such boarding houses next to proper care and medical control. However, the percentage of children undergoing training is very low: as little as 30 persons, or 6% of the total children, are trained in elementary skills. After the wards of boarding houses reach 18 years of age they are transferred to the respective institutions for grown-ups, in charge of the same ministry. The children growing up without parental care and with no training in even the simplest skills are facing - next to serious health problems – the problem of social isolation and estrangement, ultimately resulting in the impossibility to integrate into the normal life.

In 2001 **11 thousand** children, or **92%** of all the children in state institutions, were accommodated in the institutions subordinated to the **Ministry of Education**. It must be noted that two consolidated groups are singled out in the analysis of that population: the first group includes the children with mental aberrations or physical development deficiency and the disabled children (about 5 thousand persons); the second group is comprised of orphans, children left without parental care, and children coming from families in crisis, single-parent families or families with financial problems (about 6 thousand persons). The latter group includes 4.2 thousand of children living in ordinary boarding schools and trained similar to other children after normal secondary school training plans; the data on such children is used only in the analysis of the totality of children covered by the various levels of education, irrespective of the institutionalization aspect.

A similar situation can be seen among the children included in the first group: about 700 children with deficiencies (aberrations) attend specialized schools (other than boarding schools) and are trained after specialized education programs. Specialized education – according to the Law on Education (Article 33) - is a part of the comprehensive education system, which is aimed at upbringing, training, rehabilitation and social reintegration of pre-school-age and school-age children with mental aberrations and physical disfunctions, sensory and speech deficiencies, excessively emotional behavior in group, behavioral aberrations, or with a combination of the above. The problem of specialized education has been given sufficient attention recently. A number of measures were designed to improve the situation in that sphere. They are reflected in such documents as the State Education Development Program for 1999-2005 (Resolution of the Moldovan Government No. 984 of October 26, 1999), the Strategy of Education for All (currently under examination for approval), Economic Growth and Poverty Reduction Strategy (currently under development), etc. However, at present the specialized education faces a whole

range of developmental and operational problems. Not the least of such problems is the poorly developed infrastructure for specialized schools and the necessity to improve training programs, which has doubtless an adverse effect upon the quality of education for children with deficiencies and narrows their social integration possibilities.

A one-sided approach to such children taking into account only their level of education does not make it possible to demonstrate the actual situation in respect of another aspect – their social protection and support in state institutions.

Thus, based on the available information, it would be possible to characterize the profile and situation only in respect of a part of children (**6 thousand**) accommodated in the boarding schools and specialized state institutions subordinated to the Ministry of Education.

As of the beginning of the 2001/2002 school year, there were 33 operational boarding schools for children with mental aberrations or physical development deficiencies accommodating **4.2 thousand** children. As compared to the 1992 statistics, the number of children accommodated in such institutions decreased by one third. Mentally retarded children accounted for 78% of the total number of such schoolchildren, children with extremely poor eyesight and children who became deaf with age – for 14%, children suffering of polio aftereffects or cerebral paralysis – for 4%, and mentally retarded children – for 4%. Girls accounted for less than a half of such schoolchildren (41%).

Only as little as 13% of all the boarding schools have adequate facilities and premises; each sixth school is in need of capital repairs and refurbishments. Their material and technical infrastructure is similarly in need of improvement: thus, every third boarding school does not have an auxiliary farm, every fourth school does not have a TV; only 25% of all boarding schools have their own radio room or a narrow-width film projector, etc. The sanitary situation and technical conditions of school premises leave much to be desired.

Next to specialized boarding schools for children with mental aberrations or physical development deficiencies, the Ministry of Education is also in charge of 3 orphanages and 6 boarding schools accommodating and educating **1.8 thousand** orphans, children left without parental care and children from families in crisis. The number of such children grew by 19% in the last decade. The causes for such growth include – next to demise or disappearance of parents – deprivation of parental rights on the force of a court decision, and a growing number of abandonments where the mother is unknown. To a certain extent that situation can be explained with the grave financial situation in some families where the family cannot afford to support and to educate a child.

Next to specialized institutions, the Ministry of Education has specialized (targeted) daycare groups and rehabilitation classes for mentally retarded children. Where a child with aberrations or deficiencies is educated and brought up in the ordinary environment together with healthy children, that contributes to the development of behavioral and interpersonal skills as well as ability to communicate with other persons of one's age and improved social integration in the future.

In 2001 specialized (targeted) daycare groups were operating in 31 pre-schools (kindergartens), and they were attended by 1885 children (or 2% of the total children going to pre-schools), including two thirds accounted for by children with speech deficiencies, 15% - children with sight deficiencies, and 9% - mentally retarded children. It should be noted that a slight decrease in the total number of children attending such specialized daycare groups was mainly owing to

the decreased number of children with speech deficiencies. That pattern can be certainly explained with the improved provision of logopedic services.

There are classes for mentally retarded children functioning within ordinary schools. As of the beginning of 2001/2002, 920 children were attending such classes, including 59% - in grades 5 to 9, and the remainder in grades 1 to 4.

The Ministry of Education works to find support for children and teenagers left without parental care. About 1500 such children are discovered annually. Thus, out of the 1578 children of that category identified in 2001, 1243 children (78%) were accommodated in families, 262 children (17%) – sent to homes of the child, orphanages or boarding schools, 27 children (2%) were accommodated in other educational establishments, and 46 children (3%) remained without accommodation.

If we consider some of the causes for child institutionalization, it becomes evident that institutionalization could be prevented through the implementation of measures aimed at social protection of families, provision of the respective healthcare services as well as educational services at home or close to place of residence in order to ensure integration of the children with specialized needs in normal schools or other educational establishments. The development of a social service network with the involvement and direct participation of the broad public would result in de-centralization of such services. That circumstance would substantiate further growth in the number of social service centers facilitating free access to the surrounding world and cutting down the number of persons accommodated in social institutions.

The analysis of the current situation identifies other reasons – next to diseases or development derogations – contributing to child institutionalization, such as: poverty and the problems it causes as well as crisis in family.

To solve the problem, it would be necessary to consider the diversified approach towards accommodation and support of the children in crisis, requiring the improvement of the legislative and legal framework as well as social security system, the revision of the organizational structure and functions of the institutions for children, implementation and development of alternative services, etc. Thus, a draft law on children with aberrations and deficiencies is currently in the process of development under the auspices of the UNICEF mission in Moldova; that law would provide for the development of child protection forms alternative to institutionalization and conforming to the international norms. The draft is intended to protect the right of the child to grow and develop in a family environment – be it a native or adopted family. Should it be impossible, the child must be offered an environment as similar to family environment as possible through provision of such services as creation of family-type child homes, centers, etc. Creation of daycare centers for children with aberrations or territorial centers for children with grave deficiencies would require the adequacy of the provided services to the child's needs typical for his or her age, sex, and development level; furthermore, such services should be intended to solve the problems the child is facing. The above would be necessary to develop an individual program for re-integration into family, for development of the skills allowing to become of substantial use to other people and to be ultimately accepted by the society. Family-type child homes cannot be created in the required number at present due to the lack of financing. There are currently as little as 30 homes of that type in Moldova, accommodating and supporting about 160 children.

4. Disabled children in the family and in the community

There is in theory a sufficiently well developed system of providing assistance to families in Moldova. In reality the existing system cannot satisfy in full all the needs it is required to satisfy, mainly due to the lack of financing.

So what are the living standards in families with disabled children in the current situation, what are the relations between the parents and what are the causes contributing to disability? Information on living standards and situation in families with disabled children was gathered and analyzed within the above-mentioned comprehensive disability survey in the Republic of Moldova. To make the obtained data comparable, questionnaires were given at the same time to the parents in two groups of 100 families each, one consisting of families with a disabled child, and the other – of families with healthy or almost healthy children.

The survey demonstrated that every tenth family in the group of families with a disabled child was a family with many children (at least 4 children); 25% of families had 1 child, and another 25% - three children; 40% families had two children. 9% of families had more than one disabled child. Notwithstanding a difficult financial situation, 76% of the families believed they had enough food, and the remaining 13% considered they did not have enough food; the questionnaire took into account the possibility of families to produce some necessary foodstuffs in their household. The above production is doubtless explained with low family income. A disabled child born into the family or appearing in the family is a kind of psychological shock, which is very difficult to overcome. It is necessary to mobilize enormous physical and mental resources, to say nothing of time, next to additional financial resources required for diagnostics and treatment. In 63% of families the mother was forced to find a new, lower salaried job, which would leave her more time to take care of the child, and in 12% of families mothers had to quit work at all.

An absolute majority of the families covered by the survey (96%) were two-parent families. At the same time 60% of the families complained about aggravating relationships between the parents. Practically every second father did not take part in the care after the disabled child, and every tenth father said that in his case the birth of a disabled child was the main cause for his addiction to alcohol.

The survey revealed that the children were brought up in adverse conditions practically in 60% of the families with a disabled child, whereas only every seventh family out of the total number of families with healthy children could be considered a family in crisis, i.e. a single-parent family, a family in a grave financial situation or with poor living conditions, with addictions or behavioral aberrations existing with at least one of the parents.

On the total, living conditions were favorable in the case of families under survey: typically a family had a house or an apartment of two or three rooms. Most of the premises were characterized as having sufficient light, being warm and dry; at the same time practically every seventh family was living in cold or dark premises, and each tenth family had too small premises – less than 4 square meters per person.

Speaking of the parents' profile, we can state that the child's state of health and conditions are dependent to a major degree on the mother's state of health, her personal characteristics, individuality, working conditions, type of work, and lifestyle.

The survey identified considerable variations in the level of education with the mothers. Thus, the number of mothers with an unfinished secondary education was 4.8 times higher in the

families with a disabled child than in the families with healthy children. The latter group had respectively 1.5 times more mothers with secondary vocational education and 2 times more mothers with higher education.

The survey results identified certain correlation between having a disabled child and the mother's social category and profession: the number of disabled children born into a family where the mother was a clerk was 2 times lower. 67% of the mothers with disabled children worked on the farm or as unskilled labors and had secondary or incomplete secondary education. The mother's average age at the time she gave birth to a disabled child was about 30, whereas healthy children were born of mothers aged on the average about 22.

Practically every second mother with a disabled child mentioned the negative impact of hard and harmful labor conditions as the circumstance contributing to the birth of a disabled child. Every third mother with a disabled child had to come in contact with chemicals in the course of her work; every eighth mother had to lift loads exceeding 10 kg. There were 5.6 times more smokers among the mothers with a disabled child in comparison to the mothers with healthy or almost healthy children.

It is a well-known fact that the child's health is largely dependent on the mother's state of health and lifestyle during pregnancy. According to the consolidated information, 28% of the mothers under survey had rubella, measles, flue, or tonsillitis during the pubertal period (i.e. after 18 years of age); 10% had viral hepatitis. 67% mentioned during the survey their having extragenital pathologies. Mothers with disabled children prevailed among those registered as patients on dispensary records with the therapist, endocrinologist, pulmonologist, gynecologist, phthisiologist, etc. (respectively about 70% и round 12% of the mothers covered by the survey). 53% of the disabled children were born mature and 37% of them were born prematurely (whereas only every tenth child was born prematurely among the healthy children). 7% of the mothers mentioned their giving birth to children with congenital pathologies prior to delivering a disabled child, at the same time they had not applied to any genetic research centers for advise.

35% of the mothers mentioned having acute conditions of their chronic diseases, and every fourth mother with a disabled child had been recommended to terminate her pregnancy via abortion, but none had agreed.

The survey held by medical specialists identified the principal risks of giving birth to a child with a pathology resulting in disability. Alcohol consumption, the mother's health and the mother's age at the time of delivery rated the first three. They were followed (in the decreasing order) by infectious diseases, complications during pregnancy and at delivery, counter-indications to conception or delivery, hard labor conditions, a period of less than two years between two deliveries following one another, contact with harmful chemicals, work with tobacco.

Fathers with secondary or incomplete secondary education accounted for 67% of all the fathers with disabled children, whereas fathers with a higher education (22%) and with secondary vocational education (44%) prevailed in the group of families with healthy children. Professional functions involving contact with harmful chemicals were reported 4.2 times more often and professional functions involving contact with tobacco – 5.2 times more often among fathers with disabled children than among fathers in families healthy children. A similar pattern could be traced in respect of the existing harmful habits or addictions. Alcohol consumption could be found 23.2 times more often and smoking – 1.4 times more often among fathers in families with disabled children. Furthermore, 7.2% of the fathers had disabilities of varying graveness in families with disabled children.

In the group of families with healthy children 91% of the fathers were described in positive terms by their spouses, relatives and neighbors (with an emphasis on laudatory characteristics, such as respectfulness, caring attitude, diligence, etc.). At the same time 66% of the fathers were described in negative terms in families with disabled children; practically every second father in that group took no part in the care after the disabled child.

Thus, the principal risks contributing to the birth of a disabled child were on the total similar for the mothers and for the fathers.

The birth of a disabled child into a family has doubtless a significant impact on the lifestyle and psychological climate in the family. The mother suffers from an emotional stress, which becomes evident primarily in her relations with her spouse. The persisting state of anxiety, increased attention towards the disabled child and the inevitable financial problems cause the father continuous discomforts. Where the relationships in the family have been strained prior to the birth of a disabled child, child disability becomes an additional factor provoking family conflicts, mutual grievances, disagreements and misunderstandings. The survey demonstrated that a child with aberrations in development was the reason for the lower percentage of two-parent households with normal family relationships (29% as opposed to 47%); the group of households with a disabled child had a higher percentage of families with tense relationships and occasional conflicts (52%) and with frequent conflicts (up to 15%), and 13% of such families ended in a divorce.

It should be noted that the above detailed profile of the families with at least one disabled child has been developed based on the results of the comprehensive integrated survey held with participation of medical specialists, psychologists, scientists, etc.

Furthermore, **Household Budget Surveys** are held in Moldova on regular basis. Some of the households in the 2001 sample had disabled children (1.6% of the total number of households with children in the sample). The analysis of information gathered in such households demonstrated that a disabled child was the only child in 41% of such households; 43.6% of the disabled children were living in households with two children, and the remainder were living in households with many children (3 or more).

Every second disabled child lived in a two-parent household, 15% of them lived in a single-parent household, and the remainder lived in households of other types. As regards disability graveness, 38.5% of the disabled children had disabilities of Degree I; 48.7% had disabilities of Degree II; and the remainder had disabilities of Degree III. If we consider the breakdown of the disabled children by sex, we can notice that boys prevail over girls considerably (with 53.8% and 46.2% respectively).

Availability of housing is not a problem for households with a disabled child. On the average, living area per person hardly differs in households with a disabled child from that in the other households with children (making 12.3 square meters).

A relatively low availability of basic utilities in the housing should be noted, especially if we bear in mind that disabled children need specialized care. That is mainly true for the rural areas where households do not have centralized heating, hot water or indoor WCs, whereas the majority of households with a disabled child living in an urban area (88.9%) have houses (apartments) equipped with such utilities. It should be added that households with disabled children are mainly concentrated in the rural area (76.9%), which circumstance affects not only their living conditions but also the availability of basic social conveniences.

The situation of a disabled child in the household varies considerably depending on the living standards of the household. It should be remembered that the risks of becoming poor (or finding oneself in the category of low-income persons) are aggravated with the birth of every child; the situation is significantly aggravated where the child in question has a serious disease. Thus, the breakdown of households with at least one disabled child by level of consumer expense demonstrates that every third household in that category falls with the poorest (Quintile I), and only 7.7% of such households rate among the highest income households.

Although households with disabled children are paid social allowances, those payments are not sufficient to finance even the basic needs. They make as little as 11% of the subsistence minimum calculated for the children aged under 16 (MDL 444.6).

Social allowances make only 18% of the total available income, which circumstance forces the households to look for additional sources of income. As the result, the household's main income is generated from individual farming (51%). Typically, it comes as foodstuffs produced on the personal farm and consumed by the family. Thus, the household has no possibility to generate additional cash inflows, which is a significant limitation to access to the market of non-food products and services. Furthermore, households with disabled children receive less support from individuals: such support makes about 6% in the total income, whereas such support is three times higher in households with children that have no serious health problems.

The main portion of income is allocated in households with disabled children to procure food (foodstuffs account for 72.6% of the total consumer expense). We must make an emphasis on very limited affordability of other goods and services for such families. Furthermore, a disease or illness implies certain costs towards its treatment. Households with disabled children can afford to allocate as little as 3% of their total consumer expense on healthcare and staying fit.

Thus, low income in households with disabled children and a very limited availability to and affordability of the principal social infrastructure services and conveniences, and in particular medical services, and insufficient support on the part of the state and broad public is among the principal factors pre-determining social exclusion of the disabled children."

The materials used in preparation of the report:

Resolutions of the Moldovan Government:

1. No. 524 of April 24, 2002, on the Approval of the Provisional Poverty Reduction Strategy
2. No. 51 of January 23, 2002, on the Approval of the National Child and Family Protection Concept
3. No. 1321 of October 09, 2002, on the Approval of the Pilot Program “Orphaned Children”
4. No. 564 of June 14, 2000 “The National Poverty Reduction Program”
5. No. 984 of October 26, 1999 “The National Education Development Program for 1999 – 2005”
6. No. 749 of August 04, 1999 on the Approval of the Package of Medical Services to Be Provided for Free
7. On the approval of the Pilot Program “Children with Aberrations” (currently under consideration in draft)

Law of the Republic of Moldova “On Education” No. 547-XIII of January 21, 1995

Scientific works and reports on survey results:

1. L. Spinei, E. Popusoi „Handicapul infantil ca problema medico-sociala” (Child disability as a medical and social problem), Chisinau - 2000
2. The situation of the institutionalized children in the Republic of Moldova, UNICEF, Chisinau - 2001

Methodological materials:

1. Guidelines for the Development of Statistics on Programs and Policies Regarding the Disabled, UN, 1997
2. Guidelines and Principles for the Development of Disability Statistics, UN, New York, 2001

The statistical reports of the Department of Statistics and Sociology, the Ministry of Health, the Ministry of Labor and Social Security, the Ministry of Education, and other authorities