THE HUMAN RIGHTS OF PERSONS WITH INTELLECTUAL DISABILITIES

Different But Equal

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OXFORD
UNIVERSITY PRESS

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The Economics of Equality: An Exploration of Country Differences

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I. INTRODUCTION

Adopted 20 December 1971, General Assembly Resolution 2856 (XXVI) proclaims the United Nations (UN) Declaration on the Rights of Mentally Retarded Persons and reaffirms 'faith...in the principles of peace, of the dignity and worth of the human person and of social justice....' Calling for national and international action to secure the same rights as other human beings, 'to the maximum degree of feasibility', among other things, the Resolution champions 'a right to proper medical care and physical therapy and to such education, training, rehabilitation and guidance as will enable' persons with mental retardation to realize their maximum potential.[1]

For people living in the United States, a country with one of the highest per capita Gross Domestic Products in the world—an estimated $36,200 in the year 2001—Resolution 2856 simply restates what is held as a matter of fundamental values and belief. However, in the United States there have been many serious compromises of the UN Declaration that are difficult to tolerate or understand. After all, the United States has witnessed unprecedented real growth in spending for the wide range of supports and services that are called for by the UN Declaration on the Rights of Mentally Retarded Persons. Indeed, one study by Braddock[2] indicates that from 1977 to 1992, public spending for mental retardation and other developmental disabilities grew 124%, adjusted for inflation.

Efforts in the United States to assist persons with mental retardation are directed not only to meeting the remediation and habilitation needs of persons with mental retardation but also value attainment. Each year advocates and service providers in the United States strive to improve the performance and delivery of support services to persons with mental retardation and invest many millions of dollars each year in research and development and the training of professionals, paraprofessionals, and lay persons. These efforts indicate a national commitment to the notion that progress will continue as long as the government spends more money and/or reallocates current spending for evolving state of the art services.

At root, the UN Declaration prescribes the economics of equality for all countries and peoples to follow in responding to the special needs of persons with mental retardation.

II. THE ECONOMICS OF EQUALITY

Economists studying the 'social cost' of mental illness and mental retardation typically have distinguished between 'direct' and 'indirect' costs when estimating the amount by which the well being of society is reduced by mental illness or mental retardation.[3] In this usage, 'indirect costs' denote the reduced states of individual and social well-being whereas 'direct costs' specify the resources that are spent to achieve well-being. For example, direct costs generally refer to the costs of providing persons with developmental disabilities custodial, remedial, habilitative, educational, and other special services over what would have been expended if the affected persons were not disabled.[4] Indirect costs alternatively refer to those ways in which mental illness or mental retardation interferes with a person's normal functioning and reduces the person's well-being as well as the well-being of his or her friends, family, teachers, and associates. Indirect costs include: (1) the loss of output that society incurs because some people with mental illness or mental retardation do not work or produce less than would be expected of a non-disabled person of similar age and sex; (2) loss of homemaking services; (3) loss of other unpaid, volunteer work at home and in the community; (4) an increase in undesirable events and behavior, eg, crime and delinquency; and (5) other socially disruptive effects on people's lives, eg, frustration, insecurity, bitterness, marital instability, inferior child care, unwise decisions, etc.

Laws that create and fund programs providing medical, remediative, and habilitative services for persons with mental retardation seek to minimize overall social costs by increasing the direct costs of providing services in order to reduce the indirect costs of the condition. In terms of cost-benefit analysis, funding programs assisting persons with mental retardation are the 'costs' and the reductions of indirect costs of the condition are the 'benefits'. Under a utilitarian model, so long as the marginal increase in benefits exceeds costs, funding these programs is justified because overall social costs are reduced.[5]

A useful way to think about the direct and indirect costs of developmental disabilities and the economics of equality is to consider the situation of infants with disabilities. Infants born with a congenital defect that leads to mental retardation or other developmental disability are born unequal in their capacity to function as a 'normal' person. Indeed, they may have unequal chances for survival—especially if born with the combination of

mental and physical defects, eg, Down syndrome and duodenal or esophageal atresia, or if born in a country which condones direct killing or selective non-treatment of disabled infants. Those who survive and continue to live often require life-long special care and accommodation from family, friends, and the community in order to offset, to the extent possible, their unequal capacity to function. Spending to offset or reduce the inequalities that persons with mental retardation experience at birth and throughout their lives defines the economics of equality.

In the United States, every state and the District of Columbia have established major programs that seek to reduce these inequalities.[6] The extent to which these programs succeed in achieving their goal of reducing the indirect costs of mental retardation and other developmental disabilities is the subject of a very large and expanding literature.

III. SOCIAL DISCRIMINATION AND INEQUALITY

Insofar as reducing the inequalities experienced by persons with mental retardation is dependent on society's decisions to allocate resources, it is necessary to address the issue of social discrimination and its effects. Ideally, government spending is determined by political processes that translate the individual values of citizens into social choices that seek to maximize society's social utility or welfare. Social choices depend on the values that individuals ascribe to different sets of alternatives.[7] To the extent that spending for one purpose represents an opportunity cost to spend for a different purpose, social choice inevitably requires the ranking of priorities. The perceived value of the objects of beneficence as well as technological and resource constraints figure prominently in the ranking of priorities subject to social choice.

There are historical and contemporary reasons to believe that the life of a person with mental retardation has not had, and still does not have, the same value for everyone everywhere. Even in an affluent society, moral perspectives and self-interest often decide who lives and who dies; who receives available resources and who is left without—who, in effect, is allowed to join the moral community of humanity in which equality of opportunities is held forth as the normative ideal.[8]

The advent of the hospital neonatal intensive care unit (NICU) is illustrative. In communities affluent enough to afford them, access to NICUs has provoked legal battles about the proper care and treatment of disabled newborns. It has likewise spawned a whole literature relating to the rights and duties of parents, physicians, nurses, and hospitals in reaching selective non-treatment decisions—including the right of the severely

disabled child to later sue and recover damages based on a negligence theory of 'wrongful life'.[9]

Multiple congenital impairments causing mental retardation are typically implicated in NICU selective non-treatment cases, eg, Down syndrome plus duodenal or esophageal atresia or congenital heart disease, or Trisomy 18 plus congenital heart disease, and the like. In these cases, the decision not to perform corrective surgery often involves judgments about future prospects for suffering and the 'quality of life' of the neonate and other family members. The reasoning of a sampling of ethicists in this regard provides insight into the 'gut' value judgments that lead individuals and sometimes the broader community to discriminate against persons with mental retardation.

Ethicists are of no single mind about the value that should be ascribed to the lives of neonates with severe congenital defects, and their value judgments are reflected in the diverse criteria they advocate for reaching morally defensible decisions to treat, let die, or terminate life. Ethicists rooted in the Judeo-Christian tradition[10] believe that all *non-dying* neonates should be treated because there is no moral basis for choosing 'that some live and others die, when the medical indications for treatment are the same'.[11] Regardless of the neonate's state or condition, these ethicists further argue that the 'equality of life principle' should govern over considerations of the individual's future quality of life, impact on parents and siblings, possible contributions to society, and the like. Jewish law likewise takes the position that 'the title to life is absolute and equal to that of any other person, from the moment of birth,' and even if born with 'teeth and tail like an animal', the innocent life deserves protection regardless of condition.[12]

Conversely other ethicists[13] argue that the properties of 'personhood' rather than status as a human being convey the right to life. There is no right to life, these ethicists maintain, unless the individual is a 'continuing subject of experiences and other mental states that can envisage a future for itself and have desires about the future'.[14] Thus, fetuses and very young neonates with no prospect of cognitive lives are considered nonpersons, and killing them 'is morally permissible in most cases where it is otherwise desirable'.[15]

Taking the middle ground, some ethicists[16] emphasize the right of parents to 'avoid severe and unnecessary familial burdens' in a *small* number of cases. Under this view, the decision to treat, let die, or terminate life should be based on the parent's knowledge, their attitudes toward defects, the extent of risk for future harm, the family's economic resources, the welfare of other children involved, and the parent's physical and emotional capacity to cope.

Most ethicists outside the Judeo-Christian tradition express the views and values of moral relativism. This ethic tends to confer less value on the

lives of neonates whose impairments cause mental retardation as compared to neonates with other kinds of impairments. In this regard, the views and moral reasoning of ethicists about selective non-treatment undoubtedly reflect the values and behavioral tendencies of broader society. After all, can the thinking and actions that take place in the isolation of the hospital NICU be much different than what goes on outside?

What is the heritage of broader society? Until recent times infanticide was commonly practiced throughout the world. According to anthropologist Laila Williamson,[17] infanticide 'rather than being an exception has been the rule' on every continent at every level of civilization throughout history. The reasons for infanticide fall into three categories: (1) maintaining a balance between population size and economic resources; (2) eliminating defective newborns; and (3) socio-cultural, eg, protecting genealogical purity, minimizing the dowries for females and avoiding the shame of illegitimacy or miscegenation.[18]

In places such as Benin and Côte D'Ivoire, amidst a mixture of traditional practices, beliefs and superstitions overt infanticide is still practiced in cases of serious birth disabilities.[19] In other countries, evidence of a lower threshold for infanticide in general is found in reports that female infanticide is a factor contributing to lower than expected female birth rates in some areas of China and India. In South Korea, consistent with the conservative Confucian tradition that subordinates women socially, economically, and legally, an estimated 400,000 surplus bachelors is predicted in the next generation because of fetal sex testing and abortion.

Although not discussed openly, the covert practice of infanticide through selective non-treatment is probably very widespread throughout the world, and the results are reported in each country's infant mortality rates. In this context, the UN Declaration on the Rights of Mentally Retarded Persons is, therefore, an important and necessary reminder to everyone everywhere that individuals with mental retardation *are* human persons deserving of full participation in the moral community of mankind, including access to supports and services that will enable them to realize their fullest potential as human beings. The qualifying phrase, 'to the maximum degree of feasibility', however, raises some question about how the economics of equality will be operationalized in different countries. Will cultures subscribing to the Judeo-Christian religious tradition try harder to reduce inequalities—regardless of the nation's level of development and resource availability? Or is the economics of equality really contingent on resource availability and national development?

What about countries that reject Western views of human rights and the Western-influenced human rights pronouncements of international organizations such as the United Nations? According to the US Department of State,[20] Iranian government officials insist that Iran should be

judged by Islamic law rather than Western human rights principles. Likewise, in Saudi Arabia, international definitions of human rights are ignored in favor of Islamic law. Some commentators, like Huntington,[21] would interpret this as evidence of grounds for the new post-Cold War pattern of conflicts within and between countries along the fault lines of civilizations and cultures.

Other commentators, however, are critical of the perceived selective application of Western standards. For instance, responding to Huntington, Mahbubani[22] points to then recent events in Bosnia-Herzegovina and argues that 'the dramatic passivity of powerful European nations as genocide is committed on their doorstep has torn away the thin veil of moral authority that the West has spun around itself as a legacy of its recent benign era'. Citing structural weaknesses in the West's core value systems and institutions, these commentators consequently question why 85% of the world's population should accept decrees legislated by 15%.

I have undertaken an exploratory analysis of available statistics to clarify one of these issues: the influence of culture as compared to economics in explaining inequalities in the treatment of persons with physical and mental disabilities among different countries. Do cultural differences—as manifested by predominant religion—more than economic means—as indicated by per capita Gross Domestic Product—account for the inequalities among countries in the treatment of persons with physical and mental disabilities? Competing explanations for any cultural differences that may be revealed include: the type of government, political stability, and the impact of Western medical technology, as signified by the number of physicians per 100,000 population providing general health care.

IV. METHODS

A. Proxy Variables

Our measurement model for comparing and explaining the inequalities that affect the lives and opportunities of persons with mental and physical disabilities living in different countries relies on a number of proxy variables. These proxy variables are *assumed* to represent different kinds and levels of inequality, the model's dependent variables, and several independent variables that explain or predict variation in the dependent variables.

1. Infant Mortality Rate

The first and most basic dependent variable is the infant mortality rate. The infant mortality rate captures an estimated 6% of neonatal deaths that

would almost inevitably result from premature birth and a variety of congenital anomalies if not treated by high technology medicine in a hospital neonatal intensive care unit (NICU).[23] Thus, the infant mortality rate represents the inequality faced by those disabled persons who at birth do not have access to high technology medicine and therefore do not have an equal opportunity for life.

2. Support Services

After birth, survivors with congenital abnormalities often suffer lifelong physical and mental impairments. Such persons and others whose disabilities occur later in life are unequal in their ability to function in society's expected roles unless accommodated and assisted by family, kin, and neighbors as well as by governmental and/or charitable organizations. Often unaccepted and unassisted, they encounter overt as well as more subtle forms of discrimination and stigma.

The provision of informal and formal services is one sign of societal acceptance. Likewise, the level of government-funded disability services and the extent to which accessibility laws are implemented are two indicators of societal efforts to accommodate and reduce the inequalities that prevent persons with disabilities from functioning in society's expected roles.

Although this phenomenon was not quantified, we believe that government-funded disability services are typically provided hierarchically—first for persons with physical and sensory disabilities, followed as resources allow, by provisions for persons with mental retardation, and then, lagging still further behind, provisions for persons suffering from the highly stigmatized conditions of severe mental illnesses and substance abuse.[24] The latter conditions contain an imputed element of personal responsibility and blame.

3. Religion

Religion is considered one, if not the most important, of the determinants of culture. Hence, the country's predominant religion is used as the proxy for culture in determining the relative importance of the independent variables—culture, income, type of government and government stability—used to explain variation in the dependent variables.

4. Income

Income as measured by per capita Gross Domestic Product (GDP)—essentially the US dollar denominated value of a country's total production of goods and services divided by population size—represents the extent of a country's economic means to provide for the needs of its citizens, including varying levels of health care, economic assistance, and

services and accommodations to meet the needs of persons with disabilities. As previously mentioned, to the extent that a country chooses to spend a portion of its available income to offset the indirect costs of disability on individuals, families, and the community, it seeks to reduce the inequality suffered by its citizens with disabilities.

5. Government Stability

Our analytic model postulates government stability both as a necessary condition for a society to reach abiding decisions about laws and provisions that offset the indirect costs of disability and as a determinant of the available income that could be used for this purpose. Unstable regimes are generally unwise places for financial institutions and investors to put their money with an expectation of a return on capital!

6. Type of Government

Type of government represents hypothesized propensities of different kinds of government to reflect the desires and priorities of citizens in its laws and practice. The model assumes that democratic governments through free elections, majority rule, and the separation of powers, are more capable than other forms of government in transforming individual values into binding social choices of law and practice.[25] This is not, however, to deny the beneficence of some traditional monarchs or religious leaders in decisions that are of importance to them.[26]

Democratic forms of government are also believed to promote stability because they are attentive to the preferences of their citizens—a belief only partially sustained by our data. Applying our definition of stability, 90% or more of the communist regimes, parliamentary democracies, constitutional monarchies, traditional monarchies, and federal republics were characterized as stable.

7. Western Medical Technology

Last, as a proxy for Western medical technology, the number of physicians per 100,000 population providing general health care, was introduced to test a competing explanation for why one or more Western religions or one or more Western forms of government might account for lower infant mortality in poorer countries. Our analytic model postulates that religion represents differences in cultural values among countries, and that some religious values and practices might account for variations in infant mortality. But could it be that religion is really a proxy for infant mortality reducing Western medical technology that was introduced by foreign missionaries? Could it also be that different types of government and how they respond to the individual values of citizens to reach binding social choices of law and practice are actually a proxy for certain Western forms

of government that promote adoption of infant mortality reducing medical technology?

B. Data Sources

Information on disability services and building accessibility laws, as well as the extent of government instability, in 193 countries was obtained from the *1994 Human Rights Reports*.[27] The Country Reports[28] convey to the US Congress 'a full and complete report regarding the status of internationally recognized human rights', as defined in the Universal Declaration of Human Rights of the United Nations, in countries that either receive US foreign aid or are members of the United Nations.[29]

Officials of the Department of State, Foreign Service, and other US government agencies prepare initial drafts of the Country Reports based on information gathered from 'a variety of sources across the political spectrum, including government officials, jurists, military sources, journalists, human rights monitors, academics, and labor activists'.[30] These drafts, in turn, are reviewed by the Bureau of Democracy, Human Rights, and Labor, in cooperation with 'other State Department offices, US and other human rights groups, foreign government officials, representatives from the United Nations and other international and regional organizations and institutions, and experts from academia and the media.'[31] The Country Reports cover individual, civil, political, and labor rights—and, for the second consecutive year, indicate the extent of discrimination against persons with disabilities, focusing on laws, regulations, or state practices that are inconsistent with equal access to housing, employment, education, health care, or other government benefits.

Available estimates of infant mortality (rate per 1,000 live births) and income (per capita GDP) for 1992 and 2001, respectively, were gleaned from the *UN 1992 Demographic Yearbook*,[32] the *UN Statistical Yearbook*,[33] and the CIA *World Factbook*.[34] The number of physicians per 100,000 population was derived from the WHO *Statistical Information System Estimates of Health Personnel*.[35] Information on the type of government and the distribution of religions within each country was gathered from the *World Almanac and Book of Facts*,[36] the *Political Handbook of the World*,[37] and *The Statesman's Year Book, 2002*.[38] No one source provided complete information in the desired form for every country.[39]

Information on persons with disabilities contained in the Country Reports was read and coded twice to assure consistency of interpretation, and decision rules were adopted for resolving ambiguous reports.[40] Unfortunately, the Country Reports' treatment of persons with disabilities focused primarily on building access laws and the extent of their implementation.

Among their shortcomings, the Country Reports neither distinguished between persons with physical disabilities and persons with mental disabilities nor addressed their differing needs for services and accommodation throughout the range of normal living roles and activities. In fact, the phrase 'physical and mental disabilities' was rarely encountered in the Country Reports, indicating the prevailing insensitivity among international monitors of human rights to the existence of people with mental disabilities and their need for accommodations beyond physical access to buildings. Regrettably, some of this insensitivity may be the result of the cultural bias of US Department of State officials in rendering observations overseas.[41]

Given the purpose and context of the Country Reports, the task of operationalizing and coding government stability from information contained therein unavoidably involves elements of subjectivity. Twenty-three percent of the countries were characterized as 'unstable' in 1994 and 19% in 2001. Undoubtedly, our sensibilities about civility and order influenced judgments about specific countries. Rather than try to defend these judgments, decision rules and examples are provided to clarify the meanings ascribed by the author to government 'instability'.[42] Table 14.1 lists the unstable countries in 1994 and 2001 along with the sources of their instability.

TABLE 14.1. *Unstable Countries by Source of Instability, 1994 and 2001*[a]

Country	Source
Afghanistan	1994—Civil war and widespread lawlessness
	2001—US military pursuing remnants of Al Qaeda and Taliban amidst widespread land mines and factions competing for control of central government and regions
Algeria	1994—Transitional government ruled under state of emergency
	2001—After amnesty disbanding of Islamic Salvation Army, residual fighting continues
Angola	1994—Civil war and no implementation of Lusaka peace accord
	2001—After national unity government installed in 1997, serious fighting continues rendering hundreds of thousands of people homeless
Armenia	1994—Legislature unable to approve a constitution or pass an election law
	2001—Armenia–Azerbaijan conflict continues with economies of both sides hurt by inability to reach peace
Azerbaijan	1994—Overthrow of democratic government and widespread rights abuses
	2001—Armenia–Azerbaijan conflict continues resulting in 750,000 refugees and internally displaced persons and widespread corruption

TABLE 14.1. *(continued)*

Country	Source
Bosnia-Herzegovina	1994—Civil war and ethnic purging of Muslims by Serbs 2001—Occupying NATO-led stabilization force (SFOR) of 21,000 troops deters renewed hostilities
Burkina Faso	1994—Abuse and extrajudicial killings by government with little opposition 2001—President Compaore faces an increasingly well-coordinated opposition after 1998 assassination of newspaper editor by member of Presidential Guard
Burma	1994—SLORC attacked winning parties with intimidation, detention, and house arrest 2001—Followers of Nobel Peace Prize recipient in house detention are routinely harassed or jailed
Burundi	1994—Assassinations of President and President and VP of National Assembly 2001—Widespread, often intense ethnic violence continues between Hutu and Tutsi factions with tens of thousands dead
Chad	1994—Transitional government ruled with little achieved in first year 2001—New rebellion in northern Chad continues to escalate and northern ethnic oligarchy retains power despite multiparty presidential and National Assembly elections
Colombia	1994—Rights abuses by police, armed forces and widespread drug trafficking 2001—Large parts of countryside are under guerrilla control and neighboring countries worry about violence spilling over their borders
Comoros	1994—Rights abuses, killings by security forces, and interference in last elections 2001—Colonel Azali seized power in 1999 and the Organization of African Unity has yet to recognize the 2000 Fomboni Accord to resolve secessionist crisis
Croatia	1994—One-quarter of land occupied by rebel Serbs despite UN peacekeeping force 2001—Stability apparently restored with last Serb-held enclave under UN supervision returned to Croatia in 1998
Djibouti	1994—FRUD insurgency with scattered attacks on government troops 2001—Stability apparently restored by late 1994 peace accord ending three-year uprising
Ecuador	1994—Inflation at 25% and arbitrary arrests by police, extrajudicial killings

TABLE 14.1. *(continued)*

Country	Source
	2001—Military-indigenous coup toppling democratically elected president in January 2000 is expected to complete remainder of former president's term to 2003
Equatorial Guinea	1994—DPEG controls judiciary and legislature, the latter through fraudulent elections
	2001—1991 presidential and 1999 legislative elections are widely seen as flawed
Eritrea	1994—New government faces sporadic terrorist attacks by Eritrean Islamic Jihad
	2001—Stability apparently restored in December 2000 with ending under UN auspices of 1998 border war with Ethiopia
Ethiopia	1994—Transition government favors Tigreans over Amharas, the traditional power
	2001—Stability apparently restored in December 2000 with ending under UN auspices of 1998 border war with Eritrea
Gambia	1994—Gambia National Army by *coup d'état* deposed elected government and parliament
	2001—Stability apparently restored in 1996 with new constitution and presidential elections and 1997 parliamentary balloting and nominal return to civilian rule
Georgia	1994—Abkhazia declared independence; presence of UN peacekeeping force
	2001—Russian troops remain garrisoned at four military bases as peacekeepers in separatist regions of Abkhazia and South Ossetia
Ghana	1994—Transitional government; claims by four opposition parties of massive electoral fraud
	2001—Stability apparently restored with election of President John Kufuor in 2000, despite rising discontent over inflation, currency depreciation, deficits, and austerity measures
Guinea	1994—Government through Ministry of Security controlled election of president
	2001—Unrest in Sierra Leone has spilled over into Guinea creating a humanitarian emergency
Guinea-Bissau	1994—No report of instability
	2001—Still recovering from 1998 bloody civil war, crippled economy, and military meddling in civilian government
Haiti	1994—Illegal military regime ousted by US occupational forces; Aristide restored
	2001—Following 2000 legislative elections fraught with irregularities, US and EU suspended almost all aid to Haiti, where 80% of population lives in abject poverty

TABLE 14.1. *(continued)*

Country	Source
India	1994—Abuses, killings generated by intense social tensions, violent secessionists 2001—Continuing dispute with Pakistan over Kashmir, massive overpopulation, environmental degradation, extensive poverty, and ethnic strife
Iraq	1994—Ethnic divisions resulting in civil uprisings in the north and the south 2001—UN trade sanctions remain in effect due to incomplete Iraqi compliance with relevant UN Security Council resolutions; ongoing threat of US intervention
Kenya	1994—Large internal security force harasses opposition politicians and critics 2001—Country faces political uncertainty because constitution requires President Moi to step down at the next elections in early 2003
Lebanon	1994—Syrian, Israeli military forces, and armed Palestinians control much of Lebanon 2001—Lebanese armed forces extend central government over two-thirds of country, while radical Hizballah party retains weapons and Syria occupies the Bekaa Valley
Liberia	1994—Divided factionally and geographically, despite end of civil war in December 2001—Years of fighting, flight of most businesses, and unsettled domestic security disrupt rebuilding the social and economic structure war-torn country
Macedonia	1994—Severe shortages due to regional conflict and sanctions on Serbia-Montenegro 2001—Stability apparently restored with lifting of Greek trade blockade in 1995, despite continuing ethnic tension from a large Albanian minority seeking regional autonomy
Malawi	1994—Severe shortages, rapid depreciation of currency, high inflation, and drought 2001—Stability apparently restored by successful national multiparty elections in 1999 and approval for relief under the Heavily Indebted Poor Countries (HIPC) program
Mozambique	1994—After decades of war and first free election, political tensions resurfacing 2001—Stability apparently restored by popular vote for five-year term of President Chissano and abatement of inflation and favorable foreign-assisted economic growth
Nepal	1994—No report of instability 2001—Six-year Communist guerrilla insurgency to oust the constitutional monarchy continues

TABLE 14.1. *(continued)*

Country	Source
Niger	1994—Tuareg insurgency in the north, killing both soldiers and noncombatants 2001—1995 peace accord ended Tuareg insurgency, but coups in 1996 and 1999, but transition in1999 to civilian rule under National Reconciliation Council is unsettled
Nigeria	1994—Military coup in 1993 and continuing suspension of 1979 Constitution 2001—Civilian government under new 1999 constitution faces daunting task of defusing long-standing ethnic and religious tensions and rebuilding economy
Occupied Territories, a.k.a. Palestine West Bank	1994—Unrest and numerous terrorist attacks despite 1993 Declaration of Principles 2001—September 2000 intifada causing widespread violence in the West Bank, Gaza Strip, and Israel continues to escalate with hundreds killed on both sides
Pakistan	1994—Arbitrary arrest and detention, torture, and repression of Sindh-based MQM 2001—US military pursuing remnants of Al Qaeda and Taliban fleeing from Afghanistan; ongoing dispute and nuclear bomb threats against India over Kashmir
Rwanda	1994—Ethnic genocide of one-half million Tutsi and four months of renewed civil war 2001—Recovery challenged by massive population displacement, nagging Hutu extremist insurgency, and two wars in four years in neighboring Congo (formerly Zaire)
Serbia-Montenegro	1994—US and international community do not recognize the brutal FRY regime 2001—Stationing of NATO and Russian peacekeepers in Kosovo stabilizes the regime of President Vojislav Kostunica who replaced former President Milošović
Sierra Leone	1994—Military junta continues to fight rebel RUF forces and renegade RSLMF soldiers 2001—Despite a cease-fire, 13,000 UN peacekeepers protect the capital and key towns in the south and a UK force of 750 help to reinforce security and train the army
Somalia	1994—Civil war since 1988 led to UN intervention in 1992 and now withdrawal 2001—Transitional National Government created in 2000 cannot reunite unstable regions in the south where numerous warlords and factions still fight for Mogadishu
Sri Lanka	1994—Conflict continues between government and Liberation Tigers of Tamil Eelam

TABLE 14.1. *(continued)*

Country	Source
	2001—Ethnic war continues with tens of thousands killed since mid-1980s
Sudan	1994—NIF restricts most civil liberties and continues suspension of 1985 Constitution
	2001—Civil war pitting Christians and animists in the south against Arab-Muslims in the north causes 1.5 million deaths and displacement of millions of others
Togo	1994—Togo's government is too weak and fragile to ensure practical democracy
	2001—Under fire from international human rights organizations for abuses and plagued by political unrest, most bilateral and multilateral aid remains frozen
West Sahara	1994—Sovereignty remains in dispute between Morocco and the Polisario
	2001—Repeatedly postponed referendum on final status of Rabat's sovereignty is not expected to occur until at least 2002
Yemen	1994—Civil war between north and south Yemen; secessionists defeated
	2001—Stability apparently restored by unification of north and south and by 2000 Saudi Arabia–Yemen agreement on their mutual borders
Zaire, now Democratic Republic of Congo	1994—Transitional government; UDPS and others refuse to accept Kengo's election
	2001—Cease-fire signed in July 1999 but sporadic fighting continues; President Laurent Kabila was assassinated in January 2001 and his son Joseph replaced him

[a] In the seven-year span, according to the *CIA World Factbook* (2001), stability was restored in Croatia, Djibouti, Eritrea, Ethiopia, Gambia, Ghana, Macedonia, Malawi, Mozambique, and Yemen. Stable in 1994, the Communist insurgency in Nepal has destabilized that country, and Guinea-Bissau is still struggling to recover from its bloody 1998 civil war. In the statistical analyses, countries in 2001 are coded as either stable (0) or unstable (1).

C. Statistical Analyses

Descriptive statistics and regression tree analysis were used to explore and describe various facets of the analytic model.[43] The dependent variables—per capita GDP and the infant mortality rate—are clearly ratio scales. Extent of disability services (coded '0', '1', or '2') and building access law implementation (coded '0', '1', or '2') are ordinal scales with considerable quantitative variability in categories '1' and '2'. The latter dependent variables were treated as interval scales when estimating the effects of the model's independent variables.

V. FINDINGS

The median per capita GDP in 1992 among the 193 countries sampled was $1,740, ranging from $115 to $23,400. In 2001, the median had risen to $4,000, ranging from $510 to $36,400. The median infant mortality rate in 1992 was 36.5 per 1,000 live births, ranging from 3.9 to 156. In 2001, the median had dropped to 29.0, ranging from 1.5 to 193.7. Twenty-three percent of the countries had unstable governments in 1994. Almost 10% of the countries had transitional governments; another 3% were ruled by the military. In 2001, the situation had changed for the better with only 19% of the countries deemed unstable.

In both 1994 and 2001, the most common form of government was the republic (45%), followed by parliamentary democracy (17%), parliamentary republic (7%), constitutional monarchy (11%), federal republic (6%), traditional monarchy (4%), Islamic republic (2%), communist state (3%), and not elsewhere classified others (2%), such as Macau, Hong Kong, and the United Arab Emirates. The predominant religions practiced in the various countries were: Roman Catholic (31%), Muslim (26%), Protestant (22%), indigenous religions (7%), Buddhist (7%), Orthodox Christian (5%), atheist (1%), Hindu (2%), and Jewish (Israel).[44]

Government funding of disability services was as follows: Minimal funding (51%), more extensive funding (27%), and no apparent funding (22%).[45] The existence and implementation of building access laws were as follows: no law (74%), law with little or no implementation (16%), and law with more extensive implementation (10%).[46] Worldwide, the median number of physicians was 103.6 per 100,000 population. The country distribution, ranging from 1.8 to 664 per 100,000 population, indicates how unequal and skewed is the availability of Western medical technology among nations.

Regression tree analysis was used to test the hypothesis that culture, as represented by predominant religion, more than per capita income level, government stability, or general health care coverage, as measured by the number of physicians per 100,000 population, determined both the extent of government funding of disability services and implementation of building access laws. Regression tree analysis was also used to test the hypothesis that type of government more than per capita income level, government stability, or general health care coverage determined the extent of government funding of disability services and implementation of building access laws. As shown by Figures 14.1 and 14.2, the per capita income level was the dominant explanation in both cases. Type of government had no effect in either case. Protestant religion interacting with per capita income level predicted 8% of the total 44% explained variance among countries in the case of building access law implementation.

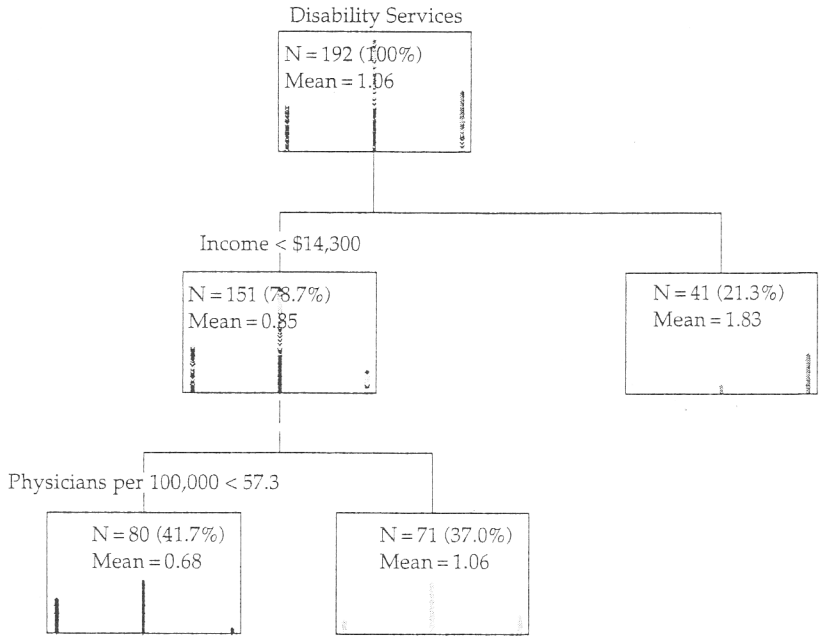

FIGURE 14.1. Regression tree for country disability service estimates, 1994 (PRE = 0.39)

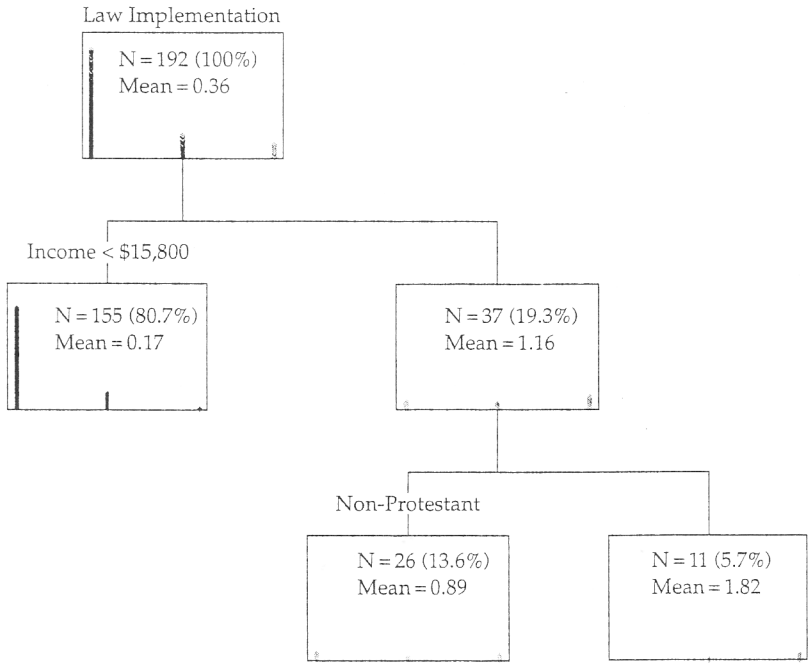

FIGURE 14.2. Regression tree for country accessibility law implementation, 1994 (PRE = 0.44)

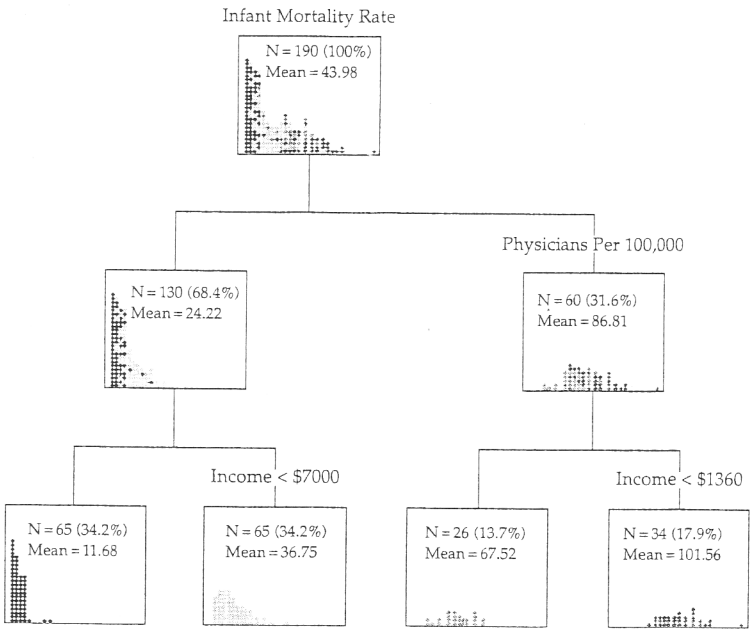

FIGURE 14.3. Regression tree for country infant mortality rate estimates, 2001 (PRE = 0.71)

Regression tree analysis was used to test the hypothesis that culture more than per income level, government stability, or general health care coverage determined the infant mortality rate per 1,000 live births. As indicated by Figure 14.3, per capita income level interacting with general health care coverage predicted the total 71% explained infant mortality variance among countries. Religion and type of government had no effect. Figure 14.4 further demonstrates the influence of per capita income and the provision of Western medical technology on country infant mortality rates. The infant mortality rate *change* from 1992 to 2001 is entirely explained by the interaction of per capita income and general health care coverage, as measured by the number of physicians per 100,000 population. Again, religion and type of government had no effect.

VI. DISCUSSION

How do we interpret these statistical findings? If we accept the infant mortality rate as a proxy for the inequality faced by persons with physical and mental disabilities at birth for having an opportunity for life, then

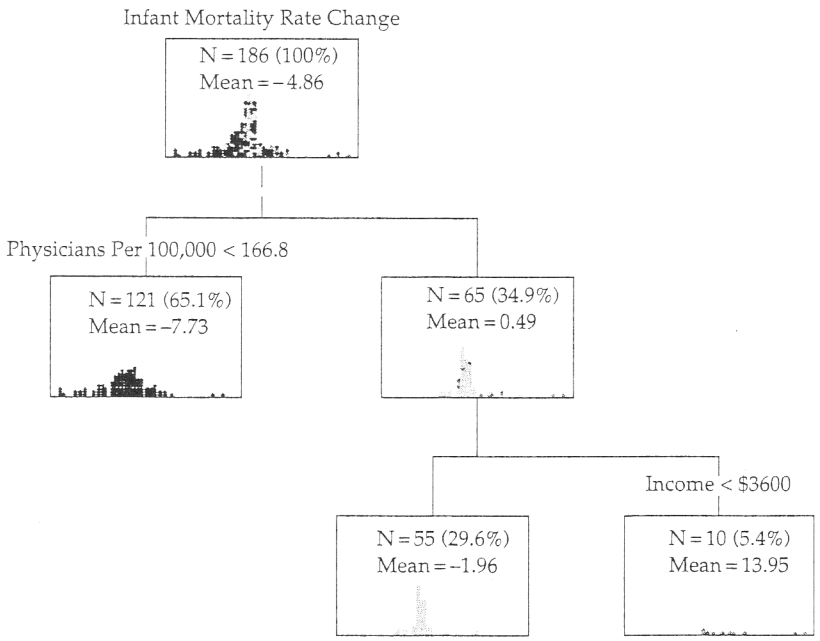

FIGURE 14.4. Regression tree for country infant mortality rate change, 1992–2001 (PRE = 0.13)

it follows that economic means, as measured by a country's per capita GDP, more than any alternative explanatory factor determines inequalities for life itself. That is, economic means more than any alternative explanatory factor determines the extent to which a society can provide disability services in order to reduce the indirect cost burden of disability on individuals, families, and the community. Notwithstanding Huntington's contention that cultural conflicts—the 'clash of civilizations'—rather than economic competition over scarce resources will dominate the post-Cold War world, available statistical evidence points to differences in economic means rather than cultural differences among countries as the best explanation for the inequalities faced by people born with a physical or mental impairment.

Available statistical evidence also suggests that culture as manifested by a country's predominant religion may shape at margin the way economic resources are allocated to accommodate people with disabilities. In countries with per capita incomes equal to or greater than $15,800, predominant Protestant religious belief appears to account for more extensive implementation of building access laws. But in Huntington's broader, more

dynamic view, there is no doubt that statistical evidence from unstable countries embroiled in conflict—Afghanistan, Algeria, Angola, Armenia, Azerbaijan, Bosnia-Herzegovina, Burkina Faso, Burma, Burundi, Chad, Columbia, Comoros, Congo Democratic Republic (formerly Zaire), Ecuador, Georgia, Guinea, Guinea-Bissau, Haiti, Indian-Pakistan, Iraq, Kenya, Lebanon, Liberia, the Palestinian Authority (formerly the Occupied Territories), Nepal, Niger, Nigeria, Ruanda, Serbia-Montenegro, Sierra Leone, Somalia, Sri Lanka, Sudan, Togo, and West Sahara—points to the inevitable consequences of future conflicts. Outbreaks of violence in countries that now enjoy stable governments will surely increase the inequalities faced by people born with physical and mental impairments in these countries. Wars kill and maim and disrupt economic activities and thus reduce available income and add to the stock of misery and the burden of care for survivors, many of whom will have acquired physical and mental disabilities in the course of the conflict.

There may be, as Huntington conjectures, future conflicts within and between countries along the fault lines of civilizations and cultures. The available data do not suggest, however, that religion per se will provoke these conflicts. Indeed, the UN Summit for Social Development in March 1995[47] suggests that conflicts are likely to erupt over staggering disparities in the economic well-being among nations—not cultural differences.

VII. CONCLUSIONS

Where do we go with these findings in the next ten years knowing that they are based on the exploration of very limited statistical data? Do we send money or missionaries, or both, to the underdeveloped countries? If missionaries, should they preach traditional religious values or the secular value of democracy as the means of expressing the will of the people and promoting political stability? If we act on the basis of the explanatory power of available statistics and other relevant information, the proper policy mix would be the combination of money for economic development and debt-forgiveness based on either religious belief or secular humanism and political pragmatism. The worldwide reduction in infant mortality rates from 1992 to 2001 that accompanied the increase in per capita GDP during that period argues strongly for adoption of such a policy by the richer nations of the world.

There is increasing recognition that relief from debt is a necessary condition for the salvation of individual countries as well as the reform of global society.[48] Soros has argued for an open global civil society to counter the excesses of globalization.[49] An international coalition of economic activists, known as the Jubilee Movement, has succeeded in obtaining debt relief for

more than twenty of the poorest nations.[50] Further restructuring of International Monetary Fund (IMF) and Work Bank policies and larger spending by the richer nations on international health and economic development are seen as the key to the advancement of global society. Soros's recommendation that 'standstills', ie, moratoriums on debt repayment, would be more productive than current policy of lending massive amounts of new money to repay the debt of bankrupt nations and maintain their overvalued exchange rates.[51] According to Soros, the ultimate challenge of globalization is to make the most of the interdependence it imposes on individual nations through collective action to provide global public goods, including law and order. He appeals to the ultimate pragmatism of abandoning narrow self-interest in favor a vision of a better world accompanied by action to combat poverty, ignorance, and repression.

In this vein, more developed countries with money and technical assistance to offer could well set aside and link a portion of support for economic infrastructure development to the creation or expansion of services for persons with disabilities, including mental retardation. The United States, for example, spends millions of dollars each year on research and development and training to improve the delivery of services to persons with mental retardation and other developmental disabilities. Would it cost that much to share the results of this effort with the less developed countries of the world?

The US government will use the Department of State's *1994 Human Rights Reports* as a resource for 'shaping policy, conducting diplomacy, and making assistance, training, and other resource allocations and as a basis for the US Government's cooperation with private groups to promote the observance of internationally recognized human rights'.[52] Subject to the approval of the US Congress, the Department of State could easily begin with the information already in its possession to implement the proposed modification of its international assistance programs. Working cooperatively with the UN and other non-governmental organizations would increase the leverage and impact of this enterprise. Debt forgiveness under the Highly Indebted Poor Countries (HPIC) initiative, approved in 1996 by the International Monetary Fund, the World Bank, and the G-7 group of leading industrialized nations, if linked to explicit plans to prevent disabilities and to habilitate and rehabilitate citizens who acquire one, would provide a strong incentive for countries to do so. At the same time, the United States by itself could make use of its existing authority under Titles II and III of PL 480, the Agricultural Trade Development and Assistance Act of 1954, as amended, and related laws to encourage needy countries to develop and implement plans to benefit persons with disabilities.[53]

Last, US Department of State officials responsible for compiling the *Human Rights Reports* as well as members of Amnesty International, Human Rights Watch, and other organizations that monitor human rights

abuses throughout the world should be sensitized to the dimensions of the problem as it relates to persons with mental as well as physical disabilities. They already do an excellent job of flagging highly visible abuses of persons with physical disabilities.[54] The reporting of less obvious matters is not taking place.

Much more needs to be done in reporting the conditions under which persons with mental retardation and other mental disabilities live throughout the world. Simply citing the existence and extent of implementation of building access laws as evidence of non-discrimination is insufficient and misleading. The job of educating officials of the US Department of State and the international human rights community about what to look for could easily be undertaken by The Arc of the United States, Mental Disability Rights International, Rehabilitation International, or other interested advocates. It is a job well worth doing and one that could eventually benefit millions of persons with mental retardation and other mental disabilities throughout the world.

NOTES

1. United Nations, *Declaration on the Rights of Mentally Retarded Persons*, General Assembly Resolution 2856 (XXVI) (New York: United Nations, 20 December 1971).
2. D Braddock, R Hemp, L Bachelder, and G Fujiura, *The State of the States in Developmental Disabilities: An Overview* (4th edn, Chicago: Univ of Illinois at Chicago Institute on Disability and Human Development, 1995).
3. eg, R Fein, *Economics of Mental Illness* (New York: Basic Books, 1958); D Rice, 'Estimating the Cost of Illness' *Health Economics Series No 5*, Public Health Service Publication No 947–6 (Washington, DC: Government Printing Office, 1996); RW Conley, *The Economics of Mental Retardation* (Baltimore: Johns Hopkins Univ Press, 1973); DS Levine and DR Levine, 'The Cost of Mental Illness' *Mental Health Statistical Series B No 7, NIMH* (Washington, DC: Government Printing Office, 1975).
4. JH Noble and RW Conley, 'Fact and Conjecture in the Policy of Deinstitutionalization' (1981) *Health Policy Quarterly* 1/2, 99–124.
5. JH Noble, RW Conley, F Laski, and MA Noble, 'Issues and Problems in the Treatment of Traumatic Brain Injury' (1990) *Journal of Disability Policy Studies* 1/2, 19–45.
6. Braddock *et al.* (n 2 above).
7. KJ Arrow, *Social Choice and Individual Values* (2nd edn, New Haven: Yale Univ Press, 1963).
8. RF Weir, *Selective Nontreatment of Handicapped Newborns: Moral Dilemmas in Neonatal Medicine* (New York: Oxford Univ Press, 1984).
9. *Curlender v Bio-Science Laboratories* 106 Cal App 3d 811; 165 Cal Rptr 477, 479, 480, 488–489 (1980).

10. Islamic religious teaching is the same. The child in Islam has an inalienable right to life and equal life chances. According to the Qur'an (6:151, cf 17:23), the third commandment in Islam is preservation of the child's life. H Abdalati, *Islam in Focus* (Indianapolis: American Trust Publications, 1975) 120. My thanks to Mohammad Totonji, Imam/Campus Minister, George Mason University, for this reference and clarification of its meaning in Muslim belief and practice.
11. P Ramsey, *Ethics at the Edges of Life* (New Haven: Yale Univ Press, 1978).
12. I Jakobovits, 'Jewish Views on Infanticide' in M Kohl (ed), *Infanticide and the Value of Life* (Buffalo, NY: Prometheus Books 1978) 23–31.
13. eg, M Tooley, 'Decisions to Terminate Life and the Concept of Person' in J Ladd (ed), *Ethical Issues Relating to Life and Death* (New York: Oxford Univ Press, 1979) 62–93.
14. ibid.
15. Weir (n 8 above), quoting M Tooley, 'In Defense of Abortion and Infanticide' in J Feinberg (ed), *The Problem of Abortion* (2nd edn, Belmont, Calif: Wadsworth, 1984) 120–134.
16. eg, MJ Garland, 'Care of the Newborn: The Decision Not to Treat' (1988) *Perinatology/Neonatology* 1/2, 14–21, 43–44; J Fletcher, 'Moral Aspects of Decision-Making' in TD Moore (ed), *Report of the Sixty-Fifth Ross Conference on Pediatric Research: Ethical Dilemmas in Current Obstetric and Newborn Care* (Columbus, Ohio: Ross Laboratories, 1976).
17. L Williamson, 'Infanticide: An Anthropological Analysis' in M Kohl (ed), *Infanticide and the Value of Life* (Buffalo, NY: Prometheus Books, 1978) 61–75.
18. EE Shelp, *Born to Die?* (New York: Free Press, 1986).
19. US Department of State, *1994 Human Rights Reports* (Washington, DC: US Department of State, 1995).
20. ibid.
21. SP Huntington, 'The Clash of Civilizations?' (1993) *Foreign Affairs* 72/4, 22–49.
22. K Mahbubani, 'The Dangers of Decadence: What the Rest Can Teach the West' (1994) *Foreign Affairs* 72/4, 10–14.
23. RF Weir, *Selective Nontreatment of Handicapped Newborns: Moral Dilemmas in Neonatal Medicine* (New York: Oxford Univ Press, 1984) 38.
24. This hypothesis is somewhat supported by the finding of a cross-sectional spending pattern for MR/DD community services among the states that depart from the more typical pattern for corrections, natural resources, and education. Braddock *et al.* (n 2 above). Our precise hypothesis as it relates to different countries is that spending for disability services increases as a function of economic means—with indeterminate time lags between sending first for persons with physical and sensory disabilities, then for persons with mental retardation and developmental disabilities, and last for the most stigmatized conditions such as severe mental illness and substance abuse.
25. KJ Arrow, *Social Choice and Individual Values* (2nd edn, New Haven: Yale Univ Press, 1963).
26. Consider the following examples. According to the 1994 Human Rights Reports, education of children with special needs has long been a priority of the Queen of Tonga. Members of the Jordanian royal family promote

programs to educate and rehabilitate their subjects with disabilities. In Bahrain, ruled since the late 18th century by the Al-khalifa family, 'a variety of government, quasi-government and religious institutions are mandated to protect disabled persons'. US Department of State (n 19 above).

27. The Country Reports were submitted to Congress by the US Department of State pursuant to ss 116(d) and 502(b) of the Foreign Assistance Act of 1961, as amended, and s 505(c) of the Trade Act of 1974, as amended.
28. US Department of State (n 19 above) Preface, 1.
29. In 1994, there were several exceptions involving countries that neither received US Foreign Aid nor were members of the United Nations, eg, the Israeli Occupied Territories, Western Sahara whose sovereignty was disputed by Morocco and the Polisario Front, and Serbia-Montenegro, which neither the United States nor the international community recognized. As of 15 May 2002, the situation had somewhat changed. The Occupied Territories were now recognized as the Palestine Authority and received some US foreign aid; Western Sahara still awaited a referendum on its final status after the Polisario Front guerrilla war ended; and Serbia-Montenegro, also known as the Federal Republic of Yugoslavia, replaced former President Slobodan Milošović with President Vojislav Kostunica in an October 2000 election accompanied by massive demonstrations and strikes.
30. US Department of State (n 19 above) Preface, 3.
31. ibid.
32. United Nations, *1992 Demographic Yearbook* (New York: United Nations, 1994).
33. United Nations, *Statistical Yearbook, 39th Issue* (New York: United Nations, 1994).
34. Central Intelligence Agency, *World Factbook* (Washington, DC: Government Printing Office, 2001), available at http://www.odci.gov/cia/publications/factbook (last viewed 15 May 2002).
35. World Health Organization, *Statistical Information System Estimates of Health Personnel* (Geneva: World Health Organization, 2002) available at http://www3.who.int/whosis/health_personnel/health_personnel.cfm?path=whosis,health_personnel (last viewed 15 May 2002).
36. *World Almanac and Book of Facts* (Mahwah, NJ: Funk and Wagnalls, 2002).
37. *Political Handbook of the World* (New York: McGraw-Hill, 1999).
38. *The Statesman's Year Book* (New York: Palgrave, 2002).
39. In 2002, the CIA World Factbook provided purchasing power parity per capita income for all countries except Western Sahara as well as infant mortality rates for all countries except Micronesia and Western Sahara. Statistics of the type needed for calculating the number of physicians per 100,000 population could be cobbled together from various sources for all countries except Western Sahara. Central Intelligence Agency (n 34 above).
40. For example, where the Country Reports did not mention the extent of services beyond the statement that people with disabilities were not subject to discrimination in the use of available government services the report was coded as 'minimal'. In those countries where the Country Reports made no mention of any services provided the report was coded as 'none'.

41. A slight digression and interpretation is appropriate here. A national survey of state vocational rehabilitation and mental health service agencies, conducted by the National Alliance for the Mentally Ill, found that with the exception of four state vocational rehabilitation agencies located in Illinois, Massachusetts, Minnesota, and Pennsylvania, the states and the District of Columbia made no mention of accommodations for persons with mental disabilities, including mental illnesses or mental retardation and other developmental disabilities, in the Self-Evaluation Reports or Plans for Correction which they had prepared pursuant to the requirements of the Americans with Disabilities Act (ADA) of 1990 and s 504 of the Rehabilitation Services Act of 1974, as amended. JH Noble, RS Honberg, LL Hall, and LM Flynn, *A Legacy of Failure: The Inability of the Federal–State Vocational Rehabilitation System to Serve People with Severe Mental Illnesses* (Arlington, Va: National Alliance for the Mentally Ill, 1997).
42. All governments described in the Country Reports as 'transitional' were coded 'unstable', as were instances of civil war, abuse, and extrajudicial killing of political opponents by government forces, insurgency movements, *coup d'état*, presence of UN peacekeeping force intervention, US intervention, control of major territory by non-government forces, major unrest and terrorist attacks, ethnic genocide or purging, government suspension of constitutional rights and restriction of civil liberties, severe economic problems arising from regional conflict and sanctions or the combination of rapid depreciation of currency, high inflation, and drought.
43. SPSS, Inc, *SYSTAT 10 Statistics I* (Chicago: SPSS, Inc, 2000).
44. **Country predominant religions** are: **Roman Catholic:** Andorra, Argentina, Austria, Belgium, Belize, Bolivia, Brazil, Burundi, Canada, Cape Verde, Central Africa, Chile, Colombia, Congo Democratic Republic (formerly Zaire), Congo Republic, Costa Rica, Croatia, Cuba, Czech Republic, Dominica, Dominican Republic, Ecuador, El Salvador, Equatorial Guinea, France, Grenada, Guatemala, Haiti, Honduras, Hungary, Ireland, Italy, Kenya, Kiribati, Liechtenstein, Lithuania, Luxembourg, Malta, Mexico, Monaco, Netherlands, Nicaragua, Panama, Paraguay, Peru, Philippines, Poland, Portugal, Rwanda, San Marino, São Tomé, Seychelles, Slovak Republic, Slovenia, Spain, St. Lucia, Switzerland, Trinidad, Uruguay, and Venezuela. **Muslim:** Afghanistan, Albania, Algeria, Azerbaijan, Bahrain, Bangladesh, Bosnia-Herzegovina, Brunei, Chad, Comoros, Djibouti, Egypt, Eritrea, Ethiopia, Gambia, Guinea, Indonesia, Iran, Iraq, Jordan, Kazakhstan, Kuwait, Kyrgyzstan, Lebanon, Libya, Malaysia, Maldives, Mali, Mauritania, Morocco, Niger, Nigeria, Occupied Territories (now Palestinian Authority), Oman, Pakistan, Qatar, Saudi Arabia, Senegal, Sierra Leone, Somalia, Sudan, Syria, Tajikistan, Tunisia, Turkey, Turkmenistan, United Arab Emirates, Uzbekistan, West Sahara, and Yemen. **Protestant:** Antigua, Australia, Bahamas, Barbados, Denmark, Estonia, Fiji, Finland, Gabon, Germany, Guyana, Iceland, Jamaica, Korea Republic, Latvia, Lesotho, Malawi, Marshall Islands, Micronesia, Namibia, Nauru, New Zealand, Norway, Papua New Guinea, Solomon Islands, South Africa, St. Kitts, St. Vincent, Suriname, Swaziland, Sweden,

Tanzania, Tonga, Tuvalu, Uganda, UK-Northern Ireland, USA, Vanuatu, West Samoa, and Zambia. **Indigenous:** Angola, Benin, Botswana, Burkina Faso, Cameroon, Côte D'Ivoire, Ghana, Guinea-Bissau, Liberia, Madagascar, Mozambique, Togo, and Zimbabwe. **Buddhist:** Bhutan, Burma, Cambodia, Hong Kong, Japan, Laos, Macau, Mongolia, Singapore, Sri Lanka, Taiwan, Thailand, and Vietnam. **Orthodox Christian:** Armenia, Belarus, Bulgaria, Georgia, Greece, Macedonia, Moldova, Romania, Serbia-Montenegro, and Ukraine. **Hindu:** India, Mauritius, and Nepal. **Atheist:** China, North Korea, and Russia. **Jewish:** Israel.

45. Country disability services funding was: **No apparent funding:** Bhutan, Bolivia, Bosnia-Herzegovina, Botswana, Burundi, Cambodia, Cameroon, Chad, Congo Democratic Republic (formerly Zaire), Dominica, Ecuador, Equatorial Guinea, Gambia, Haiti, Indonesia, Iran, Iraq, Kyrgyzstan, Lebanon, Libya, Macedonia, Malawi, Morocco, Nepal, Nigeria, North Korea, Pakistan, Paraguay, Rwanda, São Tomé, Senegal, Solomon Islands, Somalia, Sudan, Swaziland, Vanuatu, Vietnam, West Sahara, West Samoa, and Yemen. **Minimal funding:** Afghanistan, Albania, Angola, Antigua, Argentina, Armenia, Azerbaijan, Bangladesh, Barbados, Belarus, Benin, Brazil, Burkina Faso, Burma, Cape Verde, Central African Republic, Chile, China, Colombia, Comoros, Congo Republic, Costa Rica, Côte D'Ivoire, Cuba, Czech Republic, Dominican Republic, Djibouti, Eritrea, Estonia, Ethiopia, Fiji, Gabon, Ghana, Grenada, Guatemala, Guinea, Guinea-Bissau, Guyana, Honduras, Hong Kong, Hungary, India, Ireland, Jamaica, Japan, Jordan, Kazakhstan, Kenya, Kiribati, Laos, Latvia, Lesotho, Liberia, Liechtenstein, Lithuania, Macau, Madagascar, Malaysia, Mali, Marshall Islands, Mauritania, Mauritius, Mexico, Micronesia, Moldova, Mozambique, Namibia, Niger, Occupied Territories (now Palestinian Authority), Panama, Papua New Guinea, Peru, Philippines, Poland, Romania, Serbia-Montenegro, Seychelles, Sierra Leone, Slovak Republic, Slovenia, South Africa, South Korea, St. Kitts, St. Lucia, St. Vincent, Suriname, Syria, Tajikistan, Tanzania, Thailand, Togo, Trinidad, Turkey, Tuvalu, Uganda, Ukraine, Uruguay, Venezuela, Zambia, and Zimbabwe. **More extensive funding:** Algeria, Andorra, Australia, Austria, Bahamas, Bahrain, Belgium, Belize, Brunei, Bulgaria, Canada, Croatia, Denmark, Egypt, El Salvador, Finland, France, Georgia, Germany, Greece, Iceland, Israel, Italy, Kuwait, Luxembourg, Malawi, Maldives, Malta, Monaco, Mongolia, Nauru, Netherlands, New Zealand, Nicaragua, Norway, Oman, Portugal, Qatar, Russia, San Marino, Saudi Arabia, Singapore, Spain, Sri Lanka, Sweden, Switzerland, Taiwan, Tonga, Tunisia, Turkmenistan, UK-Northern Ireland, United Arab Emirates, USA, and Uzbekistan.
46. Country building access law status was: **No law:** Afghanistan, Albania, Algeria, Angola, Antigua, Armenia, Austria, Azerbaijan, Bangladesh, Barbados, Belize, Benin, Bhutan, Bolivia, Bosnia-Herzegovina, Botswana, Brunei, Bulgaria, Burkina Faso, Burma, Burundi, Cambodia, Cameroon, Cape Verde, Central African Republic, Chad, Chile, Colombia, Comoros, Congo Democratic Republic (formerly Zaire), Costa Rica, Côte D'Ivoire, Croatia, Cuba, Czech Republic, Djibouti, Dominica, Ecuador, Egypt, El Salvador, Equatorial Guinea, Eritrea, Estonia, Ethiopia, Fiji, Gabon, Gambia, Georgia,

Ghana, Grenada, Guinea, Guatemala, Guinea-Bissau, Guyana, Haiti, Honduras, Hong Kong, Hungary, India, Indonesia, Iran, Iraq, Ireland, Jamaica, Japan, Kazakhstan, Kenya, Kiribati, Kuwait, Kyrgyzstan, Laos, Lebanon, Lesotho, Liberia, Libya, Liechtenstein, Lithuania, Luxembourg, Macau, Macedonia, Madagascar, Malawi, Malaysia, Maldives, Mali, Marshall Islands, Mauritania, Mauritius, Mexico, Micronesia, Moldova, Morocco, Mozambique, Namibia, Nepal, Nicaragua, Nigeria, North Korea, Occupied Territories (now Palestinian Authority), Oman, Pakistan, Panama, Papua New Guinea, Paraguay, Peru, Poland, Qatar, Romania, Rwanda, São Tomé, Saudi Arabia, Senegal, Seychelles, Sierra Leone, Solomon Islands, Somalia, Sri Lanka, St. Kitts, St. Lucia, St. Vincent, Sudan, Suriname, Swaziland; Switzerland, Syria, Tajikistan, Tanzania, Thailand, Togo, Tonga, Trinidad, Turkey, Tuvalu, Uganda, Ukraine, United Arab Emirates, Uruguay, Uzbekistan, Vanuatu, Vietnam, West Sahara, West Samoa, Yemen, and Zambia. **Law with little or no implementation:** Argentina, Bahamas, Belarus, Brazil, China, Congo Republic, Dominican Republic, France, Greece, Israel, Italy, Jordan, Latvia, Malta, Mongolia, Niger, Norway, Philippines, South Korea, San Marino, Serbia-Montenegro, Slovak Republic, Slovenia, South Africa, Spain, Taiwan, Turkmenistan, Venezuela, and Zimbabwe. **Law with more extensive implementation:** Andorra, Australia, Bahrain, Belgium, Canada, Denmark, Finland, Germany, Iceland, Monaco, Nauru, Netherlands, New Zealand, Portugal, Singapore, Sweden, Tunisia, UK-Ireland, and USA.

47. W Drozdiak, 'Rich, Poor Meet at Summit, and Go Their Separate Ways' (12 March 1995) *Washington Post* A14.
48. JH Noble and FL Ahearn, 'Critical Assumptions in Providing Aid to Forced and Voluntary Migrants in Managua, Nicaragua' (2001) *Journal of Social Work Research and Evaluation* 2/2, 125–141; G Soros, *On Globalization* (New York: Public Affairs, 2002); JE Stiglitz, 'Argentina, Shortchanged: Why the Nation that Followed the Rules Fell to Pieces' (12 May 2002) *Washington Post, Outlook* B1, B5; JE Stiglitz, 'A Fair Deal for the World' (23 May 2002) *New York Review of Books* available at http://www.nybooks.com/articles/15403 (last viewed 14 May 2002).
49. G Soros, *Open Society: Reforming Global Capitalism* (New York: Public Affairs, 2000).
50. Stiglitz (n 48 above); see also JE Stiglitz, *Globalization and Its Discontents* (New York: Norton, 2002).
51. Soros (n 49 above).
52. US Department of State (n 19 above) Preface, 4.
53. The major authorities for grant and concessional credit food aid are the Agricultural Trade Development and Assistance Act of 1954 as amended (PL 480), the Food for Progress Act of 1985, and s 416(b) of the Agricultural Act of 1949. Amendments to these authorities are contained in Title XV of the Food, Agriculture, Conservation, and Trade Act of 1990 (FACT Act). Title II of PL 480 provides for donation of US agricultural commodities to meet humanitarian food needs in foreign countries. Title III provides for government-to-government grants to support long-term economic development in least developed countries. Donated commodities are sold on the domestic market in the recipient countries

and the revenue generated from these sales is used to support programs of economic development.

54. eg, the Country Reports noted that '[h]andicapped persons, other than war veterans, are reportedly not allowed within the city limits of Pyongyang (North Korea)...[and that] authorities check every 2 to 3 years in the capital for persons with deformities and relocate them to special facilities in the countryside'. Similarly, the Country Reports concluded that 'misdiagnosis, inadequate medical care, pariah status, and abandonment remain the norm for China's disabled population'.

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0-19-826779-7 June 2003 £100.00 Hardback 576 pp
0-19-926451-1 June 2003 £35.00 Paperback 576pp

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