



LIVING WITH DISABILITY IN MONGOLIA

Progress toward Inclusion

DECEMBER 2019

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Abbreviations

ADB	Asian Development Bank
CBR	community-based rehabilitation
CCMLA	Central Commission of Medical and Labor Accreditation
CWD	children with disabilities
DPO	disabled people's organization
FGD	focus group discussion
GOSWS	General Office of Social Welfare Services
HSES	Household Socio-Economic Survey
ICF	International Classification of Functioning
ILO	International Labour Organization
LFS	Labor Force Survey
LSAD	Living Standards Assessment Database
MIC	Medical Inspection Commission
MLAC	Medical and Labor Accreditation Commission
MOH	Ministry of Health
MLSP	Ministry of Labor and Social Protection
NAC	National Authority for Children
NCMCH	National Center for Maternal and Child Health
NESRIC	National Employment Services Research and Information Center
NGO	nongovernment organization
NRC	National Rehabilitation Center
NSO	National Statistical Office
PWD	persons with disabilities
PWDLCS	PWD Living Conditions Survey
UNCRPD	United Nations Convention on the Rights of Persons with Disabilities
UNICEF	United Nations Children's Fund
WHO	World Health Organization

Currency Equivalents

(AS OF FEBRUARY 2019)

Currency unit	–	togrog (MNT)
MNT1.00	=	\$0.00038
\$1.00	=	MNT2,630.00

GLOSSARY OF MONGOLIAN ADMINISTRATIVE UNITS

<i>aimag</i>	province
<i>soum</i>	district
<i>bagh</i>	subdistrict of a <i>soum</i>
<i>khoroо</i>	urban subdistrict

Executive Summary

The last decade—both internationally and in Mongolia—has seen increased recognition of the rights of persons with disabilities (PWD) and a call to action to put rights into practice. In 2006, the United Nations adopted the Convention on the Rights of Persons with Disabilities, which aims to ensure equal rights and full and effective participation in society for all PWD. The Sustainable Development Goals, with their call to leave no one behind, refer to PWD in various targets and implicitly require the disaggregation of key indicators for disability to reveal existing inequities and trigger actions to address them. The Incheon Strategy (2012) to “Make the Right Real” for Persons with Disabilities in Asia and the Pacific preceded the new Mongolian Law on the Rights of Persons with Disabilities (2016).

However, while various fora recognize and promote the rights of PWD and a more holistic approach to disability, the reality lags behind: information on the actual living conditions of PWD remains relatively limited, and more effort is needed to implement policies that will contribute to the creation of truly inclusive societies. This is also true for Mongolia, where little data are publicly available. This report aims to address this gap by providing information that was gathered and analyzed in the first half of 2016 as part of technical assistance for the preparation of an Asian Development Bank (ADB) project to improve service delivery and inclusiveness for PWD in Mongolia.

While this report focuses on Mongolia, we believe that some of the findings and policy implications are of much wider relevance.

Who Are Persons with Disabilities and What Is Their Prevalence?

The Law on the Rights of Persons with Disabilities (2016) adopted a progressive definition of disability, but in Mongolian society the practical understanding of disability is still hampered by stereotypes and stigma. There is a struggle between progressive thinking and deep-rooted cultural misconceptions. Disability is still predominantly considered a medical issue and something worth reporting if it is associated with a social welfare benefit, but perhaps not if it brings shame to the family.

There are contradictory estimates of the number of people with disabilities. Estimates for 2015 vary from 100,000 and 118,000 persons, or just under 4% of the population. However, two puzzling findings emerge from the data: a decline in disability when people reach pension age and a significantly higher incidence of disability among men than women. These are in stark contrast with international statistics that show disability increasing with age and an equal prevalence of disability among men and women, if not a higher disability prevalence among women in part because they tend to live longer than men.

Living Conditions

PWD face a considerable disadvantage compared to the rest of the population. In Mongolian households with one or more PWD, the poverty incidence is more than double that of households with no PWD. Among PWD of working age, 70% are not working compared to 36% of working-age people without disabilities. Among children 6 to 18 years old, only 4% of those without disabilities cannot read compared to almost half of children with disabilities (CWD). Nearly two-thirds (64%) of CWD 3–5 years old do not attend kindergarten versus nearly one-third (32%) of young children without disabilities.

Health and Disability Assessment Services

Since disability is linked to a medical condition, all PWD need to interact with the health system, both for an assessment to officially recognize the disability and for any health services they may need. However, only half of PWD have ever been received a home visit by a doctor. As a result, 30% were never referred to the *aimag* (province) hospital, where formal recognition of disability begins.

In Mongolia, the classification and assessment of disability has historically been limited largely to adults. One in three CWD (under 18 years old) has never had an official disability assessment. Compared to child disability, the assessment of adult disability is relatively well established. It is conducted through commissions in three steps: (i) an initial examination and assessment by a general practitioner, (ii) verification by a medical inspection commission at an *aimag* hospital or health center, and (iii) final verification and decision by medical and labor accreditation commissions in *aimags* and cities. The commissions make a decision regarding a person's specific degree of disability, based diagnosis and by consulting impairment tables. Social, economic, and environmental factors are rarely considered.

Social Services, Habilitation, and Rehabilitation

Mongolia still struggles to identify and provide social services for its hard-to-reach populations. Challenges include internal migration, increasing unregistered urbanization, limited access to rural populations, and capacity and resource constraints. Difficulties also relate to the dominance of a medical model of disability that focuses on medical-type rehabilitation services—often delivered in residential care settings (i.e., nursing homes)—as the main type of service offered to PWD. There appears to be little systematic delivery of social services for PWD beyond the administration of social welfare benefits, limited access to home care services (for no more than 15 days per year), partial reimbursement for transport, and a limited range of assistive devices and equipment. The scale of the challenge is illustrated by the fact that 70% of households with PWD interviewed do not have enough information about available social welfare benefits and social services. In addition, 30% of PWD want assistive devices, but only 6% have access to them. One group that appears particularly underserved includes people with long-term mental health issues or intellectual disabilities.

Access to Education

A chapter covering the right to education in the Law on the Rights of Persons with Disabilities specifies the duty of schools to adapt the environment to the requirements of CWD, the duty of parents to enroll their children in school, and the duty of social workers to play an important intermediary role and provide information and support. However, the measures currently in place go only a small way toward creating the conditions for inclusive education envisaged in the law.

Regarding the highest level of education achieved by people 15 years old and above, one in five PWD has not achieved any education, compared to just under 4% in the general population. These statistics do not capture the real disadvantage because it is unclear whether PWD received any education before acquiring the disability. According to the 2010 census, 47% of people with congenital disabilities received no education, compared to only 12% for those who acquired a disability. School enrollment records provide a direct measure of current barriers to school enrollment for CWD: attendance by CWD is significantly lower than that of other children, especially in rural areas, and attendance is lower for boys than for girls, especially in secondary and higher education. Specialized schools are found only in the capital city, Ulaanbaatar, and only about 20% of CWD attend in these schools.

Access to Employment

Employment rates for PWD in Mongolia are much lower compared to persons without disabilities. The rate of economic activity among PWD 15 years old and above was 25.2% in 2014, compared to 62.1% in the general population. There are also significant differences between PWD and the rest of the population in the type of employment. Among economically active PWD, 45% are herders, compared to 25% of the general population. The share of paid employees among PWD is low (22%) compared to the general population (50%). The average monthly salary for PWD is only 50% of the average salary earned by the general population. Persons classified as having mental disabilities are particularly worse off.

Mongolia has significantly reformed its public employment services in two main types: (i) employment promotion services or provision of occupational and vocational orientation, counselling and information, and job mediation and provision of unemployment benefits, and (ii) employment promotion measures for different target groups (including PWD) such as preparation for employment, training, support to herders, self-employers, employers, and public works. A specific program for employment provides financial support to PWD and PWD-operated businesses and offers job and business skills training to create jobs that meet the specific needs of PWD. The Mongolian Labor Code promotes employment of PWD by stipulating that organizations with more than 50 staff must employ at least 3% PWD. Noncompliance should trigger payment of a fine for every PWD not employed, but this rule has not been implemented and does not seem to achieve significant results.

Social Welfare Benefits

Both contributory social insurance and noncontributory social assistance provide welfare benefits and services. About 80% of the economically active population is insured. If they acquire a disability, people are entitled to a disability pension through social insurance if they have made a certain minimum contribution. The minimum pension is 75% of the minimum wage. In the case of work accidents, employers must make one-off payments.

Social assistance benefits for PWD include: (i) a social welfare pension for those who have lost 50% or more of their labor capacity; (ii) a caregiver allowance for single PWD or persons who need permanent care, including CWD; (iii) support for a person who needs permanent care; (iv) community-based social welfare services, including counselling and life training, funding for community groups, rehabilitation services, temporary shelter, and home-based care; and (v) 16 special entitlements, including financial assistance for fuel expenses, prosthetic devices, free transportation, communication allowance, etc.

In practice, the social protection system faces some design and implementation challenges related to coverage, adequacy, and flexibility. Informal evidence suggests that unreported and unregistered cases of disability do not receive services. Even when PWD are registered, they sometimes have only partial access to social welfare benefits. Generally, social assistance benefits are low. Finally, the

system is very rigid, prescribing entitlements that do not necessarily respond to people's individual needs. A key element missing from Mongolia's social welfare system is a link to needs assessment, so that the amount of benefits PWD receive better reflects their different circumstances.

Creating a Barrier-Free Environment

The 2016 Law on the Rights of Persons with Disabilities introduced specific articles to create a barrier-free environment and set a vision for the future. Although access to the physical environment, transport, information, and assistive devices has been legislated, implementation is not systematic and enforcement is weak. Disabled people's organizations participate in monitoring and campaigning for accessibility; they should continue to play this role to fulfill the aspirations of the law.

Public Policy to Enhance Inclusion and Participation

Unfortunately, inclusion of PWD does not happen automatically with a declaration or law. Rather, it requires a change of mentality supported by adequate public campaigns and a coherent policy framework with supporting policy interventions in multiple sectors such as employment, social welfare, health, education and other social services. Mongolia is still in a phase of transition, with some contradictory policies.

The recognition that PWD are like other people, with the same rights and responsibilities, still needs to evolve into concrete sector interventions. Seven policy recommendations can help Mongolia become a more inclusive society for PWD:

- (i) Improve understanding of disability.
- (ii) Enhance disability assessment.
- (iii) Facilitate inclusion and participation through individualized services.
- (iv) Review social welfare benefits.
- (v) Increase access to infrastructure, transport, and information.
- (vi) Promote inclusive education and employment.
- (vii) Strengthen monitoring.

I. Introduction

Across the developing world, persons with disabilities (PWD) are considerably more likely to be poor and to have lower human development indicators.¹ Their struggle to participate and make a contribution to society creates not only a sense of exclusion, but also the perception of being a burden. In many countries in Asia and the Pacific, work participation by PWD is only half that of other people, social protection is fragmented or insufficient, and only a minority of children with disabilities (CWD) receives adequate education.² This is in clear contrast to the UN-adopted Convention on the Rights of Persons with Disabilities (UNCRPD),³ ratified by 172 countries, which aims to ensure equal rights and full and effective participation in society of all PWD. The Sustainable Development Goals, with their call to leave no one behind, refer to PWD in various targets and implicitly require the disaggregation of key indicators for disability to reveal existing inequities. While the international community recognizes and promotes the rights of PWD, the reality lags behind. Information on the actual living conditions of PWD is limited, and more efforts are required to implement successful policies that contribute to the creation of inclusive societies.

In preparing the design of an Asian Development Bank (ADB) investment project to improve service delivery and promote inclusion of PWD in Mongolia,⁴ the authors worked with the Government of Mongolia and disabled people's organizations (DPOs) to gather and analyze data on the current living conditions and challenges faced by PWD. Mongolia ratified the UNCRPD in 2009 and participated in the development of the Incheon Strategy to make the rights of PWD real.⁵ In February 2016, the Parliament passed a new Law on the Rights of Persons with Disabilities. A vibrant national community and a network of organizations that promote the rights of PWD now exists, supporting a change in the understanding of disability and promoting discussion about policies of inclusion. There is a substantial amount of data in Mongolia, but these data are largely underutilized and not in the public domain. This report aims to make this information available, summarize the main findings, and consider key policy implications. Disability can be viewed as a burden and a cost, but it can also be seen as—and transformed into—an opportunity and resource for growth.

¹ World Health Organization and World Bank. 2011. *World Report on Disability*. https://www.who.int/disabilities/world_report/2011/report.

² UN Economic and Social Commission for Asia and the Pacific (UNESCAP). 2016. *The Economic and Social Survey of Asia and the Pacific*. <https://www.unescap.org/events/launch-economic-and-social-survey-asia-and-pacific-2016>.

³ The UN Convention on the Rights of Persons with Disabilities is an international human rights treaty of the UN, intended to protect the rights and dignity of persons with disabilities. The text was adopted by the UN General Assembly on 13 December 2006. <https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities.html>.

⁴ ADB provided project preparatory technical assistance (TA) for Ensuring Inclusiveness and Service Delivery for Persons with Disabilities (TA 8850-MON).

⁵ The Incheon Strategy (2013–2022) provides the Asia and Pacific region, and the world, with the first set of regionally agreed, disability-inclusive development goals. <https://www.unescap.org/resources/incheon-strategy-“make-right-real”-persons-disabilities-asia-and-pacific>.

This report is based not only on an extensive analysis of microdata in existing administrative and survey data, but also on the collection and analysis of primary data through consultations with DPOs, key informant interviews, focus group discussions (FGDs), and a small household survey, the 2016 PWD Living Conditions Survey (PWDLCS)⁶ (see Appendix).

⁶ Population Teaching and Research Center. 2016. PWD Living Conditions Survey (Household survey of PWD), for PPTA preparation. Ulaanbaatar.

II. Establishing the Basics

No global agreement defines disability. Therefore, this report uses the definition in the 2016 Law on the Rights of Persons with Disabilities (Article 4.1.1): “[PWD] include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.”⁷ This definition aligns with the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) and recognizes that disability is not only a health condition, but also a result of social and environmental barriers.⁸ In practice, disability is still predominantly considered a medical issue and something worth reporting if it is associated with a social welfare benefit, but perhaps not if it brings shame to the family. The media has been relatively quick to adopt politically correct language, even as they present the dichotomy that PWD are people to be pitied or heroes who can excel surprisingly.

Nevertheless, representatives of disabled people’s organizations (DPOs) suggest that the perception of PWD has improved during the last 10 years, at least among decision makers. Misconceptions persist. For example, Ministry of Health (MOH) campaigns have focused on the need to prevent disability, equating prevention with early intervention. Accident prevention is an important area of work, but early intervention and other forms of assistance are not cures for disability, but rather are designed to reduce social exclusion and help families and PWD make the most of their abilities.

Box: Experience of Persons with Disabilities and Their Families

“When we are working, employers are not happy that we have a child with disability. When my child is frequently sick, they do not like it.” 49-year-old woman, Dornod *aimag*

“I need to share my opinions with others. Most of the time I feel alone and stressed.” 66-year-old woman, Uvurkhangai *aimag*

“Now my child does not have friends. He likes playing basketball. Unfortunately, it is a team sport. And he is angry with me.” Mother, Ulaanbaatar

“Families who need to take care of children with disabilities lose value in society – no work, no opportunity to have a nice life.” Father, Ulaanbaatar

Source: Focus group discussions, 2016.

⁷ The Parliament of Mongolia. 2016. *Law on the Rights of Persons with Disabilities*. Ulaanbaatar. Available in Mongolian at <https://www.legalinfo.mn/law/details/11711?lawid=17711>.

⁸ The Convention on the Rights of Persons with Disabilities and its Optional Protocol was adopted on 13 December 2006 at the UN headquarters in New York. <https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities.html>.

The general public often excludes PWD. In focus group discussions (FGDs), PWD report negative attitudes, including pity, staring, ignoring, suspicion, superstition, and intolerance toward wheelchairs on public transport. One respondent suggested that her disability status prevented her from getting the chance to study abroad. Many stated that doctors convey harsh attitudes, often not talking directly to the person during a hospital visit. One parent told the story of a relative suggesting euthanasia for her son with disabilities. There are few descriptions of such extreme attitudes, as this is understood as socially unacceptable. Very few parents of children with disabilities (CWD) who participated in the household survey reported negative attitudes from teachers, although this is slightly higher in urban areas. Eighty-six percent of parents reported some kind of discrimination from other pupils, but only 22.6% report that other pupils actively discriminate or refuse to play with CWD. If children were not in school, some parents reported that their child dropped out, but only due to discrimination from teachers or pupils. The main reasons were lack of learning materials and tools, and the child falling behind at school.

A. Data Sources on Disability

Some agencies gather information about disability. The National Statistical Office (NSO) routinely collects information about PWD through a household booklet and registry, household surveys, and the census. The household registry contains information for every household, including information on whether people have a disability, the type of disability, and whether it is congenital or acquired. Such information comes directly from the primary administrative unit (i.e., *soum* [district] or *khoroо* [urban subdistrict]) that receives assessments made by the Medical Inspection Commission (MIC). The 2010 census collected the same information. Since 2012, simple questions about disability have been captured in the Household Socio-Economic Survey (HSES) and the Labor Force Survey (LFS),⁹ although the HSES has no information on whether a disability is congenital or acquired.

The Ministry of Health (MOH) compiles information about disability, capturing the same information collected by the district and *aimag* hospitals where the MIC operates. These data are disaggregated by type of disability, age group, and sex, and is used only internally. The National Rehabilitation Center (NRC) compiles information about the number of PWD and type of disability. Family doctors conduct a first screening every year while visiting each household in their administrative area. This screening identifies potential PWD. Next, the primary administrative area passes the information to the *aimag*, which compiles data for the whole country. Statistics cover six types of disability: (i) vision hearing and speech, (ii) physical, (iii) convulsions, (iv) mental illness, (v) intellectual, and (vi) multiple and/or other disabilities. These data are disaggregated by age group, sex, and province, and are not available to the public.

Recently, the National Authority for Children (NAC) started gathering information about CWD. It is unclear whether their effort is completely independent or if it relies on existing sources. Finally, the General Office of Social Welfare Services (GOSWS) collects information about PWD through the Living Standards Assessment Database (LSAD), which uses an administrative form completed during a household interview to assess household living conditions and eligibility for different benefits; it has almost full population coverage. Once again, information is collected on whether people have a disability and the type of disability. However, the advantage of this data source is the possibility of linking disability to indirect welfare assessment, employment, and other living standards indicators.

⁹ The HSES is a nationally representative survey, which aims to evaluate and monitor the income and expenditure of households, update the basket and weights for consumer price index, and offer inputs to the national accounts. The LFS aims at collecting the comprehensive set of data from households to estimate employment and unemployment characteristics, which capture the seasonal variability, location, social and economic activities in accordance with the definition and methodology of the International Labour Organization (ILO). Both HSES and LFS are regularly conducted by the National Statistics Office of Mongolia. <https://metadata.1212.mn/?ln=En>.

The 2010 Multiple Indicator Cluster Survey (2010) attempted to capture child disability based on functioning.¹⁰ The percentage of children 2–17 years old at risk of disability was estimated at 14%, which is substantially higher than estimates by official sources and with hardly any differences between boys and girls. However, survey methodology, which requires a follow-up assessment to measure the actual cases of disability, is known to substantially overestimate the prevalence of disability (footnote 1). In 2017, the Japan International Cooperation Agency published a white paper on disability in Mongolia.¹¹

B. Disability Prevalence

Estimates from administrative data are similar. NSO and MOH provided an overall number of 100,000 PWD in 2014. The NRC's estimate is 113,000 and 117,000 for the HSES and GOSWS, through the LSAD.¹² The 2010 census identified 108,000 PWD, more men than women, although the NRC reported a smaller difference. Prevalence of PWD in Ulaanbaatar is 35%, compared to 45% for the total population. NSO, MOH, and NAC all estimate around 8,000 CWD, whereas NRC and GOSWS estimates are higher (11,600 and 9,300, respectively). The NRC figure for CWD is particularly high and, unlike any other data source, they find no difference by sex. By contrast, NAC data show that 68% of CWD are boys. There is no difference in MOH data on the prevalence of disability between boys and girls under 5 years old.

Table 1: Persons with Disabilities, 2014

Indicators	NSO	MOH	NAC	NRC	GOSWS	HSES
Sex						
Male	54,864	52,444	–	58,105	63,747	65,944
Female	44,709	47,730	–	55,215	52,881	51,705
Location						
Ulaanbaatar	34,345	32,188	–	–	41,010	42,080
<i>Aimags</i>	65,228	67,986	–	–	74,598	75,569
Age (years):						
0–14	8,182	7,740	76,95	11,625	9,326	7,994
15+	91,391	92,434	–	101,695	107,302	109,655
Sex (children 0–14 years old)						
Male	4,484	4,269	5,261	5,731	5,142	4,628
Female	3,698	3,471	3,434	5,894	4,184	3,366
Total PWD	99,573	100,174	–	113,320	116,628	117,649

– = not applicable, *aimag* = province, GOSWS = General Office of Social Welfare Services, HSES = Household Socio-Economic Survey, LSAD = Living Standards Assessment Database, MOH = Ministry of Health, NAC = National Authority for Children, NRC = National Rehabilitation Center, NSO = National Statistical Office, PWD = persons with disabilities.

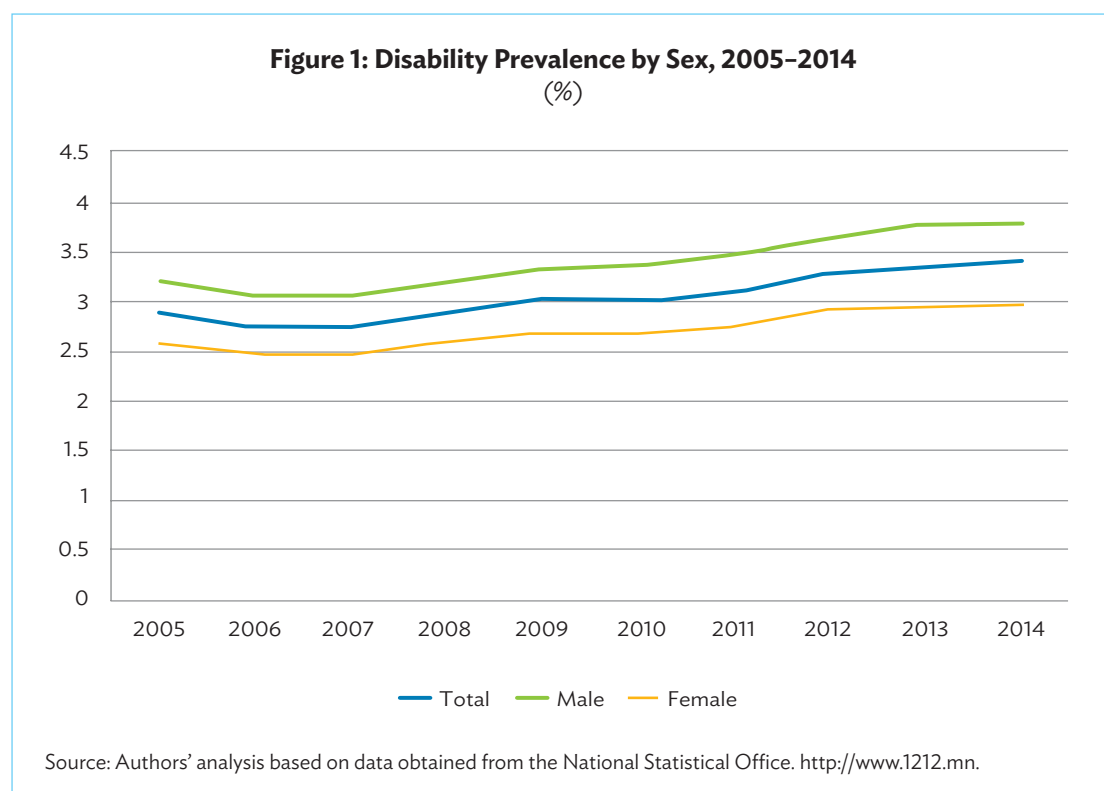
Source: NSO, MOH, NAC, and NRC data. Authors' calculation based on data from the LSAD and HSES.

¹⁰ NSO and United Nations Children's Fund (UNICEF). 2010. *Mongolia: Multiple Indicator Cluster Survey*. Ulaanbaatar <https://microdata.worldbank.org/index.php/catalog/1997>.

¹¹ Ministry of Labor and Social Protection (MLSP) and Japan International Cooperation Agency. 2017. *Disability in Mongolia in 2017: Facts and Figures*. Ulaanbaatar.

¹² These figures have been scaled up to account for incomplete population coverage. Nationally, coverage is about 93%.

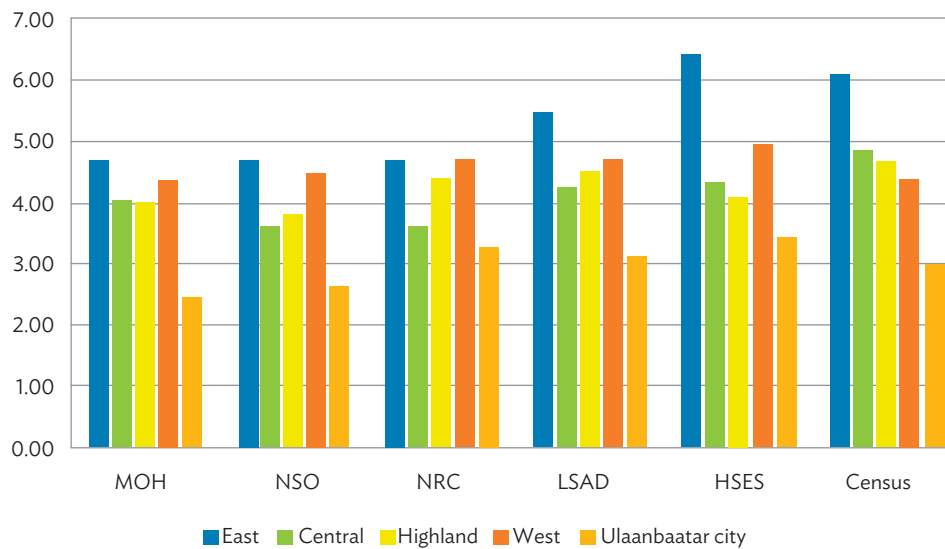
The NSO administrative register is the only source of data that provides consistent analysis. Figure 1 shows the percentage of PWD by sex from 2005 to 2014. There is an increase in the percentage of PWD, but it is unclear whether this is due to an actual surge or a gradual increase in reporting. The increase is more pronounced for men than for women. The other source of information is the NRC, which has provided data since 2006; however, close scrutiny of their data shows they are not reliable.



Although to different degrees, one common result across all data sources is that disability prevalence is highest in the eastern region and lowest in Ulaanbaatar. However, it is not easy to find the causes of the relatively higher prevalence of disability in the eastern region. In general, disability by *aimag* varies significantly (Figure 2).

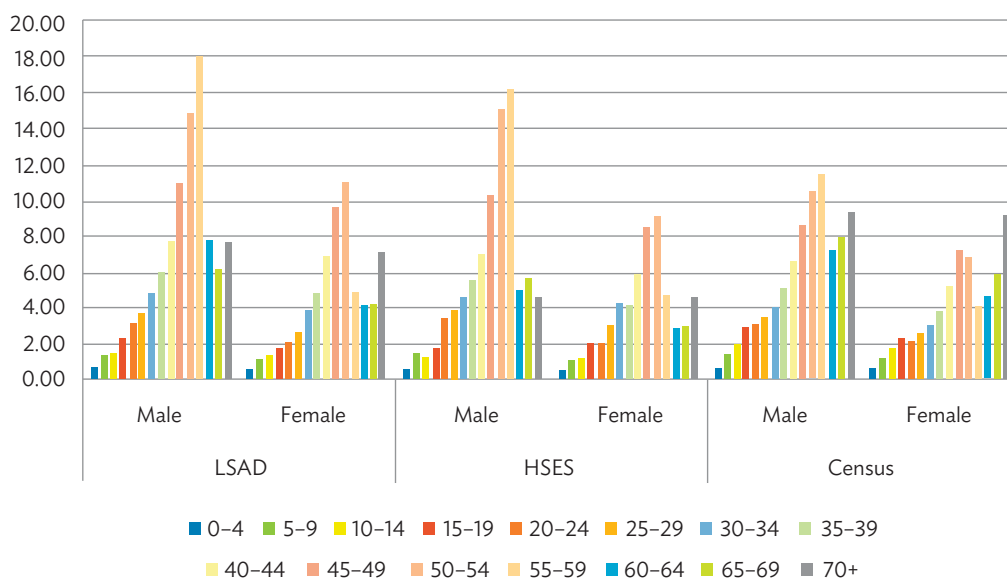
Figure 3 shows disability prevalence by age group. While there is an expected increase in disability as people age, there is a sudden decline at pension age. This decline likely is due to a reporting bias, where people report themselves as disabled when they are receiving a disability pension and then as pensioners after they reach pension age, reflecting an understanding of disability as something that applies to working-age people. This points to an underestimation of disability, as we would expect the percentage of people with disabilities to grow increasingly with age. This result is not uncommon in former Soviet Union countries, which define disability based on “labor capacity loss.”¹³

¹³ Republic of Moldova, Ministry of Social Protection, Family and Child. 2007. *Analysis of Social Protection of Disabled Persons in the Republic of Moldova*. Chisinau.

Figure 2: Disability Prevalence by Region

HSES = Household Socio-Economic Survey, LSAD = Labor Force Survey, MOH = Ministry of Health, NRC = National Rehabilitation Center, NSO = National Statistical Office.

Source: Authors' analysis based on various sources.

Figure 3: Disability Prevalence by Age Group

HSES = Household Socio-Economic Survey, LSAD = Living Standards Assessment Database.

Source: Authors' analysis based on various sources.

The lower rate of disability among the elderly could explain underestimation of disability among women: in other countries women are overrepresented among people with disabilities because they live longer than men.¹⁴ Additionally, a higher prevalence and percentage of PWD among men is found in other countries that have a similar approach to disability. In Uzbekistan, Scott and Mete conclude that the limitations that men suffer might relate more to their ability to work or that there is a greater benefit to men derived from obtaining disability status.¹⁵ In Moldova, where the authors had access to household survey data, disability prevalence is higher for men than women (8% versus 6%, respectively), but women have a significantly higher percentage of chronic illnesses than men (36% versus 28%, respectively) (footnote 13). Therefore, when comparing these general results on disability prevalence with internationally observed norms, we identified two very likely reporting biases: (i) a failure to report disability in old age, and (ii) a substantially higher prevalence of disability among men. This contradicts what is observed internationally, where the opposite is true.¹⁶

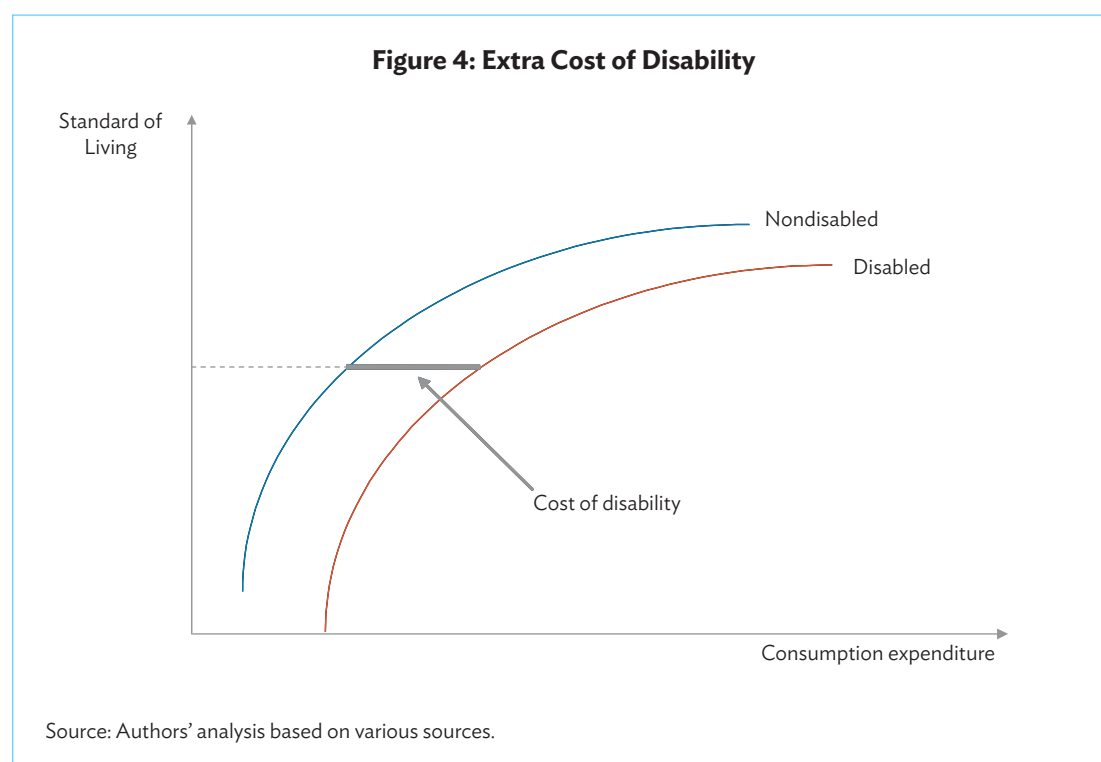
¹⁴ At older age, prevalence of disability should increase, and this is often one of the factors leading to higher overall prevalence of disability for women, whereas injury-related disability tends to be higher for men. D. Schur et al. 2014. *People with Disabilities: Side-lined or Mainstreamed?* Cambridge University Press.

¹⁵ K. Scott and C. Mete. 2008. *Measurement of disability and linkages with Welfare, Employment and Schooling: The case of Uzbekistan*, in 'Economic Implications of Chronic Illnesses and Disability in Eastern Europe and the Former Soviet Union', The World Bank.

¹⁶ S. Mitra et al. 2011. *Disability and poverty in developing countries: A snapshot from the World Health Survey*. Social Protection Discussion Paper No. 1109, The World Bank.

III. Living Conditions

The primary source of information on income poverty is the Household Socio-Economic Survey (HSES). Measures of poverty may fail to consider the specific needs of PWD, resulting in the underestimation of poverty. To reach any level of functioning and living standards, PWD incur certain extra costs. While consumption (i.e., expenditure) is used as the indicator of living standards, this must be adjusted for PWD to reflect the extra expenditure needed to reach an equivalent living standard. This can be explained at least partly by observing the consumption patterns of households with PWD. For example, the share of health expenditure by households in Mongolia with at least one member with disabilities is double that of households with no PWD.¹⁷ Using the methodology suggested by Zaidi and Burchardt,¹⁸ Carraro and Cumpa show that expenditure is 14% higher on average for a household with at least one member with disability.



¹⁷ L. Carraro and M.C. Cumpa. 2014. *Accounting for Different Needs when Identifying the Poor and Targeting Social Assistance*. <http://www.iariw.org/papers/2014/CarraroPaper.pdf>.

¹⁸ A. Zaidi and T. Burchardt. 2005. *Comparing Incomes when Needs Differ: Equivalization for the Extra Costs of Disability in the UK*. <https://onlinelibrary.wiley.com/doi/abs/10.1111/j.1475-4991.2005.00146>.

Such equivalence scales were applied to household consumption expenditure and adjusted poverty estimates were computed (Table 2). Based on per capita expenditure, the poverty incidence among households with PWD is 32%, but increases to 42% when the cost of disability is taken into account using equivalence scales.¹⁹ In this case, poverty among households with PWD is more than double that of other households. The gap is even higher when other commonly used poverty measures²⁰ (i.e., the poverty gap and the severity of poverty) are used.²¹ While poverty gap and severity of poverty are lower when using per adult equivalence scales, the gaps between households with and without PWD increases 3.5 times higher for the poverty gap and 4 times higher for severity of poverty.

Table 2: Household Poverty, 2014

Household	Poverty (%)		Poverty Gap (%)		Severity of Poverty (%)	
	Official	Adjusted	Official	Adjusted	Official	Adjusted
Households without PWD	19.9	18.3	4.7	2.8	1.6	1.0
Households with PWD	32.0	42.0	8.9	9.9	3.5	4.0
Overall	21.6	21.6	5.2	3.8	1.9	1.4

PWD = persons with disabilities.

Source: Authors' analysis based on 2014 Household Socio-Economic Survey data.

It is useful to assess the importance of these gaps using a simple index to assess their role in determining the national average. This can be interpreted as the cost of exclusion. For this purpose, a simple toolkit based on the Gini measure of inequality and the Lorenz curve can be used.²² For the poverty head count, disability increases the national percentage of the poor by 13%, the poverty gap by 22%, and the severity of poverty by 25%. Indeed, while the share of population living in households with at least one member with disabilities is only 14%, their level of poverty is very high. Figure 5 shows the poverty gap distribution between these groups and illustrates how it departs from the line of homogeneity.

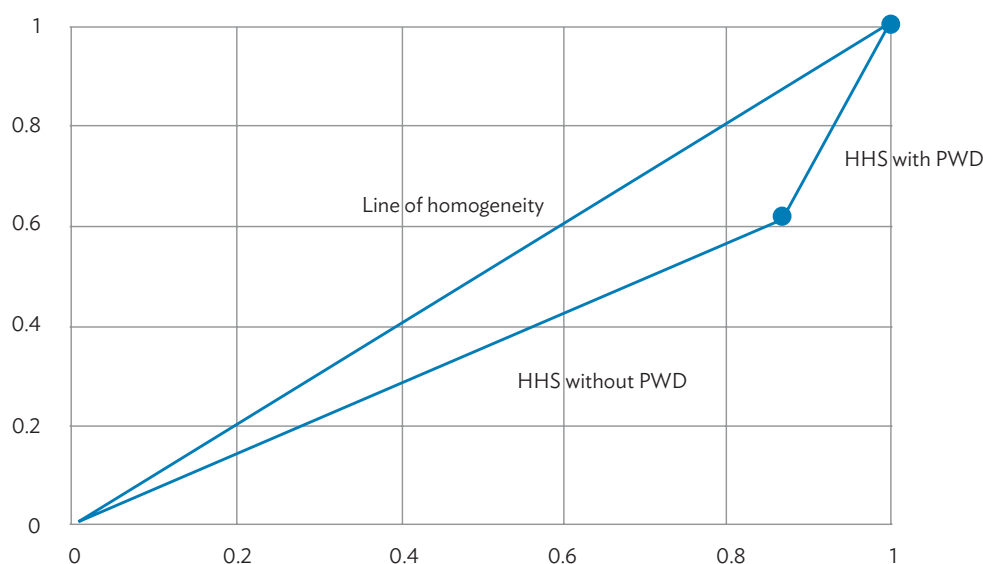
During consultations for this study, parents reported the financial impact of caring for a child with a disability, including travel and accommodation costs to attend medical appointments, costs for prescription medicines and/or treatment, purchase of special equipment, special foods, and increased quantities of basic household goods. In focus group discussions, parents reported that poverty increased their sense of isolation and marginalization because the usual stigma and discrimination associated with children with disabilities (CWD) is compounded by lowered economic status. Adults with a disability can be equally affected because of barriers to education, and they may lose their jobs or be denied opportunities for employment. They also have significant additional expenses.

¹⁹ Importantly, it is necessary to recompute the poverty line when adjusting consumption by per adult equivalent. This has been set to guarantee the same overall poverty rate as per the official estimates.

²⁰ The calculation of poverty gap and poverty severity estimates followed Milanovic (2002). B. Milanovic. 2002. *Do we tend to overestimate poverty gaps? The impact of equivalence scales in the calculation of the poverty gap*. Applied Economic Letters, Vol. 9, 69–72.

²¹ J. Foster et al. 1984. *A class of decomposable poverty measures*. Econometrica, Vol. 52, pp. 761–766.

²² L. Carraro et al. 2004. *A Quantitative Assessment of Social Exclusion in Pakistan* (Report prepared for Department for International Development), Oxford Policy Management.

Figure 5: Poverty Gap in Households with and without Persons with Disabilities, 2014

HHS = households, PWD = persons with disabilities.

Source: Authors' analysis based on data from the Household Socio-economic Survey (2014).

The Living Standards Assessment Database (LSAD) also contains information on living standards, and the living standard assessment formula takes into consideration the extra costs of disability.²³ Households with PWD are concentrated in the lower part of income distribution; more than 40% are in the poorest quintile. The data illustrate differences in living standards according to different types of disability. People with intellectual disabilities are much worse off, as are households with more than one member with disabilities. Another indicator is the literacy rate among CWD 6–18 years old. The 2014 HSES self-reported literacy assessment indicates that 43% of CWD cannot read a letter and another 15% can read one only with difficulty compared to only 4% and 8%, respectively, for the rest of the population (Table 3).

Table 3: Literacy Rates of Children 6–18 Years Old, 2014

	Reading Ability	No Disability (%)	With Disability (%)
1	Easily reading	87.93	41.78
2	Hardly reading	8.37	15.48
3	Cannot read	3.7	42.74
	Total	100.0	100.0

Source: Authors' analysis based on 2014 Household Socio-Economic Survey.

²³ This was achieved by using adequate equivalence scales to adjust the living standards indicator (i.e., the level of consumption) for the extra costs of disability, and then regressing this indicator against a set of proxies.

School attendance was computed using LSAD data for different age groups by location, sex, and disability (Table 4). School attendance rates for CWD are much lower compared to other children and are particularly low in rural areas. Girls' attendance is higher than boys', both in the general population and for CWD. Nationally, nonattendance in compulsory schools is more than 6% higher for CWD. However, this is underestimated. For example, the 2014 HSES shows that sickness and/or disability is an important reason for never having attended school, but 20% of such cases do not declare children as having disabilities; this is only reported indirectly.

Table 4: School Attendance Rates, 2014

	3–5 Years Old (%)		6–10 Years Old (%)		11–17 Years Old (%)	
	No Disability	With Disability	No Disability	With Disability	No Disability	With Disability
Ulaanbaatar	69.3	37.9	92.5	69.3	91.4	66.1
Aimag center	80.9	41.8	96.3	63.9	94.8	56.7
Soum center	81.6	46.7	97.0	67.7	94.0	59.7
Rural	31.5	11.7	93.4	45.3	87.5	36.9
Male	66.9	35.3	94.1	61.8	90.1	52.8
Female	69.1	37.0	94.7	65.1	93.9	59.8
Total	68.0	36.0	94.4	63.2	92.0	55.9

Note: Aimag = province, soum = district.

Source: Authors' analysis based on Living Standards Assessment Database.

The last important indicator is employment (Table 5 and Table 6). The percentage of employed PWD (30%) is less than half of that for all other people (64%).²⁴

Table 5: Employment Rates, 2014

Location	No Disability (%)			With Disability (%)		
	Male	Female	Total	Male	Female	Total
Ulaanbaatar	69.9	55.2	62.2	17.8	15.4	16.7
Aimag center	61.1	52.2	56.5	20.2	17.3	18.9
Soum center	65.2	57.1	61.1	34.5	28.8	32.1
Rural	83.4	74.8	79.3	68.8	60.9	65.5
Total	69.5	57.9	63.6	32.3	27.2	30.1

Note: Aimag = province, soum = district.

Source: Authors' analysis based on Living Standards Assessment Database.

²⁴ This is the employment to working-age population rate using the official working age in Mongolia; the ILO (i.e., 15 years and above) provides an employment to population rate of 24%. The estimates come from LSAD; results from HSES and LFS data are of similar magnitude.

Table 6: Employment Rate among Persons with Disabilities by Type, 2014
(%)

Employment	Primary Disability							Total
	Vision	Speech	Hearing	Motion	Mental Health	Multiple	Other	
Employed	41.0	28.1	38.2	32.1	21.4	23.4	31.6	29.9
Type of Employment								
Wage	27.8	24.89	28.15	27.34	12.35	19.9	23.34	23.31
Unpaid work	15.48	23.73	17.49	16.39	31.34	22.67	20.57	20.63
Employer	0.96	1.89	0.87	1.04	0.32	0.97	1.32	0.99
Herding	45.74	43.09	40.64	43.61	50.12	46.31	39.85	43.89
Agriculture	0.06	0	0.17	0.3	0.16	0.24	0.41	0.25
Business	6.67	3.49	9.09	7.35	3.4	7.23	9.66	7.28
Other	3.29	2.91	3.57	3.96	2.31	2.67	4.84	3.65
Total	100	100	100	100	100	100	100	100

Source: Authors' analysis based on Living Standards Assessment Database.

PWD employment rates show a gender gap: men with disabilities are more likely to be herders, while women are more likely to be engaged in unpaid work. Employment for PWD is low in the Ulaanbaatar and the *aimag* centers (Table 5). Once again, PWD with intellectual disabilities stand out as particularly disadvantaged; employment is only 21%. Among employed PWD, 81% receive no pay or work as herders. Among PWD with visual impairments, employment increases to 41% (Table 6).

IV. Health and Disability Assessment Services

Since disability is linked to a medical condition, all PWD need to interact with the health system for a disability assessment, rehabilitation, habilitation, and general health services. The PWD Living Conditions Survey (PWDLCS) found that nationally only 48% of respondents with disabilities received a home visit by the family doctor, compared to Ulaanbaatar (41%) and rural areas (57%). However, among those visited, the frequency of visits tends to be higher in urban areas. Due to the lack of interaction with family doctors, 28% of PWD were never referred to a hospital. On the other hand, 69 doctors who participated in the PWDLCS revealed that almost all family doctors (94%) frequently examined patients with disabilities. Most *soum* health center doctors (63%) and doctor-members of the commission (64%) often met with PWD.

In focus group discussions (FGDs), PWD and parents of children with disabilities (CWD) suggested that health services for PWD focus on government-paid rehabilitation, including physiotherapy, speech therapy, and some nondrug medical services. Most participants receive services locally, through state health services; others receive services from Ulaanbaatar or international practitioners:

“My child goes to the sanatorium.” (Dornod *aimag*, Bayan-Uul *soum*, B, Mother); “I received physiotherapy in the sanatorium paid from the state.” (Uvurkhantai *aimag*, Bayan-Undur *soum*, “M”, 24 years old, male PWD)

“I received physiotherapy in Ulaanbaatar, my parents paid.” (Uvurkhantai *aimag*, Bayan-Undur *soum*, some PWD participants)

“I had physiotherapy. A Japanese person came to our medical center and for 2 years I had physiotherapy. It helped me a lot...I need more physiotherapy, but if I get some physiotherapy from the medical center then it is only for 7 days per person. More days are not allowed.” (Dornod *aimag*, Kherlen *soum*, “A”, 39 years old, female PWD)

Some participants noted issues regarding the suitability, quality, maintenance, and affordability of equipment provided by health services and the social welfare office:

“[I had] speech therapy and a hearing aid. Now the hearing aid is broken. I have to pay half and the other half is paid by the state. It cost more than MNT400,000. I borrowed some money as I cannot afford to buy one myself.” (Ulaanbaatar, Bayanzurkh District, “A”, 24 years, male PWD)

“My child got a free of charge hearing aid that cost MNT700,000 from social welfare. I paid, and the money was reimbursed. But my child cannot use it and we threw it away.” (Dornod *aimag*, Bayan-Uul *soum*, “S”, 34 years old, mother of CWD)

“The orthopaedic shoes were not comfortable, so I did not use them.” (Ulaanbaatar, Bayanzurkh District, 45 years old, female PWD)

According to some respondents, supply issues also seem to affect quality and choice:

“Assistive equipment is now given once every 3 years. It seems there is only one organization importing them and the social welfare office is telling us to get from there only. A relative of the head of the Blind Association is selling assistive devices and they are not good quality ones, they cannot be used for 3 years, only for 3 months. Now everything is available on the internet, I want to choose which tool to use.” (Ulaanbaatar, Songinokhairkhan District, “B”, 38 years old, male PWD)

Participants reported that the Red Cross provided wheelchairs in addition to those they received from state services.

A. Child Disability Assessment

Historically, the classification and assessment of disability has been limited to adults. A PWDLCS survey of 241 households (March 2016) found that one in three CWD under 18 years old had never received an official assessment, and more than 70% of their parents said they did not know about the assessment. Child disability assessment was not addressed systematically until recently and previously relied on donor support. To access social welfare benefits and a caregivers’ allowance, families of CWD must seek a medical diagnosis that includes a series of medical and psychological examinations and, in the case of suspected intellectual disability, a computer tomography scan. Although the Ministry of Health (MOH) reports that such services are free, respondents viewed the costs (e.g., for transport, accommodation, and food) as prohibitive and said they can incur income losses if they are required to travel from their rural home.

Although the National Center for Maternal and Child Health (NCMCH) provides prenatal screening, this service is not routinely available in *aimags*. Infant screening is limited due to the cost of maintaining imported specialist equipment without follow-up support. For example, one deafness screening device no longer works, and there is no capacity to make repairs. The NCMCH aims to increase screening for deafness in all Ulaanbaatar hospitals, but it currently lacks the necessary resources. With support from the Republic of Korea, two sets of equipment were installed, but only one was operational. Such limitations mean that the NCMCH can screen only 50% of the infants born there.

With financial support from development partners, NCMCH initiated four project-based screening programs, and is implementing an early assessment program. All programs are for developmental dysplasia of the hip, congenital deafness, congenital blindness, and metabolic disorders. The Swiss Association of Paediatric Ultrasound introduced ultrasound screening for developmental dysplasia of the hip. *Aimags* in Mongolia identify and treat approximately 1,000 cases per year. A pediatric eye-health project was initiated in collaboration with an international nongovernment organization (NGO) to work with the NCMCH and five rural hospitals to create a model network for comprehensive vision care. The network seeks to provide services ranging from basic vision screening to complex pediatric surgeries.

The NCMCH is implementing a pilot research project to understand the incidence of specific metabolic disorders, concentrating on hypothyroidism and adrenogenital syndrome (2 cases per 1,000 screened). This necessary public health activity aims to provide early identification and treatment for prevention of the disability. With approximately 82,000 live births per year—half occurring in Ulaanbaatar and 12,000 in the NCMCH—this equal approximately 164 potential diagnoses if the screening program expands nationally and produces 24 positive diagnoses per year in the NCMCH. International good practice in early identification supports the use of developmental screening questionnaires and measurement tools to supplement clinical judgment,

so early assessment can lead to rapid early intervention. Where indicated, early assessment can be supplemented at later stages by further developmental and medical evaluation and diagnoses for longer-term treatment planning.

The multisector Children's Commission of the Ministry of Labor and Social Protection (MLSP) plans to implement a national assessment program to identify developmental delays and initiate developmental habilitation programs. The child health card (i.e., the Pink Book) will be modified to include an internationally accepted early assessment instrument, the Ages and Stages Questionnaire. Parents complete a short questionnaire related to age-specific developmental milestones. In *soums* or *khoroos*, a health professional checks the questionnaire against a standard scoring grid. If the results suggest the need for a more in-depth assessment, the child is referred to a trained district pediatrician or nurse. This more in-depth observational assessment of the motor skills, cognitive development, and communication ability of infants and toddlers 0–3 years old, which is based on a localized version of the Bayley Scales of Infant Development, will form the basis for assigning a disability status and referral for services by the Children's Commission. The Children's Commission and its local subcommissions currently operate in 21 *aimags* and 9 districts of Ulaanbaatar under the authority of local governments and the direction of the National Rehabilitation Center (NRC).

Early screening of newborn infants has been fragmented and project-based, and mostly reliant on international donors. The services are resource-constrained, and their long-term sustainability is uncertain. When specialist equipment fails (e.g., in the case of testing for deafness), the skills and knowledge required to maintain and repair the equipment is unavailable in Mongolia. The criteria for appraising the viability, effectiveness, and appropriateness of a screening program first described by Wilson and Jungner in 1968 still apply today.²⁵ However, these criteria are not universally applied in Mongolia because development and application of screening mechanisms is severely constrained by limited health sector resources. Table 7 estimates how an early assessment approach compares to newborn screening in terms of maximizing outreach.

Table 7: Identification Potential of Early Assessment and Newborn Screening

Early Assessment*	Newborn Screening			
	Deafness	Metabolic Disorders	Developmental Dysplasia of Hip	Blindness
5,355 children identified in six <i>aimags</i> and Ulaanbaatar, including deaf and blind children; based on anticipated assessment of 89,253 children ^a	462 ^b children in six <i>aimags</i> and Ulaanbaatar identified as having difficulty with hearing	164 potential cases; hypothyroidism and adrenogenital syndrome rates equivalent to two cases per 1,000; approximately 82,000 live births per year	1,000 cases per year identified and treated at <i>aimag</i> level in national screening program; corrective surgery required in 0.5% of cases	679 children in six <i>aimags</i> and Ulaanbaatar identified as having difficulty with vision

^a Children 0–3 years old (National Statistics Office 2015 population data for six *aimags* and Ulaanbaatar): 89,253 x 6% World Health Organization prevalence rate = 5,355.

^b National Statistical Office. 2015 Population Data. <https://metadata.1212.mn/?ln=En>.

* Conducted by the Children's Commission, the Ages and Stages Questionnaire, and the Bayley Scales of Infant Development. Source. Authors' analysis based on various sources.

²⁵ J.M.G. Wilson and G. Jungner. 1968. *Principles and Practice of Screening for Disease*. Geneva. WHO.

B. Assessment of Adult Disability

Compared to childhood disability, the assessment of adult disability is relatively well established in Mongolia. Conducted through commissions, the procedures include three steps:

- The attending physician—a family health center general practitioner or specialist doctor—conducts an initial examination and assessment.
- The Medical Inspection Commission (MIC) at a hospital or health center conducts further verification and makes a decision. An MIC has three to five medical doctors. This work is supervised by the MOH.
- Finally, 1 of the 30 medical and labor accreditation commissions (MLACs), which work at *aimags* under the supervision of the Central Commission of Medical and Labor Accreditation (CCMLA), verifies the MIC decision. Two subcommissions are responsible for occupational health and mental health.

MLAC disability assessments are rigorously medical. The MLAC decides a person's specific degree of disability based on diagnosis and by consulting impairment tables (in international medical insurance, "invalidity tables"). Developed by the MOH, the invalidity table lists 326 different medical diseases and provides a disability range for each disease. For example, the range for congenital spinal muscular atrophy is 70%–100% disability. Social, economic, and environmental factors are rarely considered. Work incapacity from 70% to 100% qualifies for a full disability pension, and work incapacity from 50% to 69% qualifies for a partial pension. The MLAC determines the degree and length of an insured person's inability to work for social insurance and in occupational diseases or injuries.²⁶ If a person does not meet the criteria for a disability pension (e.g., no work history) or is classified as not having a right to a disability pension, the MLAC might grant a social welfare pension.

Information on PWD is stored in the registers maintained by the CCMLA. The CCMLA has developed registration software and a database of persons subject to MLAC. As institutions that define disability *de facto*, CCMLA and MLAC have pivotal positions in Mongolia. However, the disability assessment system has been criticized for being bureaucratic, slow, and cumbersome.

Mongolian medical doctors know little about the International Classification of Functioning (ICF).²⁷ Knowledge is higher among older doctors and among family and *soum* doctors surveyed as part of the PWDLCS. The knowledge of the ICF has been gained mainly in short training events (81%), online training (42%), or postgraduate training (40%). Only 5% of medical doctors use the ICF in their professional practices. The ICF has been taught in medical schools and in schools for physiotherapists and occupational therapists since 2010.²⁸ In medical schools, the ICF is taught together with the International Classification of Diseases, but the extent of teaching is limited. It is not taught in nurse training courses. Schools for social workers teach the ICF, but the number of hours spent on the subject is minimal. Many doctors indicated that they need the ICF (81%), mainly for determining disability (39%), but also for clear and simple assessments (22%) that concur with international standards (15%). Most doctors (90%) would find it useful to have a standard form for registration of disabilities.

The commissions consist mostly of medical doctors. Assessments should include a social dimension to ensure that the commissions are multidisciplinary and to uphold continuous medical training among accredited doctors. It is likely that the number of cases for the MLACs could be reduced by prolonging

²⁶ Law on Pensions Benefits and Payments from the Social Insurance Fund against Employment Accidents and Occupational Diseases.

²⁷ A health care provider survey was conducted in March 2016 and interviewed 69 medical doctors who work in family and *soum* health centers and MLACs.

²⁸ Occupational therapy is a newly introduced profession in health care. Fewer than 100 physiotherapists work in hospitals; the number of occupational therapists is likely to be even lower.

the interval between reassessments. A large proportion of reassessments are conducted to extend disability status, and the CCMLA works continuously to differentiate the periods for which benefits are given. It is important to support and strengthen this work. If obviously chronic diseases (e.g., cancer, stroke, diabetes) receive benefits for longer time frame, the MLAC's workload will decrease. Most doctors (81%) work either in multi-professional groups or with independent professions to assess disability. A large majority of doctors (88%) find that working in multi-professional groups is worthwhile.

Seemingly, doctors already have a biopsychosocial view of disability, but they need a standardized tool for disability assessments. The prevailing medical model of disability does not meet the spirit of UN Convention on the Rights of Persons with Disabilities (UNCRPD) recommendations to adopt the human rights model of disability, which stresses the human dignity of PWD (footnote 3). There is a need to support implementation of the ICF as a social model of disability, which also includes a human rights model. The ICF is the only existing comprehensive classification that is based on a biopsychosocial model and the only one approved by WHO. The ICF uses disability as an umbrella term that covers impairments, activity limitations, and participation restrictions, and also enables consideration of personal and environmental (social) factors that influence a person's abilities. The ICF meets the demand for rights for PWD and provides a comprehensive and biopsychosocial model of functioning. The 2016 Law of Mongolia on the Rights of Persons with Disabilities states its clear intention to implement the ICF but accomplishing this will require a systematic approach throughout the government, across all sectors, and in all national and local institutions.

C. Impressions of Disability Assessment by Persons with Disabilities and Parents of Children with Disabilities

Generally, PWD and parents of CWD have a more positive impression of *soum* doctors than doctors in Ulaanbaatar or *aimag* centers, about which almost nothing is liked by Ulaanbaatar respondents regarding the disability assessment procedure. In Dornod, for example, PWD from the Bayan-Uul *soum* like that the MLAC travels to *soums* to conduct assessments. It could be that *soum* participants in FGDs have a positive impression because the assessment leads to social welfare allowances.

The attitudes and behavior of medical personnel can make PWD feel that they are “at war” with commission members:

“For the adult commission it is like war. They are saying ‘go in’, ‘go out.’ We have fear and we have no questions for the commission members. Even our family doctor who introduced me is afraid I think.” (Dornod *aimag*, Kherlen *soum*, S, 48 years old, woman with a disability)

Regarding the conditions under which the commission assessment is held, respondents referred to long wait times, long queues, and uncomfortable waiting areas (including outside, where it is cold). Required travel and expenses associated with conducting the assessments can be considerable:

“At first the family health center asked me to do blood and urine analyses. If I go to the state hospital it would take several days. So, I went to a private hospital and it cost MNT5000–MNT10,000. Next an ultrasound was needed. The state hospital ultrasound is not good, so again I went to private and it cost MNT25,000. Next a CT scan. It normally costs MNT250,000 but with contrast effect MNT270,000. So, the total cost will be about MNT400,000 to go to the commission.” (Ulaanbaatar, Songinokhairkhan District, B, 38 years old, male with disability)

“When my daughter was 4 years old, something was wrong and the *aimag* doctor advised us to go to Ulaanbaatar for additional analyses and consultation. In order to get the right diagnosis, we went to Ulaanbaatar four times. We probably spent MNT2 million to MNT3 million just for analyses.” (Uvurkhangai *aimag*, Arvaikheer *soum*, O, mother of a child with a disability)

Respondents noted particular difficulty in identifying intellectual disability in children:

“My daughter has a disability and it needed 2 years to get social welfare allowance permission. There wasn’t much cost because we live in the *aimag* center.” (Uvurkhangai *aimag*, Arvaikheer *soum*, O, mother of a child with a disability)

V. Social Services, Habilitation, and Rehabilitation

In view of the intersecting nature of the services required by PWD in the Mongolian context, this report defines social services as those that target vulnerable populations who have additional needs.²⁹ All references to children with disabilities (CWD) and PWD include people with an intellectual disability, multiple disabilities, and disabilities related to aging.

Despite advances in health care delivery, Mongolia still struggles to identify and provide social services for its hard-to-reach populations. Such struggles also relate to the continued dominance of the medical model of disability, which focuses on medical-type rehabilitation services as the main type of service. Nevertheless, key government representatives view service development in terms of rights, not welfare; community-based rehabilitation (CBR); and inclusion.³⁰ These pillars of government policy are reflected in Resolution No. 281 (August 2013), which mandates the adoption of the general plan for implementation of the UN Convention on the Rights of Persons with Disabilities (UNCRPD) 2013–2016 and led to adoption of the Law on the Rights of Persons with Disabilities (February 2016). The PWDLCS identifies a challenging baseline for delivering this vision. More than two-thirds (70%) of households with PWD lack sufficient information about social welfare benefits and social services, and of the 30% who want assistive devices, only 6% have access to them. If Mongolia expanded the list of assistive devices and provided more information about available assistive technology and equipment to PWD and parents of CWD, the percentage of better-informed PWD wanting assistive devices to maximize their participation in society likely would increase.

The lines are blurred between what can be considered CBR, statutory service provision, and early intervention and education. While interpretation can differ, all of these interventions are positive developments in providing opportunities for PWD to actively engage with their peers and communities without having to travel to receive services. The main services for PWD are in residential settings. Community-based services have been developing for some time and in a range of ways: CBR social welfare services, early childhood development services, and nongovernment organization (NGO)-operated independent living. In FGDs, some participants referenced having received services from a psychologist, although sometimes the psychologist is not located in Mongolia:

“Our *khoro* had temporarily one psychologist working. My husband became blind and he started drinking and life was hard. Then I met the psychologist and he advised me. It helped me somehow.” (Ulaanbaatar, Songinokhairkhan District, G, 36 years old, female)

“Yes, I got a psychological service. My son knows English and he helped me to find a psychologist from the US through the internet...He gave me a lot of advice and a way to solve my problem. It is a very important service. I think every *soum* and *bagh* needs to have at least one psychologist.” (Dornod *aimag*, Kherlen *soum*, S, 48 years old, female with a disability)

²⁹ *Habilitation* refers to a process aimed at helping people with disabilities attain, keep, or improve skills and functioning for daily living, while *rehabilitation* refers to regaining skills, abilities, or knowledge that may have been lost as a result of acquiring a disability or a change in one's disability or circumstances.

³⁰ MLSP interview, 13 January 2016.

However, PWDs generally have little experience with such services, except in NGOs:

“Professional psychological consultation is needed for family members. I was sick and needed this service at that time, but when I asked, I discovered that this service is not available. We need more centers like the Association of Parents of Differently Abled Children’s child development center.” (Dornod *aimag*, Kherlen *soum*, S, 49 years old, female with a disability)

The Mongolian approach to CBR has been developing for some time, with particular support from the Italian Association Amici di Raoul Follereau, an international NGO. However, implementation varies in scope and breadth. Most NGO services are developing and are delivered in Ulaanbaatar without government funding, although some also provide services in some *aimags*, and some services are paid by the social welfare system. The social welfare system, which incorporates benefits and allowances, technically permits the purchase of services (e.g., personal assistance, home-based care, or other types of services), but disabled people’s organizations (DPOs) report problems with implementation (see Section VIII).

A. Community-Based Social Services

1. Community-Based Rehabilitation

The Joint Position Paper on CBR (2004) notes that CBR is a strategy within general community development for the rehabilitation, equalization of opportunities, and social inclusion of all PWD.³¹ Although country approaches vary in scope and breadth, they have elements in common, including (i) national support through policies, coordination, and resource allocation; (ii) recognition of the need for CBR programs based on a human rights approach; (iii) willingness of the community to respond to the needs of PWD and CWD; and (iv) the presence of motivated community workers.

With the support of Italian Association Amici di Raoul Follereau, community rehabilitation committees have been established in all *aimags* nationwide to provide training and support for disability issues in the *soums*. The NRC offers partly residential and partly center-based rehabilitation services and acts as a policy advisory body to the Ministry of Labor and Social Protection (MLSP) and the government on disability-related issues. The Unurbul Center offers residential and educational services for orphans and street children. Noting that more than 30% of its children had a disability, the center established three facilities to provide rehabilitation services. Opened in November 2015, the Mongolian Child and Family Development Center serves approximately 60 children per day for physical therapy and traditional medical treatments such as acupuncture and cupping therapy.

The Association of Parents of Differently Abled Children operates six child development centers: one in Ulaanbaatar and five in *aimags*. These centers provide individual and group therapy and home-based services for 20–30 CWD and their families as well as training for doctors, parents, and associated professions. The services do not receive government funding, relying instead on donor support and fees. Both the National Association of Children with Disabilities and Autism Mongolia provide center-based rehabilitation and educational services for up to 30 kindergarten children. Under the authority of the National Authority for Children (NAC) and MLSP, Child Protection Center No. 5 was established in 2006 with support from international NGOs and is now maintained by government. This center, located in the ger district of Ulaanbaatar, supports 60 of 88 registered CWD in two *khoroos* in Chingeltei district, mostly from poor families. Facilities and staffing are limited and funding is erratic, so services do not operate as well as they once did.

³¹ ILO, United Nations Educational, Scientific and Cultural Organization, and WHO. 2004. *CBR A Strategy for Rehabilitation, Equalization of Opportunities, Poverty Reduction and Social Inclusion of People with Disabilities*. Joint Position Paper. Geneva: WHO.

2. Independent Living Services

The rehabilitation-based paradigm of support to PWD can reinforce their portrayal as sick, needing professional medical interventions, and possibly a burden to their families. The global independent living movement³² is working to replace this portrayal with one that identifies people with disabilities as experts in designing and promoting solutions that support rights fulfillment. Article 19 of the UNCRPD reinforces this approach as a fundamental right—*living independently and being included in the community*. Similarly, the Law on the Rights of Persons with Disabilities, Article 32 (2016) reinforces the concept of *rights to independent living*. This inclusive approach also supports *PWD participation in cultural life, recreation, and sport* (UNCRPD, Article 30).

The Center for Independent Living is a DPO that developed a model of independent living services and helped establish another independent living center in Ulaanbaatar. Both centers provide peer counselling and advocacy services and also train personal assistants. Because they receive no government funding, their service area is narrow. Despite sustainability problems, PWD and parents of CWD made their demands for services clear in FGDs:

“The Blind Association started this type of service from 2005. Unfortunately, it worked for 5 years and because it was a volunteer service has slowed down. We need these types of services. Of course, the person providing this needs to be paid. The government has to make a decision.” (Ulaanbaatar, Songinokhairkhan district, B, 38 years old, female PWD)

3. Workforce for Social Work, Community-Based Rehabilitation, Habilitation, and Rehabilitation

Currently, 14 tertiary training institutes, including private universities, offer professional social work courses. The Mongolian University of Science and Technology has offered a 4-year bachelor’s degree and a 5.5-year master’s degree since 1997. In 2016, the university required 30 newly enrolled students to select from three elective modules, including a 64-hour disability course introduced in 2015 that covers case management and basic counselling. Only 17% of existing social workers pursue a social work curriculum. The university has partnered with the MLSP to upgrade the professional social work skills of employed but unqualified social workers. The social work course is expanding its networks to provide a variety of disability-specific placements and guest lecturers.

The National Medical University of Mongolia is developing a core curriculum for CBR, including physiotherapy and occupational therapy. The university estimates that its graduates comprise 70% of all public sector medical professionals in Mongolia. The fifth graduating class (2016) is expected to increase the number of physiotherapists working in state hospitals to 100. Although occupational therapy is offered, enrollment is poor and the drop-out rate is high, possibly because occupational therapy is not a well-understood profession and opportunities for employment are limited. The quality of the occupational therapy training curriculum has not been assessed and updating it to meet current standards will require a significant investment. The School of Dentistry offers speech therapy as an elective postgraduate course.

4. Funding Social Welfare Services

DPOs report the availability of a home-based care service, which is available by application for 10–14 days per year and funded through the social welfare system. However, service is provided by a

³² A. Ratzka. 2005. Independent Living Institute. Stockholm. <https://www.independentliving.org/docs7/ratzka200507.html>.

government-funded private company that neither meets the needs of PWD or fulfills their rights. PWDLCS findings suggest that caregiver allowances and support for individuals who need of care do not match people's need for personal care. Only 50% of those who say they require a lot of assistance receive a care allowance. However, some people who say they do not need personal care still receive an allowance.

The relevance of social welfare benefits and allowances to services is important, particularly when considering systems for purchasing personal assistance. Similarly, they will require consideration if respite care is viable. Although funding for such allowances is currently available, it is unlikely to be sufficient to encourage people to apply for this option.

5. Access to Information

Knowing where to get information and advice is an important component of disability services that seek to enable people to fulfill their rights. This fundamental right is enshrined in the Law on the Rights of Persons with Disabilities (Article 5.1.3), thus creating favorable and accessible conditions for PWD to ensure their rights. As noted earlier, one NGO operates a nascent hotline for parents of CWD, and the NAC operates a separate national hotline for children not specific to PWD. However, the information needs of households and PWD remain mostly unmet. More than 70% of respondents to the PWDLCS said they do not receive enough information about services. Responses are similar across urban and rural locations and range from 15% of respondents asking for more information about education and skills training to 52% for social welfare services information, and more than 56% asking for health information.

6. Mental Health

Long-term mental health issues can affect a person's ability to undertake daily activities and thus can be considered a disability. Many PWD may also have a mental health condition (e.g., depression). Moreover, people with long-term mental health issues and intellectual disabilities, such as autism, have more chronic general health problems than the general population.³³ In 2006, a joint report by the Ministry of Health (MHO) and WHO noted that there were only 17 mental health professionals per 100,000 people, and primary health care staff had limited training in mental health.³⁴ Efforts to improve the care and treatment of people with mental health problems are ongoing through the United Kingdom–Mongolia Health Sector Partnership, which is working to develop community-based mental health services as an alternative to long-term hospitalization and residential care. The current statistics and classification of “mental disabilities” does not allow a proper distinction between psychiatric conditions and intellectual disabilities, and there is a tendency to confuse them.

7. Cross-Cutting Issues

The availability of specialist services is limited outside Ulaanbaatar. While limited services reflect recent population shifts encompassing an estimated 50% of the population living in and around Ulaanbaatar, this also reflects a lack of services for PWD in rural and remote communities. Outreach to those populations is possible in the health care sector due to MOH support of the Reach Every

³³ Disability Rights Commission. 2006. *Equality treatment: closing the gap: a formal investigation into the physical health inequalities experienced by people with learning disabilities and/or mental health problems*. DRC: London <https://www.gov.uk/government/publications/disability-rights-commission-annual-report-and-accounts-2006-to-2007>.

³⁴ WHO and MOH. *WHO-AIMS Report on Mental Health System in Mongolia*. 2006. Ulaanbaatar.

District and Soum initiative in collaboration with the United Nations Children's Fund (UNICEF) and WHO (MOH, WHO, and UNICEF 2015).³⁵

People with disabilities are more likely to be exposed to violence, abuse, exploitation, and neglect, and less likely to access prevention and response services. There are reports of PWD being locked in for their safety or forced to forgo paid employment to work as unpaid child caregivers at home. Other PWD are exposed to sexual violence.

Services are not reaching people with intellectual disabilities. Parents report that children with moderate to severe intellectual disabilities or multiple disabilities who obtain a place in a specialized kindergarten provided by an NGO are not able to graduate to mainstreamed or specialized schools.

There are challenges in service planning. Such challenges persist because the number of PWD who need a service is difficult to assess. Based on analysis of the Global Burden of Disease data,³⁶ estimates suggest that 5.1% of CWD 0–14 years old have a moderate to severe disability and 0.7% have a severe disability. If an estimate of 6% is applied to Mongolian population data, up to 14,000 children 0–14 years old require services.

B. Residential Care Services

Social care services not provided in the community are largely provided in national or local residential care settings or nursing homes. Nursing homes administer resources allocated for nursing directly from the state and local budget to provide shelter, food, clothing, and medicine to their residents, and also conduct activities relating to care, treatment, and rehabilitation. Some private centers also provide residential care services.

The PWDLCS conducted a rapid review of residential care institutions by collecting data from national ministries and administering a questionnaire to the managers of selected institutions. Ten residential institutions in Mongolia can accommodate persons who live in difficult circumstances and have no caregivers. Of these, only one center accommodates CWD, while national centers accommodate adults with disabilities (Table 8).

Unurbul Center serves children 2–18 years old who are full or half orphans, whose parents have had their parental rights restricted or removed, or whose parents are unable to care for their children due to mental illness. The institution aims to (i) protect every child and ensure a safe living environment, (ii) ensure children's right to develop and to be protected, (iii) ensure inclusion, (iv) create opportunities to live and develop in a family or a family-like environment, (v) provide comprehensive child protection services by preparing children to lead adult and independent lives, (vi) provide rehabilitative care and development services to CWD, (vii) provide family-based social welfare optional and/or alternative services, and (viii) provide preschool education. In 2012, the center was fully occupied (210 children). In 2015, 196 children were living in the center, 23% with disabilities—around five times more compared to the general child population.

³⁵ MOH, WHO, and UNICEF. *REDS Strategy Evaluation Mongolia*. 2015. Ulaanbaatar.

³⁶ WHO. 2004. *The Global Burden of Disease: 2004 Update*. WHO: Geneva. https://www.who.int/healthinfo/global_burden_disease/2004_report_update/en/.

Table 8: Persons with Disabilities in State Residential Care Institutions, 2012–2015

			2014			2015		
Institution	2012	2013	Male	Female	Total	Male	Female	Total
Children								
“Unurbul Center	210	184	95	69	164	108	88	196
Without parental care	210	184	95	69	164	108	88	196
Disabled	88	90	45	30	75	29	15	44
Adults								
Elderly care and development center in Batsumber	112	120	73	57	130	73	57	130
Disabled	79	64	40	33	73	44	30	74
Khovd <i>aimag</i> care center	27	30	17	12	29	18	10	28
Without family	27	30	17	12	29	18	10	28
Disabled	27	30	17	12	29	18	10	28
Total Disabled	194	184	102	75	177	91	55	146

Source: Ministry of Labor and Social Protection (formerly Ministry of Population Development and Social Protection), 2016 and questionnaires completed by institution directors.

Mongolia has two care centers for adults: one in Batsumber *soum*, Tuv *aimag*, and one in Khovd *aimag* (Table 8). Both centers provide permanent living services to citizens without caregivers, siblings, or other relatives, and who are unable to live independently and need permanent treatment and care. Many Batsumber residents have multiple disabilities: 52 with intellectual disability, 33 with mobility or physical disability, 19 with vision, and 3 with hearing disabilities. The Khovd center is relatively small (capacity= 30). In 2015, 28 adults lived there, all with disabilities. The adult centers provide residential and health care as well as rehabilitation, psychological, and nursing services.

Residential care services of this type are mainly for PWD, who are significantly overrepresented in their populations. The statutes for these residential care service providers reflect a medical model of disability.

Table 9: Children in Specialized Education School, 2012–2015

Specialized Schools	2012	2013	2014			2015		
			Male	Female	Total	Male	Female	Total
1 School No. 116	85	87	59	33	92	58	33	91
2 School No. 29	350	325	170	144	314	169	144	313
3 School No. 70	243	204	113	93	206	137	97	234
4 School No. 63	215	210	109	95	204	115	99	214
5 School No. 55	526	530	253	201	454	286	188	474
6 School No. 25	257	248	153	87	240	172	51	223
7 Kindergarten No. 10	120	120	73	47	120	75	45	120
8 Kindergarten No. 186	50	68	31	20	51	37	20	57
Total	1,846	1,792	961	720	1,681	951	775	1,726

Sources: Ministry of Labor and Social Protection, 2016, and questionnaires completed by institution directors.

In addition to residential care institutions, Mongolia has some specialized schools for CWD. The institutional care survey component of the PWDLCS identified six special schools and two specialized kindergartens, attended by 1,700–1,800 disabled students every year. All CWD in the specialized schools have parents, and all but two schools are day schools. More male students attend specialized schools than female students. The National Center for Mental Health provides services to clients with mental health problems; most patients have no family or other relatives and are unable to live independently without support. Currently, 125 people live there, 73 men and 52 women. Although the center is mainly for adults, four children 12–16 years old lived there in 2016. The Children’s Central Sanatorium mainly serves nondisabled, parentless children 0–3 years old; nevertheless, CWD older than 3 years are overrepresented in this population of babies and infants (Table 10). Sixty-one such children were classified as disabled in 2012 compared to 37 children in 2015, out of which around nine were classified as disabled (24%).

Table 10: Persons with Disabilities in Specialized Centers and the Children’s Central Sanatorium, 2012–2015

Location	2012	2013	2014			2015		
			Male	Female	Total	Male	Female	Total
Adults								
National Center for Mental Health	128	126	70	55	125	73	52	125
Without family	128	126	70	55	125	73	52	125
Disabled	128	126	70	55	125	73	52	125
Children								
National Center for Mental Health	11	8	3	3	6	2	2	4
Without parental care	11	8	3	3	6	2	2	4
Disabled	11	8	3	3	6	2	2	4
Children’s Central Sanatorium	61	57	25	15	40	22	15	37
Without parental care	61	57	25	15	40	22	15	37
Disabled	10	10	8	2	10	7	2	9
Total Disabled	149	144	81	60	141	82	56	138

Source: Ministry of Labor and Social Protection, 2016 and questionnaires completed by institution directors.

Among NGO-operated and other private institutions, the largest NGO is Badamlinhua Children’s Center, which cared for 103 children in 2012 and 77 in 2015, when 9 children were classified as disabled (Table 11). The center serves children 0–18 years old who are without family. The Mongolian Children’s Foundation serves homeless children and children without a caregiver. The Batgerelt-Ireedui NGO serves PWD older than 18 years old with mental, intellectual, and other types of impairment and who have no caretaker, and/or are homeless, and/or come from single-headed households. The proportion of CWD in the population of children in nongovernment residential care appears lower than in the state-run institutions. However, the proportion ranges from around 12%–60% across the four institutions, which still suggests over representation of CWD among children living in residential care. A UNICEF child protection system mapping report³⁷ suggests that more than 30 NGO and private children’s institutions were operating in Mongolia with little or no regulation.

³⁷ UNICEF. 2014. *A Mapping of the National Child Protection System* (unpublished).

Table 11: Persons with Disabilities in Nongovernment-Operated and Private Institutions, 2012–2015

Location	2012	2013	2014			2015		
			Male	Female	Total	Male	Female	Total
Children								
Mongolian Children Foundation	27	28	14	18	32	14	19	33
Without parental care	27	28	14	18	32	14	19	33
Disabled	0	0	0	1	1	0	1	1
Badamlinhua Children's Care Center	103	95	33	51	84	29	48	77
Without parental care	103	95	33	51	84	29	48	77
Disabled	2	9	3	6	9	3	6	9
My Home Care Center	4	3	5	5	10	5	5	10
Without parental care	4	3	5	5	10	5	5	10
Disabled	4	3	2	2	4	4	1	5
Gerel Children's Care Center	26	28	15	11	26	15	12	27
Without parental care	1	1	1	0	1	1	0	1
Disabled	2	2	0	2	2	0	2	2
New Hope Care Center	8	7	3	4	7	5	5	10
Without parental care	8	7	3	4	7	5	5	10
Disabled	1	1	1	1	2	1	1	2
Adult								
Batgerelt-Ireedui NGO	25	43	27	13	40	34	10	44
Without family	25	43	27	13	40	34	10	44
Disabled	0	0	0	0	0	0	2	2
Total Disabled	9	15	6	12	18	8	13	21

NGO = nongovernment organization.

Source: Ministry of Labor and Social Protection, 2016, and questionnaires completed by institution directors.

C. Conclusions

The Government of Mongolia pursues a CBR approach to the delivery of social services that harmonizes with the UNCRPD and the 2016 Law on the Rights of Persons with Disabilities. This approach aims to develop services that can help PWD to live their lives independently. Key elements of a strong CBR approach include locally available education, health care, and rehabilitation services; social and home care support services; accessible transport; and employment. For PWD who need support to live independently (i.e., without help from family members), the CBR approach seeks to ensure any necessary additional support to individuals in their own home as well as community-based health, education, employment, transport, and leisure. Some elements of this approach emerged when Mongolia introduced a limited range of home care services for a limited period, social welfare benefits that permitted access to some types of assistive devices, caregivers' allowances, and cash benefits that help cover the extra costs of accessing health care and/or compensate for lack of employment. The CBR approach is developing alongside a well-established system of state-operated and medically based long-term care institutions (i.e., nursing homes) and a new and burgeoning system of private or NGO-operated social care institutions. Data suggest that PWD are significantly overrepresented in these institutions and that the CBR system is not replacing them. Rather, the government is operating them in parallel. Further data are required to establish the full extent of institutionalized PWD in Mongolia.

VI. Education

The 2016 Law on the Rights of Persons with Disabilities includes a chapter on the right to education, specifying the duty of (i) schools to adapt the environment to the requirements of children with disabilities (CWD), (ii) parents to involve their children in education, and (iii) social workers to play an intermediary role. The law sets requirements to ensure inclusion of CWD by adapting and improving learning environments, and to ensure adequate training for teachers who work with children with special needs. In February 2013, the Government of Mongolia amended the Social Security Act of Persons with Disabilities, the Education Act, and other acts to provide a framework for establishing an integrated education system that can support CWD. Support to ensure the inclusion of CWD in education is currently provided through higher salaries for staff working in special needs schools and higher subsidies for every CWD enrolled in such schools. The higher subsidy is provided only to children who attend specialized schools or to schools that organize specialized classes. Primary schools receive free textbooks, but secondary schools provide free texts only to certain categories of students, including CWD. The Ministry of Education, Culture, Science and Sport also provides specific textbooks for CWD enrolled in specialized schools. Specialized schools exist only in the Ulaanbaatar. Colleges, vocational training centers, and universities receive governmental funding if PWD attend their courses, and PWD are exempt from tuition fees for higher education. However, such incentives do not seem to favor inclusive education.

These measures go only a small way toward creating the conditions for inclusive education envisaged in the 2016 law. In Clause 3, General Comment No. 4 (2016), the UN Convention on the Rights of Persons with Disabilities (UNCRPD) states that many millions of persons with disabilities continue to be denied a right to education. Disabled people's organizations (DPOs) report that access to and quality of education remains problematic for CWD of all ages and with a range of disabilities:

“There is no place which accepts children who are not able to move; and at age 7, no school will accept a severely disabled child. Even kindergartens are reluctant to take a child who has seizures and you have to beg them.” (Interview, DPO representative and parent of CWD, January 2016)

“The law says that you should include one or two children with disabilities in each class, but the understanding and attitude of teachers is questionable, so we don't want to send our children there. We actually need regulations and by-laws to make sure the law is fully implemented.” (Ibid.)

“Literacy is a big problem because of the poor quality of the education system. Deaf children go to specialized school no. 29 but all the teachers have hearing and don't have sign language, they insist on lip-reading and this is a skill child need to learn. The teachers should be signing. There are some deaf teachers, who are deaf and trained but they are not getting jobs. The deaf school should have 50/50 hearing and deaf teachers.” (Interview, PWD and DPO representative, January 2016)

“Blind children are often considered to have severe disabilities and are excluded from kindergarten and schools. This of course in turn affects their employability.” (Interview, PWD and DPO representative, January 2016)

A. Education Outcomes

Simply stated, PWD are left behind (Table 12). One in five PWD receive no education compared to less than 4% of the general population. When assessing the education achievement of adult PWD, the Living Standards Assessment Database (LSAD) is unclear on whether PWD had received any education before acquiring their disability. The 2010 census data, which distinguishes between acquired and congenital disability, reveals huge differences. Among children 6 years and older, 47% of those with congenital disabilities had no received education compared to only 12% for those with acquired disabilities. This indicates significant barriers to education for CWD.

Table 12: Education Level of People 15 Years Old and Above, 2014
(%)

Education Level	PWD	Others	Total
None	20.0	3.8	4.7
Primary	11.8	7.5	7.8
Secondary	20.7	18.6	18.7
Completed secondary	29.0	36.5	36.1
Technical and vocational	9.3	8.2	8.2
Higher	9.2	25.4	24.5
Total	100.0	100.0	100.0

PWD = persons with disabilities.

Source: Authors' analysis based on Living Standards Assessment Database.

There are also significant differences in education achievement according to different types of disability. In 2014, PWD with mental and speech disabilities were particularly worse off (Table 13). The 2010 census showed similar results, though the percentage of people with a congenital disability varies substantially depending on the type of disability: highest among persons with speech difficulties (72%), followed by mental problems (52%), hearing (39%), sight (31), mobility (26%), and other problems (16%).

Table 13: Education Level of Persons with Disabilities
15 Years Old and Above by Type of Disability, 2014
(%)

Education Level	Primary Disability							Total
	Vision	Speech	Hearing	Mobility	Mental Health	Multiple	Other	
None	13.3	45.2	14.6	11.6	44.2	23.5	7.8	20.1
Primary	15.0	11.4	12.2	12.7	11.4	12.4	9.4	11.8
Secondary	24.0	14.2	22.7	22.2	16.9	18.5	22.0	20.7
Completed secondary	28.9	21.1	32.2	31.7	18.2	27.8	36.0	29.0
Technical and vocational	9.1	4.1	10.0	9.9	5.0	9.6	12.8	9.3
Higher	9.7	4.0	8.3	11.9	4.3	8.2	12.0	9.1
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Source: Authors' analysis based on Living Standards Assessment Database.

School enrollment rates are a direct measure of barriers to enrollment for CWD (see Section III).

B. Access to Schools

The PWD Living Conditions Survey (PWDLCS) for children under 18 years old estimated the school enrollment rate at 69% and identified the same problems discussed above from more representative sources. The lack of enrollment and a higher drop-out rate associates with poverty, sex of the child (enrollment is significantly lower for boys), and remoteness. Table 14 and Table 15 show results for PWD under 30 years old and examine whether PWD (i) attended school, (ii) reached their desired level of education, or (iii) dropped out or never attended school. The distribution of PWD in these situations differs radically. CWD who dropped out or never attended school are clearly poorer than those who did not. While overall PWD distribution skews toward the bottom of the distribution, those who dropped out or never attended school are worse off.

Table 14: School Attendance among Persons with Disabilities by Poverty Group, 2016

Poverty Level	Attending or Reached Desired Level of Education	Dropped Out or Never Attended School	Total
Very poor (bottom 10% of population)	29	49	36
Poor (from 10% to 30%)	27	17	24
Average (from 30% to 70%)	32	32	31
Above average (from 70% to 85%)	11	2	8
Well-off (top 15% of population)	1	0	1
Total	100	100	100

Note: Includes 114 observations among all people under 30 years old.

Source: PWD Living Conditions Survey (PWDLCS), February/March 2016.

Table 15 shows the percentage of people who dropped out or never attended school by location and sex. This percentage increases from Ulaanbaatar to *aimag* centers and *soums*, and is significantly higher for men (43%) than for women (25%).

Table 15: School Attendance and Achievement among Persons with Disabilities by Location and Sex, 2016
(%)

School Enrollment and/or Achievement	Location			Sex		Total
	UB	<i>Aimag</i>	<i>Soum</i>	Male	Female	
Attending or reached desired level of education	72	63	56	57	75	64
Dropped out or never attended school	28	37	44	43	25	36
Total	100	100	100	100	100	100

Aimag = province, *soum* = district, UB = Ulaanbaatar.

Note: Includes 114 observations among all people under 30 years old.

Source: PWD Living Conditions Survey (PWDLCS), February/March 2016.

Among PWD attending school, 70% report difficulties in travel, including no means of transport, no caregivers to take or pick up the child from school, and fatigue. This is symptomatic of the extra needs for investment for CWD to attend school, both financial and nonfinancial. All appear to cause low attendance rates. Among enrolled CWD, 13% are unable to attend all classes. Parents report that most teachers treat CWD with care but note slightly more discrimination toward girls. Much more problematic is the interaction between CWD and other students. Indeed, a “nice attitude” is less frequent and discrimination (e.g., teasing, physical abuse, and discrimination is more common toward boys than girls). This could partly explain the lower enrollment rate for boys (Table 16) and the predominantly male enrollment in specialized schools.

Table 16: Attitude of Teachers and Pupils toward Children with Disabilities, 2016
(%)

Attitude	CWD		Total
	Male	Female	
Teachers			
Very nice attitude	96.3	88.5	92.5
Not nice/discriminate	3.7	7.7	5.7
Other pupils			
Nice attitude	48.1	80.8	64.2
No discrimination, normal	29.6	15.4	22.6
Laugh at them, do not play together, discriminate	22.2	3.8	13.2
Become a “friend” only if you have money	0	3.8	1.9
Respondents	27	26	53

CWD = children with disabilities.

Note: Multiple choice question, so figures do not add up to 100.

Source: PWD Living Conditions Survey (PWDLCS), February/March 2016.

Focus group discussions (FGDs) elicited a strong message from parents of CWD that while children often attend school, their learning is limited because the school is not properly equipped and unable to provide for children with special needs. Key reasons for dropping out include lack of learning materials and falling behind. Some evidence suggests that children not enrolled in school appear to have more severe disabilities judging from their higher care needs.

The PWDLCS reveals an education system that fails CWD. Much stronger measures are required to support the inclusion of CWD in mainstream schools. Typically, these measures would include (i) systematic teacher training, (ii) teaching assistants and other classroom teaching supports, (iii) investment in augmentative and alternative means of communication, and (iv) individualized education plans. Compared to many other countries, Mongolia provides only limited chances for residential specialized education. This represents an opportunity to build an inclusive education system without having to redirect resources from or dismantle an existing residential system.

C. Specialized Schools and Preschools

The six specialized needs schools in Ulaanbaatar enroll approximately 1,600 children and include one school for the blind and one for those with impaired hearing. Nationwide, 20% of CWD who attend

school are in specialized schools compared to 55% in Ulaanbaatar. Enrollment figures suggest that there are more opportunities for enrollment in primary schools compared to secondary schools, and few opportunities for higher education (Table 17). Dormitories are available at the blind and deaf schools, which accommodated 185 children (55.6% and 38.6%, respectively) in 2016. This represents relatively low institutionalization of CWD for education purposes, but also implies very limited access to the learning environments needed by CWD.

Table 17: Statistics on Specialized Schools, 2016

Indicators		Specialized Schools					
		25	29	55	63	70	116
Children	Primary	128	140	257	122	172	65
	Secondary	106	102	153	113	102	27
	Higher	0	82	64	0	0	16
School dormitories		0	2	0	0	0	1
Children in dormitory		0	125	0	0	0	60
	Full orphan	5	3	43	9	3	3
	Half orphan	48	38	117	34	35	17
School provides lunch		Yes	Yes	No	Yes	Yes	Yes
Type of disability	Mental	234	0	364	235	274	0
	Vision	3	3	0	0	0	88
	Hearing	0	229	0	1	0	0
	Multiple	71	42	16	165	131	20
	Cerebral palsy/epilepsy	25		24	93	55	0
	Autism	6	2	29	8	30	0
	Down syndrome	35	2	13	5	19	0
	Others	4	46	28	0	0	0

Source: Department of Education Policy, Ministry of Education, Culture and Science, 2016.

With overcrowding in mainstream kindergartens, opportunities for CWD are limited. Mongolia has two government-operated kindergartens for CWD, both in Ulaanbaatar, and some day care centers operated by NGOs, parent groups, or private individuals. Some CWD receive special services that combine rehabilitation and developmental education from NGOs, the National Association of Children with Disabilities, and Autism Mongolia. These services do not receive government funding and can charge fees. As yet, there are no minimum standards, but the MLSP reports that it is developing a regulation for child development centers and considering the introduction of standards. In response to the limited availability of public kindergartens, the NAC has reported plans to introduce a home-based childcare service, with the dual goals of care and protection. This will involve recruitment and training of salaried individuals in communities to care for children, including CWD, in their own homes or in rented spaces as an alternative to state-funded kindergartens.

VII. Employment

A. Economic Activity and Employment of Persons with Disabilities

In Mongolia, the employment rate of PWD is much lower compared to persons without disabilities. Using the 2014 Labor Force Survey (LFS), Table 18 summarizes key labor market indicators that compare PWD to the total population. In 2014, the rate of economic activity among PWD was 25.2% compared to 62.1% in the total population.

Table 18: Key Labor Market Indicators, 2014
(%)

Indicators	General Population (%)	PWD (%)
People 15 years old and above	64.8	93.9
Economically active people*	62.1	25.2
Employed	92.1	94.7
Unemployed (actively looking for work)	7.9	5.3

PWD = persons with disabilities.

* Labor force.

Source: National Statistic Office, Labor Force Survey 2014.

LFS 2014 data suggest significantly lower economic activity among women with disabilities. A second important observation concerns the higher activity rate of PWD in rural areas. This is explained by the fact that most employed PWD in rural areas are herders and self-employed due to the extremely limited choice of occupations in rural areas.

Table 19: Economic Activity of Persons with Disabilities by Location, 2014

Indicators	Male (%)	Female (%)	Total (%)
Economically active PWD*	27.3	22.0	25.0
Employed	93.7	94.0	93.8
Unemployed (actively looking for work)	6.3	6.0	6.2
Urban Economically active PWD	18.2	14.6	16.6
Employed	88.9	87.9	88.5
Unemployed	11.1	12.1	11.5
Rural Economically active PWD	41.5	36.0	39.2
Employed	97.1	98.6	97.6
Unemployed	2.9	1.4	2.4

PWD = persons with disabilities.

* Labor force.

Source: National Statistic Office, Labor Force Survey 2014.

B. Employment Types and Earnings

Typically, PWD are employed as herders or self-employed. The share of herders among PWD was 45.1% compared to 24.6% in the total population. The share of paid employees among PWD (22.5%) is significantly lower than the share in the total population (49.9%). Self-employment is higher for PWD (25.0%) compared to the total population (20.3%). FGDs revealed that the most economically active PWD are self-employed and that employers with or without experience in employing PWD cited self-employment as being easy for PWD.

Table 20: Type of Employment in Economically Active Population, 2014

Type of Employment	Total Population (%)	PWD (%)
Paid employees	49.9	22.5
Employers	1.6	1.1
Self-employed	20.3	25
Members of cooperatives and partnerships	0.1	0.6
Herders*	24.6	45.1
Unpaid family workers	3.5	5.7
Other	0	0
Total	100	100

PWD = persons with disabilities.

* Animal husbandry.

Source: National Statistic Office, Labor Force Survey 2014.

Although mainly self-employed, PWD face issues related to the sustainability of work and the uncertainty of generating income from self-employment:

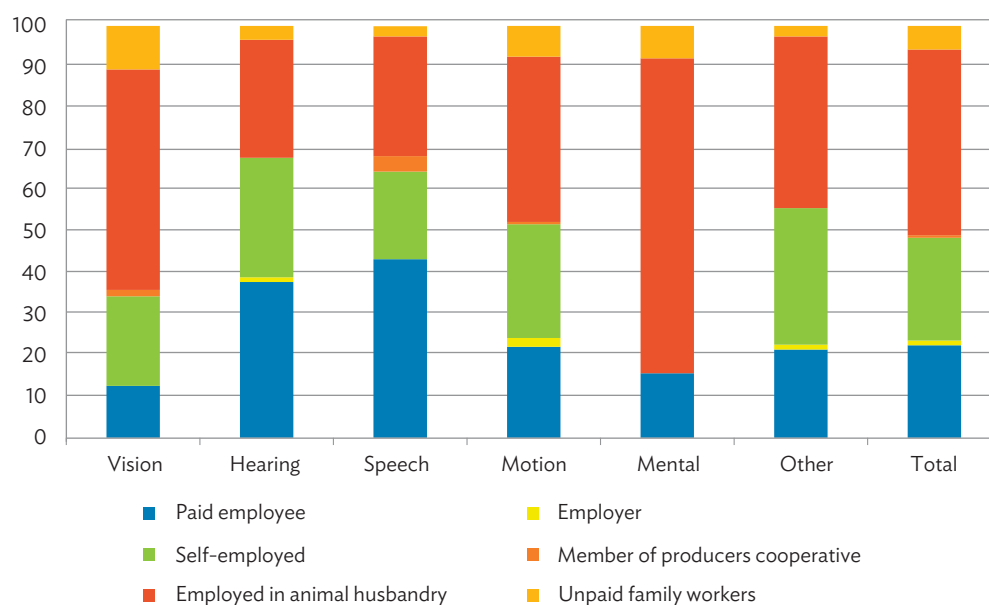
“I am self-employed. Vegetable pickling, making macaroni. Also I am making jewellery from silver. Unfortunately sales are really going down and we cannot sell our product.” (Dornod *aimag*, Tsagaan Ovoo *soum*, B, 44 years old, woman)

“I run a shoe repair unit, but people are not giving cash. People run out of cash, so I always offer my business with payment later.” (Dornod *aimag*, Tsagaan Ovoo *soum*, T, 55 years old, man)

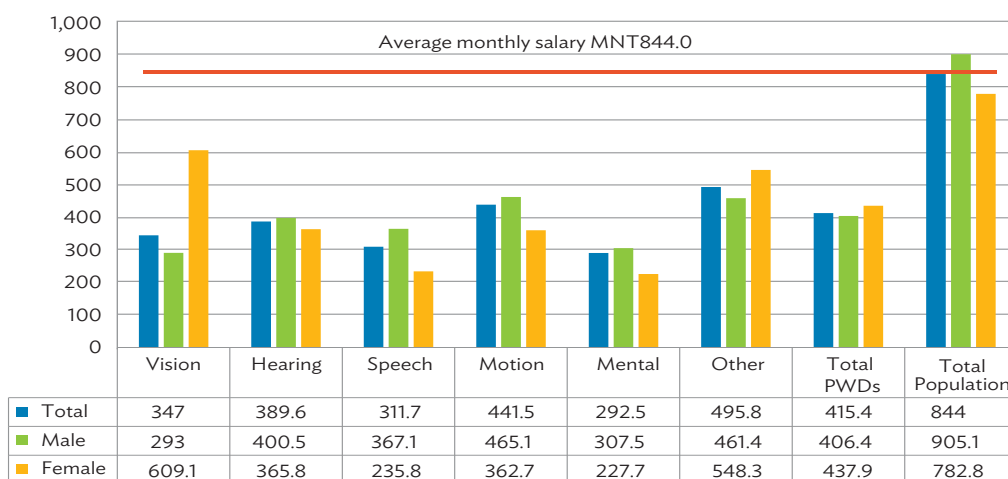
Type of employment varies according to type of disability (Figure 6). People with intellectual disabilities or vision impairment are more likely to be employed in animal husbandry, while those with hearing and speech impairments are more likely to work for pay.

Employment of PWD varies across company size and industry type. FGD participants suggest that companies with more employees are not necessarily more likely to employ PWD. Smaller companies have formal return-to-work or disability management programs and can accommodate the needs of employees with disabilities. The PWDLCS identified only 22 employed PWD. Despite a small sample, this shows that employers in the private sector are much more likely to employ PWD than employers in the public sector.

According to NSO data from 2014, the average monthly salary for the total employed population was MNT844,000; the average earnings of employed PWD are significantly below this level (Figure 7). With the notable exception of women with vision impairments, the highest salary for PWD is among persons with mobility and hearing disabilities, whereas the lowest earnings are among persons with intellectual disabilities.

Figure 6: Active Persons with Disabilities by Employment Status and Disability Type, 2014

Source: National Statistic Office, Labor Force Survey 2014.

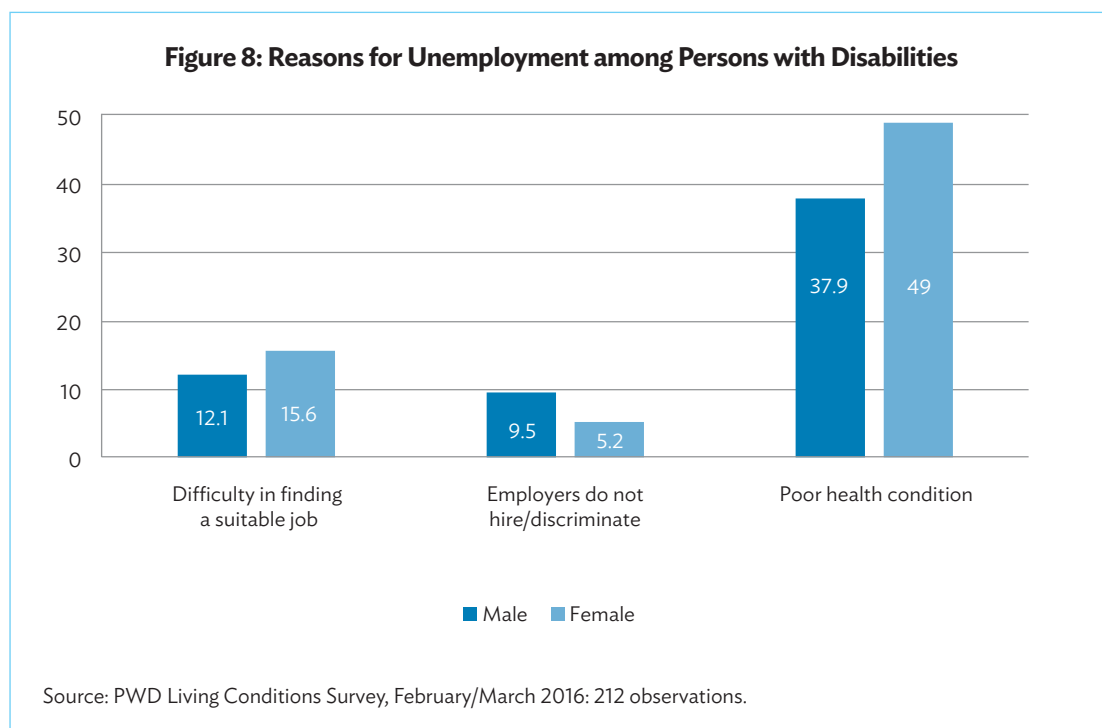
Figure 7: Average Monthly Salary of Active Persons with Disabilities by Sex and Disability Type, 2014 (MNT '000)

PWD = persons with disabilities.

Source: National Statistic Office, Labor Force Survey 2014.

C. Barriers to Employment

PWD may lack the necessary knowledge and skills for available jobs. Among PWD not working, almost two-thirds had some work experience, although the rate is lower for women. Most PWD report that the main reason for unemployment is poor health (Figure 8).



Some factors that may affect employers' attitudes toward hiring PWD emerged from the FGDs:

- **Employers having previous experience with PWD report more favorable attitudes toward hiring them.** The most frequently cited reason was that “the person had the skills that the company needed, and their disability was not considered.”
- **Employers lack of information about the quota system and monitoring is absent.** The Mongolian Labor Code stipulates an employment quota for PWD. According to Article 111, “disabled or dwarf persons shall be employed at a level of not less than 3 percent of its total staff by a business entity or organization having more than 50 employees, unless it is contrary to the job or production feature.” Business entities and organizations fail to employ PWD at the specified level must make a monthly payment for each position they should have filled. The employers stated that there is a strong need to improve monitoring of the quota legislation and provide sufficient information to employers.
- **A high percentage of employers cited the nature of the work as a concern regarding hiring PWD.** Employers ranked inability to find qualified PWD as their first challenge. In their opinion, PWD are suited to work as financial workers, accountants, cleaners, nurses, and doctors, etc.
- **Employers perceive reasonable accommodation as involving higher costs.** Companies that employ PWD cite the lack of reasonable accommodation as a barrier to employment. Even companies with experience in employing PWD do not know enough about what reasonable accommodation entails and how much it will cost. Another frequently cited barrier is socialization.

Employers may choose not to hire PWD due to fears about negative reactions from co-workers and customers.

- **Employer stereotypes and biases may result in less willingness to hire PWD.** Some employers believe individuals with disabilities are less productive. The most frequently cited reason for not recruiting PWD is the “nature of the work” (i.e., work that cannot be performed by PWD).

D. Use of Public Employment Services

Mongolia has significantly reformed public employment services in recent years. Since 2012, the Law on Employment Promotion has been amended to reflect new services and the ways in which they are organized (Table 21). The law introduced

- employment promotion services, including provision of occupational and vocational orientation, counselling and information, job mediation, and unemployment benefits; and
- employment promotion measures, including preparation for employment, employment training, support for herders and the self-employed, support for employers and public works, and support for citizens facing difficulties in finding employment (including PWD).

Table 21: Indicators of Implementation by Employment Promotion Services, 2012–2014

Indicators	2012	2013	2014
Registered unemployed	35,776	42,772	36,970
Job mediations	34,799	65,632	54,367*
Beneficiaries of employment training	15,513	17,053	6,399**
Beneficiaries of small loans	7,432	3,277	5,729
Beneficiaries in public works	30,241	45,877	25,329
Unemployment benefit recipients	10,471	15,871	16,315

PWD = persons with disabilities.

* Including 1,939 PWD.

** Including 748 PWD.

Source: Labor Market Statistics 2010–2014, National Employment Services Research and Information Center, 2015.

Under the Law on Employment Promotion, a specific program for employment of PWD aims to provide (i) financial support to PWD and PWD-operated businesses, and (ii) job skills and business skills training to create jobs that meet the specific needs of PWD (Table 22). This program targets PWD who have the capacity to work and have registered as job seekers in the government’s employment services. The person must have a valid disability assessment from a hospital and employment verification to prove that “physical, mental, intellectual and permanent sensory abilities in combination with other impediments have affected the person’s ability to function in a society like everyone for over 12 months.” (Law on the Rights of Persons with Disabilities, Article 4.1.1) Aimag employment offices are responsible for implementing this program. Monitoring data indicate that self-employment is the main measure promoted in the Employment Program for PWD. Placements in the open labor market are limited. Apart from the basic monitoring information presented here, no other assessment is available regarding the results of this program.

Table 22: Monitoring Indicators on Employment Program for Persons with Disabilities, 2015

Indicators	2015
Employed by self-employment projects	1,812
Employed by subsidies to employers	73
Job mediations	160
Beneficiaries of career guidance	797
Beneficiaries of training on business skills	1,124
Beneficiaries of vocational training to support self-employment	474

Source: Program Report, National Employment Services Research and Information Center, 2016

According to the PWDLCS, only 4 out of 22 employed PWD used employment services. Nearly all respondents who were unemployed and looking for work (212 respondents) never visited the employment services. According to employment office staff, job-matching services and training programs targeting all job seekers are provided at a sufficient level to all seekers, including PWD. However, there are no proper guidelines or procedures for offering special services to PWD. The special program for promoting PWD employment is the only guide for staff. Most officers stated that “negative attitudes of employers” are a concern in job-matching services. The survey suggests that PWD are not able to access employment services from employment offices that are tailored to their needs. All companies that participated in FGDs were asked about effective strategies for enforcement of the quota system. Table 23 shows the top five strategies for enforcing the quota system, according to companies that actively recruit PWDs and those that do not.

Table 23: Effective Strategies for Enforcing the Quota System: Feedback from Discussion Groups

Companies That Actively Recruit PWD	Companies That Do Not Actively Recruit PWD	Employment Office
Improve monitoring	Improve skills/qualifications of PWD	Provide sufficient information to employers
Modification/amendment of quota legislation	Establish reasonable accommodation	Allocation of budget for implementation
Raise employer awareness of quota legislation	Raise employer awareness of quota legislation	Employer incentives (e.g., financial support)
Improve skills/qualifications of PWD	Improve monitoring of quota system	Improve collaboration between Employment Office and Inspection Office
Change attitudes of employers toward PWD	Employer tax credits and incentives	Raise disability awareness for employers

PWD = persons with disabilities.

Source: PWD Living Conditions Survey, 2016.

Table 24 shows the top three recommendations for the government by to companies that actively recruit PWD, those that do not, and employment office staff.

Table 24: Focus Group Discussions: Recommendations to the Government

Companies that Actively Recruit PWDs	Companies Not Actively Recruiting PWDs	Employment Office
Improve skills/qualifications of PWD	Improve skills/qualifications of PWD	Provide reasonable accommodation for PWD
Disability awareness training for employers	Establish reasonable accommodation	Good partnerships with public organizations such as the Employment Office, the Inspection Office, and the Social Welfare Office
Financial support to employers that actively recruit PWD	Financial support to employers that actively recruit PWD	Conduct comprehensive research on potential employment for PWD

PWD = persons with disabilities.

Source: Focus group discussions, 2016.

E. Conclusions

Qualitative and quantitative studies by the PWDLCS and secondary data from NSO, NESRIC, and the Ministry of Labor reveal several patterns. Enhanced policy initiatives should remedy or eliminate the following difficulties and barriers:

- A much smaller percentage of PWD are employed than people without disabilities. PWD experience lower rates of employment and less paid employment compared to those without disabilities.
- The main constraints on PWD employability are lower of education and absence of job-specific knowledge, skills, abilities, and other characteristics to perform the job.
- The existing economic incentives for hiring PWD are not attractive enough to influence hiring practices.
- Workplaces lack reasonable accommodations for PWD, including interpreters, readers, or other personal assistance; modified job duties; restructured work sites; flexible work schedules or work sites; and accessible technology or other workplace adaptive equipment.
- The employment office strongly needs an officer who can help management recruit, hire, and accommodate PWD. This officer could have many roles and responsibilities, including (i) advising managers about reasonable accommodation for employees with special needs, (ii) assisting the identification of environmental barriers and modifications to allow PWD to perform duties, (iii) providing information for PWD about job opportunities and how to apply for these jobs, (iv) facilitating the placement of applicants with disabilities, and (v) monitoring and evaluating the effectiveness of PWD placement programs for the International Classification of Functioning (ICF).

VIII. Social Welfare System

The social protection system for PWD in Mongolia contains elements of both contributory social insurance and noncontributory social assistance. About 80% of the labor force is insured and social insurance entitles people to a disability pension if they acquire a disability, provided they have worked and paid social insurance contributions for at least 20 years or made at least 3 years of contributions in the 5 years before suffering an accident. If a disability assessment determines a loss of capacity to work of 30% or more, the disability pension should not be less than 75% of the minimum wage. In the case of workplace accidents, employers must make one-off payments. The main benefits provided for PWD under the social welfare law include

- a social welfare pension for PWD who have lost 50% or more of their labor capacity (MNT126,500 per month in 2015);
- an allowance for caregivers of a single person with disabilities or a person who needs permanent care, including CWD (MNT58,000 per month in 2015);
- support for a person who needs permanent (MNT60,000 per quarter in 2015 for adults with disabilities or MNT126,500 per month for CWD). Support for CWD increased substantially and was made equal to the value of the social welfare pension in 2015;
- community-based social welfare services, including counselling and life training, funding for community groups, rehabilitation services, temporary shelter, and home-based care; and
- 16 different entitlements for PWD, some targeting specific groups (e.g., the blind, PWD in need of permanent care, single PWD, etc.), and including annual financial assistance for fuel, prosthetic devices, free transport, communication allowance, etc.

The 2016 Law on the Rights of Persons with Disabilities also contains provisions regarding the creation of new special services to ensure access to concessional mortgage rates, community-based social welfare services, and services to support independent living. The presence of both social insurance and social assistance for PWD indicates good architecture, and the system distinguishes clearly between the roles of these two functions of support. In practice, however, the system faces some design and implementation challenges relating to coverage, adequacy, and flexibility.

Informal evidence suggests unreported or unregistered cases of disability that do not have access to social welfare services. Even when people with disabilities are registered, they have only partial access to social welfare entitlements. Benefits are extremely low and system is rigid, prescribing a system of entitlements that do not necessarily respond to the individual needs of PWD. The household survey shows that about 18% of PWD have not been examined by the Medical and Labor Accreditation Commission (MLAC) or equivalent Children's Commission. Concessions, discounts, and reimbursement benefits cover only one in five PWD, with benefits more likely received by PWD who are relatively better off. The PWDLCS examination of the design and implementation of disability-related benefits highlighted the following main issues:

- Social welfare benefits are too small in relation to minimum wage and minimum subsistence, and do not consider the extra costs faced by children and adults with disabilities. This is particularly true for the caregiver allowance, which is less than 30% of the minimum wage and less than 40% of the official per capita poverty line.
- To compensate for the extra costs of disability, PWD are entitled to a set of additional benefits and concessions, but these do not appear to have been developed systematically. Some entitlements do try to distinguish the level of support based on some assessment of the severity of disability.
- There is a system of reimbursement for assistive devices, but the list appears restricted and reimbursement is often insufficient. There are large variations in the quality and care of the delivery of such assistive devices.
- Community-based social welfare services could provide some rehabilitation services and home care services for PWD. However, these have not been developed, mainly due to (i) the absence of an NGO presence beyond *aimag* centers, and (ii) restrictive conditions on service provision. Moreover, PWD are limited to receiving no more than 15 days of home care assistance per year.
- There is very little support caregiver services, which might take the form of simple training and/or respite care. Theoretically, some services should exist under community-based services; in practice, services have not appeared due to problems with implementation. Asymmetries between urban and rural areas result in greater availability of services in urban areas. Concerning social insurance, and specifically health insurance, it is unclear whether caregivers of PWD are currently covered by health insurance. Even if caregivers work full-time to look after household members they are not eligible for pension contributions.

In various interviews, disabled people's organizations (DPOs) confirmed at least some of these statements, emphasizing inflexibility in the current system and failure to give PWD autonomy to decide how to spend monetary support.

International best practice in social welfare systems for PWD is linked to the conceptual approach to disability by the International Classification of Functioning (ICF). This approach moves away from viewing disability as a medical condition that needs compensation and as a percentage of work capacity loss, and toward an approach that emphasizes rehabilitation, allowing activity through assistive devices, removing barriers to participation, and whenever possible, encouraging and supporting PWD participation in the labor force.³⁸ To increase the flexibility of support and accommodate individual needs, some countries have developed packages of assistance in the form of "personal budgets."³⁹ PWD who need services receive a cash benefit that they can spend to meet their specific needs, which are based on the advice of medical and social care professionals and result in different budget allocations. This budget can then be spent by giving direct decision-making power to PWD alone or with the support of professional caregivers. The budget can usually be used to purchase social care services, equipment, therapy, and nursing services. However, those models require an advanced system of intermediation and a network of service providers, which seems far away from the current conditions observed in Mongolia.

At the same time, DPOs want to introduce more flexibility and fairness to the provision of social welfare benefits. The current system is very rigid and decides what PWD can receive without considering the diversity of needs and circumstances faced by PWD. The administration of disability benefits and concessions works through a piecemeal approach, which considers each request for support in isolation.

³⁸ M. Palmer. 2013. *Social protection and Disability: A Call for Action*. Oxford Development Studies, Vol.41. No.2.

³⁹ European Platform for Rehabilitation. 2013. *Personal Budgets: A New Way to Finance Disability Services*. www.epr.eu/images/EPR/documents/policy_documents/Paper%20on%20Personal%20Budgets.pdf [accessed 30 October 2016].

A key element that is missing from Mongolia's system is a more nuanced assessment of the needs of PWD, so that the amount they receive in social welfare benefits better reflects different needs. Some countries have developed assessment systems that distinguish between the different levels of need, which then correspond to a progressively higher monetary allowance. The review committee of the UN Convention on the Rights of Persons with Disabilities (UNCRPD) emphasizes the lack of support for PWD who have no family or relatives, and their right to live independent lives. This is recognized in the 2016 Law on the Rights of Persons with Disabilities, but implementation will require special personal assistance services and, perhaps, supported independent living services or community-based social care services provided in small apartment homes for PWD.

IX. Creating a Barrier-Free Environment

The 2016 Law on the Rights of Persons with Disabilities introduced articles to create a barrier-free environment. To assess the current situation, the PWD Living Conditions Survey (PWDLCS) reviewed legislation and policies relating to access to the physical environment, transport, and information, and also consulted with disabled people's organizations (DPOs), government representatives, PWD, and parents of children with disabilities (CWD).

Legislation regarding the physical environment, transport, information, and assistive devices for PWD includes

- the Law on Urban Planning (2008),⁴⁰ which contains a provision for accessible infrastructure;
- the Law on Construction (2008),⁴¹ which contains a provision that addresses the needs of PWD in the design and construction of buildings;
- some building standards on accessibility;⁴²
- the Law on Auto Transportation (1999),⁴³ which requires that 10% of public transport vehicles shall be accessible for PWD; and
- the Law on Social Welfare (2012) and the Law on Social Insurance (1994), which have provisions regarding reimbursement for assistive devices and equipment.

However, legislative implementation is not systematic, and enforcement is weak.

In Mongolia, three basic standards on disability accessibility are available. Key informants report that there are contradictions across the legislation and standards. For example, Accessibility Standard MNS6055:2009 states that door thresholds should not be higher than 2.5 centimeters (cm), but Fire Safety Standards require thresholds to be no lower than 4 cm. DPOs actively monitor and campaign for accessibility issues. Accessibility evaluations conducted in 2014 and 2015 by the Wheelchair Users' Association of Mongolia, together with the National Human Rights Council⁴⁴ and WHO on public service organizations, found that less than one-third of facilities are satisfactorily accessible and 2% were completely inaccessible in Ulaanbaatar. The Ministry of Roads and Transportation reports that 3% of public transport operating in Ulaanbaatar is accessible, well below the 10% prescribed in the Law on Auto Transportation.

⁴⁰ The Parliament of Mongolia. *The Law on Urban Planning*. www.legalinfo.mn/law/details/530.

⁴¹ The Parliament of Mongolia. *The Law on Construction*. www.legalinfo.mn/law/details/112.

⁴² Pavements NS 5682: 2006 and MNS 6056: 2009; Estimated space for PWD needs in civil construction planning MNS6055: 2009.

⁴³ The Parliament of Mongolia. *The Law on Auto Transportation*. www.legalinfo.mn/law/details/29?lawid=29.

⁴⁴ MOH, WHO, and Wheelchair Users Association of Mongolia. 2015. *Monitoring Report on the Environmental Accessibility of Family Clinics, Health Centers and Hospitals of 9 districts of UB*. Ulaanbaatar. <http://mn-nhrc.org/index.php?newsid=5683>; <http://mn-nhrc.org/index.php?newsid=5681>.

Among households surveyed by the PWDLCS, 70% reported that they lacked basic information, including information about social welfare benefits. The Ministry of Labor and Social Protection (MLSP) website is the only government site that includes basic accessibility functions (e.g., changing font size and black and white contrast). Sign language captioning for deaf people is limited to one news broadcast per day on two channels. Otherwise, little media content is adaptive.

The survey also found that while 39% of PWD would like to receive assistive devices, only 6% actually receive them. The most-requested devices are walking sticks, special glasses, hearing aids, and wheelchairs. Half of PWD who have received some form of device would like to receive another or, perhaps, a better device. The government provides reimbursement through its social welfare and health insurance system for 80 basic orthopedic and orthotic devices and equipment. WHO surveyed 214 PWD and staff from state organizations, NGOs, and specialized schools to compile a complementary list of devices that people would like to see included across a range of functional areas.

The head of the Wheelchair Users' Association is the sole DPO representative in the state commission responsible for authorizing buildings taller than 17 floors or funded directly by ministries or the government. The role of DPOs in these commissions is formally provided in legislation; however, it remains unclear how DPOs fulfill their verification functions, particularly at the point of commissioning once a building has been completed. International best practice provides for a simple checklist that an independent verification commission can use to monitor compliance with accessibility regulations or approved standards. Reportedly, research suggests that commission members' knowledge and understanding of the principles of universal design and ease of access are low among commission members who are responsible for verification and approval.

X. Policy Implications for Enhancing Inclusion and Participation

Unfortunately, the inclusion of PWD does not happen automatically with a declaration or law. Rather, it requires a change of mentality, buttressed by public campaigns and a coherent policy framework to support policy interventions in multiple sectors (e.g., employment, social welfare, health, education, and other social services). Mongolia is still transitioning and it has some contradictory policies. Disability is primarily understood as a condition that reduces work capacity, producing a dichotomy that views PWD as (i) unable to work, and therefore entitled to social protection; or (ii) people who do work and therefore do not need support. Disabled people's organizations strongly oppose this dichotomy because PWD do not want to simply to receive cash assistance; instead, they want support to help them overcome the barriers that prevent them from working and contributing to society.

The Law on the Rights of Persons with Disabilities (2016) forbids cessation of any pension, social welfare allowance, or social insurance for working PWD solely because they earn a salary. This aims to ensure that people have the right to work, even if they have a functional impairment. However, it goes too far in the opposite direction because it does not recognize that disability can disappear if barriers are eliminated, possibly rendering allowances and disability pensions unnecessary.

Similar dichotomies are at play in education and other social services. The government has pursued a community-based rehabilitation (CBR) approach to enhance inclusion and participation, but the long-established system of residential care facilities continues to provide services that follow a medical model of disability (i.e., treatment or rehabilitation). Such facilities are not inclusive—they require children with disabilities (CWD) and PWD to live away from home to access services. In education, legislative provisions allocate extra funding to specialized schools, but mainstream schools cannot get extra funding if they enroll only a few CWD. The 2016 law is a strong declaration by the Government of Mongolia that it is moving the country toward a society that recognizes PWD and CWD as being like other people, with the same rights and responsibilities, and moving it away from perceiving them as objects of shame or pity and a burden on society. The following recommendations can help this declaration become a reality.

A. Improve the Understanding of Disability

The concept of disability needs work regarding (i) its general definition, (ii) its interpretation throughout the legislation and the subordinate regulatory frameworks across all sectors, and (iii) the way it is communicated to workers in the public sector and the public at large. The concept of disability asserted by the Law on the Rights of Persons with Disabilities must be reflected in

- the statutes of health, education and social services;
- strategies for developing the social services workforce; and
- the job descriptions of public sector workers (e.g., police, the judiciary, health, education, and other social sector professionals).

Communication on the concept of disability should be directed at

- public and private employers,
- commercial enterprises interested in expanding their markets to more clients,
- architects and engineers building new infrastructure, and
- transport and communications specialists.

There is almost no sector of society that should not hear about the concept of disability and how it affects them, their work, and their daily life. In an inclusive society, PWD should be visible and present in schools, offices, libraries, cinemas, swimming pools and gyms, canteens, restaurants, hotels, train stations, and airports.

Policy recommendations on communicating and working to change attitudes should include

- **involving PWD and parents of CWD in shaping communication, telling their own stories,** and presenting the concept that they have been involved in that crafting;
- **communicating an understanding of disability to the media** by issuing guidelines for ethical reporting on disability issues, developed together with representatives of DPOs; and
- **creating high-quality programming for and by PWD on television and in social media** to promote a more visible profile and move discourse away from pity or hero narratives.

B. Enhance Disability Assessment

Changing the definition of disability should accompany a change in the manner of disability assessments. These changes should link to more equitable treatment by social welfare and health care systems and more options for creating pathways into education and employment for CWD and PWD. The assessment system can provide an entry into services (e.g., independent living services, assistive devices, habilitation and rehabilitation, and/or flexible social services that maximize functioning and participation). A social welfare system would be more effective if it provided assessment-based support more holistically. The key, however, is to ensure a multifaceted assessment that allows a range of factors in the individual's situation; undergoes periodic review to consider changes in functioning; or ability to participate that result from reduced barriers, maximized functioning, and/or changes to the personal family situation. Such enhancements will be critical to ensuring a systematic and comprehensive approach to early assessment, which can identify developmental delays in a timely manner and confirm that CWD and their parents receive habilitation, rehabilitation, social services, or other necessary early childhood development services.

Practical and concrete steps that gradually improve the situation include

- **introducing the International Classification of Functioning (ICF) as the basis for assessing disability.** This should include translating the ICF into the Mongolian language; training health personnel and allied professionals in social welfare, social services, and education; and piloting a new multidisciplinary instrument for disability assessment, based on the ICF's biopsychosocial model of functioning; and
- **creating a differentiated social welfare and services package based on multidisciplinary assessment.** The Children's Commission already functions as a multidisciplinary assessment commission by incorporating (i) health, education, and social perspectives; (ii) medical commissions that assess disability; and (iii) medical and labor accreditation commissions (MLACs) that assess fitness for work. These commissions can become more interdisciplinary by introducing nonmedical professionals from the social welfare, education, and employment sectors into the assessment process. Adequate training and competencies can identify differentiated needs and packages. At the very least, a distinction between medium and severe needs can lead to lower or higher benefit allocations and access to services.

C. Facilitate Inclusion and Participation through Individualized Services

Services for CWD and PWD must respond to individual needs, beginning with the initial assessment and continuing throughout the life cycle. For example, the needs of people with impaired vision differ from those of people with autism spectrum disorders, cerebral palsy, or mobility impairments. Coordinated and periodically reviewed by a qualified specialist, individualized and comprehensive life assessments can help ensure and adjust short-, medium-, and long-term goals and establish the services, support, and accommodations necessary to support maximum inclusion and participation as a child grows and develops or an adult makes individual and personal life choices. Additionally, an individualized, community-based approach can help facilitate inclusion in mainstream community services (e.g., education, health, culture, and leisure services). If a young woman with disabilities wants to play basketball, a social worker can help create opportunities for her at the local basketball court by opening a dialogue with nondisabled players and looking for ways to bring together other PWD who want to play basketball. The current default response is to build a separate basketball court or sports facility for PWD, rather than create mechanisms for PWD using and participating in existing community sports.

Either local authorities or NGOs can provide services. It is essential that services adhere to a high-quality standard that is clearly defined in the legislative framework. If NGOs can be more flexible in service provision and DPOs, especially, can develop and deliver services that are more closely attuned to the needs of PWD, government authorities can provide outreach to communities that NGOs or DPOs may not always have. A mix of government and NGO service delivery might be the optimal way of ensuring the right mix of services, including specialized services for groups of people with similar needs.

In either case, an adequately trained and supported workforce is needed, including (i) social workers, who can assess and manage cases across a range of needs and disabilities with a good understanding of CBR; (ii) physiotherapists; (iii) occupational therapists; (iv) speech therapists; and (v) assistive technology technicians. To ensure community access and minimize turnover, the workforce needs planning for education; deployment, as extensively as possible; and careful management. Allied professions (e.g., health, education, employment, and social assistance) also need training and education to help develop competencies in working with PWD in their own fields. Importantly, increased knowledge about and access to assistive technology and equipment will ensure that each individual can access and use the latest and most appropriate equipment that he or she may need and that the government provides support.

Concrete recommendations that can be implemented now include:

- **Creating mechanisms to deliver new services to communities.** Standards and regulatory frameworks are needed to describe a range of community-based services and mechanisms for accessing services. Mechanisms for accessing services can include immediate referral, following a disability assessment, to local social welfare offices or to the new social service centers planned under the ADB project⁴⁵ where trained social workers work together with PWD or parents of CWD to develop tailored packages of services for habilitation or rehabilitation, development, education, employment, housing, independent living, assistive devices and technology, and culture and leisure using a CBR approach. In the absence of services delivered by local authorities, the government could contract NGOs with already established and appropriate service models and use the regulatory framework to deliver required services to people in their communities. New

⁴⁵ ADB. 2017. *Report and Recommendation of the President to the Board of Directors: Proposed Loan and Administration of Grant to Mongolia for Ensuring Inclusiveness and Service Delivery for Persons with Disabilities Project*. Manila.

services that need development include independent living services, such as personal assistance services; parent–child–facilitator services for early childhood development; social work services that accompany each PWD through the lifecycle; and support services, such as family-based respite care to support caregivers providing 24-hour care to PWD.

- **Ensuring the creation of a workforce to deliver new services.** The revision of existing curricula in health, education, and social services (social work) for pre-service education programs and introducing in-service training on the new concept of disability, is required as a foundation for building a new workforce that can deliver new, individualized services for PWD. Education programs for allied professionals (e.g., physiotherapists, occupational therapists, speech therapists, orthopedic and assistive technology technicians) need modernization and strengthening where they already exist (i.e., physiotherapy and occupational therapy) or urgent introduction where they do not exist (i.e., speech therapy and technicians). To ensure a steady supply of specialists for community-based services in the provinces and in Ulaanbaatar, bursary schemes can be used to attract students, especially from the provinces, to these new professions.

D. Review Social Welfare Benefits

A multidisciplinary assessment that looks at the needs of PWD more holistically could be the basis for achieving better social welfare for PWD. Improvements to the current system could be achieved by:

- **Creating a unique disability allowance** by consolidating resources that currently provide a social welfare pension to PWD or CWD who need permanent care, and some of the other entitlements and benefits for PWD. Following the disability assessment, the new allowance could provide a single entry to the package of available cash support and services for PWD, which will depend on the specific needs of PWD. This would simplify access, increase transparency and equity, and also guarantee an increased coverage of PWD.
- **Reviewing caregiver allowances** by increasing their amount and linking them to the different need levels of PWD, ensuring that caregivers are covered by health insurance and that years spent as caregivers will count toward their pension eligibility.

E. Improve Access to Infrastructure, Transport, and Information

In addition to maximizing opportunities for inclusion and participation by augmenting functioning and support for PWD through services and benefits, there is a need to ensure that barriers to accessing transport, infrastructure, and information are lowered or removed. Recommendations for immediate steps to ensure strong implementation of existing legislation include:

- **Harmonizing the concept of disability via new regulations on accessibility in buildings, public transport, and information.** People who are responsible for implementing regulations need to know that they have these responsibilities, and mechanisms for monitoring implementation need to be place.
- **Training public servants** to understand disability and their own responsibilities to ensure, for example, the accessibility of information on websites in central government ministries and district or local authority public services (e.g., courts, hospitals, schools, social welfare, and employment offices).
- **Offering training to commercial entities** that are interested in expanding their markets to PWD and want to know how to meet the PWD accessibility to infrastructure, information, and transport.
- **Involving DPOs in monitoring mechanisms for accessibility** and conducting regularly scheduled disability audits for PWD with a range of functional disorders (e.g., vision, hearing, mobility, cognition, etc.), thus supporting transparency in moving toward a barrier-free environment in public places.

- **Reviewing the list of assistive devices and equipment that are reimbursable through the health and social welfare system.** Technology and equipment have the potential to substantially increase functioning across a range of domains (e.g., hearing, vision, mobility, cognition, speech, and communication) and enhance participation and inclusion. An immediate step could create a commission involving DPOs with health, education, social welfare, and social insurance professionals and experts to (i) review currently available assistive devices and technology, and (ii) define an ethical way to determine which pieces of equipment the government can afford to include in the list of reimbursable devices across a range of disabilities.

F. Promote Inclusive Education and Employment

Education and employment are intrinsically linked. PWD are underrepresented in the workforce, partially due to low educational attainment and/or the poor quality of education achieved. Assessment, individualized packages of support and services, and improved access to infrastructure, transport, and information are all important in helping ensure access to education and employment, but additional measures should be explored as well.

1. Inclusive Education

In General Comment No. 4, the UNCRPD sets out the policies and practical measures that can help make inclusive education a reality. Article 11 of the General Comment defines inclusion as distinct from integration or participation: inclusion involves a process of systemic reform embodying changes and modifications in content, teaching methods, approaches, structures, and strategies in education to overcome barriers with a vision serving to provide all students of the relevant age range with an equitable and participatory learning experience and environment that best corresponds to their requirements and preferences. Placing students with disabilities within mainstream classes without accompanying structural changes to, for example, organization, curriculum, and teaching and learning strategies, does not constitute inclusion.⁴⁶

Article 12 describes the features of inclusive education and how it can be achieved through a range of measures, including systemic changes to policy and to the learning environment, through ensuring that teachers are supported; that reasonable accommodations are made to support individuals; and that all stakeholders are partners in the process, including staff, managers, parent groups and learners.

Thus, it is necessary to harmonize education legislation with the 2016 Law on the Rights of PWD and with the state party responsibilities set out in General Comment No. 4. Harmonization could be the first step toward creating inclusive education policies that smooth existing anomalies that could be enforcing segregation rather than promoting inclusion.

2. Inclusive Employment

Similar to social services, employment services can be tailored to assess the individual needs, aptitudes, and interests of PWD and create individual pathways to employment that both prepare the employer and the individual for placement and support during the initial employment period.

⁴⁶ UN Committee on the Rights of Persons with Disabilities (CRPD). *General comment No. 4 (2016), Article 24: Right to inclusive education*, 2 September 2016, CRPD/C/GC/4. <https://www.refworld.org/docid/57c977e34.html> [accessed 5 November 2019].

Currently, Mongolia does not use such approaches.⁴⁷ However, some steps can create greater access to sustained employment for PWD, including

- **addressing supply-side bottlenecks by ensuring that employment office staff are trained and mandated to work with PWD**, thus creating individual pathways into employment by using case management methods;
- **ensuring that PWD can access skills training** in existing training programs;
- **initiating job coaching schemes or other ways to support PWD as they enter the workplace.** Such schemes could operate from the employment offices or be offered by DPOs and tailored to meet the needs of PWD with a range of functional disorders;
- **addressing demand-side bottlenecks by ensuring that employers are informed about quota legislation**, including economic incentives and penalties for nonobservance; and
- **evaluating the effectiveness of incentives and making policy changes and recommendations.** In addition, the government must inform employers about legislation and the availability of government funding to support the introduction of reasonable accommodation in the workplace. Employment offices and DPOs can be trained and supported to help employers increase their understanding of the benefits of hiring PWD.

G. Enhance Monitoring

Without regularly gathered and meaningfully disaggregated data, it will be impossible for the Government of Mongolia to monitor implementation of disability legislation and its obligations under international legal frameworks. Evidence-based policy and planning require good data on disability. Concrete recommendations to enhance monitoring include

- **adapting current survey questionnaires to measure functional disability**, following the recommendations of the United Nations Washington Group;⁴⁸
- **implementing and institutionalizing a survey of residential institutions** of all types and sizes;
- **developing methodologies and reporting templates for analysis of disability data**; and
- **supporting the National Statistical Office (NSO) in making changes in the Household Socio-Economic Survey (HSES), the Labor Force Survey (LFS), and the household booklet**, which is the tool used to collect administrative data from the social welfare system, reflect changes in legislation on disability, and meet monitoring requirements for the Incheon Strategy and UNCRPD. Changes to NSO methodologies will ensure that data can be gathered on a regular basis and disaggregated to an appropriate level.

H. Conclusion

While some of these policy recommendations may have cost implications (e.g., funding the creation of new services, training a new workforce, and expanding access to assistive devices and technology), many of the suggested policies and measures require less costly inputs, such as revision and harmonization of legislation and informing and training public officials, employers, and business people. Ensuring that the course set by the Law on the Rights of Persons with Disabilities can be maintained and that inclusion becomes a reality will require a long-term strategic vision.

⁴⁷ UNESCAP. 2016. Disability at a Glance 2015: Strengthening Employment Prospects for Persons with Disabilities in Asia and the Pacific. Available at <http://www.unescap.org/resources/disability-glance-2015-strengthening-employment-prospects-persons-disabilities-asia-and-pacific>.

⁴⁸ The main objective of the Washington Group is the promotion and coordination of international cooperation in the area of health statistics by focusing on disability measures suitable for censuses and national surveys: <http://unstats.un.org/unsd/methods/citygroup/washington.htm>.

XI. Way Forward

The Government of Mongolia and ADB have prepared a project—Ensuring Inclusiveness and Service Delivery for Persons with Disabilities—to address the need for services and support throughout the lives of children with disabilities (CWD) and PWD (footnote 48). The project will (i) strengthen and institutionalize early identification of disability; (ii) improve service delivery and access to the physical environment; (iii) improve employment prospects; and (iv) contribute to strategic development for PWD, including social welfare reform, awareness raising, and attitude change. Further, the project will highlight what PWD can do to ensure their inclusion in society: including them in mainstream economic activities, creating opportunities in education and employment, and providing access to the services they need. The project has five outputs.

Output 1: Early identification of children with disabilities strengthened and institutionalized. The project will (i) institutionalize the early identification model initiated by the Ministry of Labor and Social Protection (MLSP), and (ii) facilitate the shift from a medical to a social model in identifying CWD by broadening the skills of the people involved in early identification.

Output 2: Improved service delivery for persons with disabilities. The project will (i) implement a model of interactive parent–child–facilitator education in early childhood; (ii) establish model development centers in selected *aimag*,⁴⁹ (iii) introduce national curricula for occupational and speech therapy, physiotherapy, orthopedic technicians, and disability social workers; and (iv) strengthen the role of social workers in support of PWD.

Output 3: Improved access to the physical environment. The project will (i) develop the capacity of decision makers and strengthen institutions involved in developing and enforcing the legal and regulatory framework on physical accessibility norms (i.e., infrastructure, transportation, and information); (ii) increase inclusion of PWD in enforcement mechanisms; and (iii) increase access to affordable and quality orthopedic devices and assistive technology.

Output 4: Improved work and employment for PWD. The project will (i) establish models to increase PWD skills to enter selected industries and improve general job matching and brokerage, (ii) facilitate inclusive business and organize support systems for PWD to access regular jobs and self-employment, and (iii) strengthen participation from PWD by monitoring employers' compliance with the PWD employment regulation.

Output 5: Implement strategic development to support persons with disabilities. The project will (i) raise awareness and change attitudes toward PWD, (ii) reform the welfare system to improve targeting and financial support for PWD to access services and equipment, (iii) conduct a strategic review of the national PWD support program, (iv) introduce the International Classification of

⁴⁹ Development center for PWD will be staffed with a multidisciplinary team that delivers center-based and outreach habilitation and rehabilitation, early intervention, and independent living services for PWD and CWD.

Functioning in accordance with needs and available resources, and (v) align National Statistical Office data with information needs in relation to disability.

The project will be financed by the Asian Development Fund and the Japan Fund for Poverty Reduction, and implemented over 5 years, from 2018–2022. The MLSP is the executing agency of the project.

Appendix

Primary Research

The bulk of primary research was conducted from February to March 2016 and consisted of a Persons with Disabilities (PWD) Living Conditions Survey, a set of focus group discussions (FGDs) with PWD and parents of children with disabilities (CWD), interviews with employers and doctors, and a survey of residential institutions providing care to CWD and PWD.

To obtain information from those who tend to be less represented and have a less strong voice, data collection also covered rural areas and types of disabilities that tend to be insufficiently covered by disabled people's organizations (DPOs) such as psychiatric conditions and intellectual disabilities, especially among adults.

FGDs looked at experiences in disability assessments and a range of services, education, employment, health, and social welfare benefits and services. FGDs were conducted both in various districts of Ulaanbaatar, in two *aimag* centers (Kherlen and Arvaikheer), and in rural *soums* (Dornod and Uvurkhangai) in the same two *aimags*.

A. Household Survey

There were 241 households with PWD that were interviewed from February to March 2016. Households were identified using the Living Standards Assessment Database (LSAD), based on interviews conducted in November 2013. The LSAD identified households with PWD through its direct question: "Are you disabled?" This household survey had the specific objective of covering gaps in issues related to access to services and support needs.

Households were selected randomly within different districts of Ulaanbaatar districts and in two *aimags* (Dornod and Uvurkhangai), including households living in *aimag* centers and rural *soums*. Moreover, the sample disproportionately included more children and elderly, and also ensured there was a balance of male and female PWD.

The survey identified 303 PWD and provided a range of statistics about households and individuals. Table A1 shows the basic demographic characteristics of the sample.

The LSAD was used to assess household living conditions, and data were linked to the new survey. This allowed the questionnaire to focus on testing questions regarding functional disability and support needs, and then look at access to and satisfaction with services (i.e., disability assessment, education, employment, social welfare, media, and information).

Table A1: Persons with Disabilities, 2016

Characteristic	%	No.
Age (years)		
0–15	19.8	60
16–39	30.7	93
40 and above	49.5	150
Sex		
Male	54.8	166
Female	45.2	137
Location		
Ulaanbaatar	44.2	134
<i>Aimag</i> center	25.4	77
Soum	30.4	92

Note: *Aimag* = province, *soum* = district.

Source: Authors' household survey, 2016.

B. Survey of Residential Institutions

The survey of residential institutions aimed to understand the numbers of CWD and PWD living in such institutions, as well as children without parental care and the proportion of these who were CWD. The institutions surveyed included

- an orphanage (i.e., the Unurbul Center) managed by the Ministry of Labor and Social Protection;
- specialized schools managed by the Ministry of Education, Culture, Science and Sport;
- the National Center for Mental Health and the central sanatorium, both managed by the Ministry of Health;
- some centers operated by nongovernment organizations (NGOs) and private institutions (i.e., The Mongolian Children's Foundation, Lotus Children's Center, the "My Home" care center, the "Gere" Child-Care Center, the "New Hope" Care Center, and the Batgerelt-Ireedui NGO for adults);
- two public institutions for adults (Batsumber in Tuv *aimag* and a facility in Khovd *aimag*); and
- a facility in the National Rehabilitation Center that hosts young adults coming for vocational training from outside Ulaanbaatar.

The overall number of PWD living in residential institutions is not large (358) in 2014, which is less than 0.5% of PWD, but the percentage is higher for children than adults. More significantly, CWD represented a disproportionately high percentage of children without parental care (in 2014, almost one of three; in 2015, one of five children without parental care were disabled). Moreover, the percentage was higher for boys (35%) than girls (28%) in 2014, and also higher for boys (25%) than girls (16%) in 2015 (see Table A2 and Table A3). The reasons for leaving children in residential institutions are primarily socioeconomic: parents' rejection of the child, lack of services, and inability to cope.

While most specialized schools are not residential institutions, two offer boarding facilities for children from the countryside. Unlike children without parental care, these children are captured by household surveys. However, it is interesting to note that the sex ratio for children in specialized education (133) is higher than the sex ratio for CWD (121) in 2014. This shows that boys are more likely to attend specialized schools than conventional schools, which concurs with attitudinal behaviors described.

The majority of adults with a disability in residential institutions appear to be those with mental disabilities, confirming that this probably is the subgroup of PWD most discriminated against and marginalized.

Table A2: Children with Disabilities Placed in Care Centers by Type of Institution, 2016

Institution	Children					
	2014			2015		
	Male	Female	Total	Male	Female	Total
State care center centers*	95	69	164	108	88	196
Do not have parental care	95	69	164	108	88	196
Disabled	45	30	75	29	15	44
National Mental Health Centers*	28	18	46	24	17	41
Do not have parental care	28	18	46	24	17	41
Disabled	11	5	16	9	4	13
NGO care centers**	70	89	159	68	89	157
Do not have parental care	56	78	134	54	77	131
Disabled	6	12	18	8	11	19
Do not have parental care	179	165	344	186	182	368
Disabled	62	47	109	46	30	76

* Includes Children's Central Sanatorium.

** Mongolian Children Foundation, Lotus Children's Center, "My Home" Care Center, Gerel Children's Center, "New Hope" Care Center.

Source: Authors' survey of residential institutions, 2016.

Table A3: Adults Placed in Care Centers by Type of Institution, 2016

Institution	Adult					
	2014			2015		
	Male	Female	All	Male	Female	All
State care center*	97	78	175	99	73	172
Do not have family	90	54	144	91	67	158
Disabled	70	54	124	70	46	116
National Mental Health Center	70	55	125	73	52	125
Do not have family	70	55	125	73	52	125
Disabled	70	55	125	73	52	125
NGO care center**	27	13	40	34	10	44
Do not have family	27	13	40	34	10	44
Disabled	0	0	0	0	2	2
Total	194	146	340	206	135	341
Do not have family	187	122	309	198	129	327
Disabled	140	109	249	143	100	243

NGO = nongovernment organization.

*National Rehabilitation Center, Elderly Care and Development Center and Khovd *aimag* care center.

** Bat-Ireedui, NGO.

Source: Authors' survey of residential institutions, 2016.

C. Ad Hoc Key Informant Interviews

After the analysis of both existing secondary sources and primary data, some key informant interviews were conducted to understand prevalence differences in male and female disability.

In fact, the analysis casts doubts on the overall validity of the current sex ratio among PWD, possibly due primarily to underreporting of disability in young children and the elderly.

There were significantly different attitudes toward boys and girls, possibly explaining some of the results. For example, it appears more acceptable for boys and young adults with disabilities to be involved in simple chores that take them out of home, whereas girls and young women with disabilities are kept at home, resulting more often in hiding disabilities. It is also common to assume that it is necessary to be “tough” with boys; this may result in disregarding or ignoring some problems and may then lead either to late diagnosis or worsening health outcomes. Finally, the degree of teasing, physical abuse, and discrimination from classmates is much higher for boys than girls, possibly explaining why CWD enrollment rates are higher for girls than boys and why boys are overrepresented in specialized schools.

Living with Disability in Mongolia

Progress toward Inclusion

The last decade has seen increased recognition of the rights of persons with disabilities in Mongolia and the rest of the world. Yet, there is a call to put these rights into practice. This report presents data and information about the current living conditions and challenges faced by persons with disabilities in Mongolia. It summarizes the latest findings from a baseline study aiming to identify the need or community-based services and support for persons with disabilities under Asian Development Bank financed project that builds on the Law on the Rights of Persons with Disabilities and covers the period 2018–2022.

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